

Mr. Lefteris is currently the Vice President of Operations for University of North Carolina (UNC) Rex Healthcare. UNC Rex Healthcare, a member of UNC Healthcare, is a private, not-for-profit healthcare system with more than 6,800 workers, 660 beds, an operating budget of over \$1.2 billion in net revenues, extensive ambulatory and post-acute campuses, five wellness centers, and a large employed physician network. As Vice President of Operations, Mr. Lefteris is responsible for construction and design, real estate portfolio, facilities, culinary services, environmental services, ambulance transport, security, customer service, operational improvement, and the oncology service line.

Mr. Lefteris joined UNC Healthcare in 1999 as the Administrative Director of Operations at UNC Hospitals. In 2007, he was appointed as Vice President of Support Services and, later in 2012, appointed as Vice President of Operations at UNC Rex Healthcare.

Additionally, Mr. Lefteris is involved in the Greater Raleigh Chamber of Commerce, holds leadership roles in the North Carolina Chapter of the Leukemia and Lymphoma Society, serves on the City of Raleigh's Unified Development Ordinance Advisory Group, is a founding board member for the Blue Ridge Corridor Alliance, and is a Fellow in the American College of Health Care Executives.

Mr. Lefteris received a bachelor's degree in business administration/health care management from Appalachian State University, and a master's degree in health administration from Medical University of South Carolina.

[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.]

Vice President Ducket outlined the terms of the proposed appointment of and compensation for Chad Lefteris as Chief Operating Officer, UC Irvine Health System. The previous incumbent, Richard Gannotta, had been appointed as Chief Executive Officer of the UC Irvine Health System in June 2018.

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

5. **APPROVAL OF MARKET-BASED SALARY ADJUSTMENT FOR MARK LARET AS PRESIDENT AND CHIEF EXECUTIVE OFFICER, UCSF HEALTH, SAN FRANCISCO CAMPUS AS DISCUSSED IN CLOSED SESSION**

Recommendation

The President of the University recommended that the Health Services Committee approve the following items in connection with the market-based salary adjustment for Mark Laret as President and Chief Executive Officer, UCSF Health, San Francisco Campus:

- A. Per policy, a market-based salary adjustment of 29.4 percent, increasing Mark Laret's base salary from \$1,104,965 to \$1,430,000, as President and Chief

Executive Officer, UCSF Health, San Francisco Campus, at 100 percent time. This will be funded by Health Enterprise revenues. No State funds will be used.

- B. Per policy, continued eligibility to participate in the Clinical Enterprise Management Recognition Plan (CEMRP) annual Short Term Incentive (STI) component, with a target award of 20 percent of base salary (\$286,000) and maximum potential award of 30 percent of base salary (\$429,000), subject to all applicable plan requirements and Administrative Oversight Committee approval. Any actual award will be determined based on performance against pre-established objectives. CEMRP incentive awards are funded by Health Enterprise revenues. No State funds will be used.
- C. Per policy, continued eligibility to participate in the Clinical Enterprise Management Recognition Plan (CEMRP) Long-Term Incentive (LTI) component, with a target award of ten percent of base salary (\$143,000) and maximum potential award of 15 percent of base salary (\$214,500), subject to all applicable plan requirements and Administrative Oversight Committee approval. The LTI uses rolling three-year performance periods, and any actual award will be determined based on performance against pre-established objectives over the three-year LTI performance period. CEMRP incentive awards are funded by Health Enterprise revenues. No State funds will be used.
- D. Per policy, continued eligibility to participate in the UC Employee Housing Assistance Program, subject to all program requirements.
- E. Per policy, continuation of standard pension and health and welfare benefits and standard senior management benefits, including eligibility for senior management life insurance and executive salary continuation for disability (eligible and vested as a result of five or more consecutive years of Senior Management Group service).
- F. Per policy, continuation of a monthly contribution to the Senior Management Supplemental Benefit Program.
- G. Per policy, continued annual automobile allowance of \$8,916.
- H. For any outside professional activities, Mr. Laret will continue to comply with applicable Outside Professional Activity (OPA) policies.
- I. This action will be effective upon approval.

The compensation described above shall constitute the University's total commitment 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 a market-based salary adjustment for Mark Laret as President and Chief Executive Officer, UCSF Health. He has been with the University of California for his full career spanning almost 40 years of increasing responsibility culminating in his appointment as Chief Executive Officer for UCSF Health in 2000. Since that time, UCSF Health has seen significant growth.

The President endorsed the campus's proposal to place Mr. Laret's salary near the 75th percentile of his position's Market Reference Zone (MRZ). The increase requested is a 29.4 percent (\$325,035) market-based salary adjustment bringing Mr. Laret's salary from \$1,104,965 to \$1,430,000, which is 3.64 percent below the 75th percentile of the corresponding MRZ (\$1,484,000).

As this is a Level One Senior Management Group position, approval by the Regents is required. This position is entirely funded through Health Enterprise revenues, and no State funds will be used.

UCSF Health is the largest financial entity in UC Health. Over the past six years, UCSF Health has grown from a \$1.7 billion single licensed facility to a very large \$4.5 billion multi-entity health system through various affiliations in an effort to compete in the rapidly changing healthcare market. UCSF Health now comprises UCSF Medical Center including UCSF Benioff Children's Hospital San Francisco, the UCSF faculty practice group, the separately licensed UCSF Langley Porter Psychiatric Hospital and Clinics, UCSF Benioff Children's Hospital Oakland, the Bay Children's Physician Foundation, joint ventures with John Muir Health and Hospice by the Bay, and the recent affiliation with Dignity Health Bay Area hospitals – Sequoia Hospital, Saint Francis Memorial Hospital, and St. Mary's Medical Center.

Mr. Laret has overseen UCSF Health's substantial growth into a \$4.5 billion health system that includes multiple hospitals, other affiliates including a new accountable care organization, Canopy Health, as well as the opening of the new Mission Bay hospitals that included significant philanthropic contributions that Mr. Laret cultivated and brought to fruition.

He was appointed as the Chief Executive Officer for UCSF Health in April 2000 and has served in several leadership roles throughout his 38-year career with the University of California. He has the longest overall tenure among the five Health System Chief Executive Officers. Importantly, he has almost 25 years of combined experience at the Chief Executive Officer level in his current position with UCSF Health and in his previous role as Chief Executive Officer of UC Irvine Health.

Mr. Laret is recognized as a national leader in healthcare, having chaired the Association of American Medical Colleges (AAMC) as well as the California Hospital Association.

UCSF Health would suffer a severe impact if Mr. Laret were to leave. The campus notes that the cost of recruitment for a new Chief Executive Officer could be quite high due to extended recruitment efforts, salary costs, and strategic initiative lapses during the transition to new leadership for UCSF Health's substantial organizational and strategic efforts.

The campus also states that experiencing a leadership transition through the loss of Mr. Laret would be particularly difficult at this time for a number of reasons. UCSF Health is embarking on a \$2.5 billion hospital replacement project that will require support from community leaders and donors. Mr. Laret has earned the respect and trust of community leaders and donors who will be key to the feasibility of the hospital replacement project. Mr. Laret is leading a review and renewal of UCSF Health's strategic plan, and his leadership and credibility are essential to cementing and expanding regional healthcare partnerships as part of that plan.

