

The Regents of the University of California

HEALTH SERVICES COMMITTEE

April 13, 2018

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

Members present: Regents Blum, Lansing, Makarechian, and Sherman; Ex officio member Kieffer; Executive Vice President Stobo; Advisory member Hernandez

In attendance: Regents Ortiz Oakley, Park, and Zettel, Regent-designate Graves, Faculty Representative White, Secretary and Chief of Staff Shaw, Executive Vice President and Chief Operating Officer Nava, and Deputy General Counsel Nosowsky

The meeting convened at 12:30 p.m. with Committee Chair Lansing presiding.

1. **PUBLIC COMMENT**

There were no speakers wishing to address the Committee.

Committee Chair Lansing recalled that Regent Reiss had passed away on April 2. She praised Bonnie Reiss as an extraordinary person with intelligence, enthusiasm, passion, humor, and the ability to consider both sides of any issue. In spite of serious health problems that she had faced over the past year, Bonnie Reiss remained engaged in the business of the University as a Regent and as a member of this Committee. If one word could describe her, it might be “pure”; she had no preconceived agenda, but cared about doing what was right for the University, for its hospitals, for its students and faculty, and for the world. The University and the world were better places because of Regent Reiss. Committee Chair Lansing urged the University to continue the work Bonnie Reiss would have so much wanted. The Regents would continue their work in her memory.

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

Upon motion duly made and seconded, the minutes of the meeting of February 6, 2018 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 began his remarks by reflecting on Regent Reiss’ tremendous support for UC Health.

Dr. Stobo then commented on the omnibus budget bill recently passed by Congress. The bill provided \$37.1 billion for the National Institutes of Health for fiscal year 2018, an 8.3 percent increase over the previous year. He applauded this action by the U.S. Congress. Dr. Stobo reported that he and Executive Vice President and Chief Financial Officer Brostrom had meetings the previous month with representatives of bond rating agencies, Fitch, Standard & Poor's, and Moody's. The University was not planning to issue bonds at this point. The agencies had concerns regarding the State audit of the Office of the President, and Mr. Brostrom and Dr. Stobo tried to allay these concerns. He and Mr. Brostrom made presentations about the accomplishments of the University's academic enterprise and UC Health, which should be a source of pride in difficult times.

Dr. Stobo briefly presented and elucidated 2018 year-to-date financial figures for the medical centers. He stated that UC Health was in a strong financial position. UCSF and UC San Diego had recently opened large facilities and taken on the associated expenses; as planned, they were making a remarkable financial recovery. The operating margin for the entire UC Health enterprise was roughly four percent. Days' cash on hand and debt service coverage for all locations were above UC thresholds. The rating agencies acknowledged that UC Health's financial position was strong despite challenges in the environment.

Dr. Stobo alluded to concerns that had arisen from the recent report and recommendations by Huron Consulting. He recalled that at an earlier point, UC Health had already begun its journey, still ongoing, toward working together more effectively as a system, with the whole greater than the sum of its parts. The Huron report was incidental to this journey. The changes that were being contemplated were changes to the UC Health central administrative office in Oakland at the Office of the President. These changes would not affect the campuses directly, or the governance of the clinical and academic enterprises, or the symbiotic relationship between the two. Before proposing solutions, UC Health must understand its problems.

Dr. Stobo recalled that at the Office of the President in 2008, the academic health and clinical health enterprises were two separate units that reported to different administrators. Beginning his tenure at UC at that time, Dr. Stobo felt that this distinction was artificial, and the two separate entities were united. He outlined further changes and innovations made by UC Health since that time, such as the Center for Health Quality and Innovation, the Leveraging Scale for Value initiative, the current form of the Health Services Committee, and the UC Cancer Consortium. These were some of the hallmarks of the journey from five independent medical centers to a system. The sign of having arrived at an actual system would be UC Health-wide systems and financial integration and strategic planning.

Dr. Stobo reflected on which factors inhibited the ability of the UC Health central office to support the campuses' goals and promote systemwide development. Many challenges could not be met successfully campus by campus, but only as a system. There were at least four such challenges: declining reimbursements; rapid consolidation among provider groups and pharmaceutical companies; unpredictable health policy; and growing patient

and payer expectations. This new environment required creative solutions, scale, systems integration, agility, and rapid strategic growth. The current administrative and operational limitations of the UC Health central office within the Office of the President placed UC Health at a competitive disadvantage in this environment. To do nothing would amount to an existential threat to UC Health. Standing still was not an option.

