The Regents of the University of California

HEALTH SERVICES COMMITTEE
October 10, 2019

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

Members present: Regents Guber, Lansing, Park, Sherman, and Zettel; Ex officio member Napolitano; Executive Vice President Stobo; Chancellors Block and Hawgood; Advisory members Hetts and Spahlinger

In attendance: Regents Kieffer, Sures, and Weddle, Faculty Representatives Bhavnani and Gauvain, Secretary and Chief of Staff Shaw, Deputy General Counsel Nosowsky, Interim Executive Vice President and Chief Financial Officer Jenny, Vice President Nation, Acting Vice President Lloyd, and Chancellor Wilcox

The meeting convened at 11:10 a.m. with Committee Chair Lansing presiding.

1. **PUBLIC COMMENT**

Committee Chair Lansing explained that the public comment period permitted members of the public an opportunity to address University-related matters. The following persons addressed the Committee.

A. Ashanti Daniel spoke about the debilitating effects of myalgic encephalomyelitis (ME), or chronic fatigue syndrome (CFS), a neuroimmune disease which had put an end to her career as a nurse. She described the nightmarish conditions of this illness and the difficulties patients experience in trying to receive a correct diagnosis and in being believed by medical professionals. Individuals with ME need the University's help.

B. Martin Weiss described the effects of ME/CFS and noted that only five doctors in California were currently treating ME/CFS, while the disease affected between 100,000 and 300,000 Californians. Doctors and nurses should be trained to recognize this disease. Mr. Weiss asked that the University include ME/CFS in its medical school curriculum and continuing medical education curriculum, and that the University hire at least one specialist in ME/CFS at each UC medical center.

C. Beverly Weiss, mother of a homebound patient with ME/CFS, read a statement by an ME/CFS sufferer, describing the debilitating effects of this disease. There was not yet a U.S. Food and Drug Administration-approved treatment, and no cure. ME/CFS sufferers are too sick to work, care for themselves, or participate in society. In the words of this patient, Ms. Weiss urged UC to work toward a better future for ME sufferers.

D. Tabetha Jones, UCLA Health employee and member of the American Federation of State, County and Municipal Employees (AFSCME) Local 3299, emphasized workers' need for a fair contract and job security.

E. Nora Alvarez, member of AFSCME Local 3299, criticized the University's practice of contracting out, which resulted in the loss of good jobs at UC.

F. Reyna Avila, a patient care provider at UCLA for over 21 years and member of AFSCME Local 3299, urged the University to negotiate a fair contract.

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

Upon motion duly made and seconded, the minutes of the meeting of August 13, 2019 were approved.

Committee Chair Lansing recalled that this would be Executive Vice President Stobo's last meeting before retiring from a long and distinguished career at Johns Hopkins University, the University of Texas, and the past 11 years at the University of California. She stated that it had been an honor to work with Dr. Stobo and expressed her gratitude for his work on behalf of the University. President Napolitano thanked Dr. Stobo for his service and welcomed Carrie Byington, the next Executive Vice President – UC Health.

3. **REMARKS OF THE EXECUTIVE VICE PRESIDENT – UC HEALTH AND UPDATE ON PRESIDENT'S WORKING GROUP ON COMPREHENSIVE ACCESS**

[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 thanked the medical center administrators for working hard on behalf of UC Health. He praised their positive values and consistent efforts to do the right thing in the best interest of the patients that UC Health serves, even if this is not easy. He welcomed Carrie Byington and noted Dr. Byington's contributions to pediatrics and to the cause of women in medicine, and her achievements in mentoring, translational medicine, and pediatric clinical research.

Dr. Stobo recalled that President Napolitano had assembled the Working Group on Comprehensive Access in order to ensure that UC's values are upheld when its academic health systems collaborate with other health systems and treat patients at non-UC facilities. The group had met twice, and, among other topics, was discussing affiliation guidelines and what would be acceptable or not acceptable in affiliations. The Working Group, led by Chancellor Gillman, was to provide recommendations within 90 days of its first meeting.

4. **APPROVAL OF INCENTIVE COMPENSATION USING HEALTH SYSTEM OPERATING REVENUES FOR JOHN STOBO, M.D., AS EXECUTIVE VICE PRESIDENT – UC HEALTH, OFFICE OF THE PRESIDENT AS DISCUSSED IN CLOSED SESSION**

Recommendation

The President of the University recommended that the Health Services Committee approve the Clinical Enterprise Management Recognition Plan (CEMRP) incentive award for John Stobo, M.D., as Executive Vice President – UC Health, Office of the President, in the amount of $217,382, which includes a Short Term Incentive award of $152,102 for the 2018-19 CEMRP plan year and a Long Term Incentive award of $65,280 for the performance period of July 1, 2016 through June 30, 2019. The total recommended incentive award represents 33.3 percent of his annual base salary as of June 1, 2019.