Mr. Laret's current salary is below the 50th percentile of the MRZ for his position as Chief Executive Officer, UCSF Health. Based on Mr. Laret's breadth and depth of experience, his unique skill set in relation to leading the expansion of the health system and building strong relationships with key stakeholders, and his contributions, the President endorses the campus's request for a base salary near the 75th percentile of the MRZ to better align his base salary with the criteria described in policy. Additionally, the talent pool to replace Mr. Laret is limited and very competitive.

UCSF Health competes continually for high-quality talent at all levels of the organization and needs to remain competitive for retention purposes. Competition comes from Stanford, Kaiser Permanente, Sutter Health, the University of Southern California, and other public and private academic medical centers nationally. While the organization is conscious of managing the operating costs of UCSF Health, the long-term success of UCSF Health is highly dependent on the level of talent the organization is able to retain.

Funding for this position will continue to come exclusively from Health Enterprise revenues. No State or UC general funds will be used.

[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.]

Vice President Duckett outlined the proposed market-based salary adjustment for Mark Laret as President and Chief Executive Officer, UCSF Health.

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

6. **APPROVAL OF MARKET-BASED SALARY ADJUSTMENT FOR PAUL STATON AS SENIOR VICE PRESIDENT AND CHIEF FINANCIAL OFFICER, UCLA HEALTH, LOS ANGELES CAMPUS AS DISCUSSED IN CLOSED SESSION**

Recommendation

The President of the University recommended that the Health Services Committee approve the following items in connection with the market-based salary adjustment for Paul Staton as Senior Vice President and Chief Financial Officer, UCLA Health, Los Angeles campus:

- A. Per policy, a market-based salary adjustment of 14.2 percent (\$97,684), increasing Paul Staton's base salary from \$689,371 to \$787,055, as Senior Vice President and Chief Financial Officer, UCLA Health, Los Angeles campus, at 100 percent time. This will be funded by Health Enterprise revenues. No State funds will be used.
- B. Per policy, continued eligibility to participate in the Clinical Enterprise Management Recognition Plan (CEMRP) Short Term Incentive (STI) component, with a target award of 15 percent of base salary (\$118,058) and maximum potential award of 25 percent of base salary (\$196,764) subject to all applicable plan requirements and Administrative Oversight Committee approval. Any actual award will be determined based on performance against pre-established objectives. CEMRP incentive awards are funded by Health Enterprise revenues. No State funds will be used.
- C. Per policy, continued eligibility to participate in the UC Employee Housing Assistance Program, subject to all program requirements.
- D. Per policy, continued standard pension and health and welfare benefits and standard senior management benefits (including eligibility for senior management life insurance and executive salary continuation for disability).
- E. Per policy, continued monthly contribution to the Senior Management Supplemental Benefit Program.
- F. For any outside professional activities, Mr. Staton will continue to comply with applicable Outside Professional Activity (OPA) policies.
- G. This action will be effective as of January 1, 2019.

The compensation described above shall constitute the University's total commitment 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 for a 14.2 percent (\$97,684) market-based salary adjustment for Paul Staton, Senior Vice President and Chief Financial Officer (SVP-CFO), UCLA Health, which would change his base salary from \$689,371 to \$787,055. The adjustment will place the proposed new base salary just below the 75th percentile (\$787,100) and 7.6 percent above the 60th percentile (\$730,400) for the UCLA Chief Financial Officer position's Market Reference Zone. Because the adjusted salary is over the 60th percentile and the increase is more than ten percent of Mr. Staton's current base salary, this action requires Regental approval. The salary and incentive are funded by Health Enterprise revenues, and no State or UC general funds will be used.

The campus has expressed concern about ensuring equity with the comparable Chief Financial Officer position at UCSF Health; the appointment of and compensation for the new incumbent was approved at a base salary of \$785,000.

Mr. Staton is currently receiving a ten percent administrative stipend (\$68,937) effective for 12 months beginning in January 2018. The stipend was requested due to Mr. Staton's continuing leadership of the Revenue Cycle Steering Committee on behalf of UC Health, Office of the President to optimize and standardize processes and reports across the UC Health System to positively affect revenue and cash flow. This work has resulted in systemwide savings of \$800 million in the last five years. An annual retention payment was previously approved for Mr. Staton, originally effective from January 2015 to December 2017 and paid out in January 2016, January 2017, and January 2018.

The retention payments and administrative stipend constitute four years of payments in addition to Mr. Staton's base salary and incentive awards. UCLA Health reports that Mr. Staton will continue to lead the Revenue Cycle Steering Committee and maintain his responsibilities in relation to the Committee in addition to his membership on the UCOP Debt Advisory Committee and the Leveraging Scale for Value Supply Executive Oversight Committee.

UCLA Health reports that Mr. Staton plays an integral role in the oversight of financial operations and the development of business planning in alignment with organizational strategy for UCLA Health. Mr. Staton has served as Chief Financial Officer at the UCLA Hospital System since 2004. As Chief Financial Officer, Mr. Staton is responsible for the integrity and successful financial performance of the entities within the Hospital System, as well as for collaboration and ensuring compliance and alignment with the David Geffen School of Medicine, campus and systemwide budget and finance offices, and external agencies and network organizations.

Mr. Staton is currently responsible for approximately \$5 billion of net revenue, which includes 42,000 inpatient admissions, 2 million outpatient encounters, 3,000 full-time faculty physicians, and four hospitals: Ronald Reagan UCLA Medical Center, Santa Monica Orthopedic Hospital, Resnick Neuropsychiatric Hospital, UCLA Mattel Children's

Hospital, and the Faculty Practice Group comprised of 170 ambulatory clinics. He also provides financial oversight for the UCLA David Geffen School of Medicine.

Mr. Staton has been integrally involved in the acquisition and/or establishment of more than 170 ambulatory clinics, proposed affiliations with local area hospitals, and provided the supporting infrastructure for these areas. As a key leader, Mr. Staton also oversees contracting on behalf of the organization, which directly determines the rates of reimbursement and participation for insurance companies and third-party payers. The Risk Management office also reports to Mr. Staton in addition to Procurement and Strategic Sourcing. He is a key member of the executive leadership team and serves on a variety of University and campus-wide committees, including service as a representative to external agencies and professional organizations. Additionally, he will maintain his responsibilities for systemwide UC Health System initiatives as he maintains his current set of responsibilities as SVP-CFO, UCLA Health.

Mr. Staton's current salary is below the 50th percentile of his position's corresponding Market Reference Zone. The campus states that due to Mr. Staton's knowledge, expertise and performance, it is imperative that his salary remain market-competitive. Mr. Staton is a long-term UC employee, and his salary has fallen behind the recently hired Chief Financial Officer, UCSF Health System, who was hired at a base salary of \$785,000. The UCLA and UCSF Health systems are the two largest UC Health systems, and have the same peer comparator institutions; therefore, the CFO Market Reference Zone percentiles are the same for both campuses. In order to provide equity between the newly hired UCSF CFO (11 years of hospital-based experience as CFO) and Mr. Staton (14 years of experience for the UCLA health system as CFO), a market-based salary adjustment is being requested to place Mr. Staton's salary at an appropriate level within the position's 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.]

Vice President Duckett outlined the proposed market-based salary adjustment for Paul Staton as Senior Vice President and Chief Financial Officer, UCLA Health.

