

The Regents of the University of California

HEALTH SERVICES COMMITTEE

August 14, 2018

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

Members present: Regents Blum, Lansing, Makarechian, Sherman, and Zettel; Ex officio members Kieffer and Napolitano; Executive Vice President Stobo; Advisory members Goldfarb, Hetts, and Lipstein

In attendance: Regent Graves, Regent-designate Weddle, Faculty Representative White, Secretary and Chief of Staff Shaw, General Counsel Robinson, Executive Vice President and Chief Operating Officer Nava, and Vice President Duckett

The meeting convened at 12:45 p.m. with Committee Chair Lansing presiding.

1. PUBLIC COMMENT

- A. Ms. Jamie Kennerk, a UCLA student, stated that there had been insufficient notice of this meeting. She suggested that interested parties, such as the UC Student Association (UCSA), could receive online notification. She stated that rape kits were not available on the UCLA campus and that students were forced to go to the Santa Monica hospital site. Mental health services were also not easily accessible for UCLA students, with long wait times for appointments.
- B. Mr. Oran Farkas, a UCLA student, emphasized that the Regents should engage meaningfully with UC students. He requested that more detailed agenda items be posted on the Regents' website and expressed support for American Federation of State, County and Municipal Employees Local 3299, the United Auto Workers, and the professional librarians of University Council-American Federation of Teachers.
- C. Ms. Sharmin Khondaker, a UCLA student, stated that students' access to mental health services was limited to a certain number of clinic visits a year. She emphasized the importance of students' mental health for academic success. The dates and times of Regents meetings must be posted so that students' voices can be heard.
- D. Ms. Emelia Martinez, a UCR student and UCSA representative, stated that students at all campuses should have equal access to mental health services. Students at UC Merced or UC Riverside should not have to wait longer for appointments with counselors than students at UC Berkeley.

- E. Ms. Jenny Ceron, a licensed vocational nurse at UCLA, expressed concern about short-staffing. An insufficient nursing staff results in increased risks for patients. Given that many patients have difficulty walking or memory loss issues, she urged the University to be cautious about outsourcing. Staff hired from outside agencies were not always adequately trained to help these patients. Training these staff members takes extra time.
- F. Ms. Monica Martinez, an employee at the UCLA Medical Center, urged the University not to create situations of short-staffing that are dangerous for patients. All medical center departments should be staffed with career employees. According to news media reports, UC deals with contractors that deal with U.S. Immigration and Customs Enforcement (ICE). She stated that ICE contractors pay poverty wages and urged the University to end contracting out.

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

Upon motion duly made and seconded, the minutes of the meeting of June 5, 2018 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 on hospital rankings issued by *U.S. News and World Report*. In the State of California, all five UC medical centers ranked in the top 11. Three UC hospitals were ranked as number one in their service areas, with UCSF ranked number one in California and UCLA number two. In national rankings, among public hospitals, UCSF was second in the nation, and UCLA third. The top four hospitals in the national rankings were all private hospitals – the Mayo Clinic, Cleveland Clinic, Johns Hopkins Hospital, and Massachusetts General Hospitals. The University of Michigan Hospitals ranked fifth, and UCSF and UCLA were ranked sixth and seventh, respectively. This was cause for applause and congratulations. In response to a question by Regent Blum, Dr. Stobo stated that Stanford Health Care ranked number nine nationally.

Dr. Stobo presented a chart showing the fiscal year 2018 May year-to-date financial summary. The financial positions of all medical centers but one had improved over the previous fiscal year. All the medical centers except UC San Diego had more than 60 days' cash on hand, but UCSD would finish the year with more than 60 days. All the medical centers had a debt service coverage ratio greater than three. The medical centers were doing well financially in spite of pressures on hospital reimbursements.

Dr. Stobo then presented another chart showing the impact of the Leveraging Scale for Value initiative, with medical supply expenditures, not including pharmacy expenditures, adjusted for the number of discharges and the severity of discharges. The intervention of this initiative had changed the cost curve of actual versus projected expenditures. Dr. Stobo

stressed that without this initiative, the medical centers' cash flow would not be as favorable as it was currently.

4. **UPDATE ON STUDENT HEALTH AND COUNSELING AND UC STUDENT HEALTH INSURANCE PLAN**

[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.]

Medical Director Brad Buchman began the discussion with a general observation that the University's student health and counseling programs enjoy success in several key areas, although not without overcoming difficulties. Much of the success was due to effective partnerships with Student Affairs and the Office of Risk Services at the Office of the President, with campus administrators, and with students who participate in student health advisory committees.

Dr. Buchman recalled that in November 2014, the Regents approved the Long-Term Stability Plan for Tuition and Financial Aid, which included a five percent annual increase in the Student Services Fee for the years 2015-16 through 2019-20, with fifty percent of the increase dedicated to the hiring of mental health providers. The University was now in the fourth year of this initiative. The University had now hired 80 percent of the approved full-time equivalent (FTE) positions in this initiative. The State had agreed to cover the cost of the anticipated fee increase for the following year, but this would be one-time funding. It is difficult for the University to hire new providers when funding can be guaranteed for only one year. Fifteen counselor and three psychiatrist positions remained to be hired. Challenges in hiring included the cost of living, the need to be able to offer competitive salaries, and open labor negotiations. A positive development was that UC had completed almost 90 percent of targeted diversity hires, and had hired counselors with special expertise in trauma-informed counseling, veterans' issues, and issues for first-generation students.

The University is able to measure student access to mental health services on campus. Dr. Buchman stated that he was pleased to report that as in the prior year, students' ability to access services for urgent needs remained excellent, while access remained good for routine appointments. He presented a chart with accessibility rates. For students with urgent needs, the University's goal is to try and see them in one to two days. In academic year 2017-18, 96 percent of students with urgent requests were seen within two days. On average, these students are contacted the same day. The 96 percent rate was a one-percent decrease from the previous year, but still indicated a reasonably good response. The University reaches 99 percent of these students within a week. For routine counseling issues, the University tries to see students within two weeks. This year, as in the prior year, 77 percent of these students had received an appointment within two weeks. This was noteworthy in the context of systemwide enrollment growth of three percent over each of the past three years. There had been an 11 percent increase in the number of counseling visits offered systemwide, and a 17 percent increase in the number of psychiatry visits. Dr. Buchman stated his view that the University was maintaining a very good level of

accessibility for routine counseling issues. The University tries to schedule follow-up visits, when clinically necessary, within two weeks. In the current year, 58 percent of these students had been seen within this two-week interval, a decrease of five percent compared to the prior year. Dr. Buchman attributed this to enrollment growth and emphasized that it was difficult to keep pace with increasing demand. The University was examining other ways to meet student needs, such as internet-assisted counseling, text messaging, telepsychiatry, and telebehavioral health programs. The statistics for student access to routine psychiatry appointments were not quite as good as those for counseling. In the past year, somewhat more than 60 percent of students received their first appointment within two weeks; this far exceeded psychiatric appointment availability outside the University. This percentage also represented a decrease of about five percent compared to previous years. For follow-up appointments, about one-third of these students were seen within two weeks. Follow-up visits within that time are not always clinically necessary. Dr. Buchman expressed concern that a funding interruption would inhibit the University's ability to correct what was a small degree of falling behind on providing services.

Dr. Buchman then reported on audits of UC student health and counseling programs. There is an annual audit, and in 2017 an audit by the Office of Risk Services examined all peer review policies at UC student health and counseling centers. The audit found that peer review was taking place everywhere, and that some policies could be improved, such as policies on reporting practices and procedures, and ensuring that fair hearing rights are extended to providers who are under review. A systemwide policy on this was being developed and was currently under review by health services counsel at the medical centers. Another audit, on professional boundaries, had begun in June 2017, carried out by Praesidium, an organization that is a leader in the boundaries evaluation field. Praesidium had been conducting two-day site assessment visits at student health and counseling centers, evaluating policies and procedures, availability of literature and notices provided to students about their rights, and reporting procedures. Following these visits, Praesidium would provide feedback to clinic directors and very focused instruction for clinic providers. Praesidium had reviewed about half of the centers and initial reports were favorable. Praesidium found some challenges and opportunities to increase awareness, as in other healthcare settings. Some staff members feel that the issue of professional boundaries is only a medical center problem, while in fact it is a problem in counseling centers, and some policies and procedures could be strengthened. Dr. Buchman anticipated that this audit would be completed in the next academic year.

The University was in the final phase of implementation of the UC Immunization Policy, which was based on current California Department of Public Health recommendations. The policy includes a process to allow for medical exemptions. Beginning this fall, the University would place enrollment holds on students who were not compliant with the policy. UC would also give each incoming student a one-term grace period, a quarter or semester to catch up with required immunizations. Implementation of these compliance measures had required significant work with electronic medical records and campus registrars.

