

The Regents of the University of California

HEALTH SERVICES COMMITTEE

June 11, 2019

The Health Services Committee met on the above date by teleconference at the following locations: Palisades Room, Carnesale Commons, Los Angeles campus; Lote H-4, Carretera Federal 200 Km. 19.5, Punta Mita, Mexico.

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

In attendance: Regent Graves, Regents-designate Weddle and Um, Faculty Representatives May and Bhavnani, Secretary and Chief of Staff Shaw, and Deputy General Counsel Nosowsky

The meeting convened at 12:55 p.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. Beverly Weiss, the mother of a daughter with chronic myalgic encephalomyelitis (CME), or chronic fatigue syndrome (CFS), spoke about the severe effects of this disease and stated that many Californians had experienced frustration with UC Health's lack of awareness of and ability to diagnose CME. There were only four CME specialists in California. She urged the University to work to provide safe and effective clinical care at UC medical centers for patients with CME, train physicians appropriately, and require one continuing medical education credit course on CME for all healthcare providers.
- B. Erin Roediger, representative of MEAction, asked the University to add CME as a focus of medical education. She described the situation of a patient with this debilitating condition in detail and stressed how frightening the situation is, given that this condition does not have a cure. She requested that UC include CME in medical education and training.
- C. Emily Taylor, daughter of a mother with CME and representative of the Solve ME/CFS Initiative, emphasized the devastating impact of this neuro-immune disease, which is generally triggered by a viral infection. She asked the University to work with her organization to further education about and awareness of CME in order to prevent misdiagnosis and clear up misinformation and misunderstanding

about this disease. The Solve ME/CFS Initiative was about to launch a patient registry.

- D. Richard Weiss, UCLA professor emeritus of biochemistry and representative of the UCLA Emeriti Association, voiced concern about planned changes to healthcare benefits and plans for UC retirees and about the fact that there had not been adequate consultation with those affected. It was the understanding of the UC Emeriti Associations that the Office of the President (UCOP) had issued a Request for Proposals to privatize the UC retirement system. This would replace or serve as an alternative to the current retiree health benefit plans. A private provider rather than Medicare would decide which medical problems are coverable. UCOP claimed that this plan would save \$40 million. This change was due to take place as early as January 2020, and this left inadequate time for consultation. He requested that the Health Services Committee inform itself and the Regents about these plans and ensure that adequate time was available for consultation with retirees, emeriti, and faculty, so that this plan does not have a negative impact on the health care of UC constituents.
- E. Sharon Kramer expressed concern about the appearance of the UC name in documents that promoted what she described as false claims about the health effects of mold. The UC name should not be misused to harm the public.

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

Upon motion duly made and seconded, the minutes of the meeting of April 9, 2019 were approved, Regents Guber, Lansing, Makarechian, Napolitano, Park, Sherman, and Zettel voting “aye.”¹

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

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

Executive Vice President Stobo noted that the medical centers were continuing to perform well financially. The Legislature had recently approved the Governor’s request that \$5.3 million be available annually to support mental health services for UC students. In addition, Proposition 63 had provided \$50 million to \$60 million for mental health; the University might be eligible for some of these funds for mental health services for UC students.

¹ Roll call vote required by the Bagley-Keene Open Meeting Act [Government Code § 11123(b)(1)(D)] for all meetings held by teleconference.

4. **APPROVAL OF APPOINTMENT OF AND COMPENSATION FOR DONALD LARSEN, M.D., AS CHIEF EXECUTIVE OFFICER, UC RIVERSIDE HEALTH SYSTEM, RIVERSIDE 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 appointment of and compensation for Donald Larsen, M.D., as Chief Executive Officer, UC Riverside Health System, Riverside campus:

- A. Per policy, appointment of Donald Larsen, M.D., as Chief Executive Officer, UC Riverside Health System, Riverside campus, at 100 percent time.
- B. Per policy, annual base salary of \$500,000, which will be funded by Health Enterprise revenues. No State funds will be used.
- C. Per policy, eligibility to participate in the Short Term Incentive (STI) component of the Clinical Enterprise Management Recognition Plan (CEMRP), with a target award of 20 percent of base salary (\$100,000) and a maximum potential award of 30 percent of base salary (\$150,000), subject to all applicable plan requirements and Administrative Oversight Committee approval. Actual award will be determined based on performance against pre-established objectives and will be prorated in his first year of participation. CEMRP incentive awards are funded by Health Enterprise revenues. No State funds will be used.
- D. Per policy, eligibility to participate in the Long Term Incentive (LTI) component of the CEMRP, with a target award of ten percent of base salary and a maximum potential award of 15 percent of base salary, 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 and will be prorated in his first three-year performance period. CEMRP incentive awards are funded by Health Enterprise revenues. No State funds will be used.
- E. Per policy, standard pension and health and welfare benefits and standard senior management benefits (including eligibility for senior management life insurance and eligibility for executive salary continuation for disability after five consecutive years of Senior Management Group service).
- F. Per policy, eligibility to participate in the UC Employee Housing Assistance Program, subject to all program requirements.
- G. Per policy, reimbursement of actual and reasonable moving and relocation expenses associated with relocating his primary residence, subject to the limitations under Regents Policy 7710, Senior Management Group Moving Reimbursement.

- H. For any outside professional activities, Dr. Larsen will comply with applicable Outside Professional Activity (OPA) policies.
- I. This action will be effective as of Dr. Larsen's hire date, which is estimated to be on or about July 1, 2019.

Background to Recommendation

The President of the University recommended approval for the appointment of and compensation for Donald Larsen, M.D., as Chief Executive Officer, UC Riverside Health System (CEO-UCR Health), Riverside campus, effective upon his hire date, which is estimated to be on or about July 1, 2019. This is a new Level One position in the Senior Management Group. The addition of this SMG position and the corresponding Market Reference Zone were approved by the Regents in January 2019.

The CEO-UCR Health will report to the Vice Chancellor – Health Sciences/Dean – School of Medicine. The CEO-UCR Health will work closely with the Vice Chancellor/Dean and Chancellor to develop clinical partnerships and build financial stability for the UCR Health System as well as support the education and research mission of the School of Medicine.

The campus conducted a national competitive recruitment for the CEO position and Dr. Larsen was identified as the top candidate from a broad and diverse applicant pool due to his experience and background.

The President recommended a base salary of \$500,000, which is 2.2 percent below the 60th percentile of the Market Reference Zone (MRZ) for this position (\$511,300). The proposed base salary is consistent with Regents Policy 7701, Senior Management Group Appointment and Compensation, and reflects an appropriate salary, taking into account the scope of responsibilities as well as Dr. Larsen's depth and breadth of experience.

Consistent with academic personnel policy, the campus will be seeking an underlying non-tenured faculty appointment at zero percent time, without salary, for Dr. Larsen.

Following review and approval by the Administrative Oversight Committee, Dr. Larsen will be eligible to participate in the Clinical Enterprise Management Recognition Plan's (CEMRP) Short Term Incentive (STI) component, with a target award of 20 percent of base salary (\$100,000) and maximum potential award of 30 percent of base salary (\$150,000), subject to all applicable plan requirements and Administrative Oversight Committee approval. Actual award will be determined based on performance against pre-established objectives and will be prorated in his first year of participation.