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

7. **AMENDMENT OF REGENTS POLICY 3401 – POLICY ON STUDENT HEALTH AND COUNSELING CENTERS**

The President of the University recommended that the Health Services Committee recommend that the Regents amend Regents Policy 3401, Policy on Student Health and Counseling Centers, as shown in Attachment 1.

[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 explained that the proposed amendment to Regents Policy 3401, Policy on Student Health and Counseling Centers, included two substantive changes. The student health and counseling centers would be allowed to use the same medical records system used by their campuses' medical centers. As the student health centers become more closely integrated with the medical centers, they should use the same records system, and this should be the Epic system. The second substantive change concerned auditing. The student health centers have been audited yearly by an external organization; these audits would now be carried out by UC's Internal Audit program. The centers would be audited on a regular basis, depending on work plan of Internal Audit.

Regent Sherman asked about the cost impact of moving student health centers to the Epic records system. Dr. Stobo responded that at UC San Diego, this cost was being borne by the Medical Center. Regent Sherman asked if this was a substantial cost. Dr. Stobo responded that he did not know the cost.

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

8. **PERSPECTIVES ON THE ROLE OF NETWORK EXPANSION IN SUPPORTING THE UNIVERSITY'S ACADEMIC MISSION AND AFFILIATION PRINCIPLES**

[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 introduced this item, a general discussion of a proposed UCSF affiliation. The financial terms of the affiliation would be presented at a future meeting, and approval would be sought at a future meeting.

UCSF Health Chief Executive Officer Mark Laret explained that UCSF was contemplating a more extensive collaboration with one of its current affiliates, Dignity Health (Dignity). A close partnership with Dignity raised the issue of a public university working with a Catholic-affiliated health network. UCSF had studied the issues that might arise with regard to the ethical and religious directives of Dignity. UCSF department chairs and the UCSF Division of the Academic Senate had been involved in developing a strategy for this affiliation.

Senior Vice President Shelby Decosta referred to UCSF's 2014 Strategic Plan and its goals of being a leader in providing unique specialty services, instilling a culture of continuous process improvement for greater efficiency and lower cost, and developing a high-value system of care. In pursuit of the third goal of developing a high-value system of care, UCSF had developed partnerships in recent years with a number of different organizations, hospitals, physician groups, post-acute care companies, and others who share UCSF's values. UCSF believes that these partnerships will help it to deliver population health care successfully in the long term. Among other things, these affiliations have allowed UCSF to establish, in partnership with John Muir Health and Meritage Medical Network, a new accountable care network, Canopy Health, that currently served about 24,000 lives, was

projected to serve 50,000 lives in 2019, and had a strategic plan to increase to 200,000 lives in the coming years. Affiliations have also allowed UCSF to open new centers in new locations, such as a new outpatient center in Berkeley, a 70,000-square-foot building with primary, specialty, and urgent care and imaging services, jointly funded by John Muir Health and UCSF Health.

UCSF's network finds itself in the highly competitive San Francisco Bay Area market. UCSF and its affiliates have access to the second largest market share of inpatients, second to Kaiser Permanente, but ahead of Sutter Health, Stanford Health Care, and others. This network has contributed to revenue growth, from \$2 billion in 2014 to just over \$4 billion currently. Market share had increased over time from two percent to six percent. This growth has allowed UCSF Health to fund UCSF's academic mission, with a fiscal year 2018 contribution slightly above \$100 million for clinical support, research, and education. Other academic medical centers across the United States have pursued similar network growth strategies.

Over a number of years, UCSF had engaged in clinical collaborations with Dignity in several programs. In 2016, UCSF signed a letter of intent to begin a new and more substantial relationship and to have Dignity join the Canopy network. Since then, UCSF had implemented a management services agreement at three Dignity hospitals. UCSF had brought Dignity primary care physicians into its Clinically Integrated Network. Most recently, since October, at one of the Dignity hospitals, St. Mary's Medical Center near the UCSF Parnassus Campus, UCSF faculty have been providing daily hospitalist coverage. One reason why an affiliation with Dignity is important to UCSF is Dignity's complementary geographical presence. UCSF would gain capacity in San Francisco and a footprint in San Mateo and Santa Cruz, fairly distributed coverage throughout the Bay Area. In addition, the four hospitals that UCSF would partner with are part of a much larger system. Dignity has many other hospitals in California that might complement a UC Health statewide network.

Advisory member Lipstein noted that it would be useful to consider Dignity in the context of Catholic health care in the U.S. overall. Other than Kaiser Permanente, the largest healthcare delivery systems in the nation are Catholic-affiliated healthcare systems, such as Ascension, Catholic Healthcare Initiatives (CHI), Trinity Health, and Dignity. These systems have traded hospitals with one another over the past 20 years in order to achieve scale in specific geographic regions, giving each network a greater presence in its region. The Dignity network reflected this kind of concentration. The Catholic healthcare networks had become so large that it was critical to work with them in specific geographic regions.

Ms. Decosta continued her presentation, noting that Dignity was planning a merger with CHI, and that the merger was projected to be completed in January 2019. This would create the largest not-for-profit hospital company in the nation, with about \$28 billion in revenue. UCSF was keeping track of the approval process for the merger and considering how this merger would affect an affiliation with Dignity.

In UCSF's view there were three key issues of concern in a Catholic hospital affiliation: reproductive care, end of life care, and transparency. UCSF discussed these issues with faculty and other stakeholders to develop an approach to this affiliation. The result of this consultation was a careful approach to all UCSF affiliations, including Catholic hospital affiliations. One element of this approach is quality and brand guidelines, discussed by Dr. Stobo earlier in this meeting. As a second element, UCSF developed its own partnership and affiliate principles, something like the directives or statements of values of Catholic organizations. As a third element, UCSF develops contracts working with colleagues at the Office of the President and makes clear commitments when it develops contracts. Ms. Decosta introduced Dana Gossett, Professor of Obstetrics and Gynecology, and Division Director, who had participated in the task force that developed these partnership principles.

Dr. Gossett remarked that this consultation had sought input from faculty, department chairs, and the Academic Senate. Faculty members had substantial concerns, and especially faculty working in fields concerning women's health. The consultation had resulted in a document, a statement of UCSF values that would inform discussions with partners and affiliates, including faith-based institutions. Faculty and others involved in the consultation wished to have a positive statement or affirmation of University values, rather than simply responding to a statement of values of another organization and stating that UCSF could or could not work with certain elements of those values. Dr. Gossett emphasized that the UCSF Health Partnership and Affiliation Principles resulted from significant input and work by many people, all of whom wished to ensure that the proposed affiliation goes in the right direction.

Deputy General Counsel Rachel Nosowsky stated that the Office of the General Counsel (OGC) was asked to evaluate whether this affiliation was possible from a legal perspective. OGC believes that the affiliation is possible. The constraints on a public entity are set out in federal and State law. Under both sets of laws, the State cannot establish religion or adopt a religion. There has been much litigation on this issue over the years, and it has resulted in a set of principles articulated by the U.S. Supreme Court on the meaning of establishment of religion. "Establishment" does not apply to an activity whose primary purpose is secular, as it is in this case, where the primary purpose is to provide care to patients. Likewise, "establishment" does not apply to an activity that neither promotes nor inhibits religion, or where there is no excessive entanglement between church and state. The principles articulated by UCSF and the contracts the University was developing were all focused on addressing this concern regarding establishment. In addition, State law requires that the University be entirely independent of all political or sectarian influence, and the contracts UC was developing were intended to address this mandate. None of these laws or rules prohibit affiliations outright or require discrimination, but they require the University to proceed with caution.

