

The Regents of the University of California

COMMITTEE ON HEALTH SERVICES

May 17, 2000

The Committee on Health Services met on the above date at Covell Commons, Los Angeles campus.

Members present: Regents Atkinson, Davies, Khachigian, Kozberg, Lansing, Montoya, Preuss, Sayles, and Vining; Advisory member Kohn

In attendance: Regents Bagley, Connerly, Hopkinson, Moores, Pannor, and Taylor, Regents-designate Fong and Miura, Faculty Representatives Coleman and Cowan, Secretary Trivette, General Counsel Holst, Provost King, Senior Vice President Kennedy, Vice Presidents Broome, Darling, Gomes, and Gurtner, Chancellors Berdahl, Bishop, Carnesale, Cicerone, Dynes, Greenwood, Orbach, Tomlinson-Keasey, Vanderhoef, and Yang, and Recording Secretary Bryan

The meeting convened at 8:55 a.m. with Committee Chair Khachigian presiding.

1. STATUS OF UCSF, POST-MERGER

Chancellor Bishop reported on what has taken place at UCSF in the three months since the break up of the merger with Stanford, noting that reconstitution of the leadership and operating systems at UCSF is ongoing and that the medical center has gained patients as a result of the reconfiguration of facilities. The challenges faced by UCSF Medical Center now are similar to the challenges faced by all other academic medical centers. He believed that they can be met in the long term.

Dr. Bishop recalled that a search for a chief executive officer for the medical center yielded a prime candidate in the person of Mr. Mark Laret, former Medical Center Director at the Irvine campus. Director Laret took charge of the UCSF Medical Center in April.

Director Laret recalled that the merger ended officially on March 31. He observed that the fundamentals that made UCSF one of the country's best academic medical centers remain intact. Those fundamentals are the quality and depth of the faculty combined with a talented, committed staff of nurses and allied health professionals. The five-year period involving the merger has taken a toll on morale and on the reliability and quality of UCSFMC's core operations. He believed that all problems will be solved by elevating UCSF's clinical operations to a point where the medical center is as excellent at meeting the service expectations and medical needs of patients as it is at educating students. UCSFMC emerged from the partnership with about \$60 million in cash and about \$100 million in debt. March was a positive month, but a significant loss is projected for year end. Because of the major investments that will need to be made in

operating systems, it may take three or four years to return to a desirable level of financial performance. This timetable could be shortened or lengthened by changes in reimbursement from Medicare, Medi-Cal, or private insurers. The medical center's annual depreciation of about \$45 million will be spent on basic equipment and facilities upgrades. Making improvements in aging facilities will be very expensive. The money spent on short-term needs will make it difficult to accumulate the cash balances necessary to approach the capital markets to address UCSFMC's major long-term need, that of replacing the Moffitt and Long Hospitals.

Mr. Laret reported that recruitment has been undertaken for a chief operating officer, a chief financial officer, a chief information officer, and a director of ambulatory care. Consultants have been placed in these roles in the interim. A short-term information technology plan is being developed to address the current unreliable network systems. This year's operating and capital budgets are being completed, although some details of the dissolution with Stanford have yet to be addressed. Labor issues have come into special focus. The cost of living and housing and the transportation difficulties in the region raise special employee issues.

Mr. Laret emphasized that the administration is working to refocus everyone's attention on meeting the needs of patients. A new strategic planning process, which will include a long-term space plan and a capital plan, has begun. Finally, the administration is working to keep the faculty and staff informed of and engaged in each process. He was confident that the dedication of everyone involved would produce positive results.

Regent Preuss asked what would be done to make financial data accurate and quickly available to the Regents. Mr. Laret expressed a lack of confidence in the systems currently in place, partly because there have been changes in core registration and billing systems that generate much of the data. He believed that, although the data that are being generated are reasonably accurate, it will be necessary to start at ground level and make sure everything from general ledger systems to core billing and collection systems and cost accounting systems are operating reliably. He believed that this could be accomplished within a year. Management needs more detailed data about the performance of individual units and programs.