Recommended Compensation
Effective Date: Upon approval
Base Salary: $652,800 (as of June 1, 2019)
Recommended CEMRP STI Award: $152,102 (23.3 percent of base salary)
Recommended CEMRP LTI Award: $65,280 (10.0 percent of base salary)
Target Cash Compensation:* $870,182
Funding Source: Recommended CEMRP awards are non-State funded (100 percent from clinical enterprise revenues).

Prior Year Data (2017-18 plan year)
Base Salary: $633,782 (as of June 1, 2018)
CEMRP STI Award: $140,700 (22.2 percent of base salary)
Target Cash Compensation:* $774,482, plus possible Long Term Incentive awards starting after the end of the 2018-19 Plan Year.
Funding Source: Recommended CEMRP awards are non-State funded (100 percent from clinical enterprise revenues).

* Target Cash Compensation consists of base salary and, if applicable, incentive and/or stipend.

The incentive compensation described shall constitute the University's total commitment regarding incentive compensation until modified by the Regents or the President, 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 Clinical Enterprise Management Recognition Plan (CEMRP), previously approved by the Regents and fully funded from clinical revenues using no State funds, is a UC Health system clinical performance-based incentive plan that places a certain amount of pay at risk for each participant and pays out only if performance against pre-established objectives such as quality improvements, patient satisfaction, and financial performance are met or

exceeded. Performance-based, at-risk incentives are typical components of total cash compensation at teaching hospitals. CEMRP drives alignment of the six UC Health System locations by establishing and rewarding the achievement of systemwide objectives, organization-specific objectives, and individual participant objectives based on the CEMRP tier in which the eligible employee participates. As the Executive Vice President – UC Health, Dr. Stobo's achievement of CEMRP objectives is based on the approved systemwide short-term and long-term objectives.

This item sought approval of a total CEMRP incentive award of $217,382 for Dr. Stobo as Executive Vice President – UC Health, Office of the President. The award is comprised of a Short Term Incentive award of $152,102 for the 2018-19 Plan Year and a Long Term Incentive award of $65,280 for the performance period of July 1, 2016 through June 30, 2019.

The CEMRP Short Term Incentive (STI) award for Dr. Stobo as Executive Vice President – UC Health is tied to the attainment of a specific level of performance of 2018-19 Clinical Enterprise (Systemwide) objectives. As outlined in the CEMRP 2018-19 Plan Document, Dr. Stobo's Short Term Incentive award opportunity percentages are: Threshold – ten percent; Target – 20 percent; Maximum – 30 percent.

The results of the 2018-19 systemwide objectives are summarized below:

Base Salary as of 6/1/19: $652,800	**Weight**	**Attainment Level**	**Award %**	**Award = (Base*Weight*Award %)**
Objective #1	34%	Target	20%	$ 44,390
Objective #2	33%	Maximum	30%	$ 64,627
Objective #3	33%	Target	20%	$ 43,085
2018-19 STI Award				**$152,102**

Systemwide Objective #1: Leveraging Scale for Value (LSFV): Focused on Total Supply Chain, Labor Management, and Information Technology to improve quality, generate increased value and enhance the operating margin of UC Health across the system. The attainment of this objective is measured in the amount of savings from the LSFV systemwide effort.

This objective consisted of three areas of measurement, which resulted in an overall attainment at Target level:

a. Total Supply Chain; result was $218.81 million, which was above the Maximum attainment level ($200 million).

b. Labor Management; result was $29.7 million in increased cost, which was below the Threshold attainment level ($25 million).

c. Information Technology; result was $27.9 million, which was above the Maximum

attainment level ($26 million).

Systemwide Objective #2: Addressing Administrative Penalties – California Department of Public Health (CDPH): Penalties identified pose a financial risk, as well as substantial reputational and patient safety risks. A group of subject matter experts was formed to identify areas of vulnerability and develop best practices for compliance in those areas.

The group identified more than three areas of vulnerability and developed best practices for compliance in those areas which resulted in the Maximum attainment level (identify three areas of vulnerability and the best practice for each area to achieve compliance and avoid administrative penalties from the CDPH).

Systemwide Objective #3: Clinical Improvement: Reduction in Excess Bed Days and complete Public Hospital Redesign and Incentives in Medi-Cal (PRIME) Measures.

This objective consisted of two areas of measurement:

a. Reduction in Excess Bed Days; result was that three out of the six grouped medical centers achieved a four percent reduction in excess bed days, which was at the Threshold attainment level.

b. PRIME Measure; result was completion of 23 out of 25 measures, which was above the Maximum attainment level (complete at least 20 out of 25 measures).

Based on the achievement of the objectives as summarized above, the amount of the Short Term Incentive award proposed for Dr. Stobo is $152,102, which is 23.3 percent of his base salary as of June 1, 2019.

