The Regents of the University of California

COMMITTEE ON HEALTH SERVICES
January 9, 2003

The Committee on Health Services met on the above date in the Associates Conference Room, Building 23, Irvine Medical Center.

Members present: Regents Johnson, Kozberg, Lee, Preuss, Sainick, and Terrazas; Advisory member Seigler

In attendance: Secretary Trivette, General Counsel Holst, Senior Vice President Mullinix, Vice President Gurtner, Chancellor Cicerone, and Recording Secretary Bryan

The meeting convened at 11:40 a.m. with Committee Chair Lee presiding.

1. **APPROVAL OF MINUTES OF PREVIOUS MEETING**

Upon motion duly made and seconded, the minutes of the meeting of November 13, 2002 were approved.

2. **UPDATE ON UCI MEDICAL CENTER REPLACEMENT HOSPITAL AND LONG RANGE DEVELOPMENT PLAN, IRVINE CAMPUS**

It was recalled that at its March 2002 meeting, The Regents authorized the Irvine campus to proceed with the preliminary planning phase of the UCI Medical Center Replacement Hospital project, which is intended to address SB 1953 seismic deficiencies as well as needs generated by a growing demand for services. The project includes construction of a new hospital to replace Building 1, associated renovations and non-structural seismic improvements to Building 1A, and seismic and other improvements to central plant facilities. The schematic design of the project is complete.

At the January 2003 Regents meeting, the campus intends to request approval for three items related to this project:

A. Approval to proceed with the working drawings phase of the project. This action will permit the campus to complete design development and bid packages, with the understanding that the campus will request Regental approval of the full budget and external financing prior to going out to bid.

B. Approval of the updated Long Range Development Plan for the UCI Medical Center, which will provide a framework to guide physical development through the year 2020, including construction of the hospital replacement project and other future facilities.

C. Approval for design and environmental clearance.

It was recalled that the UCI Medical Center (UCIMC), formerly the county hospital, became a part of the University in 1976. As an academic medical center, UCIMC is committed to the tripartite mission of teaching, research, and public service. The medical center provides the core clinical experiences for UCI's health sciences students and houses faculty and students engaged in clinical research and the development and testing of new diagnostic and therapeutic techniques.

Since becoming part of the University, the medical center has become a significant public health resource in Orange County. While maintaining a commitment to care for underserved and Medi-Cal populations, UCIMC also provides a substantial portion of the county's specialized medical care for all patients. As the county's only Level 1 Trauma Center, UCIMC is vital to the area's disaster response and must remain fully operational and capable of meeting emergency medical needs in the event of an earthquake.

The UCIMC site contains over 40 structures of varying size, age, and structural integrity. Of its 453 licensed beds, 391 are available in three inpatient facilities: Building 1, the main hospital building (205 beds), completed in 1960; Building 1A (102 beds), completed in 1981; and Building 3 (84 neuropsychiatric beds), completed 1993. These three inpatient facilities house the medical center's acute care services, including intensive care services, surgical units, pediatrics and obstetrics, psychiatry, nuclear medicine, pharmacy, pathology, and emergency functions.

SB 1953 Evaluation

The facilities subject to SB 1953 compliance were evaluated by a structural engineer who determined that Building 1 has serious structural deficiencies and must be seismically upgraded by 2008 or replaced. Building 1A, the Inpatient Tower, requires non-structural bracing of equipment and building systems. In addition, several critical support facilities – the steam plant, electrical facility, and utility tunnel – require modest structural and non-structural seismic upgrades.

A study was conducted to evaluate options for upgrading the existing hospital versus replacing it with new construction. The costs associated with renovating Building 1 were estimated to be at least comparable to those of building a new hospital. Of equal concern was the operational disruption that would result from a protracted ten-year-long retrofit in an occupied acute-care facility. Furthermore, the retrofitted facility would still be an older building with little flexibility, fragmented services, and little potential for increased operational efficiency. Consequently, the decision was made to construct a new facility that will provide a state-of-the-art hospital with long-term flexibility to change over time and with greater operational efficiencies.