Dr. Buchman then reported on the UC Student Health Insurance Plan (UC SHIP), a self-funded, systemwide insurance program jointly operated by UC Health and Risk Services. UC SHIP was enjoying good financial performance and had recruited two campuses back to the Plan this year, so that nine out of ten campuses would be participating next year. For each of the past two years, premiums for students had increased between zero and one percent. UC SHIP had an accounting balance reserve of approximately \$56 million. The executive oversight board had charged a UC SHIP reserve fund investment committee to examine how these reserves might be used to benefit enrollees. UC SHIP has continued to reach out to the California Department of Health Care Services and the State Legislature on behalf of Medi-Cal enrolled students. The University was working to coordinate and provide easy access to care for students who have coverage through Medi-Cal, and it has approached these entities with a proposal that they consider premium assistance in lieu of Medi-Cal, so that UC could easily provide on-campus services as well as referrals to its network.

Dr. Buchman recalled that Regents Policy 3401, the Policy on Student Health and Counseling Centers, had been adopted in 2012. This policy established basic minimums for student health and counseling related to governance, credentialing, use of a single electronic medical records system, and annual audits. Many deficiencies noted in 2011-12 had been addressed through compliance with this policy, and through ongoing collaborative efforts by student health and counseling directors, staff, and partners at the Office of the President. Dr. Buchman noted that this policy would need to be revised in the future and provided some reasons. More than one of the UC medical centers were interested in working with the student health and counseling centers to move the centers' records to the Epic electronic medical records system. This would be a departure from current policy, which requires that all student health and counseling centers use the same medical records system. There might be good reasons to move to the Epic system, and in that case the policy would have to be amended.

Over the past year, the student health and counseling centers had been working to establish a centralized peer review body that would include all care providers. This would result in greater confidentiality, better protect the University, and allow for better objective evaluation of providers. Dr. Buchman stated that he and his colleagues would like to formalize the establishment of this body and some associated risk management roles, and this would also require a policy revision. He suggested that the University consider transitioning Regents Policy 3401 from being a Regents Policy to a Presidential Policy, retaining the core principles established in 2012, but streamlining the process for ongoing amendments and revisions. Dr. Buchman concluded that the University's student health and counseling programs were working to improve the services offered to students, and the accessibility and impact of those services.

Executive Director Stobo recalled that in 2013-14, due to an untoward event at the student health center at UCLA and a \$70 million deficit in UC SHIP, there was a change in the oversight of these two programs. The oversight of the student health centers was moved to UC Health, while oversight of UC SHIP was then shared by UC Health for medical oversight and the Office of Risk Services for operational and financial oversight. Dr. Stobo

stated his view that these changes in oversight had been successful. An outside audit in 2013-14 resulted in a very critical review of UC student health centers; subsequent audits have shown remarkable progress. Within two years, UC SHIP went from a \$70 million deficit to a positive financial position, with a \$56 million functional reserve as well as funding a public health reserve and a premium stabilization reserve. In 2013-14, the campuses were given the option of leaving UC SHIP, and half the campuses left. Currently, all the campuses except for UC Berkeley were participating in UC SHIP. Dr. Stobo anticipated that UC Berkeley would likely not join UC SHIP, as it is a large campus and could remain self-insured on its own. He credited the success of UC SHIP to the participation of students on its oversight board; students had demonstrated remarkable fiduciary responsibility.

Regent Makarechian asked what the UC SHIP reserve was used for, and if premiums would be reduced. Dr. Buchman responded that the University was exploring possibilities for use of the reserve funds, including short- and long-term investments that would generate a certain amount of interest and annuities. These funds would only be used for UC SHIP enrollees. There had been discussion of buying down premiums, but this idea had been tempered with the consideration that each year that one buys down premiums, one underfunds claims for that year, with a risk of an increase the following year. UC was examining programs that students might use to reduce rates of illness and potential need for services; it was most likely that a combination of programs would be implemented. These decisions would be made by the executive oversight board, by students on that board, and by directors of the student health and counseling centers.

Regent Makarechian asked about figures for wait times presented earlier, and if wait times were much longer at some campuses than at others. Dr. Buchman responded that the numbers presented were systemwide averages, and that there was variation among the campuses, but these numbers were objective. Regent Makarechian asked which campuses performed best and worst in terms of student wait times. Dr. Buchman responded that he did not recall which campuses these were. Regent Makarechian raised the issue of student suicide and the importance of responding quickly to student needs. Dr. Buchman responded that suicide is a very serious concern for every campus and that he could provide these data. He emphasized that the University was doing all it could to address urgent student needs and see anyone in distress immediately. Regent Makarechian observed that averages sometimes do not tell the whole story.

In response to a question by Advisory member Hetts, Dr. Buchman stated that the student health and counseling centers use the Point and Click electronic health record system. The primary users of this system are university and college health entities. Some campuses have tried to interface with Epic records at the medical centers, but the reverse had not yet been developed; medical centers could not look into Point and Click records. It would be desirable to have all student health and counseling centers using the Epic system. There would be a cost associated with this, and the medical centers differ in their capacity to assist with this effort. Dr. Buchman anticipated that Epic would eventually be implemented, noting that this would be a significant undertaking and would take some time.

Dr. Hetts asked how often UC students seek care at UC medical centers. UC San Diego Health Chief Executive Officer Patricia Maysent noted that UCSD was in the process of building out an instance of Epic in its student health center. This would allow for continuity of care when students seek care at the medical center. Dr. Buchman responded that there was one set of data that reflected care provided for UC students at the medical centers: UC SHIP receives monthly utilization data including claims for inpatient care, for outpatient specialty care at the medical centers, and care by other in-network providers. For student health and counseling centers located near medical centers, like UCSD and UCLA, the medical centers handle a large portion of the care outside the student health centers. The UCLA and UCSD medical centers provide up to 50 percent or more of this care. For campuses where the student health center is farther from a medical center, this capture rate would be lower.

UCLA School of Medicine Dean Kelsey Martin drew attention to a depression screening program for incoming undergraduates at UCLA. The School of Medicine had partnered with the campus to create an additional behavioral health/psychological well-being program. She noted that 30 percent of UCLA medical students seek behavioral health care, a significant number. Dr. Buchman remarked that among the general student population, ten years earlier, about nine percent of enrolled students sought mental health services; currently about 14 percent did.

Regent Sherman observed that demand for mental health services had grown as enrollment had grown. He asked if the demand per capita had also grown, and if so, why. Dr. Buchman responded that after correcting for enrollment growth, there was still an escalating demand for services. The situation of students was currently very different than it had been ten to 15 years prior. Competitive pressures had increased, and socialization was also a factor. The most common mental health diagnoses were anxiety and depression. This was a national and a generational issue.

Regent Sherman suggested that wellness programs deployed at UCLA could be instituted at all campuses.

UC Riverside School of Medicine Dean Deborah Deas suggested that the trends mentioned by Dr. Buchman might not necessarily indicate a change in the student population, with more anxiety and depression, but result from the fact that mental health issues were less stigmatized than they had been in the past. Many accrediting bodies and university administrators have put an emphasis on wellness programs and mental health, and students were responding to this.

President Napolitano asked how a determination is made that a student has an urgent mental health need. Dr. Buchman responded that the first step is self-reporting. In the initial discussion with the student some assessment is made. Most students with an urgent need are seen the same day.

President Napolitano asked if the initial outreach by students typically takes place by telephone or online. Dr. Buchman responded that most student health centers try to handle

this load by setting aside one or more clinicians per day for telephone consultations and assessments. President Napolitano asked how many hours a day this service is available to students. Dr. Buchman responded that a number of overlapping mechanisms were at work. During the day staff are available, and some campuses have extended hours into the evening. Each campus has an on-call service, and mental health counseling is available by phone. Pilot programs of telemedicine and telepsychiatry would be offered at five or six campuses in the fall, and another pilot program was a crisis text messaging service through campus websites. President Napolitano asked how students find out about these services. Dr. Buchman responded that this information is found on student health and counseling center websites, usually on the first or front page, and can be quickly located.

Regent Zettel asked if this service was like a suicide hotline. Dr. Buchman responded that these counselors provide a variety of services to address this and less acute needs. Students have access to counselors 24 hours a day and seven days a week; these counselors are not always UC staff. Most campuses have a counselor on backup duty, so that the outside counseling staff can follow up with the campus counselor.

Committee Chair Lansing referred to remarks made by a speaker during the earlier public comment period and asked if rape kits are available on the UCLA campus. Dr. Buchman responded in the affirmative.

