

The Regents of the University of California

COMMITTEE ON HEALTH SERVICES

April 18, 2016

The Committee on Health Services met on the above date by teleconference at the following locations: Covell Commons, Los Angeles campus, and UCSF–Mission Bay Conference Center, 1675 Owens Street, San Francisco.

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

In attendance: Secretary and Chief of Staff Shaw, Deputy General Counsel Nosowsky, Chief of Staff Grossman, and Recording Secretary Johns

The meeting convened at 1:35 p.m. with Committee Chair Lansing presiding.

1. **PUBLIC COMMENT**

There were no speakers wishing to address the Committee.

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

Upon motion duly made and seconded, the minutes of the meeting of February 3, 2016 were approved, Regents Lansing, Makarechian, Napolitano, Reiss, and Sherman voting “aye.”¹

3. **REMARKS FROM ADVISORY MEMBERS TO THE COMMITTEE**

[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 welcomed the Committee’s advisory members. The Committee would benefit from their diverse backgrounds and experience in public and private academic health systems, foundations, and health policy.

Advisory member Smith introduced himself as a graduate of the UCSF residency program in internal medicine primary care during the early days of the AIDS epidemic. Dr. Smith subsequently pursued a fellowship and studies at the University of Pennsylvania, joined the faculty at Johns Hopkins University, and had worked at the Kaiser Family Foundation and the California Health Care Foundation for the past 22 years. He currently served as a faculty member at UCSF and UC Berkeley and saw

¹ Roll call vote required by the Bagley-Keene Open Meeting Act [Government Code §11123(b)(1)(D)] for all meetings held by teleconference.

patients at San Francisco General Hospital. He hoped that his participation on the Committee would help to maintain the excellence of health care at UC and make it more affordable for those who need it.

Advisory member Ramsey informed the Committee that he had received his medical training at Harvard Medical School, completed his residency at Massachusetts General Hospital, and had been at the University of Washington, Seattle since 1978. He had begun his career as an infectious disease and white cell biochemist but moved to general internal medicine. For the past 19 years he had been serving as the Chief Executive Officer of UW Medicine and Dean of the University of Washington School of Medicine. He anticipated great changes in health care over the next five to 15 years. The current rapid changes were having a positive impact on research. The time that elapses between scientific discovery and clinical application was now only a few years, and the development of precision medicine was proceeding faster than anyone could have predicted. Health education programs must be fully integrated. The change from fee-for-service to value-based reimbursement requires a business model that is challenging to implement. UC Health in particular has the opportunity to discover new knowledge and integrate this quickly into healthcare delivery.

Advisory member Hernandez related that she had grown up in southern Arizona, attended medical school, and then had the opportunity to come to UCSF and complete her residency in the program in internal medicine primary care at San Francisco General Hospital. This experience led to an interest in public health and service as the director of public health for the City and County of San Francisco. Currently, under the Patient Protection and Affordable Care Act, there was an opportunity to consider indigent populations who earlier did not have many choices regarding health care. As a payer source, Medi-Cal was now a mainstream program. There was significant work to be done in health literacy and in improving outcomes. Healthcare delivery systems must examine how dollars can be spent to achieve desired outcomes and reduce disparities in health in California. It was also important at this time to reflect on graduate medical education and how it would adapt itself to the future workforce needs of California.

Advisory member Dimsdale, a faculty member at UC San Diego for 30 years in psychiatry, raised three issues he hoped the Committee would consider. The first was encouraging innovation in healthcare delivery. Given UC's self-funded insurance, the University had enormous incentives to experiment with innovations in chronic disease management, such as integrating medical and behavioral care delivery and pursuing a natural combination of research, clinical care, and education. The second was extending the reach of UC health services to non-health sciences locations such as Santa Barbara and Santa Cruz, either through local alliances or satellite programs from existing UC medical centers. The third issue was morale and attrition of UC medical school faculty members. Many senior and junior faculty in all faculty series are leaving the University. The Committee should examine this phenomenon and consider whether UC's experience is comparable to other leading academic medical systems.

