medicine, neurology, cardiovascular medicine, and interventional cardiology. UCR now has 281 residents in programs either sponsored by UCR or in partnership with affiliates. The School's faculty body has grown to 298. Grant funding was at $9.3 million and clinical revenues were about $22 million. The School receives only $15 million in State funding. The research program has performed well over the past few years and several research centers have been established, such as the Center for Molecular and Translational Medicine, the BREATHE Center (Bridging Regional Ecology, Aerosolized Toxins, and Health Effects), and the Center for Glial-Neuronal Interactions. The most recently enrolled class is the largest class so far, with 77 students. Sixty percent of these students are female and 52 percent have ties to Inland Southern California. This last fact is important for the School's goal of bringing more physicians to the region. Up to 40 percent of graduates of the past three years have remained in the Inland Empire for their residencies. The most recent class is also very diverse, with 39 percent of students from backgrounds underrepresented in medicine and 69 percent from socioeconomically or educationally disadvantaged backgrounds. Forty-two percent were the first in their families to complete college. UCR is trying to bring first-generation college students into medical school and enhance social mobility. As a community-based medical school, the UCR School of Medicine does not have its own hospital or medical center. Medical students and residents receive training in a distributed model with affiliates in the community. While this allows for innovative programs, there are no funds flowing from a medical center to support education and research, as is the case at the other UC Health campuses. Over 1,000 community-based faculty play a critical role, providing instruction valued at approximately $10 million a year. This is a contribution from the community, and, if it were to be lost, the School would find itself in a dire situation.

UCR Health Chief Executive Officer Donald Larsen explained that UCR Health was a nascent clinical enterprise, only about three years old at this point. While UCR does not have a hospital, it does have a clinical practice group. There were five UCR Health clinic locations, operated by UCR: three in the City of Riverside and two in the Coachella Valley, one in Palm Springs, adjacent to Desert Regional Medical Center, and the other a pediatric clinic that was about to open in La Quinta. UCR Health has many affiliates and professional services agreements with multiple hospitals in Riverside and San Bernardino Counties. UCR Health offers primary care and some specialty services that fill access gaps in the region for neurology, pain management, urogynecology, gynecologic oncology, and other areas. Clinical volume in the past three years had shown significant growth, and patient satisfaction scores have remained in the 99th percentile.

Dr. Deas referred to the recent five-year strategic planning process. Key goals for the School of Medicine are to regularize and modestly grow its education programs; deepen its commitment to clinical and population health research and better integrate its education and research missions with the basic science departments; embark on a School of Medicine-led campaign of strategic philanthropy to bolster the School's finances; and improve the ability to execute plans. Mr. Larsen stated that the strategic plan goals for UCR Health focus on improving clinical revenue and performance, as well as growth opportunities for the clinical enterprise. This includes optimizing clinical practice and provider performance, and optimizing and improving revenue cycle management, charge

capture, and managing costs. UCR Health would embark on establishing one or more Federally Qualified Health Centers in addition to its current clinical footprint and would develop broader long-term partnerships with current affiliates, with new clinical affiliates, and with the other Southern California UC Health campuses.

Dr. Deas reiterated that the School receives $15 million from the State and noted that this amount had not been adjusted for inflation since the inception of the program in 2013; for this reason, UCR had lost about $4 million in support value. The School was unable to invest in key positions and operational infrastructure and could not increase class size. The California Future Health Workforce Commission found that the UCR School of Medicine would need at least an additional $25 million in ongoing funding to address current needs and to increase class size. A review by consultants Tripp Umbach found that the School was one of the least-funded community-based medical schools in the U.S. and concluded that the School needed approximately $25 million to $30 million in ongoing funding to increase class size, as well as an incremental $45 million to reach the goal of having 125 students per class, for a total student body of 500. The past year, UCR was fortunate in that State Senator Richard Roth and Assembly Member Jose Medina sponsored two bills for an additional $25 million in ongoing funding and for a new building. The bill for $25 million in ongoing funding was not successful, but the State approved $100 million for new education building, which was an immediate priority.

Regent Sherman referred to the statistic for students in the most recent class, indicating that 69 percent came from socioeconomically or educationally disadvantaged backgrounds. He asked what was meant by "educationally disadvantaged." Dr. Deas responded that these students came from schools designated as Local Control Funding Formula Plus (LCFF+) schools, high schools lacking sufficient resources compared to other high schools in their region or in the state.

Regent Sherman asked about the tuition charged by the UCR School of Medicine and about the percentage of students receiving financial aid. Dr. Deas responded that tuition and fees amounted to about $35,000 and that at least 90 percent of the students received financial aid. This was the first year that the School qualified for the federal Scholarships for Disadvantaged Students program, and 80 percent of UCR medical students qualified for these loans.