The CEMRP Long Term Incentive (LTI) award for Dr. Stobo as Executive Vice President – UC Health is tied to the attainment of a specific level of performance of the three-year (July 1, 2016 to June 30, 2019) Long Term Incentive objective. As outlined in the CEMRP 2018-19 Plan Document, Dr. Stobo's Long Term Incentive award opportunity percentages are: Threshold – five percent; Target – ten percent; Maximum – 15 percent.

The results of the 2016-19 Long Term Incentive objective are summarized below:

Base Salary as of 6/1/19: $652,800	**Weight**	**Attainment Level**	**Award %**	**Award = (Base*Weight*Award %)**
Long Term Obj.	100%	Target	10%	$65,280
2016-19 LTI Award				**$65,280**

Long Term Objective: The purpose of this objective is to engage the Chief Executive Officers of each UC Health System together with the UCOP UC Health office to develop a UC Health-wide plan to address the challenges associated with the growing number of individuals enrolled in Medi-Cal across the State of California. Since the inception of the

Affordable Care Act, enrollment in Medi-Cal in California has increased to the extent that approximately one-third of California residents have enrolled. UC Health has experienced a ten percent increase in Medi-Cal volume; however, with the low rates of reimbursement, the system realized approximately $600 million in uncovered expenses for one year of clinical delivery. The development of a coherent, coordinated, integrated strategy for addressing this issue is estimated to take several years and was developed as basis for 2016-19 Long Term Objective.

The Long Term Objective consisted of three areas of measurement. Attainment levels were based on Threshold – Achieving one of three; Target – Achieving two of three; and Maximum – Achieving three of three:

a. Construct a new Medi-Cal physician upper payment limit (UPL) for all UC physicians. This will provide more alternative reimbursements for physicians providing care to this population. The program has been constructed and has been presented to the State.

b. Deliver on the commitment that each medical center will have a contract with at least one managed medical plan in its service area using alternative payment methods (APM). An alternative payment method was developed for each medical center based on a Hospital Quality Improvement Program (QIP) measurement under each location's respective contract with at least one managed medical plan.

c. Institute at least one care management protocol for the Medi-Cal population to provide access to UC Health. The ultimate goal is to have a "UC Health Way" for managing the health needs of the Medi-Cal population. This part of the objective was not attained at the conclusion of the 2016-19 long term objective performance period.

Under Dr. Stobo's leadership and coordination, best practices at each of the six UC Health System locations and affiliated clinics continue to be leveraged to benefit the system as whole with a demonstrated increase in the benefit of this systemwide effort year-over-year.

Consistent with Regents Policy, this award has been approved by the CEMRP Administrative Oversight Committee, the members of which are prescribed in the CEMRP 2018-19 plan document.

No State funds are used to fund CEMRP incentive awards; funding is solely from UC Health system revenues.

[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.]

Acting Vice President Lloyd introduced the item. Because the Executive Vice President – UC Health is a Senior Management Group Level One position, Regents' approval was required for this Clinical Enterprise Management Recognition Plan (CEMRP) incentive

award. The award was funded by non-State sources and thus fell within the Health Services Committee's authority for review and approval. In 2016, a Long Term Incentive was established for the Executive Vice President – UC Health and the medical center chief executive officers. The year 2019 marked the first payout of the first Long Term Incentive, calculated from July 1, 2016 to June 30, 2019. Dr. Stobo's incentive award included the Short Term Incentive for the 2018-19 plan year and the Long Term Incentive for the three-year period 2016 to 2019.

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

5. **APPROVAL OF MARKET-BASED SALARY ADJUSTMENT FOR JOHNESE SPISSO AS PRESIDENT, UCLA HEALTH AND CHIEF EXECUTIVE OFFICER, UCLA HOSPITAL SYSTEM, 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 Johnese Spisso as President, UCLA Health and Chief Executive Officer, UCLA Hospital System, Los Angeles campus:

A. Per policy, a market-based salary adjustment of 27.6 percent, increasing Ms. Spisso's base salary from $1,091,268 to $1,393,000, as President, UCLA Health and Chief Executive Officer, UCLA Hospital System, 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's (CEMRP) annual Short Term Incentive (STI) component, with a target award of 20 percent of base salary ($278,600) and maximum potential award of 30 percent of base salary ($417,900), 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 CEMRP Long Term Incentive (LTI) component, with a target award of ten percent of base salary ($139,300) and maximum potential award of 15 percent of base salary ($208,950), 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, 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 after five consecutive years of Senior Management Group service).

E. Per policy, continuation of a monthly contribution to the Senior Management Supplemental Benefit Program.

F. Per policy, continued annual automobile allowance of $8,916.

G. Per policy, continued eligibility to participate in the UC Employee Housing Assistance Program, subject to all program requirements

H. Ms. Spisso will continue to comply with the Senior Management Group Outside Professional Activities (OPA) policy and reporting requirements.