Ms. Decosta stated that with these principles and legal guidance in mind, UCSF had an endorsement from its clinical chairs to proceed with the affiliation under these conditions: that patients are fully informed about what services are and are not provided at Dignity facilities; that no UCSF full-time faculty will be asked to participate in obstetrics,

gynecology, or reproductive services at Dignity facilities; that UCSF Health's values control UCSF's positions on clinical care; and that no provider is asked to participate in any care process to which he or she has a moral objection.

Mr. Laret concluded the presentation by recalling that UCSF had been working with Dignity for the last few years, with UCSF faculty practicing at Dignity hospitals. UCSF and Dignity had worked through issues. Dignity was probably closer to UCSF's values than were many other health systems in its commitment to serve the underserved. UCSF was working with Dignity on a transgender program at St. Francis Memorial Hospital. Dignity was a participating member of Canopy Health. Mr. Laret noted that some faculty remained concerned that any affiliation with a faith-based organization is problematic on its face. UCSF was attentive to these concerns. The most ardent concern had been expressed by obstetrics faculty. UCSF believed that, by not providing obstetric or reproductive services at Dignity facilities with full-time UCSF faculty, it had addressed most of these concerns. Because so much health care in the U.S. is being delivered by faith-based organizations, for UCSF not to collaborate with Dignity would seem like a missed opportunity. Dignity's location made it critical to UCSF's market growth. UCSF was cognizant of the fact that this relationship would require constant monitoring.

Committee Chair Lansing expressed support for the affiliation, but stressed that the University should proceed carefully to avoid violating any laws or rules. She asked if nuns worked in the Dignity hospitals. Dr. Gossett responded that of the four Bay Area Dignity hospitals, two (St. Mary's Medical Center and Dominican Hospital) are Catholic hospitals, and two (St. Francis Memorial Hospital and Sequoia Hospital) are secular. To her knowledge, there were no nuns working at any of these hospitals.

Committee Chair Lansing asked about religious images in the hospitals. Mr. Laret responded that there was some religious imagery in the hospitals. Ms. Decosta added that the Dignity facilities were focused on providing a healing environment; in her opinion, while walking through the facilities, one would not feel overwhelmed by the religious images. Mr. Laret emphasized that before UCSF refers patients to a Dignity facility, the patients are clearly informed about where they are going. A major concern is a situation of a woman delivering a child in a Catholic facility, requesting a sterilization procedure, and learning that this procedure cannot be performed. UCSF has a commitment to transparency about which procedures will not be performed in Dignity facilities.

Committee Chair Lansing asked about obstetric care offered at the Dignity hospitals. Dr. Gossett responded that neither hospital in San Francisco offers obstetric services, while the other two do offer these services. The two San Francisco facilities were interested in offering more women's health services. UCSF would not participate in these services, which would be sited at St. Francis Memorial Hospital.

In response to another question by Committee Chair Lansing, Mr. Laret stressed that UCSF physicians would not be under any gag rule. They could speak with patients about any procedure or issue, including abortion and reproductive rights.

Committee Chair Lansing asked about a situation in which a patient at a Dignity facility wishes to have end of life care, and if UCSF would be able to move that patient. Dr. Gossett responded that restrictions would apply to physician-assisted suicide, but noted that this procedure is not usually conducted in an inpatient facility, but in a hospice situation. She stressed the point made earlier that there would be no gag rule on UCSF physicians; physicians would be able to discuss physician-assisted suicide, abortion, or other controversial procedures.

Chair Kieffer asked about religious imagery and recalled that litigation has arisen concerning Christian Nativity scenes on public property. He asked how this affiliation situation would be different from those situations, when Christian imagery on public property has been found to be not permissible. Ms. Nosowsky responded that the hospitals are not UC facilities. There is no blanket prohibition on religious imagery, and the religious imagery in these hospitals did not raise concerns for UC. The University needs to be careful about its actions, and intends to be careful in the articulation of principles, in contract language, and in assignments for UCSF faculty and staff.

Advisory member Spahlinger reported that Michigan Medicine, the University of Michigan health system, had a five-year affiliation agreement with Trinity Health and a four-year agreement with Ascension. In the Michigan market, these systems represent about 3 million patients. Michigan Medicine has high occupancy rates, while these Catholic hospitals have lower occupancy. Michigan Medicine as a public institution does not promote the Catholic faith. Michigan faculty deliver care at a number of Catholic hospitals; they do not deliver obstetric services. Michigan Medicine was planning a joint venture hospital where it would deliver these services in two to three years. Physicians from one of the Catholic hospitals perform sterilization procedures at the Michigan Medicine surgery center and do not have gag rules in relation to their own patients. Michigan Medicine had found these to be good relationships. These Catholic hospitals had a commitment to the underserved not found in all organizations.

Ms. Nosowsky observed that in the University's view, it would be offering Dignity patients more choices and options. These patients could come to a UCSF facility for procedures not offered by the Dignity hospitals.

Chair Kieffer stated that this positive point outweighed the risks mentioned earlier. UCSF had been thoughtful in its approach to operating in this environment.

Faculty Representative May noted that while this presentation had emphasized values shared by both UC and Dignity, the fact that Dignity is a faith-based institution would mean that certain services would not be offered at Dignity facilities. There had not been a clear statement of the difference between Dignity's values and the University's, and their different ways of providing health care. This circumstance should be clearly stated. He referred to statements made earlier that UCSF physicians at Dignity sites would be able to fully discuss procedures that could not be performed at these facilities. He asked if UCSF physicians would be able to freely refer patients to other UCSF facilities. Ms. Nosowsky responded in the affirmative.

Mr. May asked if UC employees would have access to Dominican Hospital in Santa Cruz as a Tier 1 provider under UC Care. Mr. Laret responded that he did not know, but hoped that this would be the case. Mr. May noted that UC Santa Cruz employees currently had access to Dominican, but under a higher-cost tier. Dr. Stobo responded that Dominican could be a Tier 1 provider. Mr. May asked that this be part of the negotiations, as this was an important issue for UCSC employees. Dr. Stobo responded that as a general rule, any UC affiliate is a Tier 1 provider. Mr. May requested clarification on this point. Mr. Laret remarked that this was an internal UC matter. Mr. Lipstein suggested that UC Health must sometimes negotiate with Human Resources to move employees into the Tier 1 level. Dr. Stobo countered that this would be a decision by UC Health.