Regent Sherman asked about the student debt of graduates. Dr. Deas responded that, when the School received full accreditation in 2017, the average debt level for graduates was about $130,000, much lower than the national average. This was due in part to the work the School does to secure scholarships and external funding for its students. Chancellor Wilcox observed that, as the student body grows, philanthropy must grow commensurately.

Regent Sherman asked if construction of the planned new building would allow the School to increase class size to 125. Dr. Deas responded that the School planned to grow to 125 students per year over the next five years. A new education building alone would not achieve that; other financial resources would be needed to fund more faculty and staff. She recalled that community-based faculty provide approximately $10 million in instruction

annually. UCR is concerned about possible loss of these faculty to private, for-profit medical schools which are moving into the area—one is about 15 miles from UCR. Chancellor Wilcox added that 500 students was the long-term target enrollment for the School. Dr. Deas confirmed that the new building would provide the space capacity for the increased enrollment.

In response to another question by Regent Sherman, Dr. Deas reported that the UCR clinical practice was not yet generating any support for the School of Medicine. Regent Sherman asked about the School's deficit. Dr. Deas responded that, when UCR initiated its clinical practice three years prior, the deficit was approximately $11 million. UCR had reduced this deficit with strategies for increasing revenue through professional services agreements and restructuring contracts. The current deficit was a structural deficit of about $6 million to $8 million.

Regent Park asked if this figure for the structural deficit was the amount after subsidies from the campus and the Office of the President. Dr. Deas responded in the affirmative. The Office of the President subsidy was spread over five years. The School had received the entire subsidy as of the prior year. The campus had subsidized the School to a great extent, and UCR knows that this is not sustainable.

Regent Park asked how UCR would close the structural deficit and how activities envisioned in the strategic plan might contribute to this. She asked if the model for the School would always depend on increased subsidies from other sources, whether the State or the UC system. She asked what the other medical centers could do to help UCR meet its objectives. Chancellor Wilcox responded that, when Dr. Deas joined UCR, she inherited a set of financial arrangements that were not wisely constructed and spent significant time and effort on rewriting agreements and contracts. This circumstance had prevented the UCR School of Medicine from expanding. The School must reach a certain critical size in order to balance its budget and to be an effective educational institution, and the next target was to achieve the appropriate scale. UCR has been engaged in discussions with its UC Health campus partners about how their relationships can benefit UCR and the partner campuses. Dr. Deas added that expanding the clinical enterprise might offer the potential for revenue generation through clinical services. She observed that the School had "done more with less" in its beginning years by not hiring the number of faculty and staff or building the infrastructure that a medical school really needs. This was not sustainable.

Chancellor Wilcox stated that the UCR School of Medicine was doing well and that UCR is proud of the progress the School has made. There were challenges, and one of them was how to deal with graduate medical education. UCR was in partnership with hospitals. In some of these partnerships, the hospital sponsors the residency, and UCR provides the educational element through a contract. While the fund flow is not as significant, these partnerships with hospitals are important for UCR. In other cases, UCR sponsors the residency in a hospital, which is financially more beneficial to UCR, and UCR has more control. It is important to achieve an appropriate balance between these two residency arrangements in order to fulfill the School's mission. Chancellor Wilcox referred to Regent Park's question about whether the School's model would be manageable. There are other

community-based medical schools in the country that find ways to achieve this. The UCR School of Medicine was still in a startup mode and short of resources needed. Dr. Stobo noted that there had been a discussion that morning among the four Southern California UC Health campuses about the possibility of joint programs that would benefit all four.

Regent Park stated her understanding that, in Chancellor Wilcox's view, this model would be sustainable but would need more investment to become self-sustaining. Chancellor Wilcox responded that the School had been undercapitalized from the beginning and had yet to recover from that undercapitalization.

President Napolitano stated that the UCR School of Medicine was a different model for the UC system and focused on training healthcare providers for an underserved area of the state. The fact that many students were completing their residencies in the region and remaining in the region to practice was very positive. She reminded the Regents that a proposed budget for the University would be presented at the November meeting. This budget would then be submitted to the Governor. She intended to recommend a specific line item for $25 million for the UCR School of Medicine. There was support in the Legislature and there was a compelling case to be made for State support for this School. Committee Chair Lansing agreed that there was support in the Legislature for the School.

10. **PROPOSED REQUEST FOR APPROVAL OF NEW SCHOOL OF MEDICINE EDUCATION BUILDING, RIVERSIDE CAMPUS**

The President of the University recommended that the Health Services Committee authorize the Riverside campus to request approval from the Finance and Capital Strategies Committee at a future date to construct a new School of Medicine Education Building.

[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.]