Dr. Stobo outlined principal challenges that needed to be addressed. There was a need for transparency regarding the source or use of dollars that support UC Health initiatives. Three-quarters of the UC Health budget came directly from the medical centers, while the medical centers likely had little idea of how much money they were contributing to support the central office. There was no accountability for the use of these funds. In addition to accountability and transparency, there was a need for greater agility, the ability to respond to programmatic needs in a timely manner. He noted that in the field of cancer care, MD Anderson was moving into the San Diego area, and City of Hope was moving into Orange County. UC Health also needed flexibility to grow its programs in support of the campuses. The challenges of accountability, transparency, agility, and flexibility might be addressed by examining a different way to organize the UC Health central office. This would be the next step in the evolution of UC Health, and President Napolitano planned to appoint an advisory committee to work through these issues. Executive Vice President and Chief Operating Officer Nava added that this advisory committee would produce recommendations for the President and the Board.

Committee Chair Lansing emphasized that the Huron recommendation for UC Health would not split UC Health off from the University, but would render it more transparent, accountable, and flexible, with agility to move in these difficult times.

Regent Makarechian asked about specific accountability goals. Dr. Stobo responded that he would like the UC Health central office to be extricated from restrictions that encumbered the Office of the President, particularly following the State audit. These restrictions prevented UC Health from acting with agility.

Regent Makarechian asked if Dr. Stobo had any specific proposals for better accounting for how funds are spent. Dr. Stobo responded that it would be useful to have an advisory or steering committee with appropriate representation, so that chancellors from campuses with medical centers are aware of their financial contribution to UC Health and how it is used, and understand the programs that UC Health was proposing.

Regent Makarechian asked if these funds were currently being spent without consultation. Dr. Stobo stated that he wished to avoid creating more bureaucracy, but that the idea he had just outlined would provide the campuses with a better overview of UC Health activities, and a forum for discussion.

Chair Kieffer stated his perception that the UC Health central office wished to provide assurance to the Regents and the campuses about its activities, and to provide transparency and accountability with regard to how it was spending funds. Competitors were entering the San Diego and Orange County markets. There was tremendous pressure and a need for

cost containment. He asked why coordination in some manner would be useful. Dr. Stobo responded that the example of UC Health's cost reduction activities demonstrated that it made sense to use the scale of UC Health for procurement. Another recent example was in the area of cancer research. Seven months earlier, UC Health learned that MD Anderson planned to partner with another organization in the San Diego area to become the major provider of cancer care in the area. UC San Diego has a first-rate cancer center, but that by itself would not be sufficient to blunt the competition; similarly, UC Irvine on its own could not blunt the competition from City of Hope, which recently announced that it would move into Orange County. UC Health developed the idea of marketing all five of its cancer centers together as a Cancer Consortium, which could offer more than MD Anderson or City of Hope.

Chair Kieffer stated that UC Health would like to be in a position to quickly coordinate a collective response to this kind of "invasion." He observed that the University may not recognize the importance of responding to competition, and how damaging the loss of revenue in tertiary care can be for the medical centers. The University must protect its institutions.

UC San Diego Health Chief Executive Officer Patricia Maysent recalled that UCSD had spent more than \$1 billion over the past ten years on cancer infrastructure. MD Anderson and City of Hope aspired to be the major cancer care providers not only in the San Diego or Orange County areas, but in the entire state. Their aspirations included donors, philanthropy, and the full continuum of services offered by UCSD. This matter affected not only UCSD Health but the campus as a whole. The University needed to fight this encroachment with a statewide response. These competitors spend much more money on advertising and branding than UC does. UC Health could blunt this competition if it worked together.

Chair Kieffer asked if Ms. Maysent would be concerned that the UC Health central office might at some point cross over a line in a way that would harm UCSD Health. Ms. Maysent responded that she was not worried about this; she was more concerned about alignment within UC Health and development of a comprehensive strategy. Dr. Stobo added that the medical center chief executive officers tended to criticize him more for not bringing them together often enough to collaborate than for crossing over a line.

Chair Kieffer asked about the perception that the central office would take over and that medical centers would lose their autonomy. Dr. Stobo responded that he and the central office did not have this authority. UCLA Health Sciences Vice Chancellor John Mazziotta responded that this was not a concern of the medical center administrators, who look to Dr. Stobo and the central office to carry out systemwide activities that would not be successful if undertaken by a campus. The medical centers wish to see actions taken centrally that benefit all of them, and were not concerned that the proposed recommendations would represent a change of control.

Regent Sherman suggested that a more centralized structure might help UC Health be more competitive. He asked why UC Health had not been moving toward becoming a

confederation of systems, with an identity such as UC Health at San Diego, UC Health at San Francisco, etc., rather than being five separate systems that work together on procurement and certain straightforward projects. Dr. Stobo responded that UC Health was considering this direction and had been discussing this for about three years. UC Health must proceed carefully. Each medical center has a unique brand in its local market, and UC Health does not wish to diminish or intrude on this. One must determine how to parlay the local brand along with the advantage of belonging to a larger system. UC Health had engaged an individual with experience in marketing systems to work with each location on marketing the location as part of UC Health. This work was under way.