I. This action will be effective October 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 of a market-based salary adjustment for Johnese Spisso as President, UCLA Health and Chief Executive Officer, UCLA Hospital System, to bring her base salary to $1,393,000. This item requests a market-based salary adjustment for Ms. Spisso to reflect her strength in managing the responsibilities of her position as demonstrated by her documented and sustained high levels of performance since she joined the University in 2016. The proposed base salary represents an increase of 27.6 percent ($301,732) over Ms. Spisso's current base salary ($1,091,268) and is just above the 50th percentile of the 2019 Market Reference Zone (MRZ) for her position.

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.

Ms. Spisso was appointed as the President, UCLA Health System and Chief Executive Officer, UCLA Hospital System, Los Angeles campus, on February 8, 2016. She has been integrally involved in the executive leadership of the four hospitals in the UCLA Health System, more than 180 ambulatory clinics, affiliations with local area hospitals, and the supporting infrastructure for these areas. She oversees the ongoing expansion of the UCLA Health System and has pushed the organization to redesign patient care and improve

coordination across all disciplines. She leads the executive leadership team and serves on a variety of University and campus-wide committees. Ms. Spisso is an active representative to external agencies and professional organizations at the local, regional, and national levels. She is a nationally recognized academic health care leader with more than 30 years of healthcare experience. Most recently, in February 2019, Ms. Spisso was recognized as one of 2019's Top Women Leaders by *Modern Healthcare* for influencing policy and care delivery models across the country. Under Ms. Spisso's leadership, UCLA's Ronald Reagan Medical Center received the number one rank for the best hospital in Los Angeles and in California and number six in the nation by *U.S. News and World Report* for 2019-20.

Based upon her experience, expertise, and accomplishments, Ms. Spisso is a highly sought after healthcare executive. The proposed salary adjustment will better align Ms. Spisso's base salary with the external labor market, internal equity among her peers, and the criteria described in policy given her skills, experience, and contributions. The proposed base salary and placement in the MRZ are appropriate based on her significant experience in the position, her proficiency in the required skills, her adeptness at managing the typical responsibilities, and her documented and sustained high levels of performance.

Ms. Spisso received her master's degree in health care administration and public administration from the University of San Francisco, and her bachelor's degree in health sciences from Chapman College. She received her nursing degree at the St. Francis School of Nursing. Additionally, Ms. Spisso has published numerous articles and book chapters on healthcare leadership.

Funding for this position will continue to come exclusively from Health Enterprise revenues. No State or 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.]

Acting Vice President Lloyd introduced the item and noted that UCLA Health President Johnese Spisso's current base salary was below the 25th percentile of the position's Market Reference Zone and did not reflect her performance and level of responsibility for UCLA Health. A salary increase was being requested to bring her base salary to just above the 50th percentile.

UCLA Health Sciences Vice Chancellor John Mazziotta explained that he had initiated the request for this action because he believed in rewarding exceptional performance and loyalty to the institution, and because he believed in gender equity in compensation.

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

6. **ESTABLISHMENT OF A NEW SENIOR MANAGEMENT GROUP POSITION OF CHIEF STRATEGY OFFICER, UCLA HEALTH, AND THE MARKET REFERENCE ZONE FOR THE POSITION, LOS ANGELES CAMPUS**

Contingent upon approval by the Governance Committee, the President of the University recommended that the Health Services Committee approve:

A. Establishment of a new Senior Management Group position of Chief Strategy Officer, UCLA Health, Los Angeles campus. This will be a Level Two position in the Senior Management Group.

B. Establishment of a Market Reference Zone for this position as follows: 25th percentile – $545,700, 50th percentile – $636,300, 60th percentile – $667,100, 75th percentile – $713,300, and 90th percentile – $783,400.

C. The position includes eligibility to participate in the Short Term Incentive (STI) component of the Clinical Enterprise Management Recognition Plan (CEMRP), with a target award of 15 percent and a maximum potential award of 25 percent of base salary, subject to all applicable plan requirements and Administrative Oversight Committee approval. Participation is reviewed and approved prior to the start of each CEMRP Plan Year.

D. This action will be effective upon approval.

[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.]

Acting Vice President Lloyd introduced the item, explaining that it would reclassify the UCLA Health Chief Strategy Officer position from the Managers and Senior Professionals personnel program to the Senior Management Group (SMG), and would establish the corresponding Market Reference Zone for the position. The position would continue to report to the President of UCLA Health. If approved at this meeting, the item would also be presented to the Governance Committee at the November Regents meeting according to the charters of both committees regarding the establishment of a new SMG position within UC Health that is fully funded by non-State funds.