5. AMENDMENTS TO THE CLINICAL ENTERPRISE MANAGEMENT RECOGNITION PLAN

The President of the University recommended that the Health Services Committee approve the amendments to the Clinical Enterprise Management Recognition Plan as shown in Attachment 1, the plan document for the 2018-19 plan year.

[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 briefly recalled the purpose and membership of the Clinical Enterprise Management Recognition Plan (CEMRP), which provides performance-based, at-risk compensation to UC Health employees responsible for achieving key clinical objectives. Vice President Duckett outlined some of the financial and non-financial goals and objectives rewarded under CEMRP. There is no payout if assigned objectives are not met.

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

6. UC OFFICE OF THE PRESIDENT RESTRUCTURING EFFORT: UC HEALTH ADVISORY COMMITTEE UPDATE

[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.]

Advisory member Lipstein outlined the UC Health Advisory Committee membership. This Committee had been charged with reviewing the UC Health division at the Office of the President (UCOP), identifying difficulties facing the division, and advising President Napolitano on recommendations made in a report by Huron Consulting about restructuring UCOP. Huron had presented options regarding the location and funding of the division, and whether the division should continue to have responsibility for self-funded health insurance plans and for student health and counseling.

The UC Health division was a relatively small component of UCOP, with an operating budget of about \$20 million. Approximately \$4 million of this budget came from State General Funds, \$4 million from administrative fees provided by the self-funded health insurance plans, and \$12 million, or 60 percent, was provided directly by the medical centers. Mr. Lipstein drew attention to those activities funded by medical centers, which would be the crux of one of the major recommendations of the UC Health Advisory Committee. These are activities that directly support the clinical enterprise, and activities that must have the ability to grow, respond, and adapt as the clinical enterprise grows. The Committee was keenly interested in the growth of the clinical enterprise since the passage of the Affordable Care Act (ACA), when many more people had access to health insurance than previously. There had been a nine percent growth in clinical enterprise revenue since passage of the ACA. Some members of the Committee did not see this as a dramatic development; in their view, it might reflect a price increase or a volume increase, but did not necessarily mean that the delivery system was growing. The Committee subsequently examined medical center staffing and found that it was growing at twice the rate of staff in the rest of the University. If this trend continued, within 15 years, medical center revenue, defined as the revenues that go to the hospitals and the physician practice plans, would exceed all other sources of UC revenue combined. The Regents should anticipate and plan for a time when half or more of the University's revenues might come from the delivery of healthcare services.

Committee Chair Lansing stressed the importance to the Regents of understanding that 48 percent of UC revenues currently came from the medical centers. The growth of this revenue, compared to ten years earlier, was quite extraordinary. Mr. Lipstein clarified that the 48 percent figure included funding for biomedical research and noted that one should consider not only past growth of the clinical enterprise, but the strategic imperative to grow in the future. The UC clinical enterprise would want to grow as the population grew, aged, and demanded more healthcare services. Given the recognized quality of UC hospitals as shown in the rankings cited by Executive Vice President Stobo earlier, people would seek out UC services in increasing numbers. The UC Health division would want to respond to this growth, and this would lead to problems that must be addressed.

Committee Chair Lansing recalled that about 15 years earlier the medical centers had been a burden to the University. Their growth was extraordinary. The hospitals were now a treasure for the State of California and the nation, and this must be maintained.

Mr. Lipstein remarked that UC Health did not have a diverse revenue base. Most of its revenue came from the federal government or private health insurance payers. Government

payers would come under increasing financial pressure. Unless the Medicare payroll tax were increased, or unless Medicare benefits were changed, the U.S. would begin deficit spending out of the Medicare trust fund in the 2020s. In this context, UC Health would want to consolidate in order to achieve maximum efficiencies associated with economies of scale. UC Health would want a large patient population to diversify and disperse risk. By spreading fixed costs over a larger patient base of activity, UC Health had been able to bend the cost curve in certain areas. Health systems that are able to realize economies of scale and continue to produce necessary cash flows are able to distinguish themselves along dimensions of clinical quality and service quality, and these health systems would be the winners and attract talent. UC Health would not remain a winner unless the University and the Regents provided the clinical enterprise and its leadership with flexibility, agility, and the tools to respond to a rapidly changing environment.

Against this backdrop, the UC Health Advisory Committee considered a number of issues. The 2017 State audit of UCOP and the State Budget Acts of 2017 and 2018 had placed limits on the UCOP budget and headcount. UCOP was resourced and staffed to be the leadership group of the University, but not resourced and staffed to respond to needs in the healthcare realm. In studying how these differences might be resolved, the Committee considered the Major Projects and Initiatives process, led by Associate Vice President Zoanne Nelson. The process has a relatively low threshold for requiring approval that might be inconsistent with the needs of a healthcare enterprise. Mr. Lipstein noted that the next Executive Vice President – UC Health, Dr. Stobo's successor, was likely currently in a position with signature authority much higher than \$100,000. This individual would come to the position with experience of approving projects and initiatives at a higher monetary level of authority. Another point considered by the Committee was the job classification system used at UCOP, and the question of whether these classifications include a combination of skills that reflects the healthcare job marketplace.

The Committee sought input from a variety of stakeholders and advice from subject matter experts, and this reaffirmed certain guiding principles. One principle was collaboration, helping the campuses and medical centers achieve collaboratively what they could not achieve independently. Another was the wish to derive the maximum benefits from working as a system while still respecting local control. Stakeholders indicated that they wished to maintain their current responsibilities and authorities, but within that context, all of them were advocates for greater transparency and accountability. Another guiding principle was a focus on the future state of UC Health in a changing environment.

Regent Sherman underscored the significant amount that the UC medical centers provide to support medical education, in the hundreds of millions of dollars. This was a by-product of being structured in an appropriate way. Dr. Stobo stated that these expenditures for medical education amounted to approximately \$400 million to \$450 million annually. Mr. Lipstein observed that in many universities, this amount of support is not a transparent number. However, this is a very important number, and leaders of the academic enterprise, the chancellors, executive vice chancellors, and deans, understand that the flow of funds from their clinical enterprises has become a critical component of fulfilling their educational and research mission.

Mr. Lipstein then discussed the UC Health Advisory Committee's recommendations. The Committee had been asked to consider whether the UC Health division should remain within UCOP; the Committee's recommendation was that UC Health remain within UCOP. The Committee wanted UC Health to be able to take advantage of already existing governance and management infrastructure. Consideration of the alternative, moving the UC Health division out of UCOP, raised questions of who would control, govern, oversee, and influence UC Health, and what system of checks and balances there would be.

The Committee's second recommendation was to disaggregate UC Health division activities into two groups or units. One group would comprise activities funded with State General Funds, or with administrative fees from the self-funded health plans. The second group would comprise those activities funded 100 percent by the medical centers, and the Committee was recommending that these monies and staff be excluded from current operating and budget constraints imposed on UCOP. All activities of the UC Health division would still be subject to the UC Health strategic plan, and there would be no change in the oversight of UC Health. The division would continue to report to the Executive Vice President – UC Health, who would report to the President. The Committee was not recommending any changes to the responsibilities, roles, or authorities of the Board of Regents, the Health Services Committee, or UCOP. The Committee had named the second group or entity, the activities funded by the medical centers, the "UC Health Care Collaborative." This name reflected that fact that this entity's activities were collaborative initiatives of the medical centers undertaken largely for the benefit of the medical centers. This was the area of the UC Health division budget that should not, in the Committee's view, be subject to the budget and headcount constraints that had been placed on UCOP. These activities would need to increase commensurate with the strategic imperative to grow the clinical enterprise. The UC Health Care Collaborative would be guided by the UC Health strategic plan and there would be no changes in reporting. Mr. Lipstein noted that the Committee had explored the idea of moving the UC Health Care Collaborative activities out of UCOP, into a separate location or management services unit, but found that this had raised more questions about the governance of this unit than about its growth and development.

The third and fourth recommendations were that there be no changes to the existing governance or structure of UC Health. The fifth and sixth recommendations concerned improved transparency and accountability. Mr. Lipstein drew attention to the following language from the summary of the fifth recommendation: "More frequent, structured, and systematic involvement of the chancellors in policy development, strategy formulation and funding decisions should be developed and implemented." He stressed that the chancellors are a key constituency who, with an understanding of the dynamics inside the healthcare industry, can support UC Health and its activities. The sixth recommendation was extracted from the UC Health strategic plan. UC Health would have to determine which positions and budget would be funded by State General Funds or the administrative fees mentioned earlier, and which would be funded by the medical centers. This would be an important step for transparency and accountability. The campuses would know what they are funding and what they can expect to receive from UC Health. The seventh recommendation was that UC Health functions and activities in the first group, funded by the UCOP core

operating budget (State General Funds) and by fees charged to the self-funded health plans, would remain within the UC Health division of UCOP and would continue to be subject to the same policies, processes, and budget and headcount constraints that apply to all other UCOP divisions.