Also following review and approval by the Administrative Oversight Committee, Dr. Larsen will also be eligible to participate in CEMRP's Long Term Incentive (LTI) component, with a target award of ten percent of base salary and a maximum potential award of 15 percent of base salary, subject to all applicable plan requirements and Administrative Oversight Committee approval. Actual award will be determined based on

performance against pre-established objectives and will be prorated in his first three-year period of participation, based on the number of complete months employed during that performance period.

UC Riverside completed a Health Administrative Review in April 2018 through Veralon, a health enterprise consulting firm. As part of the findings, one of the key recommendations was for UC Riverside Health to develop a senior leadership structure that would be able to rapidly grow the patient care delivery system from its current nascent stage.

The key position to drive this growth is the Chief Executive Officer (CEO), who will have primary responsibility for completing the strategic plan and executing the plan's objectives.

The CEO of the UC Riverside Health System will work collaboratively with Department Chairs to build and enhance partnerships and affiliations with hospitals and health care systems in the Inland Southern California region and the University of California Health System. The CEO will have oversight of all clinical affiliations, partnerships, joint ventures, clinical operations, marketing, contracting, and related managed care activities for the faculty.

Working with the department chairs and the UC Riverside Health System leadership team, the CEO will promote excellence across all functional areas of health system administration, focusing on a strong financial management platform and a significantly enhanced information technology infrastructure. The goal of the team will be the efficient provision of clinical excellence in a manner responsive to payer demands through a system of care that will be coordinated with UC Riverside's primary academic and research missions.

The CEO will work closely with UCR Health Sciences to ensure that both the department chairs and the rank and file faculty are fully engaged in both clinical planning and advanced clinical resource management activities, along with managed care administration. The CEO will assist the faculty as needed in ensuring exceptional performance by the Epic billing platform and other financial platforms for inpatient services. The CEO will also ensure the planning, development, and execution of clinical contracts with affiliate health systems.

Dr. Larsen has been serving as Chief Medical Officer (CMO) at Providence Saint John's Health Center since April 2015. This is a 266-bed community hospital that has been named a Top 50 hospital by Healthgrades for nine consecutive years and has been granted the Stroke Gold Plus Quality Achievement Award by the American Heart Association/American Stroke Association. Additionally, Dr. Larsen served as Executive Director of the John Wayne Cancer Institute from August 2015 to October 2018, concurrent with his role as the CMO, providing interim leadership as the Inaugural Executive Director of the Institute to steer the organization through a period of significant change.

Dr. Larsen previously worked as Chief Medical Officer, USC Verdugo Hills Hospital University of Southern California (USC) from July 2013 to March 2015; CMO, Keck Medical Center, USC from May 2009 to September 2013; Medical Director, USC Care Medical Group, Inc., from August 2006 to June 2011; Executive Medical Director, USC Student Health Center – Health Sciences Campus, from January 2008 to June 2011; and President, Medical Faculty Keck School of Medicine of USC from 2005 to 2006.

He holds an active California Medical License and an active certification from the Drug Enforcement Administration. He completed an internship in Internal Medicine at Nassau County Medical Center and his residency in Diagnostic Radiology at the LA/USC Medical Center followed by a fellowship at the LA/USC Medical Center in Vascular and Interventional Radiology. Additionally, Dr. Larsen completed two fellowships at UCSF in Diagnostic Neuroradiology and Interventional Neuroradiology.

Dr. Larsen is an active member of the American Board of Radiology and is a Fellow of the American College of Healthcare Executives. He is certified in Medical Quality from the American Board of Medical Quality.

Dr. Larsen received his bachelor's degree from Boston University, and earned his medical degree from the Chicago Medical School and a master's degree in business administration and master's in healthcare administration from University of Southern California.

[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 the item.

Upon motion duly made and seconded, the Committee approved the President's recommendation, Regents Guber, Lansing, Makarechian, Napolitano, Park, Sherman, and Zettel voting "aye."

5. **ESTABLISHMENT OF A NEW SENIOR MANAGEMENT GROUP POSITION OF CHIEF STRATEGY OFFICER AND HEAD OF HEALTH AFFILIATES NETWORK, UCSF HEALTH, AND THE MARKET REFERENCE ZONE FOR THE POSITION, SAN FRANCISCO 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 and Head of Health Affiliates Network, UCSF Health, San Francisco 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 – \$557,500, 50th percentile – \$689,900, 60th percentile – \$747,900, 75th percentile – \$834,800, and 90th percentile – \$925,700.

- C. The position also 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. 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.]

UCSF Health Chief Executive Officer Mark Laret introduced the item, explaining that this new position would be funded only by health system revenues. The previous equivalent Senior Management Group position, Senior Vice President of UCSF Health Affiliates, was held by Kenneth Jones prior to his retirement in June 2017. Mr. Laret recalled that UCSF had a growing family of affiliate organizations, including hospitals, joint ventures, the Canopy Health alliance, and a large physician network. UCSF wished to manage this entire effort as a profit and loss function and to have direct oversight. The proposed position had been reviewed by Sullivan Cotter.

Upon motion duly made and seconded, the Committee approved the President's recommendation, Regents Guber, Lansing, Makarechian, Napolitano, Park, Sherman, and Zettel voting "aye."

6. **AMENDMENT OF THE CLINICAL ENTERPRISE MANAGEMENT RECOGNITION PLAN**

The President of the University recommended that the Health Services Committee approve the amendment of the Clinical Enterprise Management Recognition Plan as shown in Attachment 1, the plan document for the 2019-20 plan year.

[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 Clinical Enterprise Management Recognition Plan (CEMRP) is a performance-based incentive program available to individuals in the UC Health clinical enterprise, linked to goals in the areas of cost reduction and improvements in patient safety outcomes, as well as goals that change from year to year depending on UC Health activities under way at the time. CEMRP has been a useful tool to incentivize performance. There was not a financial goal associated with CEMRP, but there was a financial threshold; if this threshold was not met, the University could make no CEMRP payout.

Director Rebekah Fernandez explained that the key change being proposed was a refinement to the 2018-19 plan pertaining to Section 10, "Plan Funding and Minimum Threshold for Financial Standard." Under the proposed change, the financial standard

would be the net income before intra-institutional transfers; depreciation would also not be considered in this number. Dr. Stobo clarified that the financial threshold would not include depreciation but would be based on the financial data presented to the Committee, the modified Earnings Before Interest, Depreciation and Amortization, which do not include non-cash payments or Other Post-Employment Benefits (OPEB). OPEB are post-employment benefits other than pension benefits. Including depreciation in this figure would penalize organizations with major capital projects and expenses, would be unfair to the organization overall, and would discourage UC Health locations from undertaking major capital projects. The proposed changes had been approved by the Administrative Oversight Committee (AOC), which administers CEMRP. The AOC includes the chancellors of campuses with medical centers.

Upon motion duly made and seconded, the Committee approved the President's recommendation, Regents Guber, Lansing, Makarechian, Napolitano, Park, Sherman, and Zettel voting "aye."

7. **APPROVAL OF THE PROPOSED REQUEST FOR APPROVAL FOR THE UC IRVINE CAMPUS MEDICAL COMPLEX, IRVINE CAMPUS**

The President of the University recommended that the Health Services Committee approve the (A) proposed discussion of the UCI Campus Medical Complex project with the Finance and Capital Strategies Committee, which is anticipated to take place in fall 2019, and (B) subsequent requests to the Finance and Capital Strategies Committee at its future meetings for: (1) approval of preliminary plans funding, budget, external financing, and design pursuant to the California Environmental Quality Act (CEQA), and (2) approval of any amendment or modification to the foregoing.