UCLA Health Sciences Vice Chancellor John Mazziotta reported that the incumbent, Santiago Muñoz, had been a UC employee for 15 years, the last seven years at UCLA Health. During his service at UCLA Health, he had demonstrated exceptional performance both for UCLA Health as well as on behalf of UC Health systemwide. He had played a critical role in defining and realizing many new business ventures and hospital affiliations. He had proposed innovative new mechanisms to make these agreements acceptable to both sides and had provided wise counsel on which new ventures UCLA Health should avoid. On behalf of UC Health, Mr. Muñoz had developed effective working relationships with members of the Legislature who are associated with the State Medi-Cal programs as well as with the State Medicaid director. He had optimized Medi-Cal funding for each UC

medical center, including supplemental payments, and developed new funding models, in particular for physician services in safety net hospitals, which had resulted in a $3 million annual improvement in payments to UC Health. Mr. Muñoz had been receiving a stipend from UC Health for his systemwide role. From July 2016 to June 2018, this stipend had been at 19.1 percent of his base salary; this was increased to 25 percent in July 2018 and this would carry forward until the end of the current academic year. In an August 2018 decision memorandum, President Napolitano stated that a long-term solution for this dual role needed to be identified and enacted. As there was no other individual in the UC system with Mr. Muñoz's knowledge and experience, it was recommended that the long-term solution was to add these systemwide responsibilities permanently to his job description. A Market Reference Zone for the Chief Strategy Officer position existed for the San Francisco market. Sullivan Cotter was engaged to define the Market Reference Zone for this role in the Los Angeles market. As this was a reclassification of an existing position, no additional headcount was being requested. Following approval of this item by the Health Services Committee and the Governance Committee, the compensation level for the newly created SMG position would be determined within the President's approval authority. Executive Vice President Stobo added that Mr. Muñoz was one of very few individuals who understand all the complexities of Medi-Cal funding and that he had played an instrumental role in securing supplemental payments for UC Health to which UC Health was entitled.

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

7. **MEDICAL CENTER POOLED REVENUE BONDS TAXABLE ISSUE**

[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.]

Interim Associate Vice President – Capital Asset Strategies and Finance and Associate Vice President Peggy Arrivas began the discussion of a proposed financing transaction for the medical centers. She presented charts illustrating the medical centers' debt portfolio. Currently, across all five medical centers, there was about $3 billion outstanding debt in 30-year amortizing tax-exempt bonds. The University has been using these bonds to finance capital projects at the medical centers. Over the last several months, the Office of the President had been working with the medical centers to project capital needs for the next decade. Three medical centers would have significant needs in the coming years in order to comply with California State seismic safety laws. UC has been developing strategies to finance these capital needs.

There was now an opportunity to issue a long-dated taxable bond for the medical centers, a unique opportunity in the marketplace. The University had issued century bonds in 2012 and 2015, but, recently, some other healthcare systems had also been issuing these types of bonds. Normally, one would expect to see tax-exempt financing rates lower than taxable rates. Looking into the future 30 years and beyond, there would be an inversion of the usual relationship which would be highly unusual: the taxable rates would be lower

than the tax-exempt rates. This presented an opportunity for the University to secure low-cost, taxable bonds that would help the medical centers by providing lower debt service during the next several decades. Ms. Arrivas presented charts showing the yield-to-maturity and annual debt service for traditional 30-year tax-exempt amortizing bonds, bonds that UC was currently issuing, versus interest-only bonds with a bullet payment at the end. This type of bond would be interest-only during the life of the bond. Because of the inversion of the financing rates mentioned earlier, the debt service would be lower. It would be lower because only interest would be due during the life of the bond and because the present value of the payments, including the bullet payment, was not substantially different from traditional, 30-year tax-exempt bonds. The University would like to use this vehicle to finance upcoming capital needs at the medical centers. In addition, when UC issues bonds, the campus or the medical center issuing the bonds sets aside a portion of the proceeds in UC's investment pools. The proceeds are invested to provide funds to pay off the principal of the bonds upon maturity. Assuming different investment return rates, only a small amount of proceeds would have to be set aside at the present time to ensure the ability to pay off the bonds when they come due. The University would be seeking approval to issue up to $2 billion and up to 100-year bonds. The actual size of the transaction and maturity date would be determined at the time when UC is in the market. The University would have to consider demand for the bonds and determine the right size for the transaction.

Regent Zettel asked if this type of bond would be a callable bond. Ms. Arrivas responded in the negative. Regent Zettel asked about the assurance that funds would be available to pay off the bullet. Ms. Arrivas confirmed that funds would be set aside for the bullet maturity. The University estimates the amount that must be set aside at the time the bonds are issued and monitors the returns on this amount over time.

Regent Sherman asked if UC had the ability to refinance existing bonds. Ms. Arrivas responded that the University would examine refinancing options at the time of the bond issue. Because of tax law changes in 2017, UC may not call bonds early and refinance them with tax-exempt debt; taxable debt would be an opportunity.