The next three recommendations pertained to improved operational effectiveness. The eighth recommendation was to consider raising the threshold for projects that are subject to the Major Projects and Initiatives process to a level above \$300,000. The Committee did not wish to establish a different set of rules for the UC Health division than for other UCOP divisions, but acknowledged that UC Health has a need for greater flexibility and adaptability for entering into consulting and information technology contracts that might be above the \$300,000 level. The two further recommendations pertained to challenges that UC Health encounters with job descriptions in the UCOP library of job standards under the Career Tracks system. There was an urgent need for action on this point. There were currently over 25 vacancies in the UC Health division. Until it was possible to modify the UCOP job standards, the Committee recommended, as its ninth recommendation, that UC Health make use of the Career Tracks system already in use at UCSF. The tenth recommendation concerned the dedicated healthcare recruiter recently hired by UCOP Human Resources to fill the 25 vacancies. The Committee recommended that by the end of the 2018-19 academic year, the Executive Vice President – UC Health and the Executive Vice President and Chief Operating Officer should evaluate the effectiveness of this new recruiter and report their findings and conclusions to the President.

Mr. Lipstein then outlined the final three recommendations. In its 11th recommendation, the Committee recommended that if UC Health remained within UCOP, UC Health should retain its current role as administrator of the self-funded health plans; there was no compelling reason to change this responsibility. The 12th recommendation was that the student health and counseling function and the UC Student Health Insurance Plan continue to report to the UC Health division. The final, 13th recommendation was based on concerns expressed by leaders of counseling and psychological services units within the student health and counseling centers. There is a medical management approach to behavioral and mental health issues and a psychological approach, and there has always been a tension between the two. In order for UC Health to gain a better understanding of this tension, the Committee recommended “listening and learning sessions” with participation by counseling and psychological services leadership, chancellors, and UC Health and other UCOP representatives. The increasing student demand for counseling services was an issue for other universities as well. The listening and learning sessions among various leaders would facilitate development of a coherent, systemic response and a strategic plan. Mr. Lipstein concluded with a brief outline of next steps, including feedback, further review by the President and the Health Services Committee, and presentation to the full Board.

Committee Chair Lansing praised the UC Health Advisory Committee’s recommendations for offering a straightforward solution and providing additional leeway for UC Health.

Regent Sherman noted that the Committee had wrestled with the Huron recommendation to make UC Health a separate entity. The Committee wanted to avoid creating another bureaucracy and instead favored a simple solution with accountability. The activities of the UC Health Care Collaborative would be reported to the Health Services Committee; there would be transparency.

Chair Kieffer stressed that no matter what pressures might be put on the University at this or another moment, UC would be faced with the question of how to structure its organization in the future to give UC Health the flexibility it needs to operate in the market. The pressures on UC at any given moment were not as important as the long-term view. Mr. Lipstein observed that the UC Health Advisory Committee felt that it was unfortunate that its discussions were set against the backdrop of the State audit of UCOP. Even without the State audit, all the factors identified by the Committee in its report presented a compelling case for some degree of change.

Chair Kieffer stated his view that the proposed changes for UC Health were not a reaction to the Legislature but to a changing environment. He requested that there be a discussion item on the recommendations of the UC Health Advisory Committee at the September meeting. The presentation should provide a context and overview of UC Health for new members of the Board.

Dr. Stobo recalled that the University had commissioned a report by the RAND Corporation in 2015 to recommend an optimal governance structure for UC Health. Since then, UC had received the recommendations of the Huron report and was responding to the State audit. Regardless of these particular events, it was the changing environment overall that was causing stresses for the UC Health division, and these stresses needed to be addressed. Chair Kieffer noted that these same pressures had led to the current form of the Health Services Committee. Other universities with health systems were responding to the current environment in various ways, and it would be helpful to be mindful of what was taking place at other institutions.

Regent Zettel referred to the UC Health Advisory Committee's recommendation that chancellors be more involved in decision-making, and asked how this was related to flexibility and agility. Mr. Lipstein responded that the medical centers have a reporting relationship to the executive vice chancellors and chancellors. The Executive Vice President – UC Health works collaboratively with the leadership of the medical centers. The Committee's view was that including the chancellors in this group would increase their comfort with allowing the flexibility and agility that the medical centers need, and would bring greater transparency to the UC Health budget and strategic plan. The healthcare enterprise is strategically important, one of the most valuable assets of the University, and chancellors wish to participate in UC Health's strategic direction and have an understanding of its operations.

UCLA School of Medicine Dean Kelsey Martin remarked that by having a close relationship with the campuses, the medical centers can accentuate their unique status as

academic health centers, with access to current scholarship that looks forward to new medical technology, computational medicine, and other new approaches.

Regent Blum reflected on possible major disruptions that could affect UC Health in the future. The United States was spending too much of its budget on health care, and it would be necessary to find out how to provide health care on a much cheaper basis. UC Health might not be able to continue doing business as it has been.

Regent Lansing noted that one alternative model, “concierge medicine,” was not cost-effective. She expressed concern that providers would do less for patients, such as ordering fewer cancer therapy sessions, in trying to reduce the cost of care.

Regent Blum clarified that he was concerned about possible future actions by government and how this would affect UC Health. The University must be mindful of changing circumstances.

Regent Sherman responded that this was precisely the reason for the current discussion and the proposed restructuring. It was clear that healthcare delivery would change and that there would be disruptions. UC Health would need to act collaboratively as a system in order to be able to compete.

President Napolitano thanked Mr. Lipstein and the UC Health Advisory Committee members for accomplishing a significant amount of work in a compressed period of time and producing a constructive set of recommendations.

7. **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.]

UCLA Health Chief Medical and Quality Officer Robert Cherry presented clinical quality dashboard information for the UC medical centers. He drew attention to the fact that UC Health’s indicator for excess bed days had incorporated a new risk-adjusted model from Vizient, and this would change baseline data. There had been some changes in targets for Public Hospital Redesign and Incentives in Medi-Cal (PRIME) ambulatory quality measures; this would add some complexity to the discussion, but was in line with federal and State government interpretation of the targets.

Dr. Cherry presented an executive summary chart of inpatient quality measures, noting that for all the measures shown, the UC medical centers’ performance was better than the national benchmark, which is based on academic medical centers in the Vizient dashboard. Inpatient mortality had been a subject of discussion at a recent meeting of UC Health chief medical officers and chief nursing officers. Many of these officers try to carry out “real time” mortality reviews. At UCLA, departments try to meet within 48 to 72 hours following a patient death to discuss the event, understand why it occurred, and determine

what could be learned from it. It can be difficult to gather busy clinicians, and UCSF had developed a real time mortality review using an electronic survey process. This was a promising new approach and would be reviewed over the coming months. Real time reviews are a valuable opportunity to gather information when clinicians' memories are fresh. UC San Diego and UCSF were making additional efforts to improve coding, and UCSF in particular for its transfer patients. Dr. Cherry noted that there had been recent improvements in the observed-to-expected mortality ratio at the UCLA Medical Center and the Santa Monica hospital. He attributed this to use of predictive analytics and rapid response teams.

UC Health was performing better than its national comparators in 30-day readmission rates. UC Irvine was the best performer, and for the first time, UCLA Medical Center and the Santa Monica hospital were beating California state averages. UC San Diego was successfully reducing readmissions of patients with chronic obstructive pulmonary disease. Many collaborative efforts were being made to reduce readmission rates by identifying vulnerable populations, emphasizing care coordination efforts and the transition of care from the hospital to the home, ensuring that patients receive home health care, rehabilitation services, and skilled nursing if this is needed after discharge.

All five hospitals except the UCLA Medical Center had lower rates for central line-associated bloodstream infections (CLABSI) than the benchmark, and the UCLA Medical Center was showing a downward trend. For the first three months of the year, the Santa Monica hospital had no infections of this kind. Efforts to reduce CLABSI focus on assessment during daily rounds and attention to vulnerable patient populations, such as hematology and oncology patients.

In Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) patient experience surveys, UC medical centers were performing well. In seeking to improve their HCAHPS scores, the medical centers try to integrate physician and nurse rounds, and ensure that nursing leaders carry out rounds in addition to the bedside nurse. UC hospitals strive for consistency in the questions patients are asked, and how and when they are asked. The medical centers honor the work of their nurses in various ways, including recognition and reward programs.