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

UC Irvine Vice Chancellor Steven Goldstein introduced the item by recalling that UC Irvine Health was the only academic medical center in Orange County, serving a population of 3.5 million. UCI Health is split between two campuses. The academic programs of the Susan and Henry Samueli College of Health Sciences, including Schools of Medicine and Nursing as well as a Department of Pharmaceutical Sciences and Program in Public Health that are growing toward school standing, are located in Irvine. The center of UCI Health's clinical efforts is the UC Irvine Medical Center in the City of Orange. The UCI Medical Center is an integral, community-facing component of UCI Health and had been rated among the nation's best hospitals by *U.S. News and World Report* for 18 consecutive years. This was the primary training site for UCI medical and nursing students, medical residents, and fellows, and the location of Orange County's only adult Level I and pediatric Level II trauma centers and the regional burn center. Moreover, the UCI Chao Family Comprehensive Cancer Center was one of only 49 National Cancer Institute-designated comprehensive cancer centers in the nation. One of UCI Health's highest priorities is providing Orange County and the surrounding region with the highest-

quality healthcare. To meet this need, UCI was proposing to expand its medical enterprise to the main UCI campus in Irvine.

UC Irvine Health Chief Executive Officer Richard Gannotta explained that UCI Health currently maintained a purely outpatient presence in Irvine and South Orange County. In order to respond to growing academic programs and to meet the demand for services in this market, UCI Health intended to expand health services by establishing a new medical complex with a specialty emphasis, offering inpatient, ambulatory, and emergent care services. The new complex would serve as a conveniently located single destination for key clinical programs on the UCI academic campus. Although the new facility was not intended to be a replica of the Orange campus, it represented a critical step in meeting the evolving needs of UCI Health and the communities it serves. Mr. Gannotta outlined some key features of the new facility: inpatient and ambulatory clinical services; secondary, tertiary, and some quaternary surgical and medical services; capacity for 110 to 120 beds and the ability to expand to 300. This would be a modern facility with an integrated teaching platform.

The development of the hospital on the North Campus would expand patient access and promote growth. Proximity to the main campus would allow for physician coverage opportunities and integration of clinical care, research, and teaching. The new facility would address an increasing demand for services within the Irvine Primary Service Area and surrounding markets by being the first mover in providing multispecialty care in a favorable market.

UC Irvine had explored four different facility options. The first option was an “ambulatory only” platform. The second was a “full service” option, generally like a community hospital, with no emphasis on specialized care or programs of distinction. The third option was a hospital with special emphasis but without an emergency department, while the fourth option, the option selected, was a hospital with special emphasis and an emergency department. The platform developed by UC Irvine would provide 95 to 120 patient beds, or 130 beds if observation beds were included, and with scale to increase to 300 beds. UCI had analyzed the possibility of beginning with a 300-bed facility, but this did not meet the campus’ financial requirements.

The program framework projected core clinical services in areas in which UCI Health is a leader in Orange County—oncology, neurosurgery, orthopedics, and spine health—as well as certain quaternary services, with the ability to transfer complex cases to the Orange campus.

The project would construct approximately 500,000 gross square feet of space for medical inpatient, ambulatory, and emergent care services. The exact composition of each building type was still being developed. The overall project would be designed for the most cost-efficient approach. While the capital investment for the project was projected to be significant at approximately \$900 million, the case mix, payer mix, and anticipated cost structure resulted in a financially favorable output to clear the hurdle rate. UC Irvine was proposing a combination of external financing and philanthropy to fund the project.

Mr. Gannotta presented a chart with financial indicators for various scenarios with philanthropy in the amounts of \$100 million or \$200 million.

The site of the medical complex would be the UCI North Campus, located approximately 2.5 miles from the College of Health Sciences on the main campus. One element of the complex, targeted for completion in 2022, would be a Center for Child Health, which would be made possible through Proposition 3 funding. The North Campus was located along a major artery through the City of Irvine with traffic volumes in excess of 45,000 vehicles a day. Up to 7,000 new residential units were either planned or under construction within a ten-minute driving distance of the site. The medical complex project would be built on North Campus property that is outside the California Coastal Zone. Future projects, including projects that support UCI Health's clinical enterprise, would be proposed for the adjacent land within the California Coastal Zone as the need arises. UC Irvine would pursue any needed California Coastal Commission approvals for these projects.

Executive Vice President Stobo reminded the Committee that it was reviewing this item to ensure that the project is in accord with the strategic plan of the campus and medical center.

Faculty Representative May asked how this project would be integrated with the provision of primary and secondary care at the Gottschalk Medical Plaza on campus. Mr. Gannotta responded that the project would be integrated with the Gottschalk clinic, which essentially provides primary care services. Not all members of the Irvine campus community who seek specialty care come to the UCI Medical Center; some go elsewhere.

Regent Makarechian expressed support for the project. He stressed that this was an excellent location for a hospital in Orange County.

Advisory member Hetts asked how many of the planned 120 beds would be Intensive Care Unit beds. While the distance from this location to the UCI Medical Center was only about 13 miles, in Orange County traffic and for a critically ill patient, this was a world away. He asked how UC Irvine would determine the amount of Intensive Care Unit space for this facility versus patients transferred out. He asked about UC Irvine's criterion for expanding to 300 beds. In response to the last question, Mr. Gannotta noted that the exact number of beds had not yet been established. He anticipated that there might be 16 Intensive Care Unit beds. If this facility focused on oncology and procedures such as bone marrow transplants, the needs of this patient population would determine the configuration. This hospital would have full capabilities but emphasize certain specialties. For this reason, UCI Health was beginning with a more manageable bed count. With regard to critically ill patients, such as patients with acute coronary syndrome, he noted that it was not unusual to have a primary percutaneous coronary intervention (PCI) performed at one institution and then transfer the patient for open heart surgery at another institution. This hospital would have capabilities for interventional radiology and full emergency capabilities.

Regent Park asked if there were any risks attached to the project in a time frame of seven to ten years. She asked how this facility would respond to the state's need for healthcare

specialties. Mr. Gannotta responded that the risk of inaction was the greatest risk. This was a rapidly growing area in South Orange County. Competition in the healthcare arena was becoming more intense, and this competition did not recognize the need for the capability of treating highly acute patient conditions, a capability which is found in academic medical centers. UCI Health has this capability but only had outpatient facilities deployed in the South County. This project was a logical step. From a financial perspective, given UCI Health's current service offerings, UCI Health was essentially a single, freestanding academic medical center. It was not drawing in patients from the South County and not meeting the needs of this population. The proposed programs would capture some of this patient population and make care more accessible. In financial terms, this project would allow UCI Health to balance out its portfolio by moving into an area that is competitive, but where UCI Health can deliver services that community hospitals in the area are not able to deliver.

Regent Makarechian observed that the Orange campus did not have room for expansion.

Committee Chair Lansing expressed support for the project but anticipated that fundraising almost \$1 billion would not be an easy task.

UCSF Health Chief Executive Officer Mark Laret noted that he had served as chief executive officer at the UC Irvine Medical Center from 1995 to 2000 and described this project as something UCI Health wanted to do at that time but could not realize. This project was perfectly appropriate, and Mr. Laret's only caution was that, by the time the hospital was built, UCI Health would realize that it should have built more beds. Since the overhead costs would be the same for a smaller or larger hospital, he suggested that UC Irvine look to its donor community to raise incremental funds to allow construction of a 250- to 300-bed hospital at the outset.