Regent Hopkinson asked when a comprehensive financial picture of UCSFMC separate from Stanford would be available. Mr. Laret responded that he expected to be able to provide at least an update by the July meeting. Some issues related to the splitting of cash remain unresolved. Vice President Gurtner noted that the dissolution audits will not be finished by July. The first distribution of the reserves held pending that audit will be made soon. He agreed to provide the best current data with as broad a picture as possible at the July meeting. Mr. Laret believed that, as long as there is a positive cash flow, his focus should be on correcting deficiencies in the core operational systems before taking on the financial reports.

Regent Connerly recalled that the impetus for the merger was to make it possible for two outstanding faculties to work together. He asked whether any collaboration between

them survived the split. Chancellor Bishop stated that, although there are common interests that could be pursued, no cutting edge initiatives are currently envisioned.

Regent-designate Kohn asked how the reconfiguration of Mt. Zion Hospital is proceeding. Dr. Bishop responded that patient volume has increased both at Mt. Zion and at the Parnassus site.

Regent Pannor recalled that the Regents had been hearing public comments from staff who were concerned about the stability of UCSFMC. Mr. Laret stated that the success of an organization as complicated as the medical center depends on all people being engaged, believing in the same long-term mission and goals, and working cooperatively. He reported that he has put emphasis on improving morale by meeting staff personally, providing weekly status reports by e-mail, and by conversing with groups of nurses and other front-line employees.

Regent Kozberg inquired about the status of the pediatric initiative that was to be established by the merged entity with the support of the Packard Foundation. Dr. Bishop reported that the initiative was terminated. Mr. Laret noted that it is hoped that UCSFMC will be able to expand its existing children's program.

2. **SEMI-ANNUAL UPDATE ON THE ACTIVITIES OF THE CLINICAL POLICY REVIEW TEAM**

It was recalled that the Clinical Policy Review (CPR) Team has completed four years of activity. All five of the UC medical centers, medical schools, and most of the other health science schools have been reviewed to evaluate their implementation of applicable national, State, and University policies, regulations, and accreditation standards as they relate to the quality of patient care, medical staff self-governance, professional liability, and human subjects research. Each reviewed program has received a written report and responded with an action plan. The team has conducted follow-up visits to evaluate the original recommendations and the proposed actions. Extensions of the original topics have been identified by the campuses, the team, and The Regents.

It became clear that a full-time physician administrator was needed to oversee this expanding program. In 1999, the position of Medical Services Director was approved and recruitment begun. Dr. Ronald Kaufman was appointed as the Medical Services Director in February 2000.

Since its report in November 1999, the team has continued to visit each campus, with a special focus on professional liability, risk reduction, and quality of patient care. A new committee is being formed under the direction of Dr. Eugene Spiritus, Medical Director, UC Irvine. Two meetings, one in the north and one in the south, have been held to formulate the scope and processes of the committee. Initial efforts will include cross-program adverse events, data analysis, risk reduction strategies, and assessment of high-risk activities.

In 1999, institutional compliance with federal, State, and University policies that regulate human subjects research was identified by President Atkinson for an expanded review by the CPR Team. This process has moved forward with follow-up visits to the five medical school campuses to learn about local programs and to develop a list of current concerns. Local policies have been received and review is under way. The next round of site visits is being scheduled.

The Institute of Medicine and the federal government have identified medical errors as a national concern. Medical Services Director Kaufman reported that the complex nature of health care involves making a series of decisions and conducting repetitive tasks in a process that requires mass customization. This leads to an environment that is opportune for errors which may lead to legal actions and require risk management analyses. A recent Institute of Medicine report compiled the results of studies conducted in 1984 and 1992 from which it developed rates of medical errors. These rates were extrapolated into projections of up to 100,000 deaths and a cost of almost \$30 billion annually related to medical errors. Dr. Kaufman believed that the University has an opportunity to take the lead in developing systemwide processes to assure that issues of performance are addressed and that corrective actions are implemented. He indicated that at the September meeting he would have specific recommendations for The Regents to consider. He noted that there will be financial costs involved in developing systems and policies that will help to reduce medical errors.