Dr. Cherry then discussed six-quarter trends. The average number of CLABSI cases was about 42 per quarter, and this number was decreasing. The UCLA Medical Center had around 50 percent of these cases. He underscored that efforts were under way to reduce infections, especially in the pediatric population, and among hematology, oncology, and liver transplant patients. Many liver transplant patients are immunocompromised and thus more susceptible to hospital-acquired infections.

The UC Health aggregate score for the HCAHPS nursing communication criterion had improved from below to above the 50th percentile. Dr. Cherry observed that even small gains, a few tenths of a percent, might represent a significant difference in the patient experience. These gains were due to a collective effort to improve all the domains of patient experience.

The case mix index had not changed very much for the hospitals over the six-quarter period. The case mix index uses coding and documentation to determine severity of patient conditions, and UC medical centers are attentive to coding and documentation to ensure accurate benchmarking.

Dr. Cherry cited low and favorable inpatient mortality statistics from the month of June for the UCLA Medical Center and Santa Monica hospital. UC medical centers had been reducing observed-to-expected mortality ratios in the last months.

It was the general opinion of the chief medical officers and chief nursing officers that all UC medical centers could reduce the rates of hospital-acquired pressure ulcers. UC San Diego had brought very close attention to this problem, focusing especially on heart failure patients and patients with fragile skin, and working to establish good nursing-physician collaboration. UC Irvine was seeking to document the stages of patients' pressure ulcers more accurately, to ensure that patients who are admitted with pressure ulcers are identified correctly, and focusing on patients in intensive care units. There was variation among the medical centers in how this information is collected and reported. UC nurses had formed a collaborative to share best practices and hoped to have a standardized process to implement in the coming months.

There was significant fluctuation in performance over six quarters by the medical centers in catheter-associated urinary tract infections (CAUTI). UCSF, the Santa Monica hospital, and the UCLA and UC Irvine Medical Centers were challenged by what is known as the "over-culturing" of urine samples for some types of patients. The four hospitals mentioned were seeking to adopt practices in place at UC Davis to avoid over-culturing. UC San Diego had the lowest CAUTI rate in the most recent quarter. UCSD had developed a single harm score, incorporated in its incentive program. This harm score might be replicated across UC medical centers.

Significant fluctuations also occurred in CLABSI, in particular at the Santa Monica hospital. Dr. Cherry attributed this to the fact that the volumes at this location are small, and a few numbers can cause a large swing from one quarter to the next. In efforts to reduce CLABSI, UCSF and the UCLA Medical Center were focused on hematology and oncology patients. There had been an increase in CLABSI rates at UC Irvine, and this was related to documentation.

The Vizient database had introduced a new risk model for excess bed days, and UC medical centers were faced with a new and more challenging baseline. Earlier, five or six of the UC medical centers would typically achieve targets for this criterion. For the month of April, the first month of implementation of the new model, three of the six medical centers were on target. Dr. Cherry noted that UC Health had been focused on excess bed days as a clinical goal for three years. During the first two years the opportunities for improvement had been easier to achieve. The chief medical officers and chief nursing officers decided to continue this effort into a third year, although further improvements would be more difficult to accomplish. In order to reduce excess bed days, UCSF and the UCLA Medical Center were engaged with clinical staff to develop pathways to standardize care and create

greater efficiencies in decision-making. An increase in excess bed days at UC Irvine was likely due to the new and more challenging baseline. All UC medical centers were working on improving operational efficiencies in specific areas of the inpatient environment where bottlenecks typically occur – the emergency department, operating room, intensive care units, and discharge planning areas.

Dr. Cherry concluded his presentation with performance statistics for measures from the PRIME pay-for-performance program, which is a State and federal partnership. He explained how achievement of PRIME targets is calculated. Rates for cesarean sections had been improving, with peer review to determine if a cesarean section was medically indicated. Many cases at UC Davis were found to be surgically indicated. UC Irvine was making targeted efforts to control patient blood pressure. UCLA's scores for tobacco assessment and counseling and colorectal cancer screening were slightly below the target, and UCLA was working to improve in these areas.

Advisory member Lipstein expressed concern that UC hospitals might be missing home-acquired pressure ulcers. Home care agencies associated with UC Health might report this information. UC Health should care about pressure ulcers when they are acquired at home, and skin integrity assessments would be one way to capture this factor. Dr. Cherry responded that from the perspective of population health, UC Health wants to reduce patient readmissions for a variety of issues including pressure ulcers. UCLA works with about 60 home health agencies. It was important to communicate expected UC Health standards to these agencies. UC Health was taking a holistic approach to keeping patients well at home.

Regent Makarechian asked about the six-quarter trend shown in one chart for the UCLA Medical Center, indicating a downward trend in inpatient mortality, but a slight recent increase in readmissions. Dr. Cherry attributed the downward trend in mortality rates to a proactive approach to intervention. A clinical surveillance team uses different types of predictive analytics and visits about 25 patients per day, the patients at highest risk. There had been a slight increase in readmission rates in the sixth quarter, but the most recent data again showed a downward trend. The UCLA Medical Center had refreshed its readmissions steering committee, including all stakeholders with an interest in reducing readmissions in order to take a more coordinated approach.

President Napolitano referred to a chart showing 30-day readmission rates and asked about the cause of a sharp increase at UC San Diego indicated for the most recent quarter. Dr. Cherry responded that UCSD was investigating this increase but had not yet determined a cause. When an adverse trend occurs, one looks first at vulnerable patient populations. This appeared to be an overall increase, and UCSD was still searching for the root cause. Committee Chair Lansing asked about month-to-month data. Dr. Cherry responded that one observes swings or fluctuations from month to month. All the UC medical centers were taking measures to reduce patient readmissions, working in the areas of care coordination, access to appointments, innovative strategies in the ambulatory environment, and appropriate discharge to the home environment.

UCSF Health Chief Executive Officer Mark Laret remarked that UC Health only recently began to collect these data in an organized manner. He underscored the importance of the collaboration that was taking place among the medical centers, communication, the sharing of best practices, and consideration of national trends. Dr. Cherry stated that the chief medical officers and chief nursing officers have regular telephone conferences and meetings.

8. **LICENSING INTELLECTUAL PROPERTY FOR UNDERSERVED POPULATIONS**

[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 by noting that the matter to be discussed presented a paradox in the University's public service mission with regard to patenting biomedical intellectual property. This was the case of Xtandi, a Pfizer drug that is useful in the treatment of metastatic and non-metastatic prostate cancer. One of the University's principles is to conduct research that serves the public interest and not only to publish the results, but to translate discoveries into medical treatments that are available to society. This requires a long process and substantial investment, including clinical trials, U.S. Food and Drug Administration (FDA) approval, marketing, and product manufacturing. This exceeds the University's financial resources and goes beyond UC's core mission. While the University maintains patent ownership, it typically enters into licensing agreements with commercial partners to increase the likelihood that research discoveries will result in a treatment available to the public. Licensing proceeds are reinvested in research and educational programs.

The current matter, which concerned the patenting of Xtandi in India, had made it clear that the University's mission to promote access to medications can be both facilitated and hindered by licensing patents to the private sector. UCLA's discovery of enzalutamide is publicly available as a prostate cancer medication, Xtandi, only due to industry investment, but the agreements that made this success possible also obligate UCLA to support the licensee's patent prosecution efforts. In India and elsewhere, patents prevent less expensive generic alternatives from entering the market for a limited period of time in order to allow those who made the investment to obtain a return. Patent rights provide an incentive for private industry to enter into licensing agreements that advance UC's public mission, but these patents in turn limit public access. This raised the question of how to balance these competing interests when crafting a licensing agreement. Dr. Mazziotta expressed UCLA's sympathy for concerns about drug pricing. The University had renewed its commitment to certain licensing guidelines that included the recommendation that underserved populations and developing countries should be considered when UC licenses its discoveries.

Dr. Mazziotta stated that this problem must be resolved at the time of licensing. He then outlined the history of this drug and the background to the current situation, beginning in 1980, with the passage of the Bayh-Dole Act, which allows universities to retain and own

patents for intellectual property developed through federally funded programs. In 2002, two UCLA researchers, Dr. Charles Sawyers and Professor Michael Jung, developed enzalutamide; therefore UC owns the patent. Three years later, this patent was licensed to a start-up company named Medivation, and the University is legally obligated to enforce that patent to the best of its ability. In 2007, UC was one of a number of universities that signed on to a document titled “In the Public Interest: Nine Points to Consider in Licensing Technology,” including a section about taking developing nations and underserved populations into account in the competitive drug manufacturing market. In 2007, Medivation filed for patent protection in India. Two years later, Medivation entered into an agreement with Astellas Pharma to patent the drug globally and filed patents in 50 countries. In 2010, the U.S. patent for enzalutamide was awarded to Medivation. In 2012, the University updated its licensing guidelines with recommendations about taking into account the needs of underserved populations.