Regent Park asked how the development of specialty areas in this hospital would help the state meet its healthcare goals. Mr. Gannotta responded that the project would further progress toward meeting statewide goals by providing new sites for education and opportunities to conduct clinical trials as well as serving a larger population.

Upon motion duly made and seconded, the Committee approved the President's recommendation, Regents Guber, Lansing, Makarechian, Napolitano, Park, Sherman, and Zettel voting "aye."

8. **HIGH RELIABILITY ORGANIZATIONS: JOINT COMMISSION READINESS**

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

Executive Vice President Stobo explained that the Joint Commission is an organization that accredits and certifies hospitals and health systems in the U.S.

UCLA Health Chief Medical and Quality Officer Robert Cherry referred to the Clinical Quality Dashboard information and drew attention to a few points. All UC medical centers were continuing to work to reduce the rate of readmissions. In analyzing data, UC Health would distinguish between planned and unplanned readmissions, since its efforts are mostly directed at reducing unplanned readmissions. UC Health was at its threshold target for reducing excess bed days. This was a challenging goal due to increased demand for health care within local markets and increased need for mental health services. UC medical centers were performing well on the State-mandated Public Hospital Redesign and Incentives in Medi-Cal (PRIME) criteria. Dr. Cherry noted that these benchmarks would be reset later in the year.

Dr. Stobo urged the Committee to review the Clinical Quality Dashboard information, stating that he was pleased with the trends, which indicated the success of the work done throughout UC Health to address issues of quality.

President Napolitano asked what accounted for differences in 30-day readmission rates between UC Davis and the UCLA Ronald Reagan Medical Center on the one hand and UCSF and UCLA Santa Monica hospital on the other, as shown on one chart. Dr. Cherry responded that socioeconomic status, access to transportation, access to a pharmacy, and other factors can be a barrier to ensuring good continuity of care. He noted that the rates shown on the chart included planned readmissions, which are part of appropriate care.

Advisory member Lipstein noted that the influence of socioeconomic factors on readmission rates had been confirmed in a recent peer-reviewed article. The article's authors proposed a method for risk-adjusting readmission rates at the census tract level. Dr. Cherry remarked that UC chief medical officers have discussed, in collaboration with chief information officers, how to get "street level" information in order to better understand patients and their communities before discharge.

President Napolitano asked if payer mix information could serve as a proxy. Dr. Cherry responded that the payer mix could be a potential proxy. Medi-Cal patients might face increased pressures with regard to discharge planning. UC Health makes efforts to identify vulnerable patients or patients who might need more services or resources prior to discharge.

Regent Makarechian asked about the reason for increases in inpatient mortality rates at three of the medical centers during the last quarter, shown on one chart. Dr. Cherry responded that a number of different factors contribute to this rate, such as sepsis mortality, palliative care, and early recognition and response. All UC medical centers were taking measures to reduce inpatient mortality.

Regent Makarechian asked if patients or members of the public should be concerned by the increase shown on the chart for these hospitals. Dr. Cherry responded that there was no cause for alarm or reason to avoid any hospital. He stressed that this rate depends on many different variables, including the ability to capture appropriate documentation and billing

codes. He anticipated that, with better data analytics, UC medical centers would be better able to identify and prioritize patients at risk.

Regent Makarechian asked how this chart was useful for hospital operations. Dr. Cherry responded that the chief medical officers and chief nursing officers have conference calls twice a month in addition to in-person meetings where they review Clinical Quality Dashboard information and discuss challenges and best practices. Committee Chair Lansing observed that the Clinical Quality Dashboard would allow one to recognize a recurrent problem. Dr. Cherry added that each location receives this information almost in real time and can appropriately focus its efforts.

Regent Makarechian asked if there was a chart showing which hospitals take in the highest numbers of patients with acute, serious conditions. Dr. Cherry responded that the UCLA Medical Center consistently has the highest case mix index but noted that some locations might not be capturing the severity of patient illnesses in documentation. He underscored that Clinical Quality Dashboard data points for some locations might be affected by insufficient accuracy in coding or documentation.

Regent Makarechian asked how Clinical Quality Dashboard charts would compare to medical centers nationally. Dr. Cherry responded that UC Health uses the Vizient model and benchmarks itself against other academic medical centers. He could provide information at a future meeting about UC medical centers' national rankings for inpatient mortality. Regent Makarechian asked that this information be provided.

Dr. Cherry then discussed high reliability organizations. The third leading cause of death in the U.S. is medical errors and the annual average number of deaths in the U.S. from medical errors is 325,000, fewer than from heart disease or cancer. He presented a rough calculation of deaths from medical errors minus the 20,000 complaints annually received by the Joint Commission as well as "sentinel events" reported to the Joint Commission that result in death. This calculation indicated that, annually, 300,000 medical errors resulting in death might not be reported to the Joint Commission. About 50 percent of deaths are non-preventable, and this would indicate that 150,000 preventable medical errors resulting in death are not reported.

Dr. Cherry explained that these figures provided context for understanding the focus on safety by UC chief medical officers and chief nursing officers and by the Joint Commission. High reliability organizations are those that operate in complex domains with many hazards and manage to avoid serious accidents or catastrophic failures. Examples might be aircraft carriers, electrical power grids, and nuclear power operations. Of course, healthcare environments are different from other industries, focused on optimizing human anatomy, physiology, and psychology to benefit patients who vary biologically. There is shared decision-making by patient and provider, the concept of "catastrophic failure" is different in health care than in other industries, and the learning derived from clinical research is unique to this field. Nevertheless, certain characteristics of high reliability organizations are pertinent to health care: preoccupation with failure, and examining problems and using instances of failure as a means to improve the system; reluctance to

simplify interpretations; sensitivity to operations; resilience; and deference to expertise. An optimal culture in healthcare organizations would focus on improving processes and systems rather than blaming individuals. Medical and other kinds of mistakes are often considered in various categories. Dr. Cherry distinguished the categories of human error, risky behavior, and reckless behavior, and how one might try to mitigate them.

UC Health is subject to regulatory oversight by a number of different organizations, one of which is the Joint Commission. The Joint Commission is not a governmental organization but an independent, not-for-profit organization that accredits and certifies nearly 21,000 healthcare organizations and programs. Compliance with Joint Commission standards implies consistency of care, effective processes for patient and staff safety, and high quality of care. Joint Commission surveys generally occur once every three years. Although site visits are unannounced, UC medical centers do have a general idea of when to expect visits.

Joint Commission standards are based on three basic tenets: accountability and oversight by leadership, active engagement in fostering a culture of safety, and the ability to undertake rapid improvement when deficiencies are identified.

Hospitals must meet federal eligibility standards by the Centers for Medicare and Medicaid Services (CMS) in order to participate in and receive reimbursement from Medicare and Medicaid. The Joint Commission sets its standards and establishes elements of performance based on the CMS eligibility requirements. The Joint Commission is the most prominent of a number of organizations that have both standards and a survey process that meet or exceed the eligibility standards for Medicare and Medicaid reimbursement. Hospitals certified by the Joint Commission are therefore deemed eligible to receive Medicare and Medicaid reimbursement.

UC medical centers engage in much planning and preparation to optimize and ensure readiness for Joint Commission site visits, including internal self-assessments, surveys by external reviewers, teamwork skills training, a commitment to “zero harm,” “secret shopper” audits, attention to priorities published by the Joint Commission in its annual briefings and survey activity guides, and the sharing of information about past surveys.