4. **ENDORSEMENT OF NEW BED TOWER PROJECT, UCLA MEDICAL CENTER, LOS ANGELES CAMPUS**

The President of the University recommended that the Committee on Health Services endorse the proposed construction of a new bed tower as an expansion of the UCLA Ronald Reagan Hospital on the Westwood campus of the UCLA Medical Center.

[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 recalled that under new procedures for Regents' review of capital project items, this Committee would review items with substantial impact on the clinical enterprise. The items would then proceed to the Committee on Grounds and Buildings for review of financial considerations. The role of the Committee on Health Services is to opine on the suitability of projects, taking into account the clinical strategy and needs of campuses.

UCLA Health President Johnese Spisso briefly introduced the item. The proposed new bed tower would be situated on the Westwood campus of the UCLA Medical Center. UCLA was aiming to fund about half of this construction project through philanthropy and wished to begin a fundraising campaign immediately.

Committee Chair Lansing expressed strong support for the project, stressing that there was a real need for this hospital expansion in Los Angeles. She asked about project funding. Ms. Spisso responded that UCLA would like to raise approximately \$300 million. The campus had communicated with one major donor the previous week and secured the first \$49 million.

In response to a question by Regent Makarechian, Ms. Spisso confirmed that UCLA was seeking the Committee's endorsement in order to begin the public campaign for fundraising. A full financial plan would be presented at a future meeting.

Regent Makarechian referred to background materials stating that the campus would hire consultants to develop detailed program and design concepts. Ms. Spisso explained that this referred to the pre-design phase of the project. Regent Makarechian asked why the campus was not seeking approval of a budget to hire these consultants. Vice Chancellor Steven Olsen responded that UCLA had been studying this issue for many years as part of business planning for the UCLA Health System, especially the problem of patient capacity. The plans had not reached the stage of schematic design or design development; the campus had identified a site and examined massing options. The campus would present an item with full background materials to the Committee on Grounds and Buildings at a future meeting.

Dr. Stobo stated that this proposal reflected the daily struggle of the UCLA Ronald Reagan Hospital, which is essentially inundated by patients. All five UC medical centers are full on a daily basis. Some UC hospitals must divert ambulances because their

emergency rooms are full. Dr. Stobo anticipated that there would be further proposals from UC medical centers, presented at future meetings, on various ways to deal with this lack of capacity. New construction is one solution; the medical centers have other creative solutions as well.

Advisory member Smith did not doubt that more beds were necessary, but based on his own experience, he suggested that many patients can avoid hospitalization if they receive effective outpatient care. Across the UC system, one might be able to apply a running tally of ambulatory care-sensitive conditions to determine where substitution of more aggressive outpatient care could alleviate shortages in capacity. Ms. Spisso responded that this was an important part of UCLA's strategy; more of UCLA's patient care was shifting to an outpatient setting. UCLA has about 160 outpatient sites. Reductions in length of patient stays are part of UCLA's planning. UCLA Ronald Reagan Hospital has over 100 intensive care unit beds; it is the site for the most complex tertiary and quaternary patient care. Basic patient care would be moved to community sites and UCLA has about 120 patients in hospitals throughout the community on a daily basis. UCLA uses a combination of strategies to address patient capacity.

Regent Sherman asked about how UCLA would determine the breakdown of numbers of pediatric versus adult patient beds in the proposed bed tower. Ms. Spisso responded that there had been much discussion of this question, which would be resolved in the final project design. UCLA has four target areas of growth in pediatric care; consideration of these areas would help in projecting the final number of beds. There is flexibility in UCLA's plans to change this as needed.

Upon motion duly made and seconded, the Committee approved the President's recommendation, Regents Lansing, Makarechian, Napolitano, Reiss, and Sherman voting "aye."

5. **ENDORSEMENT OF UC IRVINE MEDICAL CENTER ELECTRICAL PLANT PROJECT, IRVINE CAMPUS**

The President of the University recommended that the Committee on Health Services endorse the UC Irvine Medical Center Electrical Plant Project.

[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.]

Committee Chair Lansing briefly introduced the item. Regent Reiss asked how this project would fit into the University's goal of carbon neutrality by 2025. President Napolitano responded that she did not have this information.

