

The Regents of the University of California

**HEALTH SERVICES COMMITTEE**

December 13, 2017

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

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

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

The meeting convened at 1:20 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 October 18, 2017 were approved.

3. **REMARKS OF THE EXECUTIVE VICE PRESIDENT – UC HEALTH**

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

Executive Vice President Stobo first commented on consolidation in the healthcare market. Most recently, Ascension Health and Providence Health & Services indicated their intention to merge, creating a system of 191 hospitals with net revenues of \$45 billion. Catholic Health Initiatives and Dignity Health announced their plans for a merger to create a 139-hospital system with revenues of \$25 billion. The University would monitor the progress of these mergers. UC was also monitoring the progress of the current tax bill under consideration by the U.S. Congress, and in particular its potential impact in areas such as the health insurance individual mandate, the federal deficit and Medicare and Medicaid funding, and tax-exempt bond funding. Potential cuts to Disproportionate Share Hospital programs were also a concern, as were reductions in the 340B Drug Pricing Program. The 340B program requires pharmaceutical companies to discount certain drugs for outpatients. A reduction would be in effect for Medicare patients that would have a \$50 million impact on UC Health.

Advisory member Lipstein remarked on the status of the individual mandate and tax-exempt funding in the House of Representatives and Senate versions of the current tax bill. The erosion of the tax-exempt status of universities and hospitals was a matter of grave concern, as well as the idea that universities and hospitals might become more like for-profit entities with owners, investors, and shareholders, rather than existing for the benefit of their patients and communities. This presented a moral dilemma. No groundbreaking discoveries in medicine had ever been made at for-profit hospitals.

Committee Chair Lansing suggested that at its next meeting, the Committee discuss how UC Health would address these potential losses. Advisory member Smith asked that the Committee also consider the effect that changes in federal funding would have on graduate medical education.

Chair Kieffer referred to Mr. Lipstein's remarks, reflecting that this situation presented a moral imperative for the nation and for members of Congress, and suggested that the leadership of the University make a public statement about this issue. Mr. Lipstein observed that the proposed bill treated public and private universities differently, and in part because of this the academic medical community was not speaking with one voice on this issue. He noted that institutions were hurrying to refinance their debt before the end of the year. Chair Kieffer suggested that Committee Chair Lansing and Dr. Stobo draft a short statement on behalf of the Regents. This matter was not part of the public dialogue as it should be.

Committee Chair Lansing suggested that the University draft an op-ed column for a publication such as the *Washington Post*, *Politico*, or the *Huffington Post*. She opined that this statement would be published only after the passage of the tax bill. Regent Reiss disagreed on this last point. She emphasized that the implications of the current tax proposals for public hospitals and for the well-being of patients in the U.S. were not being discussed. A statement by the University could be signed by the UC medical center chief executive officers. Dr. Stobo stated that he would confer with Mr. Lipstein and Chief Strategy Officer Elizabeth Engel about drafting a statement.

Chair Kieffer stressed that there is an audience for this point of view, for expressing the value of public hospitals. It would be worthwhile expressing this point of view even to UC's constituencies and to the people of California. This would be an important statement of values, even if it were not to change a single vote in Congress.

Dr. Stobo then briefly reported on a recent retreat held by UC Health leadership, which was attended by Mark Schuster, the founding dean of the Kaiser Permanente School of Medicine. Dr. Schuster showed himself to be interested in dialogue with UC Health deans. An important topic discussed at this retreat was the use of patient data to improve clinical care. Dr. Stobo presented a chart with data on different therapies used by UC's five medical centers to treat patients with adult onset or Type 2 diabetes. These data were gathered from 71,000 patients. In a condensed diagrammatic way, the chart showed that there were more than 6,000 different therapeutic pathways in the treatment of these patients. It was incumbent upon UC Health to demonstrate that there was a value in pursuing these

different pathways. These data might be able to help doctors better assess which patients might respond to certain therapies.

Dr. Stobo then presented a financial summary chart for the UC medical centers, with comparison figures for fiscal year 2017 and first-quarter figures for fiscal year 2018. Overall, the medical centers showed strong performance in modified operating income and loss before health systems support, modified earnings before interest and depreciation, days' cash on hand, and debt service coverage.

As a demonstration of the tangible value of the Leveraging Scale for Value program, Dr. Stobo explained a further chart that showed medical supply and pharmaceutical expenditures for the period 2012 to 2017, adjusted for patient volume and complexity of illness. This chart showed savings of more than \$400 million since the implementation of this program. Other savings had been gained in the areas of the revenue cycle and information technology.