The Joint Commission arrives unannounced and the survey process begins with an opening conference. The Commission reviews documents such as policies, procedures, and medical records and performs individual “tracers,” taking a patient medical record and following that patient’s travel through the facility, visiting the departments where that patient was treated. Commission members speak with staff and patients. The Commission also performs “system tracers,” meeting for one or two hours with multidisciplinary groups to review areas such as quality assurance and performance improvement, infection prevention, medication management, and the environment of care. The Commission provides daily briefings, an exit briefing with the chief executive officer, and an organization exit conference for other leaders in the organization.

Some of the current priorities for the Joint Commission were cleaning, disinfection, and sterilization; dialysis, since many hospitals have outside clinical providers perform dialysis; pain management, a priority spurred by the national opioid crisis; and suicide prevention and preventing the risk of self-harm by patients. These were also priorities for UC medical centers. Medical centers that had recently undergone Joint Commission surveys found that other areas of focus for the Joint Commission were documentation, infection prevention, and medication management. UC medical centers have performed well on Joint Commission surveys. The Joint Commission maps its findings on a grid to indicate whether these are limited to a local environment or widespread and to indicate impact or severity. The average number of findings nationally was 32, while findings for UC medical centers ranged from 33 to the 60s; given the size and complexity of UC Health, these numbers were to be expected.

In response to a question by Regent Sherman, Dr. Stobo explained that the performance benchmarks for the Clinical Enterprise Management Recognition Plan (CEMRP) were not tied to Joint Commission priorities. Regent Sherman suggested that receiving high marks on Joint Commission surveys might serve as a goal or target for CEMRP. Dr. Stobo responded that UC Health could consider this.

Regent Sherman requested clarification of one of the Joint Commission priorities identified on a slide as “H&P Documentation.” Dr. Cherry explained that this referred to a patient’s “history” and “physical,” which providers and physicians are expected to have ready for other members of the team in a timely manner. Timeliness of complete documentation has been a concern in some organizations.

Regent Sherman referred to a recent op-ed piece in a major newspaper about the amount of time spent by doctors inputting data into electronic medical records; physicians reportedly spend an hour entering data for almost every hour spent providing medical care. He asked if doctors were hesitant to be diligent in documentation because it took up so much time. Dr. Cherry responded that this had been a problem for healthcare institutions even before the advent of electronic medical records. This was still an issue and to some extent reflected the leadership and culture of an organization. One of the first things the Joint Commission does in a survey is to review documents. Missing records or inadequate communications among providers say something about organizational culture. Achieving a certain minimum threshold in documentation is important in the care of a patient.

Dr. Stobo requested that, now that the Health Services Committee had been expanded, it would be reasonable for the Committee to consider having a separate working group for quality and safety. This working group could examine data in depth and raise issues and questions at the regular Health Services Committee meeting. Committee Chair Lansing suggested that Dr. Stobo find Committee members agreeable to serving on such a working group and form the group. Dr. Cherry added that the chief medical officers and chief nursing officers felt that such a working group would benefit the efforts of their group as well because some of the data in the Clinical Quality Dashboard deserve more in-depth discussion than is possible at a regular meeting.

Advisory member Spahlinger emphasized the importance of commitment to zero harm, improvement not only in rates but in absolute numbers, and transparency about absolute numbers within an organization. It is important remind everyone in the organization that every event concerns a unique human being. Dr. Cherry agreed that setting a goal of zero harm was important.

With regard to the burden of documentation, Mr. Lipstein observed that documentation requirements are extensive in all heavily regulated industries with a focus on safety, because this is the only way to demonstrate to external reviewers and inspectors that stated tasks were accomplished. The challenge was to make documentation more reflective of the work one does. Dr. Cherry observed that electronic medical records can be structured in ways that are difficult or easy for the provider; physicians and nurses at UCLA Health rated their records system favorably.

Regent Sherman asked if there was systemwide consistency in electronic medical records. Dr. Cherry responded that there was consistency in what must be documented but there might be variation in how it is documented.

Regent Sherman asked if UC medical centers were using voice recognition software so that doctors could dictate directly into medical records. Dr. Cherry responded that the medical centers have experimented with different ways of entering data into medical records to make this easier for clinicians. This depended on the individual provider. It was possible to use voice recognition software with the UC Health records system.

Regent Makarechian asked if patients may see their electronic medical record. Dr. Cherry responded that UCLA Health has an opt-in process by which physicians have to allow this. There have been discussions on developing an organizational culture in which physicians are comfortable with these open records. He anticipated that more institutions would move to open records because patients want to own their healthcare data, and they want their data to be portable and accessible.

Regent Makarechian suggested that this change might result in more accurate recording by physicians. Dr. Cherry again suggested that the healthcare environment would change and that organizations would learn to apply these new procedures effectively.

Regent Makarechian asked how the medical centers carry out “secret shopper” reviews. Dr. Cherry responded that there are walkarounds and patient experience rounds by medical center leadership. These reviews focus not only on employee performance but also on the state of the facility, general cleanliness that meets infection prevention standards, and storage of high-risk medications. Medical centers occasionally engage a third-party reviewer, but most of these readiness rounds are carried out by the medical centers’ own leadership teams. The reviews are sometimes “secret” in that clinicians do not know that a review is under way. UCSF Health Chief Executive Officer Mark Laret commented that UCSF uses the “secret shopper” method to determine real wait times for patients who call for an appointment, insurance issues, and how welcoming the reception is for patients.

9. **UC DAVIS HEALTH: INTERRUPTING THE CYCLE OF HOMELESSNESS, MENTAL ILLNESS AND INCARCERATION**

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

UC Davis Human Health Sciences Vice Chancellor David Lubarsky recalled that he had come to UC Davis 11 months prior. During his initial survey of UC Davis Health operations, he was informed that there were extended wait times for emergency services. Internal and external stakeholders were very much satisfied with the quality of physician care but dissatisfied with the process flow. A closer examination showed that there were too many patients in the hospital and that many patients in the hospital and the emergency department had psychiatric and medical illnesses. Without addressing mental illness in the community and the revolving door into acute care services, which are entwined with homelessness, UC Davis Health would not be able to improve its process flow and provide quick care to patients in the emergency department.

Dr. Lubarsky briefly provided statistics illustrating the extent of the work done by UC Davis Health in Sacramento, a 626-bed Level 1 trauma center with 36,000 discharges annually. Thirty-seven percent of patients are Medi-Cal patients. UC Davis Health has 250,000 patient bed days a year and one million outpatient visits. It is a \$3 billion health system, of which \$2.6 billion is accounted for by clinical care. UC Davis Health is the only academic medical center from Sacramento to the Oregon border and serves 33 California counties. It has a nationally ranked hospital and children's hospital as well as 17 additional outpatient locations. Sacramento County does not have a county hospital; UC Davis Health serves as this hospital, and many underserved patients use the emergency department as a primary care venue. UC Davis Health fulfills safety net responsibilities and provides tertiary and quaternary care for most of Northern California.

The need to provide acute care for homeless patients is not a problem unique to Sacramento. There were 100,000 homeless patients admitted to California hospitals in 2017, a 28 percent increase since 2015. Thirty-five percent of homeless patients have mental illness as their primary discharge diagnosis, but Dr. Lubarsky stressed that this figure understates the real extent of the problem of mental illness, hospital admissions, acute care, and homelessness, because many homeless patients have mental illness as a secondary discharge diagnosis.