Upon motion duly made and seconded, the Committee approved the President's recommendation, Regents Lansing, Makarechian, Napolitano, Reiss, and Sherman voting "aye."

6. **APPROVAL OF APPOINTMENT OF AND COMPENSATION USING NON-STATE FUNDS FOR DEBORAH DEAS AS DEAN – SCHOOL OF MEDICINE AND CHIEF EXECUTIVE OFFICER OF CLINICAL AFFAIRS, RIVERSIDE CAMPUS AS DISCUSSED IN CLOSED SESSION**

Recommendation

The President of the University recommended that the Committee on Health Services approve the following items in connection with the appointment of and compensation using non-State funds for Deborah Deas as Dean – School of Medicine and Chief Executive Officer of Clinical Affairs, Riverside campus:

- A. Appointment of Deborah Deas as Dean – School of Medicine and Chief Executive Officer of Clinical Affairs, Riverside campus at 100 percent time and a faculty appointment at zero percent time.
- B. An annual base salary of \$625,000, plus eligibility to earn \$150,000 in annual incentive/bonus compensation paid as a “Z” component under the Health Sciences Compensation Plan (Academic Personnel Manual Section 670), for a total potential cash compensation of \$775,000. The incentive/bonus compensation will be based on achievement of milestones in four categories: academic achievement, philanthropy, the research enterprise, and clinical affairs.
- C. Per policy, accrual of sabbatical credits as a member of tenured faculty.
- D. Per policy, standard pension and health and welfare benefits.
- E. This appointment will be effective May 16, 2016.

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

Background to Recommendation

The President of the University recommended approval of the appointment of and compensation for Deborah Deas as the Mark and Pam Rubin Dean of the School of Medicine and Chief Executive Officer of Clinical Affairs, Riverside campus, at 100 percent time, effective May 16, 2016. Funding for this appointment will derive exclusively from non-State funds.

The Committee on Health Services was asked to approve a proposed salary that exceeds the maximum of Deans’ Salary Band 3 within the academic Deans’ Salary Structure. While Chancellors hold the authority to appoint academic Deans at salaries within the

Deans' Salary Structure, individual salaries that exceed the maximum salary within the Deans' Salary Structure require approval by the Regents.² This item came before the Committee on Health Services under Bylaw 12.7, which states that the Committee has primary jurisdiction over "appointment and compensation of UC Health executives whose compensation is paid solely from sources other than State general fund support to the University (e.g. clinical revenues, charitable contributions, et al)."

Because UCR does not have a hospital, the campus has no Vice Chancellor for Health Sciences position. UCR does have clinical operations, however, and the Dean – School of Medicine will be expected to expand them considerably. Therefore this position is something of a hybrid, and these duties require a competitive salary.

Dr. Deas' annual salary, funded exclusively from non-State funds, is proposed at \$625,000 plus eligibility to earn \$150,000 in annual incentive/bonus compensation paid as a "Z" component, consistent with policy, under the Health Sciences Compensation Plan (Academic Personnel Manual Section 670). The appointment would be effective May 16, 2016. This salary properly reflects the scope of the candidate's responsibilities, academic credentials, track record of performance, and depth of expertise. In addition, per policy, Dr. Deas will be eligible to participate in the UC Home Loan Program, subject to all applicable program requirements; receive a Faculty Recruitment Allowance of \$150,000, per Academic Personnel Manual - 190, Appendix E; and receive reimbursement for reasonable and eligible moving costs.

Dr. Deas has served as Interim Dean of the College of Medicine at the Medical University of South Carolina (MUSC) since September 2014. In that role, she established the strategic vision for the college, worked collaboratively to further its threefold mission, successfully recruited college leaders, and managed a budget of \$300 million. Previously, she served as Senior Associate Dean for Medical Education, with oversight for undergraduate medical education, graduate medical education, continuing medical education, diversity, admissions, and student affairs. During a long and distinguished career at MUSC, Dr. Deas also served in other administrative roles, including Senior Associate Dean for Diversity, Associate Dean for Admissions, and Clinical Advisor. She led MUSC's accreditation process with the Liaison Committee on Medical Education, the body charged with accreditation of medical schools in the U.S. and Canada. This experience will be very useful as the UCR School of Medicine continues its accreditation process. Consistent with the mission of UCR's School of Medicine, Dr. Deas has a demonstrated record of serving the medically underserved. This broad range of expertise makes her eminently qualified to serve as Riverside's next Dean, School of Medicine.