Project Description

New Hospital. The new hospital, which will replace Building 1, will provide 189,297 assignable square feet to accommodate 191 beds, including intensive care and burn units, medical/surgical units, and pediatric and infant services. The facility will also house 13 operating rooms, other diagnostic and treatment facilities, administrative and support services, and other acute care functions. An additional 25,000 square feet of unfinished shell space ultimately will provide another 30-bed medical/surgical unit when additional funding becomes available. The additional 30 beds will provide the increased capacity needed to meet projected demand resulting from population growth in Orange County, the aging of that population, increasing patient acuity, UCIMC's rising reputation, and increasing numbers of referrals. This need is evidenced by the growth in the hospital's average daily census, which increased by 23 percent between 1997-98 and 2000-01.

The site for the new hospital is directly north of Buildings 1 and 1A. This location accommodates a number of existing buildings, including two seismically "Poor" structures – a hospital support facility completed in 1959 and a parking structure completed in 1978 – and several small buildings that will be demolished prior to construction of the hospital. The project also includes demolition of Building 1 and Building 10, a seismically "Poor" building that is connected to Building 1, and redevelopment of their sites after completion of the new hospital.

The site for the replacement hospital is in conformance with the updated Long Range Development Plan for the medical center.

Building 1A Renovation. Following completion of the new hospital, Building 1A will continue to house inpatient obstetrics and medical/surgical units as well as the hospital's emergency and imaging departments. In order to connect these essential diagnostic and treatment services with the new hospital, Building 1A will be renovated to construct a physical connector at the second level. Construction of this linkage requires relocation and reconfiguration of the emergency reception and waiting area. In addition, the emergency department's ambulance entrance and pedestrian access will be relocated.

The project scope will include modest non-structural seismic corrections in Building 1A for compliance with SB 1953, including the bracing of equipment and building systems in critical care areas such as emergency, imaging, and labor and delivery.

Central Plant Improvements. In order to modify existing utilities to accommodate the new hospital building, steam lines will be upgraded and additional capacity added for electrical power, cooling, and emergency generators. A central plant facility will be constructed to house new chillers, and structural and non-structural seismic corrections will be made to parts of the plant.

Construction is expected to begin in late 2003, with completion of the new hospital, Building 1A, and central plant improvements scheduled for December 2007, and

demolition of Buildings 1 and 10 and associated site work scheduled for completion in December 2009.

The cost of this project is anticipated to be under $340 million and will be funded from $235 million in State lease-revenue bonds (SB 1953), plus a combination of external financing, hospital reserves, capitalized leases, and gift funds that will be raised by the Irvine campus over the next several years.

Long Range Development Plan

The 2003 LRDP identifies building space, circulation, parking, and infrastructure sufficient to support the patient care, teaching, and research mission of the medical center and the College of Medicine through the horizon year 2020. The LRDP allows for an intensification of development from the existing area of 910,000 gsf to 1,900,000 gsf, including additional inpatient, ambulatory care, academic, research, administrative, and support facilities. While certain planning concepts from the 1977 LRDP remain valid, the LRDP also identifies new concepts that will help guide development. Examples include enhancing the environmental character of the medical center, increasing site density to an urban scale while providing more open space, and creating sites for future facilities by removing outdated buildings. The LRDP also establishes planning zones to guide the location of future buildings.

Chancellor Cicerone introduced UCI Medical Center Director Cygan, who discussed the clinical enterprise and the new hospital project. He stated that the medical center and the College of Medicine comprise one of the most dynamic components of UC Irvine. The hospital is one of the largest in Orange County and contributes in a vital way to the economy and quality of life in the region. Its 1,000 medical staff members represent approximately 20 percent of all physicians in the county. Of those, about 300 are employed full time. Between the medical school and the hospital, there are 5,000 employees and a budget that exceeds half a billion dollars, making the College of Medicine and the hospital the county's fifth largest employer.

Dr. Cygan discussed the demographics of Orange County, noting that in the past 20 years the community has become the state's second largest and expects a 15 percent growth in population by 2015. It also has become far more ethnically and culturally diverse. The non-Latino white population is 52 percent; the Hispanic population is 33 percent and is projected to surpass the former in the next ten years; and the Asian and Pacific islander population is nearly 14 percent and is projected to grow to 20 percent in that time. The medical center is ideally situated to serve the region, as there are about 5 million people within 20 miles of it. In addition, it runs strategically located community clinics. As a University hospital, the UCI Medical Center is distinguished from all other medical centers in the county by its mission to provide high-quality patient care in a manner that supports the education and research missions of the College of Medicine.