Regent Sherman asked if UC Health would move patients from one medical center to another for better treatment. Committee Chair Lansing responded that this had been a goal and that it was already occurring. She recalled how the idea of collaboration among the medical centers was first discussed many years earlier and had gradually evolved toward the UC Health system. The UC Health system was in a strong position to negotiate contracts, but individual medical centers were not in a strong position by themselves. Dr. Stobo added that when campuses think of initiatives, they think of pursuing them as a system. UC Health's financial position would not be what it was at this point without working collaboratively as a system. Individual medical centers would not be able to negotiate the same commercial insurance reimbursement rates or achieve the same cost reductions on their own.

Chair Kieffer requested confirmation that proposed changes to the UC Health central office would not reduce funds available to the campus medical centers; UC Health would continue to operate its finances internally. Dr. Stobo confirmed this, and observed that the inability to be competitive in the clinical market is a factor that causes UC's medical education function to lose money. Committee Chair Lansing reflected on the progress made by UC medical centers. Fifteen years earlier, the University's hospitals were losing money.

4. **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.]

UCLA Health Chief Medical and Quality Officer Robert Cherry presented the clinical quality dashboard for UC medical centers. He noted that ambulatory quality measures had not been updated because UC Health was still waiting for population health statistics. Inpatient data had been updated and finalized through December 2017, and some data had been updated through the first quarter of 2018.

With regard to inpatient mortality, Dr. Cherry noted that Vizient, the academic medical center cohort that UC uses as a benchmark, readjusts its methodology every few years. Many UC medical centers were unaffected by the most recent risk adjustment methodology, but UC Davis appeared to be disproportionately affected. UC Davis had been working with Vizient to determine the causes of this, and Dr. Cherry stated that the next

quarter results for UCD would be improved. UC Irvine was redoubling its efforts to reduce mortality related to sepsis, and to ensure that the right care is provided at the right time, especially for terminally ill patients. Provision of appropriate palliative care for terminally ill patients is part of the risk adjustment model. UC Irvine was also working to improve documentation reflecting case acuity or severity and the disease burden of the patient. UCLA had been performing better on the criterion of risk-adjusted mortality, in particular, by proactively identifying patients at risk for clinical deterioration and deploying a special nursing team.

Dr. Cherry then discussed 30-day readmission rates, noting that even after efforts are made to reduce rates, it may take a year to 18 months to see improvements. The overall UC average of 13.3 percent was close to the national competitor average of around 13.1 percent. UC had been making progressive improvements, and the next quarter's results would be interesting. While UC Davis had the highest rate, 14.88 percent, this would come down to 13.43 percent in the coming quarter. Dr. Cherry anticipated that UC Davis and other medical centers would move closer to the national competitor benchmark.

The results of patient surveys reflected the quality of care and how well physicians and nurses communicate with patients. Certain questions, such as questions about courtesy and respect, might indicate trends for the quality of nursing. UC Davis was carrying out nursing leadership rounds to engage patients and deliver relationship-based care. UC Health was working to streamline communication and messaging for patients.

Regent Sherman asked about a correlation between UC Davis readmission rates and patient satisfaction. Dr. Cherry responded that sepsis was the major cause of readmissions. The reasons for focusing on patient experience were not related to readmission rates, but to ensure that UC Health lives up to its values as an organization. UC Health wishes to be a destination for population healthcare, wellness, and preventive care, and trust must be established in patient-caregiver relationships in order to accomplish this.

Regent Makarechian observed that UC hospitals care for more patients with severe conditions, or patients close to the end of life, than do other institutions. He asked how this is taken into account. Dr. Cherry responded that the risk-adjusted methodology takes this into consideration. He acknowledged that because of UC hospitals' status as academic medical centers providing tertiary and quaternary care, they receive patients with acute conditions, transferred from Providence Health and Services, Dignity Health, and Kaiser Permanente hospitals. UC Health wishes to ensure that these transfers are appropriate, and that UC can deliver care at a higher level than the organization the patient is being transferred from. There are variables in risk adjustment for inpatient mortality which take comorbidity into account, patients' histories of heart attack, stroke, obesity, and diabetes in addition to the current diagnosis. UC Health benchmarks itself against other academic medical centers. The inpatient mortality rates presented on a chart reflected a cohort of hospitals also providing tertiary care. UC San Diego Health Chief Executive Officer Patricia Maysent observed that risk adjustment is not a perfect science. Different agencies apply risk adjustment differently, and some methodologies are better than others. She opined that the Centers for Medicare and Medicaid Services (CMS) star rating system did

not properly reflect the severity of the conditions of patients at UC medical centers. Dr. Cherry stated his view that although risk adjustment methodologies were imperfect, in this case, because UC Health was benchmarking itself against about 110 other academic medical centers, the information was credible.