Sacramento's homeless population increased by 38 percent from 2015 to 2017 and might have increased by the same percentage again in the past two years. Of those homeless who can be counted and surveyed, 64 percent have mental health issues, 54 percent have post-traumatic stress disorder, 58 percent are self-reported drug users, 35 percent have medical problems including traumatic brain injury, and 33 percent are characterized as long-term, chronically homeless individuals.

Currently, the UC Davis Medical Center had 82 patients who had been in the hospital for more than a month, 36 patients who had been in the hospital for more than three months,

and about a dozen patients who had been there for almost two years. Between 20 percent and 25 percent of the hospital's acute adult medical and surgical bed capacity is filled with patients who cannot be discharged. There is nowhere to send them because there is no medical psychiatric facility in all of Northern California. This accounted for a large number of excess bed days.

In the past, about ten of the 66 emergency department bays were occupied on average at any time by involuntary psychiatric holds. On June 3, 2019 the emergency department had a record 29 out of 66 beds occupied with involuntary psychiatric admissions. Seventy percent of these patients are Medi-Cal patients or indigent. UC Davis Health had seen a dramatic rise in the number of these patients during the past year, from 8,000 to 13,000 hours a month of emergency room bed time for involuntary psychiatric admissions. This problem could not be solved at the level of hospital operations but needed to be addressed at the community level.

For the past 12 months, UC Davis Health hospital capacity had been at 102.3 percent every day, while a national benchmark calls for a maximum capacity of 80 percent. In 2018-19, the emergency department was 70 percent occupied 24 hours a day, including hallway beds. All 66 emergency department bays are occupied 24 hours a day, 365 days a year. The previous year, UC Davis Health had to deny 6,000 transfers due to lack of capacity.

The current system was failing patients in need, including acute care patients who should be transferred, as well as homeless people with psychiatric diagnoses. Sacramento County had not increased mental health and homeless services despite the burgeoning need in the region. Private and nonprofit organizations as well as County and State agencies were poorly coordinated, without a shared or standard system of records, making it difficult to track individuals.

Dr. Lubarsky estimated that Sacramento County did not have half the number of beds needed for psychiatric care. There were only four psychiatric facilities that would take patients with concomitant medical problems in all of Northern California and none in Sacramento.

Advisory member Lipstein asked about a mental health urgent care location indicated on a slide. Dr. Lubarsky explained that this was an urgent care clinic but stressed that patients with a medical problem and a psychiatric diagnosis are sent to emergency departments. There was a lack of an appropriate facility, and UC Davis Health works with Dignity Health, Sutter Health, and Kaiser Permanente to try to assist the City and County of Sacramento.

Many efforts had been made to address this problem but had been insufficient. UC Davis Health contributed \$4 million to create a board and care facility in association with a Federally Qualified Health Center. UC Davis doctors provide urgent care mental health services for the County and psychiatric services for the County jail system. UC Davis Health entered into a formal partnership with the County to provide integrated behavioral health support services. This was not enough: the region needed acute care services, board

and care facilities, integrated behavioral health, and a way to provide social services that did not yet exist.

As a path forward to address these needs, Dr. Lubarsky proposed that these various functions should be located on a single campus, providing a comprehensive set of health services: a medical and psychiatric emergency department and hospital; an inpatient psychiatric facility; an urgent care mental health treatment center or crisis stabilization unit; acute and chronic outpatient services; and intensive integrated behavioral and mental health services, including substance use disorder treatment for inpatients and outpatients. It would make sense to locate all these services on one campus, but more was needed. If one wanted to interrupt the cycle of incarceration, continued homelessness, mental illness, and excessive use of acute patient care services, one must provide services to address the underlying problems that lead to homelessness and mental illness to begin with. The campus would include City, County, and State social support agencies, a board and care facility, homeless shelters, tent areas for homeless people who do not wish to stay in a shelter, transitional low-cost housing, job training programs, and placement services. The campus could also be used for jail diversion and rehabilitation.

Dr. Lubarsky described the case of a homeless patient with schizophrenia. This individual was starving, was caught breaking and entering, arrested, sent to jail, and spent 45 days in a detoxification program for methamphetamine use. This individual was then released, became homeless, had an overdose, and was taken to the UC Davis Medical Center emergency department. This individual was in the hospital for 13 to 15 days, was discharged to but did not go to a respite facility, and was now back on the street. This episode might have cost \$100,000, the patient was not helped, and emergency medical services were burdened. Having a campus support system with all the services needed to help individuals rehabilitate themselves might address this repeating cycle. A financial model for this system, discussed in an August 2018 article in *Health Affairs*,² was based on self-interest and return on investment for key community stakeholders, who must contribute. UC Davis Health had recently convened 70 stakeholders in Sacramento, representing the City, County, State, all four local health systems, the jail system, public defenders, mental health professionals, and others, to discuss this with one of the initiators of the Haven for Hope in San Antonio, Texas, and the Bexar County Mental Health Jail Diversion program. This program in San Antonio was a functioning model and had been replicated in a few smaller cities.

The San Antonio program did not have a medical and psychiatric hospital, board and care facility, or inpatient psychiatric facility, but had all the other essential features enumerated earlier. There were currently 811 residents on the San Antonio campus, and 4,725 people had moved from the campus to permanent housing. The support services provided included primary care, integrated behavioral care, substance abuse treatment, job rehabilitation, and psychological counseling. Ninety percent of the people who moved from the campus did not return to homelessness. The average length of stay on the campus was six months. The number of homeless people in downtown San Antonio had decreased by 80 percent, and

² Len Nichols and Lauren Taylor, "Social Determinants as Public Goods: A New Approach to Financing Key Investments in Healthy Communities."

3,000 individuals returned to a job. The campus is adjacent to the Bexar County Mental Health Jail Diversion program, which performs inpatient and outpatient medication-assisted treatment.

The cost avoidance resulting from this program in San Antonio was over \$100 million, and the estimated 20-year taxpayer return on investment, based on the first eight years of operation, was 1,000 percent. This program was not a cost but an investment with extraordinary dividends. The calculated return on investment did not even take into account important factors such as economic development opportunities downtown and, most important of all, the reclamation of human dignity, life, and health. Even only in terms of dollars and cents, this model makes sense.

Dr. Lubarsky briefly mentioned a program in Los Angeles County called Housing for Health. For participants in this program, there was a 70 percent reduction in visits to hospital emergency departments.

The proposed solution in Sacramento would be to replicate the San Antonio program with additional psychiatric care facilities on a single campus. The proposal had generated interest and excitement. Other attempted solutions have failed. The San Antonio model was the one successful model in the United States. Health systems spend tens of millions of dollars every year treating patients who do not get better, and hospitals are filled with patients who cannot pay for the acute care they need. Emergency services cannot always respond to 911 calls within the required four minutes because they are busy servicing the homeless population dispersed throughout Sacramento County. Law enforcement officers also spend a great deal of time bringing homeless people to jail or the emergency room rather than policing in the community. There is an economic disadvantage for everyone when the downtown area is considered a bereft zone. A great deal of money has been spent on City, County, State, and private nonprofit efforts that are not effectively coordinated but could cooperate on a single campus. Dr. Lubarsky noted that he had had discussions with the California Department of Health Care Services about how this would move inefficient and wasteful spending from the mental health budget to the acute care budget of Medi-Cal, spending incurred when Sacramento hospitals treat people with minor medical conditions because they cannot be sent anywhere else.