Dr. Stobo briefly outlined a strategic planning effort currently under way in the UC Health office at the Office of the President, a roadmap with 12 goals for the next five years. The goals were interrelated and reflected the services that UC Health's central office needs to provide for the campus health systems.

Advisory member Dimsdale suggested that UC Health add another goal to this list, related to faculty recruitment and retention, which required a systemwide focus. Currently, half of U.S. physicians reported significant burnout and these rates were increasing. Burnout signified exhaustion, cynicism, and decreased efficiency, and this problem was particularly prominent in certain specialties, in neurology, in emergency room and primary care, and in oncology. UC Health was losing doctors even as it was seeking to expand. Stanford Health recently reported that it was losing 90 doctors to burnout and estimated the cost of this loss to be \$84 million at a minimum. The situation for the UC medical centers was not likely to be very different. The UC medical campuses were using different measures to assess morale and faculty turnover. Stanford and the Mayo Clinic were taking steps to address faculty burnout, and UC Health should add this topic to its strategic planning. Dr. Stobo responded that it was too late to add this topic to the strategic plan, but that he would discuss the possibility of developing a systemwide approach with the medical school deans.

Chair Kieffer requested clarification of the strategic plan goal to "more effectively influence public policy as a system." Dr. Stobo responded that UC Health had not been a major player in health policy, either in California or at a national level, but should use its expertise to influence policy. Regent Reiss asked if the UC Health office worked in coordination with UC's governmental affairs offices in this effort. Dr. Stobo responded that UC did not yet carry out this effort effectively as a system. Ms. Engel added that, due to limited resources, the University typically takes a reactive approach, responding to crisis issues. This strategic plan goal proposed the formation of a policy team at UC Health to develop the kind of coordination mentioned by Regent Reiss, a proactive approach to identifying issues of concern, disseminating information, and developing positions.

Chair Kieffer asked if UC Health had considered patient surveys in developing its strategic plan goals, as well as the needs and wishes of the public. Ms. Engel responded in the negative, but noted that the strategic plan goal just discussed concerned public policy and public affairs. In advocating for programs like Medi-Cal, UC Health would work with patients and those who represent them.

Chair Kieffer observed that data on patient satisfaction could be presented in discussions with the Legislature. Ms. Engel responded that pursuit of this goal would include dialogue with the Legislature, and explaining UC Health's activities, work, and achievements to policymakers. Mr. Lipstein pointed out that patient advocacy is divided into groups by disease or patient age, with different organizations advocating for different groups. Regent Reiss suggested that Dr. Stobo write a "bragging" letter to members of the Committees on Health of the State Assembly and State Senate, underscoring the depth of UC Health's knowledge and experience and the fact that UC is happy to share this with the State in addressing healthcare issues.

4. **OVERVIEW OF REPORT FROM THE PRESIDENT'S AD HOC TASK FORCE ON HEALTH DATA GOVERNANCE**

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

UCLA Vice Chancellor John Mazziotta introduced this overview of a report recently submitted to President Napolitano by the President's Ad Hoc Task Force on Health Data Governance. The Task Force was charged with examining the issue of sharing health data, both within UC Health and with third parties.

Many research institutions, and all large healthcare organizations, have large and rich data sets. The University is unique in having large data sets as well as world-class scientific expertise and data analytics. The University has a moral and legal responsibility to safeguard and secure its patient data. Based on its own discussions and consultation with other large healthcare organizations in the U.S., the Task Force came to the conclusion that UC has a responsibility to analyze and share data in order to generate new knowledge and insights. Securing data alone is not good or effective stewardship, and the financial motivation to generate revenue is also not a sufficient reason for gathering patient data.

Chief Strategy Officer Elizabeth Engel explained that a key goal of the Task Force was to streamline the University's ability to use and share its data. The Task Force developed six principles to guide data use. The first principle is attention to the University's responsibility and mission, including gathering data, disseminating knowledge, and contributing to the public good. Second is the concept of justice. UC Health operates in a fragmented healthcare system with significant inequalities in care and outcomes, and data use should benefit communities with the greatest medical needs. Third is active stewardship, including using and sharing data for the public good. Fourth is trustworthiness and patient engagement; UC data practices should be worthy of the public trust, and patients must have a voice in the governance of data use. Fifth is sharing clinical data outside UC for public

benefit. Transactions involving health data must demonstrate a clear public benefit from the outset. The sixth principle is promoting alignment and collaboration, ensuring that data use is optimized in support of the University's mission.