Dr. Cygan reported that in addition to its medical student programs and residency training, there are 59 allied health profession programs affiliated with the local community colleges and the State University system. These programs include nursing, pharmacy, physical and occupational therapy, and dialysis. The medical center also has a role in providing continuing education through programs that reach thousands of physicians throughout the western states. It reaches out also to non-physician community groups to make them aware of developments in healthcare.

University hospitals distinguish themselves by advancing medical science. Dr. Cygan noted that the medical center's faculty brought in over $100 million in research grants in 2002. Its 14 research centers funded by the National Institutes of Health include a national cancer genetics center, an Alzheimer's research program, and a center for the medical application of lasers, and help raise the stature and the visibility of the Irvine campus and its hospital. The hospital is involved in over 250 clinical trials on human subjects. Staff at its general clinical research center help faculty enroll patients in their studies, design the studies, and ensure that the patients are treated ethically and with little risk. Some noteworthy trials include gene therapy for pancreatic cancer, cancer prevention, and ovarian and cervical cancer treatments. Recently an N.I.H. trial was begun to investigate the causes of renal failure in diabetics and its relation to genetics.

Dr. Cygan discussed the medical center's clinical programs. He noted that UCI has begun to distinguish itself in a number of ways from the 30 hospitals that serve the community. It is the largest, has the most beds, has the largest ambulatory care system, and has a number of unique programs suited only to a university hospital. It has the only Level I Trauma Center, which handled 1,650 cases of severe trauma last year. It also has the only regional burn center, one of only 60 in the country verified by the American College of Surgeons. In addition, the medical center plays an important role in the county and statewide in disaster and bioterrorism preparedness.

As a former county hospital, UCI Medical Center has a legacy of caring for the underserved in the community. It continues to be the region's major safety-net facility. Dr. Cygan reported that its clinics in Santa Ana and Anaheim are federally qualified and receive supplemental payments and that its clinic in Westminster, the largest Vietnamese community in the country, is staffed mostly by Vietnamese professionals. In addition, a privately funded program reaches out to the Asian community to teach them about the cancers that are particularly common among them and to encourage early cancer screening.

Dr. Cygan reported that the medical center continues to be the largest provider of care to the county Medical Services for Indigents program. Although it is one of 25 hospitals that participate, it had 29 percent of all MSI admissions last year. It is also the largest provider of primary and specialty care for the Orange County Medi-Cal program.

The medical center has a pediatrics service second in size only to the one at Children's Hospital. Dr. Cygan noted that it has an outstanding neonatal team, an innovative

center for pediatric urology, and a program for early diagnosis of autism, which has experienced explosive growth in California. Medical students created a program to reach out to the county's children by providing in-home immunizations.

Dr. Cygan reported that, because the demands on a physician's time have become so great and have made it difficult for many community doctors to go back and forth between their offices and the hospital, the hospital has hired full-time board certified physicians who stay in the hospital to provide inpatient care, allowing for an intense and close association during hospital visits, and who then send the patients back to their community physicians for follow-up treatment.

Programs to keep senior citizens as healthy as possible are run by eight board certified geriatricians, the largest group in the county. Dr. Cygan reported that the hospital has a gero-psychiatry team to take care of seniors whose mental status has deteriorated and a health assessment program for seniors who can benefit from the evaluation of a multidisciplinary team. A senior mobile clinic was started recently that travels to senior centers to deliver care, and there is a new forensic center for the evaluation of elder abuse and neglect.

Increasingly, UCI is becoming known for the high quality of its specialists. Dr. Cygan described a limb salvage program, the comprehensive digestive disease center, a continuing education center for urologists, and a surgical program that employs the use of a minimally invasive robotic device. He believed that these specialists, combined with the hospital's attention to patient service, have caused an explosive growth in surgical procedures, ambulatory care, and admissions. The medical center is well supported by the University and the UCI Foundation and is enjoying improved relationships with the media. It has been designated as California's safest hospital and has been named two years running by *U.S. News and World Report* as a best hospital in the fields of gynecology and kidney diseases. Last year it was the University's best-performing hospital. Dr. Cygan observed that it has come a long way since its days as the county hospital. It is, however, limited by its physical plant. In order to continue competing, the technological infrastructure of the hospital must be improved. He believed that a new hospital facility is the critical next step in allowing the campus to reach its vision of having one of the nation's best university hospitals. The new hospital will be able to uphold the teaching, research, and patient care missions of the old, but it will be more patient friendly and will facilitate the delivery of care.