Mr. May asked about the marketplace-related risk to UCSF if this affiliation did not come about. Dr. Gossett responded that UCSF was routinely turning patients away. The care UCSF could provide was currently constrained, and UCSF was regularly sending patients to competitor institutions. UCSF urgently needed to gain capacity, space, and resources. With regard to Mr. May's question about common values, Dr. Gossett commented that in her view as an obstetrician-gynecologist, Dignity had more common, shared values with UCSF than did other potential partners in the Bay Area. Dignity had invested more in community health than other organizations, and Dr. Gossett described Dignity as UCSF's closest ally in the field of population health. Referring to Dignity's Statement of Common Values, she noted that there were fundamentally three clinical procedures that could not be performed in a Dignity facility. One was in vitro fertilization, but because in vitro fertilization is never conducted in a hospital, this restriction would have no impact on UCSF's reproductive endocrinology practice. A second procedure that had been mentioned was assisted suicide, and end of life care does not involve inpatients. There was no gag rule constraining UCSF physicians, and patients would have access to end of life care. The third procedure was "direct abortion," defined as abortion that is intended to end the life of a fetus, without any other purpose. This procedure is prohibited, even in Dignity's secular hospitals. Direct abortion is distinct from an ectopic pregnancy, pregnancy outside the uterus, which is considered a threat to a woman's health; removal of the fetus in these cases is considered treatment for a condition that is threatening the woman, with the unfortunate result that the fetus dies. The vast majority of elective abortions are performed in outpatient facilities, including those performed at UCSF, with the exception of some later-term abortions performed in hospitals. Any patient at one of the Dignity hospitals who needed an elective abortion would be referred to the appropriate UCSF facility.

Mr. May asked about sterilization. Dr. Gossett responded that sterilization procedures were allowed in Dignity's secular hospitals. UCSF had a gynecologic surgical service at St. Francis Memorial Hospital, now in place for about four months, with no restrictions on tubal ligation, intrauterine contraception, and vasectomy.

Mr. May asked about prescriptions for birth control. Dr. Gossett responded that there would be no limitations on prescribing birth control at the secular hospitals. Because there is not much obstetric or gynecologic service at St. Mary's Medical Center, this issue does not arise frequently at this hospital. There would be no reason not to continue a patient's birth control if she were admitted to the hospital for another condition. Mr. May asked if a

primary care physician at St. Mary's Medical Center would prescribe birth control. Dr. Gossett responded that a physician there would be able to do so. Catholic institutions prescribe birth control for women with menstrual disorders. There is no restriction on counseling on all contraception options, and no limitation on the provision of a prescription for birth control at any of these facilities.

Committee Chair Lansing emphasized the importance of transparency regarding the differences in values between UC and Dignity, and transparency for patients about which services are or are not available at the different facilities.

Mr. Lipstein reflected on the difference between conflict of values and coexistence of different values. He discussed the example of Barnes-Jewish Hospital in St. Louis, which was formed by Barnes, a Lutheran hospital, and the Jewish Hospital of St. Louis. The Barnes-Jewish network also includes Christian Hospital and Missouri Baptist Medical Center. Washington University faculty work at all these hospitals in spite of having different values. No faculty member is forced to perform a procedure to which he or she has an objection. Missouri Baptist Medical Center does not dictate the prescribing habits of physicians on staff, and this is also true of Dignity. In Mr. Lipstein's view this example showed that faith can assist the healing process, as long as faith or beliefs are not imposed. The faculty physicians in the Barnes-Jewish facilities demonstrate tolerance of different faiths and values, with the goal of treating the human condition. Faculty can show leadership and set a positive example for students, residents, and other physicians.

Committee Chair Lansing concurred with Mr. Lipstein's statement, stressing that UCSF should provide all the facilities and care needed by patients in their geographic area, and that patients must know all options. OGC must monitor the affiliation to ensure that it does not enter into a gray area in terms of laws or regulations.

Advisory member Hernandez expressed agreement with the view stated earlier that Dignity, compared to other potential partners, aligned best with the University's values. Dignity had invested significant monies in the community in many important areas, including social determinants of health and affordable housing. The issues of mission alignment that had been discussed were important, but if UCSF were going to continue to grow market share, Dignity would be a natural partner for UCSF. Dr. Hernandez remarked that UCSF had found ways to develop its market share and expand its capacity without the need for capital expenditures. She observed that reductions in healthcare costs in California had largely not been the result of mergers, consolidations, or affiliations. She asked if UCSF would be exporting the UC cost structure into a lower-cost delivery system, or the reverse, if UCSF would lower its costs through an affiliation with Dignity. One could not expect insurance premiums to decrease and health care to become affordable as the healthcare delivery system continued a process of consolidation. UC, as a public institution, has a profound responsibility to be mindful of costs as it develops these networks.

Committee Chair Lansing stated that an important question was whether UC would impose higher costs as it consolidates and controls more of the market, but stressed that an important goal of UC Health is to provide access to care. Mr. Laret recalled that UCSF had

about six percent market share, or 18 percent with its affiliates. He identified Kaiser Permanente as the behemoth in this market. One of UCSF's goals in this affiliation is to move patients who are cared for at high-cost UCSF locations to lower-cost Dignity locations in order to lower cost overall. He concurred with Dr. Hernandez that costs have increased as hospital consolidation has occurred. UCSF should remain mindful of this issue and be prepared to report on this in the future.

Committee Chair Lansing asked why Dignity was able to provide care at lower cost. Mr. Laret responded that an important reason for this is that Dignity does not support an academic mission.

Regent Sherman referred to the legal requirement that the University be entirely independent of all political or sectarian influence. He noted that there are many affiliations in the U.S. like the one being proposed, and asked if this has been tested in court. Ms. Nosowsky explained that the clause on being independent of all political or sectarian influence is found in Article IX, Section 9 of the California Constitution. Arguments on establishment often refer to a 1971 U.S. Supreme Court decision in *Lemon v. Kurtzman* with the three criteria of a primary purpose that is secular, activity that neither promotes nor inhibits religion, and no excessive entanglement of church and state. This has been tested in many different contexts, but Ms. Nosowsky was not aware of any case in this specific context. Nevertheless, any public entity considering an affiliation with a faith-based organization is mindful of these criteria in developing its affiliation and ensuring that it does not cross this line. This requires careful contract language, a careful approach to the principles of the affiliation, and monitoring after the affiliation is in place.

Regent Sherman asked if UCLA had affiliations with any Jewish hospital in Los Angeles. UCLA Health President Johnese Spisso responded that UCLA has a joint venture effort with Cedars-Sinai and Select Medical to operate a 138-bed rehabilitation hospital in Century City. Regent Sherman asked if any of the issues just discussed had arisen in that joint venture. Ms. Spisso responded that the issue of religious directives had not arisen. She recalled her prior professional experience at University of Washington Medicine, which established a similar type of relationship with PeaceHealth, a faith-based organization. There were similar debates about this University of Washington relationship. Ms. Spisso stated that this affiliation led to improved services for the community. PeaceHealth had resources in areas where there were service gaps, and this was beneficial for patients.

UC Davis Vice Chancellor of Human Health Sciences David Lubarsky reported that UC Davis was seeking to expand its relationship with Dignity for the same reasons as UCSF. The UC Davis hospital was running at a census of 110 percent, and UC Davis was beginning to curtail its elective surgery schedule due to lack of beds. A nearby Dignity hospital had an occupancy rate of less than 50 percent. The further progress of this affiliation at UCSF was important for the future of the UC Davis Medical Center in Sacramento as well. As UC Health considers its natural partners in the California marketplace, these would most likely be Dignity and Adventist Health, which are both faith-based organizations. UC Health needs a set of guiding principles and rules in order to

engage productively with these organizations and to be successful in providing care. Dignity costs are much lower than UC Davis costs. UC Davis Health would like to export lower-acuity cases to Dignity so that patients can receive care at a lower price, and so that UC Davis can focus on specialty and high-acuity care.