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² In a November 2009 action, the Regents approved the transfer of academic Deans from the Senior Management Group personnel program to the Academic Personnel program (*Deans' Salary Structure Proposal: Transfer of Deans from the Senior Management Group to Academic Titles*). The Deans' Salary Structure and the return of Deans to governance under the Academic Personnel program were the final steps implementing Section 240 of the Academic Personnel Manual (APM - 240, Deans). This action returned recruitment and retention of Deans to campus authority, allowing Chancellors to exercise their authority when fulfilling campus needs for senior academic leadership.

Committee Chair Lansing briefly introduced the item.

Upon motion duly made and seconded, the Committee approved the President's recommendation, Regents Lansing, Makarechian, Napolitano, Reiss, and Sherman voting "aye."

7. **OVERVIEW OF THE UNIVERSITY OF CALIFORNIA'S GRADUATE MEDICAL EDUCATION SYSTEM**

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

Associate Vice President Cathryn Nation began the discussion by remarking that California has a fairly small medical student and resident education system for a state its size. On a per capita basis, California has the third-lowest medical student enrollment among all U.S. states with medical schools. Only four states do not have medical schools. In the current 2015-16 year, California has a total of 7,000 students enrolled in its 12 medical schools. California has ten allopathic or M.D.-granting medical schools and two osteopathic schools. Three are private nonprofit schools of medicine at Loma Linda University, the University of Southern California, and Stanford. The tenth M.D.-granting institution, California Northstate University, is a for-profit medical school in Elk Grove which admitted its first class of 50 students the previous fall. Three other entities have publicly announced plans to open new medical schools in the state. California University of Science and Medicine or Cal Med plans to open a school of medicine in San Bernardino County in the next year or two. Kaiser Permanente also plans to open a new medical school in Southern California, and California Health Sciences University recently announced its plans to open a for-profit medical school in the San Joaquin Valley.

The Accreditation Council for Graduate Medical Education (ACGME) is the national entity that accredits training programs. ACGME recognizes and accredits 27 types of specialty programs and more than 100 subspecialty programs. There are currently 878 ACGME-accredited residency training programs in California; 375 major medical and surgical specialty programs train about 80 percent of the house staff in California, while a greater number of subspecialty programs train a smaller number of subspecialists, about 2,100 residents or fellows. These California programs are run by 84 sponsoring institutions. UC is by far the largest sponsor of graduate medical education. Private institutions are another major sponsor. Other sponsors are Kaiser Permanente, children's hospitals, which train pediatricians, and an array of community-based programs.

There are nearly 11,000 medical residents and fellows enrolled in programs statewide. Dr. Nation presented a chart showing current numbers of residents and fellows enrolled in UC's programs. The numbers ranged from a small but growing number at UC Riverside to the largest programs at UCLA and UCSF. About 80 percent of California trainees are graduates of an allopathic medical school, while about seven percent attended

an osteopathic school, and this latter number was growing. About ten percent of California trainees were international medical school graduates.

Of UC's current medical residents, about 36 percent were enrolled in primary care training programs, including pediatrics, family medicine, internal medicine, and obstetrics and gynecology. Another 25 percent were receiving training in specialty programs such as psychiatry and dermatology. Another 20 percent were enrolled in hospital-based specialties such as emergency medicine, critical care anesthesiology, and radiology. About 19 percent of UC's trainees were enrolled in 14 unique surgical specialty training programs including general, cardiothoracic, orthopedic, vascular, and other forms of surgery.

The return on investment in these programs has historically been very positive for California. According to recent data from the Association of American Medical Colleges, almost 70 percent of those who complete their residency in California remain in the state to practice. More than 60 percent of those who receive undergraduate medical education in California remain in California. Almost 70 percent of graduates of public medical schools, essentially the UC schools, remain in California, although some may have to leave the state for their residency training.