Regent Kozberg stated that the media had reported that the hospital is limiting admissions, and she wondered about the effect of this on the public and the University. Dr. Cygan explained that last year 63 percent of all medical services for the County's indigent program outpatients and about 30 percent for indigent inpatients were provided at UCI. Indigent patients may go to community hospitals to get care for their immediate needs, but often they are referred to UCIMC for further care. In the last few years particularly, as UCI has received more patients and from a larger cross section of the community, its faculty have been overwhelmed. Previous administrations have tried to deal with the County on this issue of patient dumping,

and he believed that the care of this category of patient is a community responsibility. UCIMC does more than its fair share, but its operating rooms and clinics do not have the capacity to care for these patients plus all the other patients who deserve the quality of care available at the medical center. Following negotiations with the County, it was established that patients who live outside what has been defined as the catchment area must now go to the network of community clinics that exists in Orange County and that are closer to where they live. If these patients need a service that the community hospital cannot provide, UCI will provide it. Since this has happened, UCI has seen about a one-third decrease in inpatient days of MSI patients and a one-third decrease in clinic visits. Dr. Cygan believed that the community has recognized that UCIMC cannot continue to function as the county hospital and has accepted the new arrangement as fair and reasonable.

Regent Terrazas noted that emergency rooms are closing around California that were providing primary care to many indigents. He asked whether the emergency room at UCIMC had been affected. Dr. Cygan acknowledged that many emergency rooms have closed in Los Angeles County, but he reported that Orange County has not followed that trend.

Regent Lee recalled that recently the President and the Governor had emphasized the importance to the country of providing jobs and expanding the biotechnology industry. He believed construction of the new medical center would create many new jobs in construction and other fields and will also enhance biotechnological research.

Dr. Cygan introduced Campus Architect Gladson, who provided a brief overview of the planning process for the new hospital. Ms. Gladson recalled that the design for the new hospital had been approved the previous month by the Committee on Grounds and Buildings. The design team identified goals consistent with those of the medical center. These included the following:

- Create a place where patients and families feel special.
- Provide clear way finding.
- Create an Orange County landmark.
- Enhance the image of the former county hospital.
- Develop an architectural vocabulary that will integrate the look of the existing campus with the new hospital.
- Provide spaces that will facilitate teaching and research.
- Design a plan that will be sufficiently flexible to accommodate changing medical technology.

Ms. Gladson recalled that the medical campus has a master plan that divides it into sectors focusing on inpatient, outpatient, and research functions. She noted that community members get their first impression of the medical center while driving on Interstate 5. The design for the new hospital takes account of the building's scale as seen from that freeway as well as from the entryway to the medical center. The design team believed that adding a building marker or icon was an important key to creating an identity for the hospital. The marker, which will be a set of glass towers, will become the main lobby and family waiting area. Arcades and colonnades will be used to redefine and integrate the new and old areas, the building's surroundings will frame it as a distinct space, and the development of a classical architectural vocabulary will give it a sense of timelessness. A central garden will offer a pleasant view from inside the building and a landmark to help patients orient themselves while finding their way around. Ms. Gladson noted that comments from the members of the Committee on Grounds and Buildings were helpful in refining the design.

Regent Johnson noted that the hospital was being built with the future in mind and would provide excellent patient care and cutting edge technology. She asked about the assignable square footage relative to the current space. Ms. Gladson responded that the new building is 409,000 gross square feet. Current codes and licensing require patient and operating rooms to be of a size that will accommodate moving equipment around easily. The new hospital will have the same number of beds as the old. In response to a further question by Regent Johnson, Chancellor Cicerone reported that the project will cost about $370 million. The mandate to replace the hospital from a seismic point of view had been funded in the amount of $235 million through State lease revenue bonds. Of the remaining amount, hospital reserves will fund about $20 million, debt financing $35 million, equipment leasing $25 million, and private donations $50 million. He noted that there is strong community support for the project.

Regent Terrazas approved of the idea of new construction rather than seismic retrofitting. He noted that no beds would be out of service during the construction. Dr. Cygan indicated that the new hospital will be slightly under its licensed bed capacity. He recalled that although 391 beds are in use, about 380 will be in use when the hospital opens in 2007, and it will have the capacity to add 30 medical/surgical beds.