In 2016, Pfizer acquired Medivation and all its patent rights. In the same year, India rejected the patent application for the drug, and UCLA monetized royalties from the drug. UCLA sold the royalty rights, valued at \$1.14 billion, to a company named Royalty Pharma. UCLA received \$520 million, which was invested and would pay out over ten years. Depending on market performance, this investment might produce approximately \$60 million a year for research, scholarships, and fellowships. Also in 2016, Pfizer asked the Supreme Court of India to rehear the case of its patent application, an attempt to reverse the earlier decision.

UCLA heard from advocacy groups because the cost of the patented drug Xtandi in India would be about 40 times the average daily wage. Committee Chair Lansing received a letter from the Union for Affordable Cancer Treatment, and Dr. Mazziotta responded to this letter. UCLA formed a task force to evaluate these issues. The task force was charged with optimizing prosecution of UCLA intellectual property, embracing the document “In the Public Interest: Nine Points to Consider in Licensing Technology,” setting boundary conditions, and producing guidelines for licensing. In its report, the task force recommended that UCLA include provisions in future licensing agreements that provide for discounted pricing to underserved populations and developing countries, and establish a fund at UCLA with drug licensing royalty revenues to help subsidize the cost of drugs for those populations, with the expectation that the licensee would match these funds. The task force guidelines were accepted by the Chancellor. In the course of implementation, UCLA discovered that the Bayh-Dole Act restricts the use of revenue from such patents; they are to be used only for research and education. UCLA was considering ways in which the royalty revenues might replace other funds and the same subsidy could be achieved. In May, Dr. Mazziotta wrote to Pfizer and Astellas Pharma, encouraging them to offer low-cost or no-cost pricing for underserved populations. The Supreme Court of India was scheduled to hear Pfizer’s case on August 16, and was expected to render a decision in the following two to three weeks. Dr. Mazziotta concluded that in licensing drugs or medical devices, the University must keep in the forefront of the negotiations the challenging balance of ensuring that the benefit of a discovery is available to all while not removing the incentive for a private sector partner.

Regent Zettel asked if the company's investment in developing and marketing the drug had been recovered at this point. Dr. Mazziotta responded that he did not know; Pfizer and other companies would not provide this information. The cost of bringing a drug to market is substantial. The University's share of the revenue stream, based on projected future earnings, would be more than \$1 billion.

Regent Makarechian underscored his preference that UC resources be used for the benefit of UC students. He suggested that the University reexamine its process for licensing patents to start-up companies. Dr. Mazziotta responded that this process reflected the world of drug, antibody, and medical device manufacturing. A discovery is first licensed to a start-up company. With venture capital, the discovery is brought to the point of maturity, and then another entity takes the drug through the FDA approval process. Regarding Regent Makarechian's first comment, Dr. Mazziotta recalled that the UCLA task force had recommended that some small portion of the income to the University could be used to subsidize the cost of drugs if the licensee would match these funds; he noted that UC expected that this would not be a one-to-one match, but a 50-to-one or 100-to-one match. The University must keep the licensee engaged in negotiations to arrive at a deal so that the drug is made. At the same time, the University must demonstrate commitment by contributing some amount of its own royalty revenue when it expects the licensee to make a much greater contribution. This type of negotiated business deal would be different in each case.

Regent Makarechian expressed support for this kind of matching arrangement, with the licensee contributing a multiple of UC's contribution. The University might also appeal to charitable foundations to support this endeavor. If the University decided to pursue this, he suggested that there be significant restrictions on the re-marketing of a drug.

Committee Chair Lansing observed that for every success story, there are many more start-up companies that fail. This was a risky business, and drug companies often invest much money without results. The University had been examining how it invests in this area. President Napolitano confirmed that the University had set aside some funds held by the Chief Investment Officer to invest directly in innovations and inventions that result from UC-related research.

Committee Chair Lansing concluded by underscoring the complexity of this matter and the risky nature of investments in this field. She thanked Dr. Mazziotta and UCLA for their handling of this matter. The public mission of UC, the mission to serve the underserved, and the outstanding research that takes place at UC are an important part of the University's greatness.

The meeting adjourned at 3:25 p.m.

Attest:

Secretary and Chief of Staff

Additions shown by underscoring; deletions shown by strikethrough

**The University of California
Clinical Enterprise Management Recognition Plan (CEMRP)
For Plan Year July 1, ~~2017~~ 2018 through June 30, ~~2018~~ 2019**

1. PLAN PURPOSE

The purpose of the University of California Clinical Enterprise Management Recognition Plan (CEMRP or Plan) is to provide at-risk, variable incentive compensation opportunity to those employees responsible for achieving or exceeding key Clinical Enterprise objectives. Consistent with healthcare industry practices, UC Health Systems use performance-based incentive compensation programs to encourage and reward achievement of specific financial and/or non-financial objectives (e.g., quality of care or patient satisfaction and safety, budget performance) and strategic objectives which relate to the Clinical Enterprise's mission.

The annual Short Term Incentive (STI) component of the Plan provides participants with an opportunity to receive a non-base building cash incentive based on the achievement of specific annual financial, non-financial, and strategic objectives relative to the mission and goals of the UC Health enterprise.

The Long Term Incentive (LTI) component is a non-base building incentive that is intended to encourage and reward top executives of the UC Health enterprise for the achievement of multi-year strategic initiatives, to support and reinforce those results that will promote UC Health and its long-term success, and emphasize the importance of the long-term strategic plan. In addition, the LTI assists in retaining the executive talent needed to achieve multi-year organizational objectives by complementing (but not duplicating) the focus of the rest of the Clinical Enterprise Management Recognition Plan. The Executive Vice President (EVP) – UC Health and the Chief Executive Officers (CEOs) of each of the Health Systems will participate in the LTI.

The overall Plan encourages the teamwork required to meet challenging organizational goals. The Plan also uses individual and/or departmental performance objectives to encourage participants to maximize their personal effort and to demonstrate individual excellence.

2. PLAN OVERSIGHT

Development, governance and interpretation of the Plan will be overseen by an independent Administrative Oversight Committee (AOC) comprised as follows:

- Executive Vice President – Chief Operating Officer
- ~~The~~ Chancellor of every campus with a Health System
- ~~The~~ Vice President, Systemwide Human Resources
- ~~The~~ Executive Director, Systemwide Compensation Programs and Strategy

The AOC, in its deliberations pertaining to the development or revision of the Plan, may consult with the EVP – UC Health, and representatives from the Health Systems. The AOC will abide by

the Political Reform Act, which would prohibit Plan participants from making, participating in making, or influencing decisions that would affect whether they participate in the Plan, the objectives that will govern whether they earn awards under the Plan, and the amount of awards paid to them under the Plan. The Office of General Counsel will be consulted if there are any questions about the application of the Political Reform Act in this context. The Senior Vice President – Chief Compliance and Audit Officer will assure that periodic auditing and monitoring will occur, as appropriate.

3. PLAN APPROVAL

The Plan will be subject to an annual review conducted by the AOC to address design issues and market alignment. The Plan will be implemented each year upon the approval of the AOC if no changes to the Plan are being recommended.

If the AOC recommends any substantive or material changes to the Plan, including, but not limited to, changes in the award opportunity levels, the AOC will obtain the approval of the President and the Regents' ~~Committee on Health Services~~ Committee before implementing such changes. Reasonable efforts, given all circumstances, will be made to delay implementing substantive or material Plan changes until after the end of the current Plan year. However, if changes are implemented during the Plan year that would affect the award calculations, changes will only be applied prospectively to the remaining portion of the Plan year. Plan changes recommended by the AOC that are not material or substantive, or are deemed to be technical corrections, may be approved by the AOC after consultation with the President and will then be implemented by the AOC at an appropriate time. The Regents will receive reports of all changes to the Plan.

4. PLAN YEAR

The CEMRP year will correspond to the University's fiscal year, beginning July 1 and ending the following June 30.

The applicable performance period for CEMRP's LTI component will begin July 1 of the Plan year and end three years later on June 30th.

5. PLAN ADMINISTRATION

The Plan will be administered under the purview of the Executive Director, Systemwide Compensation Programs and Strategy, at the Office of the President, consistent with the Plan features outlined in this document, and as approved by the President and the Regents' ~~Committee on Health Services~~ Committee. The Plan features and provisions outlined in this document will supersede any other Plan summary.

6. ELIGIBILITY TO PARTICIPATE

Eligible participants in CEMRP are defined as the senior leadership of the Clinical Enterprise

who have significant strategic impact and a broad span of control with the ability to effect enterprise-wide change.