Dr. Nation then discussed the financing of graduate medical education. Medicare is the single biggest funder of graduate medical education nationally. In fiscal year 2014-15, UC received a total of \$273 million in Medicare funding to support direct and indirect costs of medical education. However, this funding does not cover the cost of training even those residents who are in Medicare-funded positions. UC receives roughly \$100,000 per resident, but training costs are close to \$150,000. This difference contributes to the funding gap, but another challenge derives from the fact that nearly two decades earlier, in 1997, Congress limited the number of total positions for which teaching hospitals can receive Medicare funding. The number of Medicare-funded positions in UC's five major medical centers, not including UC Riverside, is 2,151. UC has 377 positions for which UC receives no funding. UC hospitals are left to cover \$40 million beyond Medicare support.

Dr. Nation outlined challenges for graduate medical education. There are persistent threats in federal funding cuts for Medicare. State budget cuts have led to rising fees and dramatic increases in debt for UC medical students. There are longstanding workforce challenges in California. In 51 of 58 counties, there are shortages in certain health profession areas. The workforce is among the oldest in the country. Large numbers of California physicians are planning to retire in the near future. There would be continuing challenges regarding access to graduate medical education. This was reflected in the pent-up demand to open new medical schools. The Riverside campus would work to expand its graduate medical education infrastructure as its School of Medicine grows. There are looming challenges in the Central Valley. There are concerns about faculty and residents' well-being and the need to maintain adequate access to mental health counseling services.

UC's medical education programs have instituted innovative measures to address California's needs. Notwithstanding budget challenges, UC has added roughly 350 new medical student positions, an enrollment expansion through the UC PRIME initiative, which focuses on the needs of medically underserved communities, and which has achieved an exceptional level of medical student diversity. The UCR School of Medicine admitted its first class of 50 students in fall 2013. Among other innovative programs, UCLA has an international medical graduate program, a pre-residency training program that improves participants' competitive eligibility to enter family medicine training programs. In 2014 UC Davis launched an accelerated competency-based education program in primary care, an intriguing concept that allows students to complete four years of medical school and three years of primary care training in six rather than seven years. This saves students a year in time and fees on the pathway to providing primary care in California.

Dr. Nation concluded that there would be growing expectations of the University: that UC increase educational content about healthcare quality and outcomes, teach about new and emerging healthcare technologies, and develop new models of care. There are already increasing expectations for institutional accountability on the part of ACGME and other accreditors. The University is hopeful that there may be some new funding for graduate medical education as part of a ballot initiative in the upcoming year.

Advisory member Ramsey noted that two of the greatest current challenges for health care were reduction of per capita costs and improving the quality and safety of care. In both areas, residents and fellows are in a position to make a positive impact. He asked if there are organized programs within the UC residency system to involve residents in quality and safety improvement and cost reduction. Dr. Nation responded that all UC's medical campuses have developed programs to increase teaching and emphasis on healthcare quality, outcomes, and cost savings. UC expects that its house staff can identify priority clinical goals, and many campuses also have incentive programs that allow house staff to identify programs and priorities for which they would recommend funding. UCSF Medical Center Chief Executive Officer Mark Laret stressed the important role of residents. Residents have brought about improvements in patient wait times for admission to the emergency room. Dr. Nation added that residents are leaders in the use of technology in this area, inspiring colleagues to identify paths to improvement.

Advisory member Smith stated that UC should have an explicit goal of reducing the cost of medical training, just as it has already focused attention on reducing unnecessary costs for care. The UC healthcare delivery system is more expensive than that of its competitors. To some extent this expense can be attributed to its teaching function. If UC could teach at lower cost, it could be more competitive in delivery. He noted that UC Davis made impressive use of simulation laboratories and models. UC could state explicitly that it wishes to train doctors less expensively and more efficiently, using distance learning. This would make UC more competitive and allow medical students from low-income backgrounds to begin their practice without a heavy debt burden. Dr. Nation concurred that more work needs to be done in this area. There are simulation centers at all UC medical schools. There are not many online or distance education

offerings in the core curriculum for medical students and residents, partly due to the value of the patient care experience. The consequences of major State budget cuts have forced all the medical school deans to examine medical education costs. Sharing of best practices has led to savings in time and effort.