Regent Makarechian asked if this was also true of readmission rates. Dr. Cherry responded in the affirmative; for this criterion, UC Health was also comparing itself to other academic medical centers. CMS compares UC Health to all other hospitals, while the Association of American Medical Colleges has revised this methodology by separating teaching hospitals from the entire pool of 3,000 hospitals. Comparisons of UC Health with other teaching hospitals are more favorable, because these comparisons take sufficient account of the complexity of care.

Regent Makarechian asked if these statistics were available online. Dr. Cherry responded that CMS data were publicly available. The Vizient database was not publicly available, but shared within that collaborative.

Advisory member Hernandez asked if there was variability in access to palliative care at the UC medical centers, which might account for variation in the inpatient mortality rates. Dr. Cherry responded that there was some degree of variability. He noted that it is difficult to recruit physicians to specialize in palliative care, and that it is difficult for physicians to raise the issue of palliative care with patients and patients' families at the time of a diagnosis of cancer or other disease.

Dr. Hernandez referred to large-scale surveys of health providers, which indicated that providers would like to be more engaged in palliative care at an earlier stage, but that there was not enough system infrastructure. The University is a major provider of the healthcare workforce, and UC had a unique opportunity to expand palliative care. UCLA Health President Johnese Spisso responded that UC Health has been exploring this area, adding social workers and nurse practitioners for inpatient and outpatient services, and examining how to invest in this area. In response to a question by Committee Chair Lansing, Ms. Spisso explained that while UC Health provides palliative care, there was not yet sufficient investment in this area, which was growing quickly.

Dr. Hernandez remarked that patients come to UC medical centers seeking state-of-the-art, high-acuity care. Good care should include palliative care at an early stage. There was a general shortage of palliative care and palliative care providers. Providing palliative care early on would reduce inpatient mortality and provide something patients want as part of their care delivery. Committee Chair Lansing agreed with Dr. Hernandez's assessment, and underscored how difficult it is to introduce palliative care at the time of a first diagnosis. The University must provide palliative care and invest in a better infrastructure for this care, and determine how best to introduce it to patients. Dr. Cherry responded that introducing palliative care is an iterative process. UCLA Health Sciences Vice Chancellor John Mazziotta noted that a workshop was held for UCLA oncologists, practicing these conversations with actors. The focus is on optimizing the quality of life at every stage of the illness. Individuals need training to have these conversations; one cannot assume they

will do this successfully. Committee Chair Lansing observed that sometimes, members of a support team other than doctors may be best suited to having these conversations.

Dr. Cherry then continued the presentation. He presented a chart with information on central line-associated bloodstream infections (CLABSI), including actual numbers of infections by institution and numbers of central line days, the number of days a catheter was in place. The number of central line days for the fourth quarter of 2017 was approximately 37,000 days, while the number of infections was 44. The hospitals with the largest absolute numbers of infections, Ronald Reagan UCLA Medical Center, UC San Diego, and UCSF, also had large numbers of central line days. The hospitals are always evaluating a patient's need for a central line, or whether medication can be delivered through a peripheral line, for example. The University aspires to reduce the number of infections to zero.

Data on case mix index indicated that this factor had remained stable over the last few years. Referring to a chart with information on rates of hospital-acquired pressure ulcers, Dr. Cherry noted that since UC Health began compiling these data for the Committee, there had been productive, robust discussions among chief nursing and chief medical officers on sharing best practices in various areas. Pressure ulcers include not only bed sores, but can be caused by cervical collars or tracheostomy tubes. In this regard, there have been discussions about the types of beds and mattresses UC hospitals use, products used to reduce pressure ulcers, and documentation of patients who already have pressure ulcers when they enter the hospital.

Data for catheter-associated urinary tract infections (CAUTI) showed an increase at the UC Davis Medical Center in the last quarter. In response, UC Davis was initiating a nursing-driven protocol in order to reduce the number of catheter days and the number of infections, and to avoid overuse of cultures. Dr. Cherry anticipated improvement at UC Davis in this area. There had also been an increase in CLABSI at the UCLA children's hospital, which was attributed to the departure of clinical leaders. When turnover of leading staff occurs at various levels of the organization, there may be increases in rates of infection or other outcomes. UCLA was trending toward improvement.