Regent-designate Seigler emphasized the importance of getting the message out to private hospitals and entrepreneurs in the area that caring for the less fortunate is a community responsibility. He wondered what UCI could offer hospitals in Orange County in terms of on-site continuing education in order to make it more attractive to community hospitals to care for these patients, who could then can have less travel time and remain closer to their families. Dr. Cygan responded that, while UCI is reaching out to other hospitals, the key issue in Orange County is the underfunding of the Medical Services for Indigents program. The possibility of moving the MSI program into the County Medi-Cal program was investigated, but it was determined

that to provide a Medi-Cal level of services to this population would cost twice as much as the County was willing to invest.

At this point the Committee recessed to tour the hospital's neonatal, emergency, and neurosurgery departments.

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The Committee reconvened at 1:55 p.m.

3. **UPDATE ON MEDICAL LIABILITY, RISK REDUCTION, AND QUALITY OF CARE PROGRAMS AT THE UNIVERSITY OF CALIFORNIA'S ACADEMIC MEDICAL CENTERS**

Vice President Gurtner introduced the following individuals, who discussed the University's Professional Medical & Hospital Liability Program (Professional Liability) and the work which continues at the medical centers and at the Office of the President to ensure that patients receive consistent and high quality care: Mr. David Taylor, Medical Services Director, Office of the President; Dr. Gibbe Parsons, Hospital Medical Director, Davis campus; Dr. Eugene Spiritus, Medical Director, Irvine campus; Dr. Tom Rosenthal, Chief Medical Officer, Los Angeles campus; Dr. Lee Hilborne, Director–Quality Services, Los Angeles campus; Dr. Cecilia Smith, Medical Director, San Diego campus, and Dr. Theodore Schrock, Chief Medical Officer, San Francisco campus.

National Malpractice Crisis

It was reported that medical malpractice insurers nationally are experiencing an increase in claim frequency and severity. According to Physician Insurers Association of America, during the period 1991 through 2001 the percentage of claims costing in excess of $1 million dollars increased nearly four fold. There have also been unpredictable jury verdicts. Additionally, investment yields have declined due to falling interest rates and are no longer available to subsidize premium rates to the extent they once did. Several medical malpractice insurers have ceased all underwriting. In 2001, long-time industry leader St. Paul announced that, due to unsustainable losses and the "unfavorable tort environment," the company would no longer write new medical liability coverage, nor would it renew the policies of its physicians, hospitals, and other health care provider customers. Twenty percent of American Hospital Association members have cut services in the last two years due to the insurance crisis.

California Malpractice Situation

California benefits from the Medical Injury Compensation Reform Act of 1975 (MICRA), tort reform legislation enacted during the first medical malpractice crisis, but despite the benefits of MICRA, California is not immune from the increasing

severity of verdicts and settlements. The components of a medical malpractice settlement or jury verdict are lost wages, future and past medical care expenses, loss of consortium, if applicable, and non-economic damages for pain and suffering. MICRA caps non-economic damages at $250,000, but cost of living increases, including increasing costs for health care, contribute to the cost of malpractice settlements and verdicts. Additionally, plaintiff attorneys frequently attempt to circumvent MICRA limits by pleading causes of action that are not subject to MICRA caps, such as elder abuse and battery.

University of California Self Insured Professional Liability Program Status

A 2001 professional liability actuarial study indicated that the frequency of medical malpractice claims has been flat relative to the risk-adjusted exposures. The estimated annual increase in the average claim cost was about 5 percent. The University commissioned a benchmarking study to evaluate systemwide program results. The study's findings indicate that the University's professional liability claim costs are lower than those of most of the benchmarked entities, due primarily to lower claim frequency relative to exposures.

University of California Medical Center Quality and Risk Management Processes

All of the University's medical centers have strong reputations for high-quality, state-of-the-art patient care. Each is surveyed triennially by the Joint Commission on Accreditation for Hospitals and Healthcare Organizations. In 2001-02 all were surveyed and all performed exceptionally well. The University's medical centers voluntarily participated in the Business Roundtable's and the Pacific Business Group on Health's Leapfrog Initiative in 2001-02. This initiative is designed to rate hospitals in three areas related to patient safety. The three "leaps" are computerized physician order entry systems, ICU intensivist staffing, and high volumes of certain surgical procedures. The University's medical centers all received superb ratings, and UCIMC was the only California hospital with top scores in multiple categories.