Chancellor Hawgood reflected on factors that must be brought into balance. There is a general belief that the highest-quality medical education requires small group and faculty interaction time. This involves the cost of faculty. In addition, many agencies oversee UC's medical education programs and regulatory requirements are constantly increasing. The introduction of for-profit medical schools would be a disruptive force in this situation. These schools would not be cheaper for students, but their cost of providing instruction would be lower. It is difficult to determine the costs of medical education versus healthcare delivery. The University's estimate of the real cost of training a medical student is approximately \$70,000 annually, plus or minus 15 percent. Tuition covers about half of that expense and the other half must be covered in some other way.

Regent Makarechian referred to information presented earlier according to which California has only 18.4 medical school students enrolled per 100,000 in population, compared to a national median of 30.3 students. He asked if California was importing doctors from other states, and in which states enrollments were highest. Dr. Nation responded that for a long time, California has relied on in-migration of physicians trained elsewhere. Over four decades, enrollment did not change much at the five UC medical schools and the three private, non-profit schools, although the population grew considerably and the demand for medical education grew proportionately. Currently California sends more than three times the number of its own students out of state for medical school. Medical schools across the country have students from California. The size of California's medical education system is too small to meet the demand. She concurred with Chancellor Hawgood that a test would come with the arrival of private, for-profit schools that will train large numbers at high cost. Currently, medical schools in the Caribbean train many California students. Some of these schools admit classes of 500 students as often as three times a year, with annual tuition of approximately \$55,000. These students have dreams of coming back to California to practice but are left with enormous debt. California's medical education system did not grow because the state relied on students and residents coming back to California to practice, which they have done in large numbers.

UC Irvine Vice Chancellor Howard Federoff concurred with Chancellor Hawgood that the for-profit medical schools would put the education of medical students and residents in a new and more complex context. These schools would also create a great debt burden for their graduates. The question of how that debt burden can be underwritten would influence their graduates' choices of pursuing a career in primary care or some kind of very specialized care. One should be mindful that the debt burden of medical residents is substantial.

Chancellor Hawgood remarked that although not much was yet known in detail about the proposed new Kaiser Permanente school, it presented an interesting model because

Kaiser is a closed system that educates for its system. Kaiser has considered the possibility of students being employees while they are students. This model might graduate students with significantly less debt. Students at the Kaiser school would have very little exposure to traditional research disciplines, something the UC system offers. This is a cost borne by UC medical schools that would not be borne by the for-profit schools, which have no research infrastructure.

Advisory member Hernandez noted that the Health and Medicine Division of the National Academies, formerly the Institute of Medicine, has studied the issue of how graduate medical education might be funded differently than it has been for the past 40 years. Many of the issues discussed by the Committee are national issues. Many institutions that sponsor graduate medical education programs had expressed opposition to the Division's recommendations for different financing. It might be worthwhile for the Committee to examine these recommendations to determine whether any could be piloted in California and advocated on a national level. The current model in which Medicare largely funds part of graduate medical education is not sustainable, even if costs are reduced. The Committee might be interested in considering reasonable ways to move from Medicare to a different mechanism.