Chancellor Wilcox briefly outlined the item. The UCR School of Medicine faced two significant challenges: funding and space. With regard to space, the School was currently occupying about 20,000 square feet in the top floor of an existing classroom building. The first floor and core of this building is a data center that cannot be moved. UCR was using modular buildings for medical student study and gathering space. The School also had some space in the basement of the Orbach Science Library and was leasing space in the Intellicenter, the building where the UCPath Center is located. The Intellicenter building is located six miles from the campus and not convenient for the School. The current site of the modular buildings was one possible site for the new building.

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

11. **IMPLEMENTATION UPDATE OF STRATEGIC PLAN FOR UC HEALTH DIVISION OF THE OFFICE OF THE PRESIDENT**

[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, in fall 2017, a strategic plan for the UC Health Division at the Office of the President (UCOP) was developed. The plan was somewhat delayed when President Napolitano launched a comprehensive review of UCOP functions and appointed an advisory committee on the UC Health Division. In fall 2018, the advisory committee produced two major recommendations. One was to create a subdivision within UC Health, the UC Healthcare Collaborative. The activities of the Collaborative would be funded by the medical centers, and this part of the budget would be allowed to grow consistent with the strategic plan. The second recommendation was that there be continuous communication with a variety of stakeholders about the strategic plan, including chancellors of campuses with medical centers, and to provide updates on the progress of the strategic plan. Dr. Stobo presented a chart listing the 12 strategic plan goals. He noted that the UC Health Division 2018-19 budget actuals came in several million dollars below budget, mainly due to hiring delays.

Chief Strategy Officer Elizabeth Engel recalled that UC Health has established a data warehouse with clinical data from all UC medical centers as well as claims data from UC's self-funded health plans. One of the strategic plan goals is to establish a center to leverage systemwide data. As another plan goal, UC Health was also establishing a small quality/population health management function. By comparing standards of care, patient outcomes, claims, and other data, UC medical centers and health plans would be able to identify and implement best practices within the system with the goal of improving patient care and reducing costs.

Ms. Engel presented a chart with results for UC performance on quality measures issued by Medi-Cal in July. The California Department of Health Care Services had established a Quality Incentive Program (QIP), directing Medi-Cal-managed care plans to make payments based on providers' performance on designated benchmarks and on quality outcomes. This was part of an ongoing effort by the State to transform Medi-Cal into a more value-based program. The chart indicated that UC medical centers were performing well on some measures but were behind on others. Ms. Engel noted that a shortcoming in these measures did not necessarily indicate a deficiency in the quality of care UC Health is delivering; it might indicate a deficiency in how UC is documenting this care. UC Health locations are successful in implementing best practices and there are ongoing improvement efforts. Efforts are also well under way to address documentation issues identified during the initial reporting period.

Ms. Engel then outlined how systemwide data have aided the population health function. Using a "divide and conquer" approach across the five medical centers, information technology teams were able to implement mechanisms to track QIP measurements in a matter of weeks. This was possible because the campuses collaborated to create the same

data models and shared code. The UC Health data team also developed patient-specific metrics that allow physicians to understand which metrics merit special attention for particular patients. This was an important instance of turning data insights into action. Because it is possible to implement these tools quickly, UC Health can help the medical centers maximize incentive payments. In April, UCSF was achieving 55 percent of its measures, which represented an incentive payment of approximately $10 million. Using the data warehouse tools, UCSF was now in a position to achieve 95 percent of its incentives, for a QIP payment of at least $17 million, and there was a possibility of further improvement before the reporting period ended in December.

UCLA School of Medicine Chief Medical Officer Samuel Skootsky, M.D., presented a chart showing UC Health's efforts to reduce pharmaceutical costs for UC's self-funded health plans. The chart indicated that the expense per quarter was decreasing. This was achieved using a population health approach. UC Health has searched for opportunities within certain common drug classes for either brand to generic substitution or generic to generic substitution, which was becoming more important, as well as cost reduction opportunities for certain individual drugs. He noted that UC medical centers must deal with a large number of formularies.

The population health groups on all medical campuses have also collaborated on diabetes care. Their first task was to develop a definition of diabetes care at UC, and the definition they arrived at includes both primary care and endocrinology. Dashboards were developed in collaboration with the clinical data warehouse. These indicate patient demographics and how well diabetes is being controlled. Dr. Skootsky then discussed a chart with systemwide opportunities for improving diabetes care, based on claims and clinical data. The benchmarks used were Integration Healthcare Association health maintenance organization (HMO) benchmarks, a strict standard.