Regent Makarechian asked if different equipment and procedures at different hospitals accounted for differences in rates of CAUTI and pressure ulcers. Dr. Cherry remarked that UCLA had changed its bed product a few years earlier and experienced a dramatic reduction in pressure ulcers; UCLA shared this information with colleagues, and the other UC hospitals were evaluating this. The sharing of best practices was also employed in reducing CAUTI. Increases in infections such as CAUTI and CLABSI may be due to changeover in leadership or complacency. There may be a need to revisit a unit and check on its adherence to best practices.

Regent Makarechian asked about the relative roles of training versus equipment in reducing the occurrence of infections and pressure ulcers. Dr. Cherry responded that rates of pressure ulcers could be reduced by equipment and best practices. For reduction of both CLABSI and CAUTI, it was necessary to ensure that adherence to best practices was maintained.

Dr. Cherry then commented on data for excess bed days, which was one of the goals included in the Clinical Enterprise Management Recognition Plan. He explained that each incoming patient receives a diagnosis. Based on this diagnosis, there is a number of days that the patient is expected to be in the hospital. Both CMS and Vizient have measures for this factor; UC Health uses the Vizient measure, which better reflects the complexity of UC patient conditions. Not all patients can be discharged based on a statistical model, but UC Health was working to improve operational efficiencies and clinical pathways to ensure that patients are discharged safely. Each UC medical center was meeting the target for this criterion in this fiscal year. There had been an increase at all UC facilities except UC Davis. UC chief medical and chief nursing officers believed that this was related to the influenza season and a surge in influenza cases. Unexpected medical events in UC Health populations can have an adverse impact on hospitals' operational efficiency. Dr. Cherry concluded with remarks on rates for cesarean sections at UC medical centers, one of the measures in the State's Public Hospital Redesign and Incentives in Medi-Cal. UC hospitals were reviewing this, trying to decrease these rates, and ensure that cesarean sections were medically appropriate.

In response to a question by Regent Makarechian, Dr. Cherry noted that a mere four percent decrease in excess bed days would result in capacity for 400 additional patients per year. If UC Health can reduce excess bed days safely, it can care for more patients.

Committee Chair Lansing asked about the original Affordable Care Act proposed by former President Barack Obama, recalling that hospital reimbursements could be affected if readmission rates were too high. Dr. Cherry responded that this condition is still in effect. Committee Chair Lansing emphasized that UC Health's efforts, reflected in the dashboard report, were motivated by the wish to improve patient care and by economic considerations.

5. **HEALTH CARE VENDOR RELATIONS POLICY UPDATE**

[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.]

Deputy General Counsel Rachel Nosowsky discussed policy recommendations the University was beginning to consider regarding conflict of interest in its clinical operations. All healthcare providers in the U.S. are actively targeted by the marketing departments of pharmaceutical and medical device manufacturing companies. Increasingly, since passage of the Physician Payments Sunshine Act, these companies have focused on nurses and physician assistants, who are not subject to the same transparency reporting requirements. Data concerning prescribing practices are difficult to obtain. In spite of the existence of electronic medical records, these data are not centralized and not easily available, particularly in the outpatient environment, and not even from commercial sources. Although significant attention has been paid to the problem of vendors providing gifts, vendors were still providing these gifts, including meals and travel, which are believed by many to have an influence on prescribing practices. Through internal review, UC Health had become aware of opportunities to reduce gaps in policy and training. Some examples of policy violations that occur widely and are not limited to UC include transparency

failures, the use of separate companies to receive payments, and violations of leave policies.

Ms. Nosowsky outlined some policy recommendations. One would be to enhance disclosure requirements. Currently, UC faculty in the Health Sciences Compensation Plan were subject to disclosure requirements, but not all physicians practicing at UC participate in the Plan. UC disclosure requirements did not apply to nurses, physician assistants, procurement staff, and others who influence UC Health purchasing practices. The proposed disclosure requirements would enable internal UC oversight by committees and compliance officials. Centralization of reporting would help the work of quality, safety, and utilization review committees.

When UC policies are first issued, definitions may not necessarily be as clear as they could be. Individuals sometimes violate policies because they do not fully understand them. The University has dozens of policies that address conflict of interest. Another current recommendation was to help people better understand the relationship of these policies, focus on conflict of interest in clinical work, and improve the policies. Training on conflict of interest issues and requirements could be improved, and an internal website could be established as a ready source of information for faculty and staff. Other recommendations were to require and streamline entry of drug and device prescription data into electronic medical records, and develop standardized language for clinical informed consent forms; currently the language used in UC informed consent forms was inconsistent. Ms. Nosowsky noted that in some cases, patients have made allegations that they did not know that a particular physician or healthcare provider had a financial interest with a company, and that they would have made a different healthcare decision had they known this. Thus, work to improve and standardize informed consent forms would be helpful. Some institutions post information about financial interests online; others do not. Typically, this is information about the amounts of money a doctor has received from a company. The final recommendation would be to provide explicitly for disciplinary and corrective action for policy violations; there was a need for consistent procedures. Ms. Nosowsky anticipated that a draft policy would be presented in the near future.