President Napolitano commented that two of the major financial stressors on UC Health were Medi-Cal and Medicare. Medi-Cal does not pay the full cost of treating patients, and UC takes on a greater share of Medi-Cal patients than other health systems. Medicare does not cover the cost of educating physicians. If the University does not anticipate changes in Medi-Cal's or Medicare's practices, it must think holistically about its business model and how to close these funding gaps, such as reducing the cost of training and finding different revenue sources to support graduate medical education. President Napolitano requested clarification of the relationship between undergraduate medical education and graduate medical education, the link between the medical school degree and residency. She asked if all students enter residency programs equally situated, or if some have to catch up in some way. She also asked about the demography of UC residents, considering gender, race, ethnicity, and urban or rural background. She asked if this population of residents was changing and if so, how. Dr. Nation responded that for undergraduate and graduate medical education, UC's schools are among the top medical schools in the country. UC's medical programs have more applicants than they can accommodate – 5,000 to 7,000 each year – for a total number of about 700 available places for first-year students. UC has to turn away many qualified, competitive applicants. UC's medical students are highly competitive. The data from this year's graduating classes showed that roughly 40 percent of graduates move to another UC location, a large number of graduates move to residency programs in California, and a smaller number leave the state for residency training. UC's medical students are in high demand as entering residents and tend to succeed in their training programs. Graduate medical education is the path to licensure to practice in a state and to eligibility for certification as pediatricians, surgeons, and subspecialists. Although there is no automatic link between UC's medical school programs and its graduate medical education programs, many of UC's medical students go on to training at UC. Many UC-trained physicians remain in California.

Dr. Nation then responded to President Napolitano's question about whether entering residents are equally situated. In terms of ability, preparation, and academic success, UC medical students and house staff do extremely well by all measures, such as pass rates on national examinations, success in securing a license to practice, and success in entering and completing training programs. Dr. Nation did not have demographic data for the 5,000 residents enrolled at UC. UC Health would be examining data on this in the coming weeks. The current-year medical student enrollment data for the PRIME initiative, for 377 students, showed that 67 percent were from underrepresented groups. The diversity in UC's medical student classes has increased to one of the highest levels in recent memory. There is a greater level of diversity in the medical student community than in the house staff, and greater diversity in the house staff than among junior faculty. The level of diversity declines as one moves up the academic ladder.

Regent Makarechian asked if the very successful performance by UC medical students meant that graduates of UC programs earn more than physicians trained at other institutions. He asked if the University tracks its graduates and the location of their practices. He recalled that one motivation for the new School of Medicine at UCR was to provide more physicians in an underserved region. Dr. Nation responded that UC was now doing a better job of tracking medical school graduates and residents. It understands the importance of knowing where these physicians are practicing. UC hopes to maintain a connection with them also in the hope of building philanthropic contributions for endowments, an area in which UC has been at a competitive disadvantage. UC San Diego Health System Chief Executive Officer Patricia Maysent added that one of UC's greatest strategic levers, especially in building affiliations with other medical centers, is the fact that UC has residents and fellows, a pipeline of subspecialists sought after by affiliates.

Regent Makarechian remarked on the uneven concentrations of physicians in different parts of California. Ms. Maysent observed that recent graduates or fellows should not be put out into a market by themselves; sometimes it is prudent to pair them with senior or mid-level faculty to make this model successful.

Dr. Nation responded to Regent Makarechian's question about physician salaries. She did not have salary data for graduating house staff, those who complete UC's residency training programs. She commented that the market is huge and increasingly competitive in many specialties, particularly in specialties that are in short supply. In some parts of California, psychiatrists cannot be recruited at almost any salary. There are growing shortages of general surgeons throughout the state. The market is strong and salaries are competitive. UC graduates have many choices. Executive Vice President Stobo added that graduates of UC's programs are very attractive to other providers and entities. It would behoove the University to find creative ways to keep talented individuals within UC rather than allowing them to be recruited away by Kaiser, Sutter, Scripps and other health systems. Dr. Nation reported an interesting statistic from Kaiser Permanente; Kaiser hires more primary care physicians each year than the number of graduates from UC medical programs.

Committee Chair Lansing stated that UC must consider the issue of retention.

Dr. Hernandez stressed the success of the PRIME program in diversifying UC's medical programs. Medical students are increasingly trained by faculty whose life experiences are not like students' experiences. If UC wishes to retain its graduates, it should be mindful of its faculty appointments to ensure that the faculty are a reason for graduates to remain in the UC system. There would be no easy solution.

Dr. Dimsdale hoped that UC would carefully examine these data, including ethnicity of faculty, for different series of faculty, junior and senior.

Committee Chair Lansing requested that Dr. Hernandez share the Health and Medicine Division report with the Committee.

The meeting adjourned at 2:45 p.m.

Attest:

Secretary and Chief of Staff