Eligibility to participate in CEMRP's LTI component is reserved for those senior executives who are in a position to make a significant impact on the achievement of long-term strategic objectives, specifically the EVP – UC Health and the CEOs at each of the Health Systems.

Plan participation in any one year does not provide any right or guarantee of eligibility or participation in any subsequent year of the Plan.

Plan participants may be added after the Plan year has begun, subject to CEMRP's eligibility requirements and AOC approval.

Participants in this Plan may not participate in any other incentive or recognition plan during the Plan year, including the Health Sciences Compensation Plan, except in the event of a mid-year transfer within the University. Specifically, if a Plan participant is eligible for only a partial year award under this Plan because a mid-year transfer of position renders him or her eligible for Plan participation for only a portion of the Plan year, he or she may participate in a different University plan for the other portion of the Plan year. Concurrent participation in this Plan and another University incentive plan is not permitted.

CEMRP STI participants must have a minimum of six months of service to participate in the Plan and will receive a prorated award in their first year of participation. Similarly, participants who were not working for a significant portion of the Plan year may receive a prorated award in appropriate circumstances, as determined by the AOC. Participants who transfer within the University to a position that would not be eligible for participation in the Plan are eligible to receive a prorated award for that Plan year if they worked in the CEMRP-eligible position for at least six months.

An LTI participant hired or promoted into an LTI-eligible position between July 1 and December 31 of the Plan year will be assigned one or more long-term objective(s) for the three-year period that begins with the Plan year and will be eligible for a prorated LTI incentive opportunity for that period. The prorated LTI award will be determined by dividing the number of complete months employed during that three-year period by the number of months in the full performance period (36 months).

Prior to the beginning of the Plan year, the AOC will approve the Plan's participants and provide the President and the Chair of the Regents' ~~Committee on Health Services~~ Committee with a list of participants for that Plan year, including appropriate detail regarding each participant.

7. AWARD OPPORTUNITY LEVELS

As part of their competitive total cash compensation package, Plan participants are assigned threshold, target and maximum incentive award levels, expressed as a percentage of their base salary. These award opportunity levels serve to motivate and drive individual and team performance toward established objectives. Target awards will be calibrated to expected results while maximum awards will be granted only for superior performance against established

performance standards. Actual awards for any individual participant may not exceed the maximum award opportunity level assigned. Award opportunity levels are determined, in part, based on the participant's level within the organization and the relative scope of responsibilities, impact of decisions, and long-term strategic impact. If a participant changes positions during the Plan year within the same institution (defined as the participant's Health System) and the participant's level within the organization changes based on the table below, the participant's award should be adjusted to take into account the amount of time spent in each position.

CEMRP STI Annual Award Opportunity (as percent of salary)

Position Level within Organization	Threshold Opportunity	Target Opportunity	Maximum Opportunity
EVP – UC Health and Health System Chief Executive Officers	10%	20%	30%
Other “Chief Levels” and Other Key Senior Clinical Enterprise Leadership	7.5%	15%	25%
Other Key Clinical Enterprise Leadership	7.5%	15%	20%

The individuals eligible to participate in CEMRP's LTI component will be assigned one or more long-term performance objective(s) for the three-year period that begins with each new CEMRP Plan year, resulting in overlapping three-year LTI cycles. The LTI Threshold, Target, and Maximum award opportunity for the EVP – UC Health and the CEOs will be 5 percent, 10 percent and 15 percent, respectively, as shown in the chart below. The actual awards will be based on final assessments at the conclusion of the three-year LTI performance period and paid at the same time as the STI awards are paid.

CEMRP LTI Award Opportunity (as percent of salary)

<u>Position Level within Organization</u>	<u>Threshold Opportunity</u>	<u>Target Opportunity</u>	<u>Maximum Opportunity</u>
EVP – UC Health and Health System Chief Executive Officers	5%	10%	15%

8. PERFORMANCE STANDARDS

Each Plan participant will be assigned Performance Objectives which have standards of performance defined as Threshold, Target, and Maximum performance consistent with the following:

Threshold Performance – Represents the minimum acceptable performance standard for which an award can be paid. This level represents satisfactory results, but less than full achievement of stretch objectives.

Target Performance – Represents successful attainment of expected level of performance against stretch objectives.

Maximum Performance – Represents results which clearly and significantly exceed all performance expectations for the year. This level of accomplishment should be rare.

The same performance standards will be used for LTI performance objectives, but they will relate to performance over a three-year period rather than a one-year period.

9. PERFORMANCE OBJECTIVES AND WEIGHTINGS

Prior to the beginning of each fiscal year, a series of financial and/or non-financial performance objectives will be established for each participant, consistent with the mission and goals of the Clinical Enterprise and each Health System in the Clinical Enterprise.

Systemwide Clinical Enterprise level ~~systemwide~~ objectives encourage the Health Systems to work together for the benefit of the entire Clinical Enterprise system. Institutional performance objectives encourage local teamwork and recognize the joint effort needed to meet challenging organizational goals. Individual or departmental performance objectives are designed to focus attention on key individual or departmental initiatives.

For purposes of this Plan, individual/departmental performance objectives should not be the same activities that are normal job requirements or expectations. Job performance is assessed as part of the Annual Performance Review Process. All CEMRP performance objectives must be stretch in terms of achievement potential, must be aligned with specific Institutional and/or Clinical Enterprise initiatives, and are often peripheral but related to or integrated with ongoing job responsibilities.

Each of the STI and LTI performance objectives will relate to one or more of the categories below:

- Financial Performance
- Quality Improvements
- Patient Satisfaction
- Key Initiatives in Support of the Strategic Plan
- People and other Resource Management

There will be no more than nine STI performance objectives for each participant in CEMRP comprised of the following: (1) Up to three objectives relating to the performance of the *Clinical Enterprise* (defined as Systemwide); (2) Up to three objectives relating to the performance of the *Institution* (defined as the participant's Health System); (3) For all participants other than those eligible for the LTI component, up to three objectives relating to *Individual* and/or *Departmental* performance. If an Individual/Departmental performance objective has three components and the Threshold, Target, and Maximum performance standards are framed as “meet one of three,” “meet two of three,” and “meet three of three,” respectively, each component must have equal

importance and weighting. While this type of Individual/Departmental performance objective is permissible, Individual/Departmental performance objectives with clear metrics for each performance standard are preferred.

Annual STI Individual/Departmental performance objectives will be established and administered by each participant's supervisor in consultation with the CEO of that Health System for all participants other than those eligible to participate in the LTI component.

The annual STI Institutional performance objectives for each Health System will be established and administered by the EVP – UC Health in consultation with the respective Chancellors in advance of the Plan year.

The annual STI performance objectives for the Systemwide Clinical Enterprise level ~~systemwide~~ will be established by the President, who may consult with the Chair of the Regents' ~~Committee on Health Services~~ Committee.

LTI participants will also be assigned one or more LTI performance objective(s) for each three-year performance period. The LTI performance objective(s) will require longer-term, multi-year efforts to achieve. LTI performance objectives must contain details that define Threshold, Target, and Maximum performance and include metrics and benchmarks, as appropriate. The LTI performance objectives will be established by the President, who will consult with the Chair of the Regents' ~~Committee on Health Services~~ Committee.

All performance objectives must be SMART (specific, measureable, attainable, relevant, and time-based). Assessment of participants' performance and contribution relative to these objectives will determine their actual award amount.

Peer group and/or industry data must be used where appropriate to provide a benchmark and performance standard. Performance objectives at the Clinical Enterprise and Institutional levels are typically measured against relative peer/industry benchmarks in the market. Where an established internal or external benchmark is used, baseline metrics must be included to enable a determination of the degree to which the intended results would require stretch performance. The Chief Human Resource Officer at each Health System will be responsible for ensuring that all Individual/Departmental objectives for participants at that location meet the SMART standards before obtaining sign-off from the CEO and Chancellor. The STI and LTI performance objectives for all participants will be subject to review and approval by the AOC prior to the beginning of the Plan year or as soon as possible thereafter. The AOC will consult the Senior Vice President – Chief Compliance and Audit Officer in an independent advisory capacity during its review of Plan participants' objectives.

The participants' performance toward their assigned STI objectives may be measured across three organizational levels as noted above (Systemwide Clinical Enterprise, Institutional, and Individual/Departmental) and will be weighted according to the percentages listed in the table below.