Based on these principles, the Task Force formulated three foundational recommendations: pioneer a patient-informed, justice-based model of health data use; develop criteria and a process for evaluating projects involving access to UC health data by outside parties; and establish a systemwide-level office to identify and accelerate projects and partnerships to realize the public benefits of sharing health data. In pursuit of the first recommendation, the Task Force suggested that UC appoint a team of experts to consider a number of questions, such as how current regulations should change to account for technological and scientific advances. There was wide recognition that the current regulatory framework, including the Health Insurance Portability and Accountability Act and the Common Rule governing human subject research, does not address the kind of work UC Health and other research institutions can carry out with machine learning and data analytics. Another important question was how to determine if data-driven research benefits the public. The second recommendation, regarding project evaluation criteria, proposed the development of a systemwide policy governing the management and active stewardship of health data, a systemwide Health Data Governance Committee with representatives from each campus, and a Health Data Set Access Repository, a tool to identify potential competing interests among the campuses and to manage the multiple requests UC receives from outside parties for access to the same data. The third recommendation was to establish a systemwide health data office, to be led by a chief health data officer. The office would guide strategy, identify opportunities, resolve legal, ethical, and reputation issues, and analyze outcomes.

Chancellor Block observed that even individual investigators were being approached with requests to share data. The University needed a policy to address this, and the Task Force's activity was very pertinent at this time.

Advisory member Smith cautioned that some patient data sets may not be as valuable as they appear. He referred to the preceding discussion and Executive Vice President Stobo's presentation of a chart with information on percentages of patients who received various diabetes treatments. A major study had demonstrated that up to 20 percent of new prescriptions are never filled. Without information from a health plan, pharmacy benefit manager, or some verification of what percentage of prescriptions have been filled, UC might be led to draw incorrect conclusions about the effectiveness of diabetes medicine. It is difficult to apply certain data successfully without collaboration with other parties, in particular the insurance industry. Dr. Mazziotta concurred that verification should be as stringent as possible for the best study results. Dr. Stobo emphasized his view that UC patient data are valuable and can demonstrate trends and problems. The University has access to insurance claims data, which he described as stagnant rather than real-time data.

Regent Sherman asked if all UC medical centers share data with one another and have effective means to do so. Dr. Mazziotta responded in the affirmative.

UCLA Dean Kelsey Martin affirmed the need for UC policy in this area, as more genomic, imaging, and pathology data, and data of other kinds are gathered. The existing UC patient data still needed to be assessed in a scholarly way.

Ms. Engel stated that UC Health would work toward providing a full data picture as described by Dr. Smith. Dr. Mazziotta added that currently, discussions with outside entities were taking place without a necessary policy framework; this might lead to collaborations with erroneous conclusions, collaborations that present brand problems, or other types of liability. The Task Force wanted to avoid creating more bureaucracy and to ensure that business decisions can be made in a timely manner.

Dr. Stobo noted that Optum had opened a West Coast data center in conjunction with the University. UC Health would use Optum data to enhance patient care. Advisory member Lipstein referred to the diabetes treatment data displayed earlier. In his view, these data indicated that the variability in treatment might not benefit the patient. Combined data sets as described by Dr. Smith would provide a more complete picture of a patient. He encouraged the University to continue its gathering and analysis of internal patient data, which would improve care.

#### 5. **UC SAN DIEGO HEALTH BUDGET OVERVIEW, SAN DIEGO CAMPUS**

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

UC San Diego Health Chief Executive Officer Patricia Maysent recalled that UC San Diego began its clinical mission in the late 1970s when it took over the Hillcrest Medical Center, which had been a County hospital. UC San Diego's clinical enterprise had expanded significantly in the past decade. She noted that UCSD was the only campus where the student health program was part of the campus clinical enterprise.

UC San Diego Health had carried out a reorganization over the last few years. The Faculty Practice was now organized as the Clinical Practice Organization, a structure that would allow UCSD to scale and manage the ambulatory environment in a way that it could not in the past. UCSD Health accounted for 64 percent of total UCSD campus revenues, and 57 percent of total sponsored research funding.