Regent Kozberg asked how the University will measure its progress at reducing medical errors. Dr. Kaufman explained that there are national initiatives in federal licensing and accreditation that will require formal reporting. It will be necessary to develop a centralized collection point to facilitate systemwide medical center reporting. Regent-designate Kohn observed that the issue of medical errors was not new and that all health services have long had systems in place to monitor patient care. Dr. Kaufman believed that a method needs to be established of relating the specific subset referred to in the Institute of Medicine report to the existing data on actual performance. The University needs to know the scope of the performance being captured and whether that scope should be broadened or redefined. Dr. Tupin, Chair of the Clinical Policy Review Team, expressed confidence in the University's current system of monitoring and agreed with Regent-designate Kohn that it should not be overhauled without confirmation that the magnitude of medical errors at the University's medical centers merits it. President Atkinson recalled that the CPR Team was established because it was clear that Regental policies and federal governmental requirements were being interpreted and pursued differently among the University's medical centers. He believed it was important to ensure that the system is complying with these policies.

Dialysis programs under contract to outside vendors continue to be monitored by the team. Quality of care oversight continues in a satisfactory manner in the two contracted dialysis programs, which are at UCLA and UC Davis. Faculty are acting as medical directors and key clinicians in the programs. Regent Pannor asked about the status of the sale of UCSF's dialysis unit approved by The Regents at the November 1999 meeting. Dr. Tupin reported that the negotiations authorized by The Regents ended in

a stalemate. No further negotiations are being pursued with the outside vendor that was identified at that time. It is planned to attempt to solicit a new partner for the program.

3. **CHALLENGES FACING UC MEDICAL CENTERS AND UPDATE ON SYSTEM OPPORTUNITIES PROJECT**

It was recalled that at the Regents' March 2000 meeting, the Committee on Health Services requested that information be provided on the problems and issues facing the University's medical centers. Inclusive in this study was to be a discussion on integration and collaboration among the medical centers and recommendations for further collaborative efforts.

The Department of Clinical Services Development, in cooperation with the medical center directors and staff, has examined areas of challenge and opportunity for collaboration. This report outlines the problems facing the UC institutions and provides a broad overview of what future collaborative efforts may be pursued.

Progress to Date

Problems and Issues Facing Academic Medical Centers

Market-driven changes, which have had a profound effect on the financing and delivery of health care in California, have presented significant challenges to the University of California's academic medical centers. These financial pressures have resulted in lower net incomes, which limit the ability of the medical centers to generate and access capital. The revenues of the medical centers are also relied upon to support the schools. Any decline in clinical financial results directly affects teaching and research capabilities and the overall academic mission. Viewed in isolation, no single problem or issue can be blamed on the decline of the financial condition of the University's medical centers. However, the cumulative effect of all these problems and issues raises the level of intensity of the medical centers' struggle.

Declining Revenues

Preliminary cost report data indicate that the average hospital operating margin has declined from 4.5 percent to 3 percent in 1999 – a one-year income drop of over 30 percent. Margin is even worse for major teaching hospitals, falling below 1 percent on average this year. Contributing to these revenue decline factors are the Balanced Budget Act of 1997, continuing pressures from managed care payors, and an unexplained leveling of the case mix index.

The Balanced Budget Act of 1997 is expected to balance the federal budget by the year 2002 through a \$140 billion reduction in projected federal spending. About \$115 billion (82 percent) of those reductions come from reductions in Medicare payments. For the UC medical centers, Medicare represents roughly 25 percent of the

total payor mix. The projected net impact to the UC medical centers is a \$138.8 million loss in revenues over the five-year period. Although as the Balanced Budget Act Refinement Act of 1999 has provided some temporary relief from the original legislation, long-term decreases in Medicare payments are expected to continue.