Faculty Representative Bhavnani asked how UC Care, a UC self-funded healthcare plan, could be made more affordable for UC employees with lower salaries. Dr. Stobo explained that this matter was not within the purview of the UC Healthcare Collaborative, although it was part of the overall strategic plan. This year, the increase in the premium was far less than the five percent upper limit. He acknowledged that UC Care was more expensive than the Kaiser Permanente plan but pointed out that UC Care is a preferred provider organization (PPO) plan. Enrollees can choose a provider, an option not available in the Kaiser HMO plan. In general, HMO plans are less expensive than PPO plans. UC Health would like to make the Health Net Blue and Gold HMO plan more competitive with Kaiser and serve as an alternative to Kaiser for UC employees. The University's healthcare plan premiums would never achieve parity with Kaiser due to UC Health's other activities and missions in education, research, and public service. Ms. Engel added that the initial scope of work for the new quality/population health management function was focused largely on reducing costs in UC Care.

Ms. Bhavnani asked that UC Health's strategic plan include the goal that all UC employees have access to UC health care. UC Davis Human Health Sciences Vice Chancellor David Lubarsky responded that all the medical center chief executive officers were committed to

the goal that all UC employees be able to receive care at UC Health. As an experiment, UC Davis was parity pricing with Kaiser. Currently, employees with a dependent going away to college may only choose UC Care for all family members. Dr. Lubarsky hoped that it would become possible to have family members out of state covered by UC Care while family members in California could be covered by the Blue and Gold HMO plan. This would reduce costs and be a favor to employees.

Regent Park asked that the strategic plan be presented to the full Board, with participation by incoming Executive Vice President Byington. President Napolitano responded that this would be arranged and that she would speak with Dr. Byington.

12. **UPDATE ON QUALITY WORKING GROUP**

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

Executive Vice President Stobo recalled that the Quality Working Group had begun its activity at the last Committee meeting. UC Health has a variety of quality initiatives that are ongoing. These initiatives examine a variety of types of data, including inpatient and ambulatory care data from chief medical officers and chief nursing officers, which are regularly presented in the Clinical Quality Dashboard. Another type of data pertains to medical liability and risk, while another type concerns quality and population health. Integration of these three sources of data was taking place at the level of individual institutions, but UC was not doing a good job of this at the systemwide level. Therefore, Dr. Stobo had asked Regents Makarechian, Park, and Zettel as well as Advisory member Spahlinger to serve on this Quality Working Group, to meet on a regular basis to discuss these data sources and how they can be used to advance the quality of UC Health.

Dr. Spahlinger reported that the Working Group had met that morning for the second time. The Working Group discussed its charge, reviewed inpatient and ambulatory care data, and considered liability data. He noted that these liability data included not just malpractice but other incidents relevant to quality or process improvement. The Working Group also discussed population health and the medical centers' long-term quality goals. Dr. Stobo remarked that UC Health has the responsibility of bringing together these three sources of data.

13. **COMMUNITY HEALTH NEEDS ASSESSMENTS AND IMPLEMENTATION PLANS, 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 UC medical centers are required to carry out a Community Health Needs Assessment every three years, and that this has to do with the medical centers' tax-exempt status. In addition, in California, private health institutions such as Kaiser Permanente and Sutter Health are required to report on the health benefits

they provide the community. UC is not required to make this report, but Dr. Stobo noted that all the medical centers do a great deal of good for their communities. Kaiser and Sutter use these reports as part of their public relations. UC Health is doing work that is at least equal to that done by Kaiser and Sutter but did not have a regularized method for reporting this. UC Health was working to develop a regularized documentation, from each medical center, medical school, and clinical enterprise, of the benefits it provides for California communities in education, research, and clinical services. He anticipated that this report would be presented to the Committee in spring 2020. This report would publicize all the good that UC Health does for California communities and it would be a good exercise for the organization.

Faculty Representative Bhavnani asked if the University could boost research on racial inequality in health, noting that there did not appear to be philanthropic support for this. Dr. Stobo responded that there is interest in this topic at the UC medical centers. UCSF Health Chief Executive Officer Mark Laret stated that UCSF is focused on health inequities in San Francisco and involved in collaborative efforts across all the city's hospitals. UCSF plays a leading role in addressing homelessness and mental health issues in the community. UCSF has received philanthropic support for these efforts. UCLA Health Sciences Vice Chancellor John Mazziotta reported that similar efforts were ongoing in Los Angeles, where UCLA works with the Martin Luther King, Jr. Community Hospital. UCLA Health supports the Venice Family Clinic, providing faculty and students on a volunteer basis as well as funding and infrastructure support. UCLA's Mobile Clinic Project provides eye and dental care to homeless and vulnerable populations, and UCLA has mental health programs in collaboration with the County of Los Angeles.

The meeting adjourned at 2:15 p.m.

Attest:

Secretary and Chief of Staff