UCSD Health Chief Financial Officer Lori Donaldson reported that UCSD Health ended the last fiscal year exceeding its budget, with a favorable variance to margin. The new Jacobs Medical Center opened in fall 2016 and became fully operational around January 1, 2017. The opening of this new facility contributed to a six percent volume gain over the prior year. The UCSD Health margin was favorable primarily due to revenue as well as cost report settlements and Medi-Cal supplemental funds that were higher than expected. UCSD Health ended the year with a strong cash position, with 94 days' cash on hand, due to disciplined control of capital spending. The budget for the current fiscal year showed projected growth from the first full year of operation of the Jacobs Medical Center, and growth from affiliated hospitals and physician partners. UCSD anticipated opening its La

Jolla Outpatient Pavilion in spring 2018, dependent on licensing. A delay in opening this facility would cost approximately \$800,000 a month in fixed costs. UCSD Health was continuing to focus on its operational excellence initiatives. Over the course of the past four years, UCSD Health had saved about \$280 million through these initiatives, and for fiscal year 2018 it was on track to achieve \$72 million in savings. Ms. Donaldson stated that her greatest concern in looking to the future was managing UCSD Health's cash position, given the need for appropriate, market-based clinical faculty compensation, the need to invest in clinical programs, and capital needs. She briefly reviewed figures of actuals compared to budget for fiscal year 2017. UCSD Health fell slightly behind its volume projections for the year, but with significant growth year over year. The operating revenue was favorable to budget by almost four percent. Modified net income was more than 80 higher than budgeted. The controllable margin, excluding actuarial expenses for Other Post-Employment Benefits, was six percent.

Projections for the next few years indicated ongoing growth for inpatient and ambulatory volume. Revenues were growing at a rate consistent with volumes. UCSD Health was experiencing stresses in its Medi-Cal and Medicare reimbursement. Ms. Donaldson pointed out that the pension actuary expense varies significantly from year to year, causing challenges for the budgeting process. UC San Diego Health provides a great deal of community benefit; this amounted to \$260 million in fiscal year 2017. The campus provides certain signature services, such as a student-run free clinic. UC San Diego Health was very active during a recent outbreak of hepatitis A in San Diego County, with vaccinations for patients and staff, outreach to vulnerable populations, and scientific guidance provided to the City and County.

In fiscal year 2017, 40 percent of the patients served by UCSD Health were underfunded. This percentage of Medi-Cal and uninsured patients had been consistent over the past five years. There had been a significant migration from the Medi-Cal fee-for-service population to the managed Medi-Cal population, with an impact on reimbursement. The population of commercially insured patients had declined by about two percent over the past few years. Ms. Donaldson noted that a reduction of one percent in UCSD's commercially insured business represented an annual cost of about \$15 million. She concluded by recalling that the Jacobs Medical Center had added 245 patient beds to UCSD and \$117 million in fixed costs.

Ms. Maysent observed that UCSD Health's achievement of \$280 million in cost savings had required much coordinated work. The campus had a disciplined approach to its operational excellence initiatives, and it projected to achieve total savings of \$350 million by the end of fiscal year 2018. In the face of increasing expenses and declining government reimbursement, UCSD's strategic response was not to reduce the number of Medi-Cal patients but to increase the number of commercially insured patients. UCSD Health was seeking models of growth that would be cost-sustainable. Its strategy was focused in four major areas: broadening UCSD's ambulatory footprint, with attention to the payor mix; building out UCSD's clinical integration network and Accountable Care Organization network; deepening affiliate relationships; and campus redevelopment, especially at the Hillcrest Medical Center.

UCSD Health operates in a very competitive market. UCSD has a market share of about ten percent in San Diego for inpatient care, but only two percent for ambulatory care. Ms. Maysent described this as an emergency situation. UCSD Health had competed for but not been chosen to participate in an Accountable Care Organization for Qualcomm, the largest employer in San Diego. Qualcomm employees did not want to change their primary care physicians, and UCSD Health did not have clinics in areas where Qualcomm employees live. UCSD Health was working on an extensive strategic plan, using its clinical integration network and Accountable Care Organization, and building a new model for primary care. The five-year forecast was for significant expansion of UCSD Health's network of locations. Ms. Maysent recalled that UCSD has eight hospital affiliations. In January 2018 UCSD Health would be announcing a cancer services collaboration with Eisenhower Medical Center in the Coachella Valley. The forthcoming development of the Hillcrest Medical Center would require a new ambulatory care building, replacement of the hospital itself, and possible construction of multi-family housing on the 30-acre site to generate ground lease revenue. UCSD Health and the general campus were working together to develop a shared vision for these projects.