Approximately half of the UC medical centers' revenues come from managed care organizations. While all healthcare providers are currently experiencing cost-cutting pressures, academic medical centers have the additional challenge of funding expenses related to education, research, and a disproportionate share of indigent care. This is further complicated by the difficult case mix and high-end quaternary services provided at the medical centers. The continued health plan consolidation, the refusal of managed care organizations to pay the costs associated with teaching and research, and the health plans' efforts to control costs, have resulted in a continued decline in revenues from the University's largest payor source.

Another declining revenue factor is the increased competition of community providers for tertiary cases. Inherent in academic medicine is the transference of skills and technologies to community providers for their use. Ultimately these same community providers end up competing with academic medical centers for patients and thereby diluting the number of tertiary referrals to academic medical centers.

Compounding the declining revenue factor is the unexplained leveling of the Medicare case mix index, which is responsible for perhaps one-third of the financial downturn. Medicare case mix index is the measure of the level of severity of a patient's illness and subsequent cost to treat the episode of care. Tied directly to hospital reimbursement, the case mix index historically has increased by about 2 percent per year, yielding a commensurate increase in revenues. With this leveling and in some cases decline in the case mix index, medical centers are seeing decreases in reimbursement.

Lastly, although not tied directly to revenue or expense, is the fact that most major academic medical centers have large endowments to help offset short-term operating shortfalls and to support significant programmatic efforts. The UC medical centers do not have such a resource and have never been encouraged to develop it independent of the schools of medicine.

Increasing Expenses

Between 1996 and 1999, expenses increased 3.5 percent, while revenues increased 2.3 percent per adjusted discharge. Expense increase factors can be attributed to the rising costs of salaries, technology, supplies, and pharmaceuticals. For instance, national expenditures for prescription drugs rose by an average of 14 percent annually during the years 1996 through 1998. In addition, recent increases in administrative burdens related to compliance programs and non-standardized reporting obligations have increased expenses.

As the patient populations have shifted to more outpatient settings, in an effort to control costs, so must the educational setting shift in order to provide a balanced education experience. Training medical students in ambulatory settings is more costly than training them in inpatient settings. The presence of teaching in an ambulatory care setting results in longer patient visits, thereby affecting overall productivity ratios. Factors such as location and travel time between facilities also increases the expense of outpatient-setting training.

Current Collaborative Efforts

At campus levels, some of the UC medical centers have pursued regional integration strategies by developing relationships and collaborations with local community hospitals and physicians. In addition, there are a number of systemwide functions being coordinated by the Office of the President. These include risk management, legislative-lobbying efforts, Medi-Cal medical education funding negotiations, and numerous oversight and communication efforts.

Barriers to Further Collaboration and Integration

Several potential barriers exist with regard to further integration and collaborative efforts. Currently, the University's organizational and governance structure promotes and encourages campus autonomy whereby the medical centers operate as separate and distinct entities. Each medical center is responsible for supporting its own medical school, its own financial performance, and capital generation. There is no consolidated fiscal accountability and therefore no financial incentive to collaboration. Although this autonomy makes each campus unique and distinct in its capabilities, it is also a hindrance to collaborative efforts. Competition between medical centers and their medical schools for research monies, faculty, and a few high-end quaternary services creates a driving force to maintain an edge in medical research and development. Any potential benefit from collaboration and integration must be weighed against the broader goal of diversity among campuses and development of innovative local programs and strategies.

Another barrier to collaboration is that healthcare and the delivery of its services are regional phenomena, and therefore any line of inquiry must focus primarily on the regional market and its conditions. The market strategies of individual medical centers will depend greatly on the underlying market dynamics, the penetration of managed care, and the degree of competitive rivalry in each local market place.