Regent Park observed that the recommendations concerning disclosure and behavior had an important ethical element. She asked if the recommendations also addressed economic issues, and noted that pharmaceutical marketing can drive physicians to use higher-priced products. Ms. Nosowsky recalled that datasets on prescribing activity are not easily available, and often incomplete, not covering an entire hospital, for example. Some data are difficult to extract from medical records. The proposed recommendations would help UC Health gather data in order to monitor certain developments. An uptick in the use of a certain drug or medical device might be a sign of fraud, the new indication of a better drug, or the replacement of an unpatented device with a higher-cost patented device. Currently, UC Health did not have enough data to determine this adequately.

UCLA Health President Johnese Spisso remarked that one of UC Health's internal safeguards is provided by routine meetings of the chief pharmacy officers. The medical centers examine data and look for unusual practice patterns. When new drugs come on the

market, pharmacists carry out a drug use evaluation and present information on the drug's efficacy to physicians. UC clinicians are receptive to this information. Over the past year, UC Health had focused efforts on identifying less costly but equally efficacious drugs. Executive Vice President Stobo added that, by drawing on UC Health's clinical data warehouse, with information from roughly 16 million patient records, one could determine which were the most expensive drugs being used at each medical center. Exceptions and anomalies could be identified and their causes established.

6. **PROPOSED REQUEST FOR APPROVAL OF HILLCREST CAMPUS REDEVELOPMENT PHASE 1, SAN DIEGO CAMPUS**

The President of the University recommended that the Health Services Committee approve the San Diego campus' proposed discussion of the Hillcrest Campus Redevelopment Phase 1 with the Finance and Capital Strategies Committee at the May 2018 Regents meeting and the San Diego campus' proposed requests to the Finance and Capital Strategies Committee for: (1) approval of preliminary plans funding at the July 2018 meeting, (2) approval of the budget and external financing by early 2019, and (3) approval of design pursuant to the California Environmental Quality Act (CEQA) by spring 2019.

[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 UCSD operates two health campuses, the La Jolla campus, site of the Jacobs Medical Center, and the Hillcrest campus in midtown San Diego. The Hillcrest hospital was originally a county hospital, built in 1963. UCSD leased the hospital in 1966 in pursuit of its clinical and medical education missions. The hospital serves a high proportion of Medicaid patients, about 40 percent. UCSD operates a Level 1 trauma center at the Hillcrest facility, as well as a regional burn center, a comprehensive stroke center, an emergency department, geriatric health, and adult behavioral health, including a locked unit. UCSD has one of the largest HIV/AIDS programs in the U.S.; it began at Hillcrest in 1983. A significant amount of research is carried out at Hillcrest.

Currently, UCSD was expending approximately \$20 million to \$25 million annually to keep this hospital operational. Systems and infrastructure were antiquated. Ms. Maysent emphasized UCSD's commitment to the Hillcrest community. There is no other county hospital in San Diego; Hillcrest and Scripps Mercy Hospital are the two facilities that provide most county medical care.

The Hillcrest redevelopment project had been embraced by both UCSD Health and the general campus, and the project was being envisioned within the context of UC San Diego's broader strategy. The Chancellor had commissioned a Long Range Development Plan (LRDP) for Hillcrest in fall 2016, a \$2 million planning process. The acreage at Hillcrest included small parcels of land that UCSD did not own or control. Over the last several years, the campus had acquired these parts of the property, so that it now owns

60 contiguous acres, 30 of which can be developed. UCSD can make changes to roads, entrances, and exits.

A great deal of infrastructure would need to be built on this property: parking, central plant, roadwork, and shoring up. This project would be different from the Jacobs Medical Center, where UCSD built new capacity. Hillcrest was fundamentally a hospital replacement project; replacement was required by 2030 to comply with seismic safety laws. The campus had considered various economic models and determined that it could set up a ground lease vehicle with developers to build multi-family housing on a portion of the property. This would generate income to support the Hillcrest infrastructure and respond to a tremendous community need for multi-family housing in the area. The campus projected that the pre-paid ground leases might provide a \$200 million increase in revenue.