Weighting of STI Annual Objectives

Position Level within Organization	<u>Systemwide /</u> Clinical Enterprise Level	Institutional Level	Individual and/or Departmental Level
<u>EVP – UC Health</u>	<u>100%</u>	<u>0%</u>	<u>0%</u>
EVP – UC Health and Health System Chief Executive Officers	50%	50%	0%
Other “Chief Levels” and Other Key Senior Clinical Enterprise Leadership	30%	50%	20%
<u>Other UC Health Leadership</u>	<u>80%</u>	<u>0%</u>	<u>20%</u>
Other Clinical Participants	20%	50%	30%

The supervisor of each Plan participant will provide him/her with: (a) the participant’s performance objectives for the Plan year, (b) the performance standards that will be used to measure Threshold, Target, and Maximum performance for each objective, (c) the performance weightings that will apply to the participant’s performance objectives, and (d) a copy of this Plan document.

10. Financial Standards and Plan Funding

10. PLAN FUNDING AND MINIMUM THRESHOLD FOR FINANCIAL STANDARD

Full funding of STI awards for participants at a Health System in the plan year is contingent upon that Health System’s ability to pay out the awards while maintaining a positive income from operations. This minimum threshold financial standard is based on Modified Operating Income (Loss) which is Revenue less Expenses, excluding the non-cash portion of Other Post Employment Benefits (OPEB) as reported to the Regents’ Health Services Committee.

~~Full funding of STI awards for participants at a Health System in the Plan year is contingent upon that Health System’s ability to pay out the awards while maintaining a positive net cash flow from operations before intra-institutional transfers.~~

In the event that the Health System cannot meet that financial standard for the Plan year, and the Health System attains key Institutional non-financial objectives, the AOC may consider and approve, in consultation with the Chancellor and EVP – UC Health, partial STI award payouts for some or all of that Health System’s Plan participants based on the Award Opportunity Levels defined above and participants’ achievement of their assigned STI performance objectives for the Plan year.

11. INCENTIVE AWARD ELIGIBILITY CRITERIA

Participants must be active full-time employees of the University at the conclusion of the Plan year (i.e., as of midnight on June 30th) to be eligible to receive an STI award for that Plan year,

unless the circumstances of their separation from the University entitle them to a full or partial award as set forth in the Separation from the University provision below in Section 13.

LTI participants must be active full-time employees at the conclusion of the three-year period associated with an LTI performance objective (i.e., as of midnight on June 30th of the third year) to be eligible to receive an LTI award for that period.

Participants must have at least a “Meets Expectations” or equivalent overall rating on their performance evaluation for the Plan year to be considered for an STI award under the Plan for that Plan year or an LTI award for the performance period that concludes at the end of that Plan year. A manager may reduce or eliminate an award according to the participant’s overall performance rating with the approval of the AOC. However, an overall performance rating below “Meets Expectations” will eliminate the total award for that participant for that Plan year or performance period.

A participant who has been found to have committed a serious violation of state or federal law or a serious violation of University policy at any time prior to distribution of an STI or LTI award will not be eligible for such awards under the Plan for that Plan year and/or performance period. If such allegations against a participant are pending investigation at the time of the award distribution, the participant’s award(s) may be withheld pending the outcome of the investigation. If the participant’s violation is discovered later, the participant may be required to repay awards for the Plan years and/or performance periods in which the violation occurred.

Likewise, when it has been determined that a participant’s own actions or the participant’s negligent oversight of other University employees played a material role in contributing to a serious adverse development that could harm the reputation, financial standing, or stability of the participant’s Health System (*e.g.*, the receipt of an adverse decision from a regulatory agency, placement on probation status, or the adverse resolution of a major medical malpractice claim) or, with regard to the EVP – UC Health and the Clinical Enterprise overall, the AOC has the discretion to decide that the participant will either not be eligible for an STI or LTI award under the Plan that year or will receive an award that has been reduced as a result of and consistent with the participant’s role with regard to the adverse development. If the participant’s role with regard to the adverse development is still under investigation at the time of award distribution, the participant’s award for the Plan year may be withheld pending the outcome of the investigation.

If the participant’s role in the adverse development is discovered later, the participant may be required to repay awards for the years in which the actions or negligent oversight occurred.

12. INCENTIVE AWARD APPROVAL PROCESS

At the end of each Plan year, proposed incentive awards will be submitted to the Executive Director, Systemwide Compensation Programs and Strategy. Except as set forth below. Awards amounts will be reviewed and approved by the AOC. Any incentive award for the EVP – UC Health will require the approval of the Regents’ ~~Committee on~~ Health Services Committee in addition to the approval of the AOC. The AOC will consult the Senior Vice President – Chief

Compliance and Audit Officer in an independent advisory capacity during its review of proposed incentive awards. The AOC will provide the chair of the Regents' ~~Committee on Health Services Committee~~ and the President with a listing of award recommendations before awards are scheduled to be paid. On behalf of the AOC, the Executive Director, Systemwide Compensation Programs and Strategy will provide the President and the Regents with the award details in the Annual Report on Executive Compensation.

Approved incentive awards will be processed as soon as possible unless they have been deferred pursuant to the provision set forth below.

Annual incentive awards will be payable in cash, subject to appropriate taxes and pursuant to normal University payroll procedures. The participant's total University salary (which includes base salary and any stipends, but does not include any prior year incentive award payouts or disability pay) as of June 1st of the Plan year will be used in the calculation of the incentive award amount. The assigned Description of Service code of "XCE" specific to the Plan **must** be used when paying awards to Plan participants.

This Plan may be terminated or replaced at any time for any reason upon the recommendation of the President, in consultation with the Chair of the Regents' ~~Committee on Health Services Committee~~. Reasonable efforts, given all circumstances, will be made to delay Plan termination until after the current Plan year has concluded. However, if the Plan is terminated during the Plan year, awards for the current year will still be processed based on participants' performance during the portion of the Plan year prior to termination.

Notwithstanding any other term in the Plan, current year incentive awards may be deferred if the Regents issue a declaration of extreme financial emergency upon the recommendation of the President or if the Systemwide Clinical Enterprise experiences a ~~systemwide negative cash flow consolidated negative income from operations based on Modified Operating Income (Loss) which is Revenue less Expenses, excluding the non-cash portion of Other Post Employment Benefits (OPEB)~~. In such situations, the deferral would be made upon the recommendation of the AOC and require the approval of the President and the Chair of the Regents' ~~Committee on Health Services Committee~~. In such a case the current year deferred awards will earn interest at the Short Term Investment Pool rate. Award payments that have been approved, but deferred, will be processed and distributed as soon as possible. In no event will awards be deferred longer than one year.

The University may require repayment of an award that was made as a result of inappropriate circumstances. For example, if there is an inadvertent overpayment, the participant will be required to repay the overage. If the participant has not made the repayment before an award for the employee for a subsequent Plan year is approved, the outstanding amount may be deducted from the employee's subsequent award.

13. SEPARATION FROM THE UNIVERSITY

The table below indicates whether a participant who separates from the University will be eligible to receive a full or partial STI award and also specifies when forfeiture of such awards

will occur. Retirement will be determined based upon applicable University policies. In order to determine the most accurate STI award for the current Plan year, partial payments will be calculated at the end of the Plan year and issued in accordance with the normal process and schedule.

Reason for Separation	Separation During Plan Year (i.e., on or before June 30, 2017-18 <u>2018-19</u>)	Separation on or after July 1, 2018 <u>2019</u>
Voluntary Separation for any reason other than retirement	<ul style="list-style-type: none"> Forfeiture of STI award for 2017-18 <u>2018-19</u> Plan year. 	<ul style="list-style-type: none"> Payout of full STI award for 2017-18 <u>2018-19</u> Plan year.
<ul style="list-style-type: none"> Retirement Medical separation due to disability Death* Involuntary separation due to reorganization or restructuring 	<ul style="list-style-type: none"> Partial STI award for 2017-18 <u>2018-19</u> Plan year. 	<ul style="list-style-type: none"> Payout of full STI award for 2017-18 <u>2018-19</u> Plan year.
Involuntary termination due to misconduct or inadequate performance	<ul style="list-style-type: none"> Forfeiture of STI award for 2017-18 <u>2018-19</u> Plan year. 	<ul style="list-style-type: none"> Forfeiture of STI award for 2017-18 <u>2018-19</u> Plan year.

*In such cases, payments will be made to the estate of the participant.

LTI awards are not eligible for full or partial payment if a participant separates from the University before the conclusion of the applicable three-year LTI performance period; forfeiture will occur.

14. TREATMENT FOR BENEFIT PURPOSES

Incentive awards under this Plan are not considered to be compensation for University benefit purposes, such as the University of California Retirement Plan or employee life insurance programs.

15. TAX TREATMENT AND REPORTING

Under Internal Revenue Service Regulations, payment of incentive awards under this Plan must be included in the participant's income as wages subject to withholding for federal and state income taxes and applicable FICA taxes. The payment is reportable on the participant's Form W-2 in the year paid.