Dr. Lubarsky presented a list of stakeholders engaged in this proposal to date. He and his colleagues had engaged with the executives of the San Antonio program and were applying for a foundation support planning grant from the California Health Care Foundation. They were also working to identify the appropriate “trusted brokers” to help convene the project. The brokers were currently Dr. Lubarsky and Peter Beilenson, M.D., Director of the Sacramento County Department of Health Services. They were calculating the simple return on investment, the return in monetary terms only, without consideration of the social good; identifying services to be provided and considering the location of such a campus; and prioritizing the first step, which would probably be the establishment of a medical psychiatric facility in the City of Sacramento. In a few weeks, Dr. Lubarsky would meet with representatives of the management consulting firm McKinsey and Company’s pro bono consulting service who had experience working on homelessness issues in San

Francisco and who had offered to help set up a 501(c)(3) organization similar to Haven for Hope in San Antonio and suggest a governance and structural model. This would not be a UC initiative, but, in Dr. Lubarsky's view, the County of Sacramento wished the University to take a leading role in the project, recognizing its status as an academic institution and its commitment to a social mission. He looked forward to hearing the Regents' views on how much effort the University should be contributing to this project versus the County and other participants. Dr. Lubarsky concluded his presentation with a rough conceptual site plan for the campus. A possible location might be one of the parks in Sacramento where hundreds of homeless people were currently camped out.

Committee Chair Lansing asked if this model could be expanded for a metropolis like Los Angeles, which might need 20 or more such campuses. Dr. Lubarsky responded that many Mental Health Services Act funds remained unspent in California. In Los Angeles County, this might amount to as much as \$1 billion. The model could be expanded for Los Angeles, with perhaps five rather than 20 campuses. San Antonio had almost 20,000 homeless people and managed to reduce these numbers. He emphasized that this type of campus not only reduces the number of homeless individuals but provides support services that keep people who are nearly homeless from becoming homeless.

President Napolitano expressed support for this mission. Taking on this challenge was an effort worthy of UC, as a public university with hospitals and medical schools. To ensure the success of this venture, the major participants needed to agree on the project manager, who would have responsibilities for all elements of the project, and be willing to contribute funding to pay the project manager. She asked about the proposed first step of establishing a medical psychiatric facility. Dr. Lubarsky responded that the first step would be to site such a facility. Currently, UC Davis Health and the other local health systems were hampered in their ability to deliver good care to both acute care and psychiatric patients. The facility could be built by a third party. The savings that would be generated by the new facility could be directed to development of the campus.

President Napolitano remarked that construction of this facility would be a major project in its own right. She asked about the timeline and staging. Dr. Lubarsky responded that different timelines and staging were possible. Establishing a medical psychiatric facility first would free up funds early on.

President Napolitano asked how long, in general, people in San Antonio who moved to the campus resided there, and what they did subsequently. Dr. Lubarsky responded that they resided on the campus about six months before moving to permanent housing and jobs. The San Antonio program had moved about 5,000 people to permanent housing, and only about ten percent of these people had returned to homelessness. He noted that not all homeless people want to reenter society and a regular job. Programs like this could not solve every problem but could provide a pathway to reenter society for those who wish to do so. For those who do not want to reenter society, the campus would provide a safe haven.

President Napolitano stressed that this initiative would need a project manager and staff. The current brokers should develop a budget and seek support from foundations as well as

asking potential partners for planning support. Dr. Lubarsky responded that he anticipated that there would be support from health systems in the area and from City, County, and State entities when a 501(c)(3) organization was established.

Regent Sherman asked why the Department of Veterans Affairs (Veterans Administration) was not included in the list of stakeholders engaged in the proposal. Dr. Lubarsky responded that the Veterans Administration would be a natural ally in this effort. There were many homeless veterans. The project had not yet engaged with the Veterans Administration but realized that this was an oversight.

Regent-designate Weddle suggested that UC campus staff and student leaders who work on student basic needs might be of use to this project. Dr. Lubarsky responded that the San Antonio campus relies on about 1,000 volunteers annually.

Committee Chair Lansing referred to news reports of students living in cars who might not officially be considered homeless but who were, in fact, homeless. Dr. Lubarsky responded that about 30 percent of homeless people have become homeless due to economic factors, while about 35 percent of homeless people suffer from mental illness; it was important to address both factors.

President Napolitano observed that information on the demographics of the Sacramento area homeless population, such as categories of age, gender, and mental health status, would help structure the project. Dr. Lubarsky responded that these factors are intertwined in the actual life stories of homeless people. A campus is needed to provide medical care, mental health care, housing, and support services to return people to jobs. If one addresses only one of these needs, homeless people are still overwhelmed by the other three. He identified this as the reason why many efforts to reduce homelessness have failed.

Committee Chair Lansing concluded the discussion by expressing the enthusiasm of the Committee for this project, which would address one of the greatest problems facing the United States.

The meeting adjourned at 3:25 p.m.

Attest:

Secretary and Chief of Staff

The University of California
Clinical Enterprise Management Recognition Plan (CEMRP)
For Plan Year July 1, ~~2018-2019~~ through June 30, ~~2019~~2020

1. PLAN PURPOSE

The purpose of the University of California Clinical Enterprise Management Recognition Plan (CEMRP or Plan) is to provide at-risk, variable incentive compensation opportunity to those employees responsible for achieving or exceeding key Clinical Enterprise objectives. Consistent with healthcare industry practices, UC Health Systems use performance-based incentive compensation programs to encourage and reward achievement of specific financial and/or non-financial objectives (e.g., quality of care or patient satisfaction and safety, budget performance) and strategic objectives which relate to the Clinical Enterprise's mission.

The annual Short Term Incentive (STI) component of the Plan provides participants with an opportunity to receive a non-base building cash incentive based on the achievement of specific annual financial, non-financial, and strategic objectives relative to the mission and goals of the UC Health enterprise.

The Long Term Incentive (LTI) component is a non-base building incentive that is intended to encourage and reward top executives of the UC Health enterprise for the achievement of multi-year strategic initiatives, to support and reinforce those results that will promote UC Health and its long-term success, and emphasize the importance of the long-term strategic plan. In addition, the LTI assists in retaining the executive talent needed to achieve multi-year organizational objectives by complementing (but not duplicating) the focus of the rest of the Clinical Enterprise Management Recognition Plan. The Executive Vice President (EVP) – UC Health and the Chief Executive Officers (CEOs) of each of the Health Systems will participate in the LTI.

The overall Plan encourages the teamwork required to meet challenging organizational goals. The Plan also uses individual and/or departmental performance objectives to encourage participants to maximize their personal effort and to demonstrate individual excellence.

2. PLAN OVERSIGHT

Development, governance and interpretation of the Plan will be overseen by an independent Administrative Oversight Committee (AOC) comprised as follows:

- Executive Vice President – Chief Operating Officer
- Chancellor of every campus with a Health System
- Vice President, Systemwide Human Resources
- Executive Director, Systemwide Compensation Programs and Strategy

The AOC, in its deliberations pertaining to the development or revision of the Plan, may consult with the EVP – UC Health, and representatives from the Health Systems. The AOC will abide by the Political Reform Act, which would prohibit Plan participants from making, participating in

making, or influencing decisions that would affect whether they participate in the Plan, the objectives that will govern whether they earn awards under the Plan, and the amount of awards paid to them under the Plan. The Office of General Counsel will be consulted if there are any questions about the application of the Political Reform Act in this context. The Senior Vice President – Chief Compliance and Audit Officer will assure that periodic auditing and monitoring will occur, as appropriate.