Regent Sherman asked when the University would go to market. Ms. Arrivas responded that the University had been working with the California State Treasurer's Office and that an underwriter had been assigned to the transaction. She anticipated that UC would issue the bonds in early 2020.

Regent Sherman asked if there would be any competition with the School and College Facilities Bond on the March 2020 ballot. Ms. Arrivas responded that this bond issuance would be in advance of the March ballot. The University times its issuances to ensure that they are in the appropriate place, given market conditions.

Regent Guber asked who the prospective buyers of these bonds would be. Ms. Arrivas responded that the University's bonds are owned by a number of large investors, such as Fidelity, Vanguard, and Franklin Templeton. UC bonds are also purchased by insurance companies and banks. The University has a diverse pool of buyers. Ms. Arrivas concluded

the discussion by noting that an action item for the bond issuance was planned for the November Regents meeting.

8. **SPEAKER SERIES – MOLECULAR DIVERSITY IN HUMAN CANCER: ORIGINS OF PRECISION CANCER MEDICINE**

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

Committee Chair Lansing introduced Dennis Slamon, M.D., chief of the Division of Hematology/Oncology at UCLA Health, who had recently been awarded the 2019 Lasker-DeBakey Clinical Medical Research Award for development of the breast cancer drug Herceptin. UCLA Health Sciences Vice Chancellor John Mazziotta cited a proverbial statement to the effect that in the battle between a river and a rock, the river always wins. He described Dr. Slamon as a "river of perseverance." Against all odds, he succeeded in bringing the cancer drug Herceptin from the laboratory to Food and Drug Administration approval and clinical use. This approach launched the field of targeted cancer therapies. Herceptin is aimed at treating what had been the most lethal form of breast cancer. An estimated three million women around the world have been treated with Herceptin, and this treatment has prolonged their lives. Dr. Slamon was the recipient of many awards, including the 2019 Sjöberg Prize from the Royal Swedish Academy of Sciences. Dr. Mazziotta observed that this kind of achievement at the highest level demonstrated the imperative that UC Health maintain its strong commitment across all missions—research, education, patient care, and community engagement. UC Health clinical practices allow clinician-scientists like Dr. Slamon to identify important biological problems and these practices help fund research, which produces new discoveries and treatments.

Dr. Slamon began his remarks by noting that much pivotal work on new cancer treatments has been carried out in the University of California system. He spoke about the molecular diversity of human cancer and its implications. Cancer research must look to new approaches. In the past, cancer treatment was dominated by three major approaches, and Dr. Slamon characterized them as "one size fits all" approaches, based on organ system cancers. Physicians treated lung cancer as a disease, colon cancer as a disease, and breast cancer as a disease. This was far too simple a view. Some breast cancer patients had a good outcome with surgery, radiation, and, when needed, cytotoxics, while others had a very poor outcome. This was not due to the merits of the treatment or the physician, but to the fact that this is not one disease. It took a surprisingly long time to reach this conclusion and the realization that there are many subtypes of breast cancer. The transformation of a normal cell into a malignant cell can occur by many different pathways. Depending on the pathway, the outcome and behavior of a cancer might vary significantly. This realization was an important paradigm shift.

The traditional treatment approaches have included surgery, in which surgeons remove the primary tumor and try to ensure that they remove all tumor cells. Surgeons remove all tumor cells that they can see, but sometimes cells escape from a primary tumor and move to other parts of the body. These cells then "set up shop" and cause a recurrence or

metastasis, despite the fact that surgeons have removed all the cells they could see. Another traditional approach is radiation therapy, directing ionizing radiation beams at the site of the tumor or metastasis in an attempt to kill cells. Of course, one cannot radiate the entire body without doing considerable damage to normal tissues. Medical oncologists pursue another approach, systemic therapy, taken as a pill or intravenously, that moves throughout the body in hopes of finding cells outside the primary tumor bed and killing them. Until recently, systemic therapy has been based on non-specific "bombs" thrown in the hope of killing more bad cells than good cells. These bombs are designed to kill rapidly proliferating cells, and, unfortunately, they also kill rapidly proliferating normal cells; this explains why cancer patients suffer effects like hair loss, gastrointestinal symptoms, and bone marrow suppression. The traditional approaches have had significant successes, and, at this time, one can cure almost half of cancer patients using these approaches. The approaches of the past 45 years were based successes achieved in the 1960s. Combination chemotherapy transformed Hodgkin's disease from a uniformly lethal disease to a curable disease. For the next four decades, the medical world mixed and matched drugs and chemotherapies. For some cancers this approach was effective, such as childhood leukemia, some adult lymphoma, and testicular cancer. This approach has not worked as well in treating other major high-incidence malignancies.

There has been a paradigm shift based on certain premises. The first is that cancer is not a single disease. The second, especially important premise is that cancer is not a single disease even within a given histology. Not all colon cancers, lung cancers, or breast cancers are the same. Based on these premises, the medical world needed to reconsider its standard therapies.