The challenges of Hillcrest included the fact that it was an outdated facility, not seismically compliant, that would have to be replaced by 2030. The infrastructure was inadequate for modern healthcare delivery models. The locked mental health unit itself would probably only last another five years. There would be a transition to more outpatient settings. UCSD has a special role as a safety net provider in the region. The project would restructure and reorganize the 35-plus buildings for better coordination of care and research, and driving into and out from the campus would be made easier.

UCSD Director of Physical and Community Planning Robert Clossin observed that this complex redevelopment project provided a unique opportunity. He presented a diagram of the site, describing the existing hospital, streets, and site access. Most research activities were located in structures north of the hospital, and there were outpatient facilities south of the site. Two large parking structures would be replaced in the first phase of the project. The first step in the planning process was determining the location of the new hospital; it would be located north of the existing hospital. All services and research would have to be kept in operation while the new hospital was being built.

The residential district would be located on about 12 acres on the western side of the site, and would likely be built in two phases. The healthcare facilities would be located on the north and east sides. To the south of the site would be a mixed use area for a community wellness facility. UCSD had determined that the existing Hillcrest hospital could not be repurposed due to its age, and it would be demolished. When the hospital was demolished, the center of the site would furnish space for a gateway open space area. Outreach and discussions with the community had been taking place over the past year-and-a-half. Area residents felt that this neighborhood did not have much open space, and this would be an opportunity to create such a space. The LRDP would extend to 2035. The campus was planning for hospital capacity of up to 300 beds, and up to 1,000 residential units. The mixed use area would contribute to the total square footage of approximately 2.7 million, compared to the current total of slightly over 1 million square feet.

Mr. Clossin presented and described an architectural rendering of the possible appearance of the finished site in 2030-32 to give an idea of massing and scale. He pointed out that the buildings would provide views of the ocean and downtown San Diego. The campus would

present items at future Regents meetings for approval of preliminary plans funding, budget and financing, and design and California Environmental Quality Act-related approvals for Phase 1 and the LRDP. Phase 1 would occupy slightly more than ten acres, with the 200,000-square-foot outpatient pavilion, a parking structure, a multi-use facility, and road improvements. Additional parking would be located below the buildings. He anticipated that about 2,400 spaces would be provided to replace the two existing parking structures. Ms. Maysent expressed UC San Diego Health's intention to provide financially accretive high-end outpatient services that would allow replacement of the hospital and long-term development of the property. Currently, outpatient cancer services were scattered across the Hillcrest campus; these services would be located in comprehensive clinics. Mr. Clossin described features of the site as shown in an architectural rendering video, a simulated aerial view moving over and around the buildings and spaces of the future Hillcrest campus. He noted that three-quarters of the site is surrounded by canyons. Ms. Maysent concluded by expressing UCSD's confidence in its ability to secure funding for Phase 1 of the project. There were still many financial and programmatic details to work out.

Regent Makarechian expressed concern about the levels of UCSD Health's days' cash on hand, debt service, and earnings before interest, depreciation, and amortization (EBIDA), given the size of this project. In addition, the San Diego campus had many other projects under development. He asked if there had been discussions with the campus' Chief Financial Officer to ensure that a situation of budget deficit would not occur. He also asked if this project would involve any program duplications. He remarked that this was an expensive construction site and wondered if some of the proposed facilities might be built elsewhere. Ms. Maysent responded that prior to opening the Jacobs Medical Center, UCSD Health had the highest EBIDA and margin in UC Health. UCSD Health opened this \$1 billion facility and still had a healthy margin, and the margin was increasing. In its ten-year forecast, UCSD Health projected that it would return to high levels of profitability. The campus Chief Financial Officer was one of the main visionaries for this project. The project would be built over the course of ten years. There might be a financial dip following the opening of the outpatient pavilion, but ultimately this facility would be financially accretive. There were many elements in this project, and at this point there were possibly six different ways the development of the hospital could be financed. UCSD would not take that step and not bring forward an item to the Regents until the campus was certain it could sustain the debt service or the impact of building on the site. In response to another question by Regent Makarechian, she confirmed that financial detail would be presented to the Finance and Capital Strategies Committee. She acknowledged that this is a challenging site for construction due to the canyons. Another challenge lay in the fact that UCSD would be replacing this hospital while competition in the healthcare marketplace became more intense; the campus was including contingencies in its long-term plans for Hillcrest. Mr. Clossin added that UCSD would avoid building in or along the canyons. There were about 30 acres of developable land. The main impact of the construction would be felt by the neighborhood, and UCSD would have to work to mitigate effects such as dust and noise. In response to Regent Makarechian's concern regarding possible duplication of facilities, Ms. Maysent observed that except for women's and infant services, the Jacobs Medical Center was currently full, and this gave UCSD confidence

about building out the Hillcrest campus. For certain major services, such as cancer and cardiovascular care, Hillcrest would accommodate patients from the Jacobs Medical Center.