In accordance with State law, each UC medical center has a medical staff committee to handle issues of quality assurance and medical risk management. Typically, these committees operate subject to privileges that include the peer review privilege of section 1157 of the Evidence Code and the attorney-client privilege.

The Quality Improvement or Performance Improvement Committee of the medical staff at each UC medical center is responsible for developing an annual performance plan, which entails monitoring performance, analyzing current performance, and improving and sustaining improvements of processes and outcomes of patient care. These activities are carried out through interdisciplinary teams, clinical service, and department activities and peer review.

The Medical Risk Management Committee (MRMC) reviews malpractice cases and provides guidance about the standard of care. Each hospital has a Hospital Risk

Manager who serves as the key liaison between the hospital and medical staff with regard to risk management and the MRMC. Day to day responsibility at the Office of the President for oversight and consultation in matters of hospital risk management lies with the Professional Liability Program Manager.

All physicians on the premises of a University hospital who have been granted a University appointment are extended coverage under the Professional Liability Program when providing health care and related services. This approach eliminates any adversarial relationship that might otherwise arise between hospital personnel and the medical staff when there is an unfortunate incident or claim. Medical malpractice cases that are settled or tried that result in an adverse judgment award of $30,000 or more are reported to the Medical Board of the State of California. The Medical Board investigates many cases in order to determine whether some action should be taken with respect to the license of involved faculty physicians. In addition, Section 805 of the Business & Professions Code provides for reporting to the Medical Board discipline and other adverse action taken with respect to a faculty physician's privileges.

Activities of the Systemwide Medical Directors

The systemwide medical directors, all of whom coordinate quality improvement programs and participate in MRMCs at their respective medical centers, have conference calls twice a month and meetings every other month. The meetings are part of the overall peer review process of the medical centers in conjunction with the Office of the President. One of the meetings' goals is to reduce risk through the sharing of information, policy development, and recommendations intended to lead to better patient care. Adverse events and their analyses are routinely presented for rapid dissemination.

Clinical Services Development, the Office of General Counsel, Risk Management, and the Office of Research are resuming Clinical Policy Review Team campus visits in 2003, with explicit focus on the interface between risk and quality functions at the medical centers. The project aims to ensure that there is follow up by hospital quality departments and medical staff offices based on claims, sentinel events, and physicians with multiple claims experience.

The medical directors have authorized, and Clinical Services Development has coordinated, the development of a systemwide online incident reporting system which provides early notification of problems and the ability to track trends. Because all medical centers will use identical reporting rules, the online system will allow the comparison of systemwide trends.

The medical directors have organized and received funding from the Agency for Healthcare Research and Quality for SAFER California Healthcare (Strategic Alliance for Error Reduction), which promotes research and education in the area of patient safety and the reduction of medical errors.

UCOP Medical Services Director Taylor showed slides to illustrate how the University prepares for and responds to problems that arise. He noted that the medical directors are responsible for ensuring that care provided to patients at the University's hospitals and clinics is of the highest possible quality and that a patient who comes to the University for care has an excellent, successful, and safe experience. He provided an overview of malpractice concerns, claims rates, and the role of the medical director at each medical center. He then discussed medical liability in the context of maintaining high-quality care and the growing national movement for patient safety and how the University has responded.

Mr. Taylor reported that the average payment in a malpractice settlement is now greater than $300,000, which is an increase of 60 percent since 1998. Many malpractice suits involve very common problems. Efforts at reducing risk in these areas usually involve educational and programmatic interventions, and some of these areas are related to documentation of care, informed consent for procedures, communication among providers and between providers and their patients, supervision of resident house staff, and the transfer of the care of patients between systems and providers. The medical directors or chief medical officers are responsible for clinical affairs in the management of the hospital and health systems. The University's medical directors are senior members of the faculty. Several are also involved in medical group practice management, and two are graduate medical education deans. The medical directors play a key role in accreditation of the hospitals by the Joint Commission, the State Department of Health, Medicare, and the California Medical Association. They are also responsible for quality of care and patient safety programs, risk management and risk reduction, medical staff operations, utilization review and management, physician credentialing and discipline, and peer review. The medical risk management committee system at each campus provides input to legal counsel and feedback to clinical departments and quality-of-care committees. The medical directors have launched systemwide projects, received grant funding, and rapidly disseminated information. Collaboration also involves the Office of the President's divisions of Clinical Services, Risk Management, and the General Counsel.