Advisory member Lipstein asked about a chart of health system support trends. For fiscal year 2017, the total amount of support for the academic mission and faculty physicians was \$155 million against net income of \$74 million. He asked if this was the net income amount after support, or if UCSD had to pay for this support from the \$74 million. Ms. Maysent responded that UCSD had to pay for health system support from the \$74 million. This represented a significant challenge. Medi-Cal patients made up 40 percent of UCSD Health's payor mix, and there was a crucial difference between reimbursement for patient care and what UCSD needed in order to pay its faculty market-rate salaries.

Mr. Lipstein asked if UCSD was experiencing a deficit, given that this support was being paid from the \$74 million of net income. Ms. Maysent responded that UCSD was using cash reserves to address this. Mr. Lipstein emphasized that it was important for the Regents to understand this dilemma, a situation that could not continue in this manner. Ms. Maysent concurred with this view.

6. **POTENTIAL LEADERSHIP TO MANAGE THE LEVERAGING SCALE FOR VALUE INITIATIVE AND CORRESPONDING MARKET REFERENCE ZONE**

[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 the Committee had discussed revised Market Reference Zones (MRZs) for UC Health positions in the Senior Management Group in March 2017, as recommended by the UC Health Executive Compensation Working Group. At that time, the Regents' Governance and Compensation Committee had deferred action, requesting further information. The revised MRZs would be presented to the Governance and Compensation Committee at the January 2018 meeting.



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

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

UCSF Chief Medical Officer and Executive Vice President – Physician Services Joshua Adler presented updated information on the University’s clinical quality dashboard. He reported that on balance, UC Health’s performance was stable for the criterion of patient mortality, while there had been a slight improvement in 30-day readmission rates; it was still too early to determine the cause of this improvement in readmissions. Performance had also been consistent for central line-associated bloodstream infections, although there had been an increase in infection rates for the two previous quarters at the UCLA Santa Monica hospital. Some of the causes of this increase had been identified. The key issue was compliance with a set of procedures for cleaning, accessing, checking, or removing central lines and changing dressings, and this need was being addressed; UCLA Santa Monica appeared to be trending back in a favorable direction with regard to infection rates. This was an example of the importance of maintaining a safe environment for patients with complicated care, when certain procedures must be performed repeatedly.

UCLA Health President Johnese Spisso commented on this situation at the Santa Monica hospital. The Ronald Reagan UCLA Medical Center had been filled beyond capacity and moved some patients to Santa Monica. The Santa Monica hospital received many more patients with central lines than it has cared for in the past, and new training for the nurses was needed. During the past month, infection rates at Santa Monica had returned to within an expected threshold. UCLA Vice Chancellor John Mazziotta stated that this demonstrated how rolling averages were most truly representative of hospital performance. Events like this overflow might cause a momentary glitch that would be identified, investigated, and reversed.

Dr. Adler pointed out a new category and column of data provided in the charts presented, a six-quarter average for each location and performance criterion. A quick comparison of figures for the current quarter with six-quarter averages would indicate whether current performance was better or worse than recent averages. Dr. Adler presented results for patient satisfaction surveys in three areas – willingness to recommend a hospital, and doctor and nurse communication. In all three areas, the most recent quarter was better than the six-quarter average, and there was an upward trend across UC Health.

Dr. Adler then discussed UC Health’s performance in reducing pressure ulcers among patients, which he described as average, and which could be improved. UC Health had formed an internal collaborative of teams to examine this issue and identify opportunities for improvement. The first major finding was that tracheostomy tubes, placed in patients’ necks when their airways are obstructed or no longer effective, are a major source of pressure ulcers. The use of tracheostomy tubes is common for patients with head and neck cancers, and for patients who have had thoracic and cardiac surgery. Certain best practices had not been shared systemwide, such as use of foam dressings sutured in place below the

tube. UC Health was also testing a new type of tube which might perform better. The second major finding concerned patients in intensive care units. UC Health has a disproportionate share of intensive care patients, and many cases of pressure ulcers occur in intensive care units. It is difficult to turn a patient with unstable vital signs, due to fear of causing a worsening of the patient's condition or dislodging equipment. Some UC intensive care units have found innovative ways to turn patients safely. UC Health would also test repositioning devices and work to standardize recording of pressure ulcers in electronic medical records.

Advisory member Smith reflected that, in discussing patient safety, actual numbers of individuals who have been harmed can be more meaningful than observed versus expected rates. Dr. Adler responded that UCSF tracks the number of patients harmed by type of harm and unit; this has led to greater engagement by staff to prevent harm. UC Health could include patient numbers with this dashboard information.

The meeting adjourned at 3:05 p.m.

Attest:

Secretary and Chief of Staff