Committee Chair Lansing anticipated that the UCSF affiliation with Dignity would serve as a blueprint for other UC medical centers, and would be important for UC Health systemwide.

Advisory member Hetts praised Mr. Laret and Ms. Decosta for their engagement with faculty on the issue of this affiliation, so that UCSF faculty were comfortable with this relationship. There were many potentially thorny issues, and there had been much discussion. Dr. Hetts noted that it was difficult to access UC Health services in San Mateo County, only a few miles south of San Francisco. UC Health should consider in which parts of the state it is difficult to access UC care.

Committee Chair Lansing stated that this affiliation might provide an opportunity to create an environment that heals the mind as well as the body, and promotes tolerance.

Mr. May asked how much capacity Dignity would provide for UCSF, or how much space it would free up for UCSF. Ms. Decosta responded that UCSF would need to relocate between 70 and 100 patients of its average daily census to Dignity facilities. Both of the Dignity San Francisco hospitals were under 50 percent capacity. Mr. May asked how these hospital managed to stay in business at such low capacity. Ms. Decosta responded that they are part of a big corporation.

Referring to a chart shown earlier, Mr. May asked why UCSF had experienced relatively small growth in revenue and big growth in market share between 2009 and 2014, but significant revenue growth and only small growth in market share between 2014 and the present. Mr. Laret responded that part of the reason for the trend between 2014 and the present was that UCSF Benioff Children's Hospital Oakland joined UCSF. Ms. Decosta added that the market was shrinking between 2009 and 2014, with lower volume. Following passage of the Affordable Care Act, volume grew, but share itself did not shift as much after 2014.

Mr. May referred to another chart showing projected revenue growth between 2017-18 and 2027-28. He asked if revenue per capita would remain constant or was projected to increase somehow. Mr. Laret responded that this chart reflected UCSF's ten-year plan, which included many assumptions and variables leading to the projected outcome. An important element of the plan was UCSF's need to grow over the next ten years in order to remain financially viable and support its academic mission.

Committee Chair Lansing anticipated that UC Health might engage in further affiliations with Dignity and other faith-based organizations. Because this would be the first such affiliation with Dignity, it was important that it succeed.

9. **WORKING TOGETHER: CONDUCT EXPECTATIONS IN HEALTHCARE SETTINGS AND INITIATIVES TO PREVENT AND ADDRESS DISRUPTIVE BEHAVIOR**

[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 incidents at the medical centers had led to discussions of how to address disruptive and sometimes unprofessional behavior by physicians. In his view, UC Health appeared to tolerate this behavior longer than it should.

UCLA Health Chief Medical and Quality Officer Robert Cherry observed that disruptive physician behavior is an issue of concern for vice chancellors, deans, chief executive officers, and chief medical officers. Medical staff have responsibility for oversight of clinical care and professional behavior by physicians, but ultimately, judiciary responsibility resides with the governing bodies at each institution as a failsafe mechanism. It is difficult to respond to disruptive behavior for many reasons. There are regulatory and licensing bodies that can withdraw physicians' licenses or certifications in egregious situations, such as physical abuse, addiction, flagrant errors or dishonesty, and felony convictions. There are many other disruptive behaviors that can compromise patient safety but do not reach this level or standard, and these pose a challenge.

The range of disruptive behaviors includes overt actions, such as verbal abuse, as well as passive-aggressive behavior, such as being quietly uncooperative. While these behaviors can be found in any industry, in the healthcare setting they can compromise high-functioning teams and clinical care.

Many physicians have laudable traits, being highly skilled individuals, well-read, intelligent, hard-working, and with a desire to achieve results. But less desirable behaviors may be associated with this "Type A" personality, and these individuals can become self-centered, inflexible, arrogant in their viewpoints, and intimidate others. They may be very articulate and thus able to rationalize their behavior. Conversations with physicians who are disruptive can be challenging.

UC Health tries to exert control over its organizational culture and environment, rewarding good behavior, in particular with regard to patient safety. UC Health is cognizant that mistakes are made, sometimes through slightly risky behavior, and sometimes through truly reckless behavior. UC Health strives for a culture of transparency, where people are comfortable about reporting adverse events and speaking out about problems in the organization. In this kind of culture, there is less feeling of a power differential and more of a collaborative team spirit among physicians, nurses, other health professionals, and staff. UC Health also strives to have a learning culture, recognizing and closing gaps, even if these gaps have not caused harm to a patient.

UC Health collects data on physician behavior. Disruptive behavior is exhibited by physicians in positions of power. Most providers have witnessed disruptive behavior, and

it can lead to low morale in the team environment, with staff turnover, poor team effectiveness, low patient satisfaction, increased costs, and reputational harm. A situation of a physician berating a staff member in front of a patient can cause reputational harm. Because of the power differential in these situations, these behaviors may go unreported and unaddressed. The ability of teams to trust one another and communicate effectively can be compromised by a single individual, and this can lead to a loss of the necessary focus on patient care.

Dr. Cherry outlined some of the causes of disruptive behavior. Some contributing organizational factors are the high-stakes clinical environment, demands for productivity, and fear of litigation. Factors related to the individual that may lead to disruptive behavior include substance abuse, stress related to the physician's own life events, and fatigue. Some physicians have personality disorders and are lacking in "emotional intelligence," the ability to understand others. Some physicians lack resilience in dealing with stress.

From the perspective of a chief medical officer, behaviors are considered disruptive when they have the potential to affect care and patient safety. Responding to disruptive behavior by physicians is challenging. Various UC entities have oversight responsibility – medical staff, Human Resources, clinical chairs, deans, the Academic Senate, and the Title IX Office, and coordination among these entities can be difficult. There are also legal and regulatory barriers. Under California law, it is possible to suspend a physician if there is an immediate threat to patient safety, but the interpretation of what this means varies among providers and others concerned with patient safety, and it may be difficult to determine when a physician has crossed over the line.

Dr. Cherry observed that UC Health's systems for navigating these situations were still underdeveloped. There are mitigation procedures recommended by the Joint Commission. The leadership of hospitals and medical centers should model appropriate behavior, and institutions should have relevant policies and practices in place, and analyze relevant data. Culture of safety surveys indicate which areas within institutions are most at risk. It is important to promote communications, education, and training on creating healthy environments, environments where problematic behavior would be addressed in real time. The University has relevant systemwide policies; in Dr. Cherry's view, the University's challenges pertained to organizational culture. UC Health follows national standards in hiring new medical staff, but it may be difficult to find out in a timely manner about past disruptive behavior by an individual at a previous institution. It is difficult to approach physicians who are powerful and well-respected about disruptive behavior. Because of the many units and divisions in UC Health, it may be difficult to know who clearly has responsibility for taking action. There were opportunities for UC Health to effect a culture of safety with greater transparency. In some cases there may be inherent bias in favor of the respondent. Dr. Cherry stated that UC Health was conservative in its response to disruptive behavior, due to lack of training, guidance, and understanding, fear of litigation, or hesitancy about criticism of a physician who brings about good clinical outcomes. Some clinical chairs are risk-averse, avoiding challenging conversations with aggressive individuals who tend to rationalize their behavior.