Mr. Taylor discussed the size and scope of clinical contacts that take place at the University's hospitals and clinics. He reported that the total number of hospital discharges is greater than 133,000 and there are more than 3.5 million ambulatory visits per year. The number of cases that have an undesirable outcome or allegation of liability is relatively very small. Cases opened in the system have declined from just over 700 three years ago to 692 last year. The figure is not a measure of suits or settlements but rather all cases opened, including potentially compensable events and deposition representations. This decline, while not dramatic, represents close attention by the medical directors and their staffs to the goal of maintaining a high quality of care and the prevention of adverse events that are an immediate risk to patients and could lead to claims. The value of understanding sentinel events is extremely important. Sentinel events are managed in a way that requires close analysis and understanding, which the University has labeled "root cause analysis." This process, which is a common management technique, is designed to solicit multiple points of

view and a detailed review of events. Sentinel event management also allows for the analysis and understanding of potential claim management. In complex work such as patient care, there are many systems and processes in need of continuous improvement. The improvement of performance is the bedrock of hospital quality management.

Mr. Taylor reported that root cause analysis is only one of many methods of data analysis used to monitor quality. Pharmacy practices, infection rates, patient satisfaction, and physician performance are also analyzed in order to provide a comprehensive picture of patient care. The response to a sentinel event can lead to many positive outcomes which go well beyond the potential defense and response to a particular claim.

Mr. Taylor noted that in their meetings the directors identify best practices. In the past five years, interest has increased in medical errors and patient safety. A study released in 1999 estimated that there are 44,000 to 98,000 excess deaths per year in U.S. hospitals. A range of 3 percent to 38 percent of hospitalized patients are affected by iatrogenic illness or injury. From 2 percent to 35 percent of hospitalized patients suffer adverse drug events, and there are greater than 7,000 deaths per year from drug reactions. There are 2 million hospital-acquired infections per year. The patient safety approach seeks to change how health care works and encompasses quality improvement and risk reduction, as well as a reassessment of the system and culture of clinical care. This approach seeks to apply the methods of aviation and other high-risk industries to health care in order to reduce mishaps. These efforts should yield better patient care, fewer bad outcomes, and fewer claims. The University has launched a web-based, UC-wide incident reporting system that permits early warning of adverse events. This novel initiative permits a standardized approach to data analysis systemwide and allows for the collection of reliable information on errors, to consolidate a database of adverse events, and to compare and benchmark systemwide trends. In addition, the Office of the President's Clinical Policy Review initiative for 2003 will target efforts which the medical directors have identified over the past several years as priorities. The intention is to help speed the adoption of best practices and to foster the development of stronger links between the risk and quality committees. Some areas to be assessed are physicians with multiple claims and reporting, how the competencies of residents are determined by their supervisors, the implementation of the Joint Commission's national patient safety standards, and human subjects programs. SAFER California Health Care, the response of the UC medical directors to the federal initiative, is directed by Dr. Hillborn. Its first patient safety summit attracted nearly 300 participants and a nationally prominent group of speakers. Other UC campuses have other efforts in patient safety. UC Davis has a center for research and outpatient safety. UCSF has edited a comprehensive evidence-based report on patient safety and created a website for doing morbidity/mortality consultations on line anonymously. UCSD has founded a San Diego Center for Patient Safety. Efforts will continue in 2003 toward improving care for all Californians.

Regent Preuss believed that all the Regents would benefit from the information that Mr. Taylor had provided on the systematic steps that the University is taking to prevent the recurrence of medical mistakes. He asked whether any decline in the number of cases of medical mistakes was expected. Ms. Terri Kielhorn, Manager of the Professional Liability Program, responded that, although a decline would be welcome, it is likely that plaintiff attorneys will continue to find new ways to challenge medical care.