Systemwide Opportunities

The decade of the 1990s may be characterized as the decade of massive consolidation of hospitals to form Integrated Delivery Systems (IDSs) through vertical integration. Broadly defined, IDSs are organizations that, through ownership or formal agreements, align healthcare facilities in order to deliver integrated healthcare services by improving quality and reducing costs. Hospitals were convinced that if they grew larger

they would be able to draw more patients, leverage significant economies of scale, and achieve more favorable contracts. Today these IDSs are questioning the value of consolidation and integration and of forming hospital networks and vertically integrated healthcare systems. Several recent studies indicate that the economic advantages hospital networks and IDSs were expected to derive from consolidation have largely eluded them. National for-profit hospital chains have prospered some through expansion, but they have benefited less from the structural advantages of combining assets than from the sharing of best practices between facilities.

As healthcare providers continue to feel the effects of a financially challenging future, healthcare systems and hospitals must think more systematically about integration and collaboration. Consolidation for the sake of consolidation bears little fruit. However, there remain many compelling reasons to collaborate on local, regional, and even national levels and to explore collaborative efforts among the UC medical centers. Hospitals must clearly define the strategic rationale and benefits of collaboration and integration, and the benefit of industry experience must be considered as the UC clinical enterprise seeks to sustain needed margins.

Recommendations

In pursuing any further integration efforts, the following questions must be addressed:

- Will systemwide collaboration create tangible economies of scale, thereby reducing operating expense?
- Will systemwide collaboration provide competitive advantages within local markets as well as regional markets?
- Will systemwide collaboration help balance areas of high risk and exposure?
- Will systemwide collaboration enhance or damage the tripartite mission of the academic medical centers?
- Will systemwide collaboration enhance access to capital markets for debt financing?
- Should systemwide collaboration include the schools of medicine as part of the clinical enterprise?

Future areas for systemwide collaboration identified as priorities for further exploration and pilot programs are related to revenue enhancement and expense reduction. Each project and pilot will be reviewed in light of the integration factors mentioned above and weighted against the mission of the University. In addition, a study will be undertaken to review the potential value of integrated planning in an effort to differentiate the UC medical centers from competitors.

Vice President Gurtner reported that the University will continue its efforts in Washington to secure better funding for medical education. Ways are being discussed of bringing Regents into direct contact with the legislative process both in Washington and Sacramento.

Mr. Gurtner reported that discussions have begun with the Department of Human Resources in the Office of the President on the possibility of providing systemwide healthcare for University employees. Statewide managed care contracting opportunities are also being pursued. There are several projects under way for vendor contracting and capital equipment purchase pooling.

During the upcoming year, Mr. Gurtner noted, new ways of generating capital will be explored. The capital money available in the current budget is earmarked for seismic safety. Individual campuses do not have the margins to generate sufficient capital for their needs.

Regent Hopkinson observed that the adoption of new ways to save money must be accompanied by careful tracking of the quality of the medical centers' services to their customers. Director of Clinical Services Shannon reported that quality measures are in place at each campus, but she agreed that the data need to be collected and consolidated in order to demonstrate that the University is sustaining its reputation of providing high-quality healthcare. Mr. Gurtner believed that a plan for reporting consolidated data would be in place within the year.

Regent Kozberg suggested that campus foundations unite to provide broad support for the University's effort to enhance federal funding for medical education. She then asked whether the University could join the current trend in industry of pooling resources to do purchasing. Mr. Gurtner acknowledged that there were opportunities for pooling, but he cautioned that there were also risks. He believed that the campuses should be free to decide how they would prefer to risk their resources.

Regent Preuss suggested that it may be helpful to examine the possibility of operating more like a for-profit entity, where decisions are made quickly, rather than to accept that as a non-profit enterprise with a traditional approach, the University is constricted from moving forward as trends change and opportunities arise.

Regent Sayles was also disturbed that the initiative to consolidate purchasing was not proceeding quickly enough, in light of industry trends. Director Shannon noted that the medical centers already purchase as a group as members of the University Health System Consortium, an entity that has merged recently with another large group representing community hospitals. More than 50 percent of their goods are purchased through the consortium, and they are positioned to expand that effort. She indicated that at the July or September meeting an update on that initiative could be provided. Senior Vice President Kennedy noted that there has been an enormous effort that could be documented for the Regents both at the medical centers and systemwide to reduce procurement costs.