UC Health was in the process of determining next steps. All the chief medical officers, deans, and clinical chairs take this matter very seriously and share best practices to address disruptive behavior. Dr. Cherry noted that another cause of disruptive behavior may be burnout, which is treatable and reversible. All the medical centers have a chief physician wellness officer and a medical staff physician well-being committee. The medical centers also all have patient grievance committees, responsible for following up on patient grievances. All UC medical centers have a disruptive behavior policy in addition to a local code of conduct.

Other programs are also available to UC Health to address disruptive behavior. All the medical centers make use of the Vanderbilt Patient Advocate and Reporting System, which enters patient complaints against individual physicians into a database. Based on specialty and the number of complaints, UC Health can determine if a physician is at a higher than usual risk for malpractice suits due to his or her behavior and engage in proactive outreach and education. This approach results in self-correction of the problematic behavior in about 75 percent of cases. UC medical centers also participate in the Vanderbilt Co-Worker Observation Reporting System (CORS), which collects information on staff complaints against physicians. Medical centers without the CORS program have an equivalent system to review staff complaints in real time, escalate matters to appropriate individuals, and address problematic behavior. UC medical centers have marketing teams who scan social media for complaints posted on websites such as Yelp, RateMDs, and Vitals. All the medical centers conduct physician culture of safety surveys and physician burnout/resiliency surveys in order to target and customize action plans. The medical centers and schools of medicine collaborate on these efforts. There is coaching for individuals. At least one medical center participates in the Communication and Optimal Resolution Program, an approach that emphasizes early disclosure to patients and their families and takes into account the fact that when adverse events occur, sometimes the caregiver needs care as well.

Dr. Cherry concluded the presentation by noting that the Executive Vice President – UC Health, the chief executive and chief medical officers, and the deans are focused on improvement of policies and practices regarding disruptive physician behavior and on providing guidance for areas of uncertainty. At an upcoming UC Health leadership retreat meeting, disruptive behavior and physician engagement and burnout would be central topics.

Regent Graves asked if there were existing survey data, or if survey data would now begin to be gathered. Dr. Cherry explained that he had been referring to two types of surveys. A culture of safety survey and a physician burnout survey are carried out by all the UC medical centers. Targeted solutions are based on the data from these surveys. Another type of survey was in preparation for the chief medical officers to determine common best practices across UC Health.

Regent Graves noted that it would be helpful to see some of these data in order to gain an idea of the extent of problems and where problems arise. UC Health did not appear to have a proactive approach. There might be a need for additional training for new employees.

Dr. Cherry responded that UC Health does engage in proactive involvement. The Vanderbilt programs are carried out proactively to identify physicians before they might engage in disruptive behavior. Nevertheless, there was a collective understanding at UC Health that there were opportunities for improvement. UC Health has found that the various entities with oversight responsibility sometimes carry out investigations of the same physician in isolation from one another, and is working on the question of how to share information appropriately to arrive at a coordinated decision. There could be more consistency across UC Health regarding expected behavior and codes of conduct. In Dr. Cherry's opinion, a change in the culture of the organization was needed. In spite of current policies and procedures, UC Health needed to overcome certain perceptions about the balance of power and coordinate across the medical centers and schools of medicine, because many physicians hold both medical staff appointments and faculty appointments.

Regent Graves asked if the data were coded in some way to allow one to identify the types of problems that arise. Dr. Cherry responded that there were data on the number of potentially disruptive events that are occurring among physicians and the extent of the problem, but many UC Health stakeholders believe that this problem is underreported.

Chancellor Block asked if there are programs or best practices to ensure that employees feel confident that they can report bad behavior. Dr. Cherry responded that this was a matter of the organizational culture, and ensuring that people feel safe to report incidents without fear of retaliation. When UC Health has conversations with physicians who have engaged in disruptive behavior, it makes clear to the physician that he or she must not take retaliatory action, and that UC has policies to address retaliation. Disruptive behavior is often reversible, and reporting can help save careers.

Faculty Representative May emphasized the importance of this topic, noting that disruptive behavior occurs not only at the medical centers, but also on campuses. The University should address disruptive behavior in a wider context of faculty morale. Former Advisory member Dimsdale had frequently spoken about this issue to the Committee, and the Academic Senate has written to the President regarding faculty morale. The Academic Senate looked forward to substantive work with UC Health and the campuses to address disruptive behavior in the general context of faculty morale. Dr. Cherry responded that physician and staff wellness are an important factor. The University must endeavor to reduce stress in the work environment, allowing people to perform optimally. UC Health is cognizant of the fact that physician burnout can lead to disruptive behavior, but burnout is not an excuse for egregious behavior. The morale of physicians, nurses, and staff is very important.

Regent Sherman identified one aspect of this problem as a lack of response from leadership. He asked what systems are in place to ensure that the University is responding to complaints by patients and staff and that these matters are addressed. Dr. Cherry explained that UC Health responds to incidents, and that the response varies depending on the status of the physician and where the physician works. A certain process would be applied for an independent practitioner or community physician. For a faculty member or member of the medical staff, the adjudication process depends on whether that individual is a member of

the Academic Senate or not. Development of a coordinated response or path is complicated when multiple entities are involved, such as Human Resources, the Title IX office, and a school of medicine.

Regent Sherman asked if there is a failsafe mechanism to ensure that any complaint is responded to in some way. Deputy General Counsel Rachel Nosowsky responded that UC Health did not yet have a failsafe. An initiative led by Dr. Stobo, with the chief medical officers, aims to develop a comprehensive approach to conduct expectations and disruptive behavior, and to remove barriers and develop pathways to resolving problems. She anticipated that UC Health data dashboards could be further developed to address questions of organizational culture, not just of patient safety, so that the Committee and the Board are aware of where and what kinds of problems arise.

Dr. Stobo remarked that one motivation to pursue this effort was personal knowledge of one case in which unprofessional, disruptive conduct by a physician was not dealt with and ultimately led to the death of a patient. Earlier intervention might have prevented this tragic outcome.

Committee Chair Lansing noted that incidents of improper conduct by physicians, with negative consequences for patients and institutions, were frequently reported in the news media. Improvement was needed in several areas. An employee is more likely to report misconduct by a peer than by a superior. Employees need a strictly confidential mechanism to report misconduct. UC Health needs a mechanism or path to ensure that every complaint is responded to in some way. Physician burnout is easier to address. Committee Chair Lansing described this as a work in progress. She asked when UC Health would have guidelines for addressing these issues. Dr. Stobo and Ms. Nosowsky responded that these matters would be discussed at an upcoming UC Health retreat meeting in April 2019, with a report following the retreat.

Advisory member Spahlinger asked about a confidential reporting mechanism for UC employees. Ms. Nosowsky explained that the University has a compliance hotline, and employees are informed about using it.

Dr. Spahlinger asked if the University has a standard escalation protocol. Ms. Nosowsky responded that there was not a standard protocol at the systemwide level, and not even at all the campuses. In significant cases of disruptive behavior by physicians, individuals have reported that there was a culture of fear and intimidation, and no one dealt with it. She reflected that in some sense, it did not matter whether this was a perception or reality. One of the challenges for an institution and its leadership is to ensure that employees know and see that misconduct will not be tolerated. The effects of adverse incidents can last long after the incidents themselves, even with new leadership in place.