Regent Makarechian voiced concern about how buildings on the site might perform in an earthquake. He asked if UCSD had considered any alternatives to this site. Ms. Maysent responded that available property in the region was scarce. A move out of the Hillcrest area would be politically controversial and likely damage the UCSD Health brand.

Regent Sherman asked about the net increase of patient beds and outpatient square footage being planned. Ms. Maysent responded that no net new beds were being projected; in fact the number of beds might be slightly reduced. This would depend on the degree of financial flexibility UCSD had. She anticipated that the inpatient facility would have 200 to 300 beds. The outpatient pavilion would provide approximately 200,000 square feet.

Regent Sherman remarked that this project involved a great expense but would result in no additional beds. This would be a difficult revenue model. Ms. Maysent agreed that this was a difficult revenue model, but noted that this was the case for many hospitals in California. The Hillcrest hospital had to be replaced by 2030 at great cost, about \$4 million per bed. The 2030 seismic safety replacement requirements would be difficult for other UC Health locations as well. Small district hospitals were currently closing, unable to fulfill this requirement.

Regent Sherman referred to the canyon setting, traffic flows, and the neighborhood, and asked if UCSD had concerns regarding California Environmental Quality Act compliance. Ms. Maysent responded that UCSD had held many community open house events. There was significant support in the community for this hospital replacement. Mr. Clossin added that UCSD had begun community outreach immediately. There were concerns about construction and traffic, but the neighborhood community overwhelmingly wished to keep this facility in Hillcrest.

Committee Chair Lansing asked why UCSD had decided not to add more patient beds. Ms. Maysent responded that this was a financial decision, based on replacement costs. UCSD was confident in its ability to build the outpatient facility, confident that the facility would be financially accretive, and that primary care access points around the region would direct patients to this center. Even if a situation arose in which UCSD was unable to build the hospital here, the campus felt that there was no risk in implementing Phase 1 of the project, because the outpatient hub was clearly needed.

Committee Chair Lansing stated that while the Health Services Committee was approving the project concept, the Finance and Capital Strategies Committee would have to be convinced that the financial figures made sense. The project might have to add more beds to be financially feasible.

Regent Makarechian reiterated his concern about the campus' debt coverage and its ability to afford this project.

Regent Sherman asked what kind of functions would be housed in the wellness center. Mr. Clossin responded that this had not yet been programmed. It likely would be a neighborhood fitness center with a swimming pool, a community amenity, with multi-family dwellings nearby.

Ms. Maysent remarked that there were many risks inherent in this project. If multi-family housing could not be built, this would derail the plan. The various components of the plan must work together.

Regent-designate Graves asked if this housing would be available to anyone. Ms. Maysent responded in the affirmative, but noted that there would be advance advertising to faculty, staff, and graduate students. Less expensive micro-units would be included, but this would not be low-income housing; it would be market-rate housing.

Regent-designate Graves asked if there had been discussions with the campus about reserving spaces for faculty, medical residents, and graduate students. Ms. Maysent responded that this was a possibility. The only restriction imposed by the Chancellor had been that this would not be undergraduate housing. Regent-designate Graves asked UCSD to explore the possibility of reserving housing spaces for the UCSD populations he had mentioned.

Regent Zettel praised the LRDP for being well-considered. She asked if UCSD was factoring in declining reimbursements in the financial presentation of the project that would be presented to the Finance and Capital Strategies Committee. Ms. Maysent responded in the affirmative. Changes in reimbursement were included in the ten-year financial forecast.

Chair Kieffer emphasized the strategic importance of this project and commended the campus' vision. He asked that the presentation to the Finance and Capital Strategies Committee include a summary of strategy, the factors influencing the campus' decision, and the motivation for replacing a hospital rather than building a new one.

Advisory member Hernandez praised UCSD for its long-term planning and concept, the thoughtful way it planned to go about using a large body of land in an urban center, allowing UCSD to build capacity and take into account the needs of the local community. The idea of building housing close to hospital facilities like these was visionary. The housing would involve a lease to a private developer. She asked that UCSD reserve some part of that housing for mixed-income housing. She observed that UCSD might have more influence on the development than anticipated because of the scarcity of land in San Diego. Dr. Hernandez referred to planning for the acute care facility, and hoped that acute care psychiatry and the locked psychiatric unit would remain part of this plan. The State had a significant shortfall of locked psychiatric unit beds. This service was not profitable but there was an enormous need. Ms. Maysent responded that the locked psychiatric unit was a challenging matter. UCSD Health was working on this issue, but it had not yet been resolved.

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

The meeting adjourned at 2:40 p.m.

Attest:

Secretary and Chief of Staff