An astounding number of processes take place when a cell divides, whether a normal or a malignant cell. Every time a normal cell divides, an exact copy of its blueprint must be made, without any mistakes. When two cells then divide into four, the same thing must happen. This process replicates DNA, with 17,000 to 21,000 genes. In human fertilization, one fertilized cell multiplies to between one and five trillion cells in a period of nine months, a remarkable biological phenomenon. This process does not end when one is born. Adults have an average of 50 to 100 trillion cells. Many of these cells are multiplying all the time. Bone marrow produces 17 billion new neutrophils, a type of white blood cell, in a 15-hour period. In case of an infection, a signal is sent to produce more cells to fight the infection, and this number would increase to 50 billion white blood cells. When the infection has ended, a signal is sent to stop producing this many cells. Cells all over the body, in different organs, are multiplying. If no mistakes are made, there is no problem, but mutations in individual genes can lead to problems. One can accelerate mutation rates through smoking tobacco and exposure to radiation and certain chemical carcinogens. However, even if one leads a healthy lifestyle, mistakes can arise during the process of cell division. Under normal circumstances there are "spell check" mechanisms in the cell that find and correct mistakes, and, if there are too many mistakes, a cell is not allowed to replicate. In the case of cancer, these checks and balances are lost and cells with mistakes continue to proliferate. The "spell check" mechanisms in the cell work well until about age 35, and less efficiently thereafter. Advances in obstetrics, the development of antibiotics, and better understanding of heart disease and diabetes and how to combat these diseases

have allowed people to live longer lives. All cancer is genetic, but not all cancer is inherited; only about ten to 15 percent of cancers are inherited. The vast majority of cancers are genetic based on the fact that the genes, which regulate growth, mutate.

Dr. Slamon described the signaling process, mentioned earlier, which triggers the production of more cells. Once a receptor is engaged on the surface of the cell, it sends a signal through the cell to the nucleus via the signal transduction pathway. Each signal in this pathway is coded by a different gene and a different protein, any of which can become broken. These accelerator genes send a signal to the nucleus and the cell divides. There is another set of genes to stop the process of production, suppressor genes that produce proteins that arrest cell growth. More than 1,000 genes are closely involved in growth regulation. Nature has a large canvas on which to paint mistakes. Cell division and turnover occur throughout one's life. In the field of cancer studies, there has been excitement about the fact that, in the last 25 years, scientists have been able to identify the genes and proteins that carry out these functions and to study how they break down. This can occur in any tissues of the body.

Current efforts were focused on the study of growth-regulating genes. Many were identified by two scientists at UCSF, Michael Bishop and Harold Varmus. They identified oncogenes, cancer-causing genes which are maintained in all cells. One might ask why cells would include oncogenes. Scientists at UCSD, among others, first discovered that some oncogenes play a role in normal growth regulation, undergo mutation, and promote abnormal growth. Researchers at UCLA had collected about 620 cell lines from patient tumors in an effort to gain an overview of the heterogeneity of these diseases. Breast cancer affects about 1.5 million to 1.6 million women globally every year, with about 550,000 deaths. In the United States, there are 200,000 new cases of breast cancer annually, and about 39,000 deaths.

Different breast cancers do not look the same under the microscope and have very different characteristics. Scientists now had an understanding of the genes that are responsible for these cancers. UCLA studied its 51 breast cancer cell lines and the growth-regulating genes. Dr. Slamon and his colleagues extracted the DNA of different breast cancers and tested for a gene called HER2 (human epidermal growth factor receptor 2), one of four such genes. HER2 sits on the surface of the cell and receives signals. The testing of different breast cancers revealed varying amounts of HER2. In 20 to 25 percent of breast cancers, too much HER2 is produced. In 1987, Dr. Slamon found that patients whose tumors contained HER2 had a much different outcome: a much shorter disease-free survival and shorter overall survival. When treated with standard therapies, these patients had the worst outcomes.

Work in the laboratory focused on targeting the HER2 alteration. The fact that HER2 was associated with a bad outcome could indicate either that HER2 is a marker, showing that there is an aggressive tumor, but nothing more, or that HER2 plays a role in causing the bad outcome. If the latter were the case, this would make HER2 a target in tumor cells to be addressed by some kind of intervention. In the laboratory, human breast cancer cells without the HER2 alteration were converted into cells with the alteration. This mimicked

what was happening in patients. Results showed that cancer cells grow much more rapidly with the HER2 alteration. HER2 is not a simple flag but plays a role in causing cancer. Given this target validation, Dr. Slamon and his colleagues used antibodies against HER2, comparing tumor growth when treated with a control antibody and with an experimental anti-HER2 antibody. This work was done in collaboration with scientists at Genentech in the hope of developing a more effective, less toxic therapy that would lead to better outcomes for patients. The drug, Trastuzumab or brand name Herceptin, was approved in 1998 for metastatic breast cancer and in 2005 for early breast cancer. Dr. Slamon presented a chart showing the effectiveness of Herceptin compared to surgery and chemotherapy in percentages of disease-free survival. Herceptin had led to survival rates more than 50 percent better than in the past. This introduced the idea of targeted therapies for cancer. Dr. Slamon believed that this precision cancer therapy approach could be used to treat other forms of cancer when the "broken" genes are identified. Work was going on all over the world on this approach, but Dr. Slamon and his colleagues in the UC system were among the pioneers in making this therapy a reality.