President Atkinson believed that it would be helpful to mail to all Regents a description of opportunities in systemwide purchasing and contracting, the complications associated with them, a rationale for not pursuing certain of them, and a timeline for developing those that it may be practical to pursue. Regent Sayles believed that such a report would be particularly useful for Regents who lobby the federal government for higher reimbursement rates. Committee Chair Khachigian noted that the issue has been the focus of discussions with the medical center deans and directors. She urged Regents who wanted to know further details about current medical center issues to attend the briefings that are being scheduled between regular meetings.

4. **ACTIVITY AND FINANCIAL STATUS REPORT ON HOSPITALS AND CLINICS**

Vice President Broome outlined the latest medical center financial reports and commented on current trends. She noted that the reports that are sent out every month

are hospital focused; they do not include other activities of a clinical nature that are included in campus financial statements. They are hospital based because the financing is carried on the books of the hospitals, which are the entities capable of having bonds issued for capital needs.

Ms. Broome pointed out that examining the key indicators at the beginning of the reports provides a quick way to see what is happening overall with operations and the financial position. The reports also include some traditional financial statements, income, balance sheet, funds-at-risk, and budget and actual projection comparisons. A more extensive analysis is provided quarterly. For operations, the bottom line or excess of revenue over expenses is shown combined, by medical center, and by individual expenses and revenues. Most centers have shown a decline in revenue in 2000.

The main factors affecting the medical centers' financial performance are the competitive managed care market, flattening or declining reimbursements, and increasing expenses in key areas. Ms. Broome observed that it is difficult to control costs fast enough to keep up with increasing expenses. With such tight margins, the slightest shift can cause losses. Besides increases in expense categories, because volumes are up expenses also are up at all centers, while levels of cash have been declining.

Ms. Broome reported that the medical centers at the Davis, Irvine, and San Diego campuses are expected to end the year above budget with a combined margin of 3.8 percent, while the Los Angeles Medical Center is expected to show a loss.

Regent Kozberg asked whether the University interacts with the Department of Managed Care to collect on delinquent contractor accounts. Mr. Gurtner indicated that he would check into whether individual cases are pursued in that way.

Regent Hopkinson requested information on the patient mix at each hospital and how it affects the numbers. Ms. Broome suggested that was a complicated area that could be explained best during a Regents' briefing on hospital issues. Chairman Davies added that the issue of expenses versus fund transfers was complicated, and he urged all Regents who were interested in learning more to attend the briefings. In answer to a further question by Regent Hopkinson, Ms. Broome reported that by the end of June all the University's medical centers will be using consistent reporting practices that follow generally accepted accounting principles.

Regent-designate Kohn noted that the UC San Diego Medical Center had achieved an impressive margin. He asked whether the lessons that were learned at San Diego through The Hunter Group could be applied to the University's other medical centers in order to prevent their having to go through a similar traumatic experience. Ms. Broome believed that it was possible, but she observed that at San Diego the changes were effected during a crisis where lesser measures could not be considered. It would be difficult to galvanize the medical centers sufficiently to achieve the same effect in less serious situations. Mr. Gurtner noted that in the three years during which

The Hunter Group worked at San Diego, a new culture was developed that strong leadership and discipline have made it possible to maintain.

Regent Vining observed that UC San Diego Medical Center is dominating its competition. Besides being profitable, it has become the provider of choice in its area. He suggested that the other medical centers consider particularly what could be done to make them more attractive to patients.

Regent Preuss was concerned that the receipt of varying levels of State subsidies masked the true financial performance of individual medical centers. President Atkinson emphasized that the fortunes of the University's medical centers rise and fall year by year because of the chaotic healthcare environment. He believed that in considering the effect of the subsidies the Regents should keep in mind that the University's medical centers would be capable of becoming as competitive as any private hospital or group if they were to give up research and teaching and cease to be safety nets for their communities. He indicated that he would mail to all Regents further information on patient mix and the nature of the subsidies.

The meeting adjourned at 11:05 a.m.

Attest:

Secretary