Committee Chair Lansing commented on the difficulty of changing an organizational culture and emphasized the importance of confidentiality and building trust. It was good that UC Health was addressing this issue.

10. UC HEALTH CAPITAL FINANCIAL PLAN

The President of the University recommended that the Health Services Committee waive its authority to review the UC Health-related projects included in the 2018-28 Capital Financial Plan approved by the Regents in November 2018, subject to the following conditions:

A. The Health Services Committee's waiver shall not apply to the following projects:

UC Davis	<ul style="list-style-type: none"> - Hospital Bed Replacement Tower - South Placer Development
UC Irvine	<ul style="list-style-type: none"> - Irvine Campus Inpatient Specialty Hospital - Irvine Campus Outpatient Clinic and Ambulatory Surgery Center
UCLA	<ul style="list-style-type: none"> - Westwood Patient Tower Addition
UC Riverside	<ul style="list-style-type: none"> - School of Medicine Education Building
UC San Diego	<ul style="list-style-type: none"> - Hillcrest Outpatient Pavilion - Hillcrest Replacement Hospital - Hillcrest West Wing Replacement
UC San Francisco	<ul style="list-style-type: none"> - Helen Diller Medical Center - Proton Therapy

B. The Health Services Committee's waiver shall apply only to the extent of UC Health-related projects at the medical centers and campuses occurring during fiscal years 2018-19 to 2023-24 (Waived Projects); and

C. Any Waived Project requiring review, approval, concurrence or other action by the Finance and Capital Strategies Committee shall require consultation with 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 explained that this item would be treated as a discussion item rather than an action item. He recalled discussions that had taken place, when the Health Services Committee Charter was adopted, about which Standing Committee should most appropriately approve UC Health capital projects. While projects that directly affect a campus' health enterprise strategic plan should be brought to the Health Services Committee, some items might not need to be approved by the Health Services Committee, such as purchases of property, leases, or design issues. Under this action, such items would

be routed to the Finance and Capital Strategies Committee. If the Finance and Capital Strategies Committee had questions about an item's impact on the strategic plans of UC Health, that item would be brought to the Health Services Committee. This action would expedite the campuses' ability to have projects approved. This would be an important decision, and Dr. Stobo anticipated that this item would be introduced again at a future meeting.

Committee Chair Lansing stressed that medical center chief executive officers and medical school deans should be kept apprised of capital projects being proposed, even if these projects are not brought to the Health Services Committee. Dr. Stobo agreed, and explained that this action would reduce delays. Currently, presenting a lease item to the Health Services Committee before it is presented to the Finance and Capital Strategies Committee can postpone action by at least two months. UCSF Health Chief Executive Officer Mark Laret clarified that it was important to determine if the members of the Health Services Committee were comfortable with the action being proposed.

Regent Sherman asked if there would be changes to the authority of Health Services Committee to approve transactions, with respect to thresholds such as dollar amounts and percentage limits of revenue. Dr. Stobo confirmed that there would be no change in this respect.

11. **UC SAN DIEGO HEALTH AFFILIATION WITH EL CENTRO REGIONAL MEDICAL CENTER: IMPACT ON QUALITY AND BRANDING, SAN DIEGO CAMPUS**

This item was not discussed.

The meeting adjourned at 1:40 p.m.

Attest:

Secretary and Chief of Staff

Additions shown by underscoring; deletions shown by strikethrough

Regents Policy 3401: Policy on Student Health and Counseling Centers

POLICY SUMMARY/BACKGROUND

The Regents are committed to delivering high quality health and counseling services to the students of the University of California in a coordinated, consistent and integrated fashion, including through the University of California Student Health Insurance Plan (UC SHIP), and adopt the following in furtherance of that goal.

POLICY TEXT

- A. Each Student Health and Counseling Center (“Center”) shall have a governing body, ultimately reporting to and acting under the direction of the Chancellor, which body shall include no fewer than three members, at least one of whom shall be a licensed physician (or for counseling centers, a licensed psychologist), at least one member who has a health care administrative background and, for counseling centers, at least one member who is a licensed psychologist. Exceptions for members other than the licensed physician (or for counseling centers, a licensed psychologist) may be approved by the ~~Senior~~ Executive Vice President, UC Health Sciences and Services.
- B. ~~Each Center shall have a written set of~~ The Executive Vice President for UC Health, after consultation with the Center governing bodies, the Chancellors, the Vice President for Student Affairs, and the Health Services Committee, shall establish (and amend as necessary) a set of minimum standards for bylaws, policies or other comparable governing documents under which the Centers operate. which shall be reasonably consistent for all Centers.
- C. The credentials of each health care practitioner employed at each Center shall be verified by the University before such practitioner begins ~~working~~ providing care at the University or to its students at other locations in connection with University programs, and at an interval of no more than every three years thereafter. Initial primary source verification of practitioner credentials shall be performed on the University’s behalf by a single credentialing verification organization approved selected by the Senior Executive Vice President, UC Health. Sciences and Services in consultation with the Chair of the Committee on Health Services.
- D. All Centers shall employ one electronic medical records health information system that meets interoperability standards established by the Office of the National Coordinator for Health Information Technology or by other applicable government agencies or accreditation bodies, is capable of securely sharing data across all locations, and is shared across all locations and managed in compliance with University policy. With a Chancellor’s approval, following consultation with the Office of General Counsel and the Office of Ethics, Compliance and Audit Services to confirm compliance with applicable law and University policies, a Center may instead utilize a University hospital’s

~~electronic medical record. The use of any third-party application or service shall have a unified administration, common templates, nationally standardized coding systems as specified in the Health Insurance Portability and Accountability Act and implementing regulations (HIPAA), and standard billing practices for patient services, and shall be selected require approval by the Senior Executive Vice President, UC Health, in consultation with the Chief Risk Officer and the Chief Information Security Officer. Sciences and Services in consultation with the Chair of the Committee on Health Services.~~

- E. ~~The results of any audits or management advisories issued by the University's Internal Auditors, and of any investigations performed by the University's compliance officers, related to this policy shall be reported to the members of the Health Services Committee. The Senior Vice President, Health Sciences and Services, in consultation with the Chair of the Committee on Health Services, shall direct an external organization to conduct an annual audit and/or risk review of the services provided at the Centers, the results of which shall be reported to the Committee on Health Services. The Senior Vice President, Health Sciences and Services shall also meet on a regular basis, but no less than biannually, with the Center Directors.~~

COMPLIANCE/DELEGATION

Implementation and compliance with this policy shall be administered by the Office of the Executive Vice President, UC Health (or any successor position based on a change of title), in consultation with the Vice President of Student Affairs.

NO RIGHT OF ACTION

This policy is not intended to, and does not, create any right or benefit, substantive or procedural, enforceable at law or in equity by any party against the University of California or its Board of Regents, individual Regents, officers, employees, or agents.

PROCEDURES AND RELATED DOCUMENTS

Procedures, guidelines, and related documents implementing this policy are posted online at <https://www.ucop.edu/uc-health/initiatives/studenthealth.html>. Changes to these documents do not require Regents approval, and inclusion or amendment of references to these documents can be implemented administratively by the Office of the Secretary and Chief of Staff upon request by the unit responsible for the linked documents.