Committee Chair Lansing observed that Dr. Slamon had encountered resistance to and lack of support for this work and had made many unsuccessful requests to Genentech before Genentech took on this project. She emphasized how many people's lives have been saved by this treatment.

President Napolitano disclosed that she had experienced a recurrence of breast cancer and received Herceptin among other treatments. She thanked Dr. Slamon, stating that she owed a great deal to him and to his persistence.

Regent Guber asked if patient attitude bears a relation to outcome. Dr. Slamon responded that a patient's general demeanor and outlook can affect outcomes. In response to a question by Committee Chair Lansing, he clarified that a patient's attitude does not have an effect on causation, but can help a patient get through a therapeutic regimen. Depression can suppress the immune system, but he cautioned that this insight was based on soft data.

Faculty Representative Bhavnani asked how time-consuming precision cancer therapy is and how one could expand these therapies to treat more patients. Dr. Slamon responded that scaling up this therapy was an important issue; research in healthcare delivery is important. Even the most incredible medicine, if not delivered, will produce no results. He expressed frustration that drugs like Herceptin are not available to everyone, and this was in large part due to the cost of the drugs. There must be a rational adjustment in the healthcare system because these treatments are inordinately expensive. Companies that have developed drugs should have a return on their investment, but drugs must reach patients and have an impact. Healthcare costs were escalating in the U.S., and there would have to be a reckoning at some point.

Chancellor Block stated that he personally knew patients who had been treated by Dr. Slamon and expressed appreciation to Dr. Slamon for his work, which has been life-changing.

Regent Sures asked when one might expect to see better outcomes for other forms of cancer, whether this might be in the near future or in ten to 30 years. Dr. Slamon responded that, while improvements would not happen tomorrow, this would not be a ten- to 30-year process. Researchers have taken the lessons learned from the study of HER2 to study other diseases, in particular pancreatic cancer, and to try to identify what is broken, rather than pursuing surgery or cytotoxics. Inroads were being made. Dr. Slamon believed that new therapies would have an impact on pancreatic cancer in the next two to five years. This had already been occurring in the treatment of lung cancer, which had been a uniformly lethal disease. Genetic alterations have been identified that are now treated with precision therapy in the form of small molecule inhibitors. This can extend the lives of subsets of patients with lung cancer. This is an expansive disease that must be dissected into its component parts. When genetic alterations are identified and treated, the outcomes are impressive.

Regent Zettel asked if the HER2 treatment would be effective for prostate cancer. Dr. Slamon responded that the relevant gene in this case, the BRCA gene, was related to the ten to 15 percent of inherited cancers, and that the mutation is found in the repair pathways. If these mutations occur, all the cells in the body do not have a repair mechanism in place to correct "errors." Patients with these inherited mutations have a higher incidence of breast, ovarian, prostate, and pancreatic cancer.

Committee Chair Lansing stated that this had been an extraordinary presentation and expressed the University's deep gratitude to Dr. Slamon for his life-saving work.

9. **SCHOOL OF MEDICINE UPDATE, RIVERSIDE CAMPUS**

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

Executive Vice President Stobo briefly introduced this item. At a recent UC Health leadership retreat there was discussion about the financial challenges for the UC Riverside School of Medicine. There was agreement about UC Health's overall commitment to work with UCR to address these challenges. UC Health and UCR worked together to develop a strategic plan with the assistance of Manatt Health.

UCR School of Medicine Dean Deborah Deas recalled that the School opened in 2013. The School's mission is to train a diverse physician workforce and to create programs in both research and healthcare delivery to benefit the people of Inland Southern California. The School's mission is guided by the values of inclusion, integrity, innovation, excellence, accountability, and respect. The Inland Empire region is a substantially underserved area, with about 35 primary care physicians per 100,000 population, compared to 70 to 80 physicians, the ratio which is recommended. When the UCR School of Medicine opened, it enrolled 50 students. The School has since grown and currently has 291 M.D. students and 36 Ph.D. students. UCR has worked hard to develop a robust pipeline program for middle school through undergraduate students. There are about 1,100 students enrolled in this pipeline program, which is important for the School's mission to serve people in the Inland Empire. UCR has built residency programs in the areas of family medicine, internal

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