Regent Terrazas noted that the Regents too often see the horror stories as opposed to the good things that have been implemented with regard to risk management. He commended the group's efforts and suggested that the Regents be warned early about any trends in practices and patterns that could become problematic. He advocated making sure that clinicians and other health professionals in the University's employ who have impairments are monitored so that if they are not participating in or have not completed diversion programs they are not being put in situations where they can cause any harm to themselves, their colleagues, or patients. He stressed the importance of reporting problems promptly to the appropriate licensing authorities concerning those professionals who are deficient, incompetent, or grossly negligent. Also, because the University is heavily involved in research, attention must be paid to institutional review board oversight with regard to informed consent, especially with regard to the elderly and language-impaired people. Lastly, he recommended that settlements entered into not include confidentiality agreements, which impair the University's ability to fulfill its public mission by sharing information on best practices. General Counsel Holst assured him that the University does not enter into confidentiality agreements in connection with its settlement agreements.

Director Spiritus reported that each medical staff has a committee to deal in confidence with impaired physicians, who are monitored and are subject to having their privileges withdrawn and being reported to the State. Also, research oversight programs have been developed at most of the campuses. Research protocols may be audited to make sure that informed consents are handled appropriately, and outcomes data are surveyed in order to protect both patients and employees.

Ms. Joanna Beam, University Counsel, reported that the University is required to report to the State any disciplinary action that has been taken for what is called "disciplinary cause or reason" for one of its physicians. Those reports occur if there has been a summary suspension for medical cause or disciplinary reason or following a due process hearing after the physician has been given the opportunity to disclose the facts as he understands them and to cross examine any experts who may be offered.

Regent Sainick recalled that the litigation reports received from the General Counsel reveal that the incidence of claims is low. The cause for true liability is even lower. Given the volume and acuity of the University's patients, he believed that the statistics were favorable.

Regent Kozberg asked about trends in medical liability insurance. Ms. Kielhorn responded that overall claim costs have increased for the system by about 6 percent this year, or about $51 million, which is consistent with the experiences of other California hospitals. Claim count has remained consistent relative to risk-adjusted exposures and is also consistent with other California hospitals. Statistics for California are favorable compared to the rest of the nation. MICRA has kept down the cost of insurance for California physicians and is being evaluated as a model by the federal government. Senior Vice President Mullinix noted that an annual report to the Regents describes the University's experience and compares it to that of others.

Regent Johnson complimented the work of the hospital directors and their colleagues and stated that she looked forward to hearing more about the 2003 initiative of the Clinical Review Task Force.

Regent Lee noted that the University trains the best doctors and lawyers and asked what could be done to make sure they understand the professional issues involved in medical malpractice. Director Smith assured him that the University is teaching future doctors not only clinical skills but also the importance of risk reduction and quality performance. An effective way of imparting this information is through the mentoring relationship that is established between faculty and students.

UCI College of Medicine Dean Cesario commented that the work environment of a University hospital is stressful in that it involves treating a high volume of patients, many of whom are exceedingly sick, while also conducting training. It is a situation in which the probability for adverse events is high. He believed that the medical directors play an important role in minimizing those risks. It is critical for students to practice in an environment where they are given early warnings and are taught how to deal with adverse events when they happen.

Regent Preuss believed that the University has an exceptional healthcare system. Medical Service Director Taylor responded that he was pleased with the effectiveness of the risk management program, but he assured the Committee that efforts at further improvement will continue.

Regent Kozberg asked whether changes in technology pose any problem to physicians. Chief Medical Officer Schrock acknowledged that, although it can be a challenge to bring new and innovative techniques into daily practice, in many cases people at the campuses are the inventors. They share their experience with others, who disseminate the information to their colleagues, and as residents come through, they pick it up. The process does not take long in most cases. Generally, there is no resistance to learning technology that improves patient care and safety.

Regent Terrazas noted that the standard of care for the practice of medicine in whatever field is the clinician's field of choice is in part established by the training and education he gets. Students should be made aware that achieving a standard that is higher than regulations should be a goal. For instance, having a third party chaperone

present in obstetrical and gynecological cases may not be required by law, but it is a smart thing to do. The University should help to establish the standard of practice not just for its own graduates but for everyone who practices medicine. He suggested lecturing students about how to prevent litigation. Director Parsons affirmed that students undergo instruction in risk management and participate in mock depositions.

Committee Chair Lee thanked the participants and complimented them on the development of their risk management and quality maintenance strategies.

The meeting adjourned at 2:55 p.m.

Attest:

Secretary