3. PLAN APPROVAL

The Plan will be subject to an annual review conducted by the AOC to address design issues and market alignment. The Plan will be implemented each year upon the approval of the AOC if no changes to the Plan are being recommended.

If the AOC recommends any substantive or material changes to the Plan, including, but not limited to, changes in the award opportunity levels, the AOC will obtain the approval of the President and the Regents' Health Services Committee before implementing such changes. Reasonable efforts, given all circumstances, will be made to delay implementing substantive or material Plan changes until after the end of the current Plan year. However, if changes are implemented during the Plan year that would affect the award calculations, changes will only be applied prospectively to the remaining portion of the Plan year. Plan changes recommended by the AOC that are not material or substantive, or are deemed to be technical corrections, may be approved by the AOC after consultation with the President and will then be implemented by the AOC at an appropriate time. The Regents will receive reports of all changes to the Plan.

4. PLAN YEAR

The CEMRP year will correspond to the University's fiscal year, beginning July 1 and ending the following June 30.

The applicable performance period for CEMRP's LTI component will begin July 1 of the Plan year and end three years later on June 30th.

5. PLAN ADMINISTRATION

The Plan will be administered under the purview of the Executive Director, Systemwide Compensation Programs and Strategy, at the Office of the President, consistent with the Plan features outlined in this document, and as approved by the President and the Regents' Health Services Committee. The Plan features and provisions outlined in this document will supersede any other Plan summary.

6. ELIGIBILITY TO PARTICIPATE

Eligible participants in CEMRP are defined as the senior leadership of the Clinical Enterprise who have significant strategic impact and a broad span of control with the ability to effect enterprise-wide change.

Eligibility to participate in CEMRP's LTI component is reserved for those senior executives who are in a position to make a significant impact on the achievement of long-term strategic objectives, specifically the EVP – UC Health and the CEOs at each of the Health Systems.

Plan participation in any one year does not provide any right or guarantee of eligibility or participation in any subsequent year of the Plan.

Plan participants may be added after the Plan year has begun, subject to CEMRP's eligibility requirements and AOC approval.

Participants in this Plan may not participate in any other incentive or recognition plan during the Plan year, including the Health Sciences Compensation Plan, except in the event of a mid-year transfer within the University. Specifically, if a Plan participant is eligible for only a partial year award under this Plan because a mid-year transfer of position renders him or her eligible for Plan participation for only a portion of the Plan year, he or she may participate in a different University plan for the other portion of the Plan year. Concurrent participation in this Plan and another University incentive plan is not permitted.

CEMRP STI participants must have a minimum of six months of service to participate in the Plan and will receive a prorated award in their first year of participation. Similarly, participants who were not working for a significant portion of the Plan year may receive a prorated award in appropriate circumstances, as determined by the AOC. Participants who transfer within the University to a position that would not be eligible for participation in the Plan are eligible to receive a prorated award for that Plan year if they worked in the CEMRP-eligible position for at least six months.

An LTI participant hired or promoted into an LTI-eligible position between July 1 and December 31 of the Plan year will be assigned one or more long-term objective(s) for the three-year period that begins with the Plan year and will be eligible for a prorated LTI incentive opportunity for that period. The prorated LTI award will be determined by dividing the number of complete months employed during that three-year period by the number of months in the full performance period (36 months).

Prior to the beginning of the Plan year, the AOC will approve the Plan's participants and provide the President and the Chair of the Regents' Health Services Committee with a list of participants for that Plan year, including appropriate detail regarding each participant.

7. AWARD OPPORTUNITY LEVELS

As part of their competitive total cash compensation package, Plan participants are assigned threshold, target and maximum incentive award levels, expressed as a percentage of their base salary. These award opportunity levels serve to motivate and drive individual and team performance toward established objectives. Target awards will be calibrated to expected results while maximum awards will be granted only for superior performance against established performance standards. Actual awards for any individual participant may not exceed the maximum award opportunity level assigned. Award opportunity levels are determined, in part,

based on the participant’s level within the organization and the relative scope of responsibilities, impact of decisions, and long-term strategic impact. If a participant changes positions during the Plan year within the same institution (defined as the participant’s Health System) and the participant’s level within the organization changes based on the table below, the participant’s award should be adjusted to take into account the amount of time spent in each position.

CEMRP STI Annual Award Opportunity (as percent of salary)

Position Level within Organization	Threshold Opportunity	Target Opportunity	Maximum Opportunity
EVP – UC Health and Health System Chief Executive Officers	10%	20%	30%
Other “Chief Levels” and Other Key Senior Clinical Enterprise Leadership	7.5%	15%	25%
Other Key Clinical Enterprise Leadership	7.5%	15%	20%

The individuals eligible to participate in CEMRP’s LTI component will be assigned one or more long-term performance objective(s) for the three-year period that begins with each new CEMRP Plan year, resulting in overlapping three-year LTI cycles. The LTI Threshold, Target, and Maximum award opportunity for the EVP – UC Health and the CEOs will be 5 percent, 10 percent and 15 percent, respectively, as shown in the chart below. The actual awards will be based on final assessments at the conclusion of the three-year LTI performance period and paid at the same time as the STI awards are paid.

CEMRP LTI Award Opportunity (as percent of salary)

<u>Position Level within Organization</u>	<u>Threshold Opportunity</u>	<u>Target Opportunity</u>	<u>Maximum Opportunity</u>
EVP – UC Health and Health System Chief Executive Officers	5%	10%	15%

8. PERFORMANCE STANDARDS

Each Plan participant will be assigned Performance Objectives which have standards of performance defined as Threshold, Target, and Maximum performance consistent with the following:

Threshold Performance – Represents the minimum acceptable performance standard for which an award can be paid. This level represents satisfactory results, but less than full achievement of stretch objectives.

Target Performance – Represents successful attainment of expected level of performance against stretch objectives.

Maximum Performance – Represents results which clearly and significantly exceed all performance expectations for the year. This level of accomplishment should be rare.

The same performance standards will be used for LTI performance objectives, but they will relate to performance over a three-year period rather than a one-year period.

9. PERFORMANCE OBJECTIVES AND WEIGHTINGS

Prior to the beginning of each fiscal year, a series of financial and/or non-financial performance objectives will be established for each participant, consistent with the mission and goals of the Clinical Enterprise and each Health System in the Clinical Enterprise.

Systemwide Clinical Enterprise level objectives encourage the Health Systems to work together for the benefit of the entire Clinical Enterprise system. Institutional performance objectives encourage local teamwork and recognize the joint effort needed to meet challenging organizational goals. Individual or departmental performance objectives are designed to focus attention on key individual or departmental initiatives.

For purposes of this Plan, individual/departmental performance objectives should not be the same activities that are normal job requirements or expectations. Job performance is assessed as part of the Annual Performance Review Process. All CEMRP performance objectives must be stretch in terms of achievement potential, must be aligned with specific Institutional and/or Clinical Enterprise initiatives, and are often peripheral but related to or integrated with ongoing job responsibilities.

Each of the STI and LTI performance objectives will relate to one or more of the categories below:

- Financial Performance
- Quality Improvements
- Patient Satisfaction
- Key Initiatives in Support of the Strategic Plan
- People and other Resource Management

There will be no more than nine STI performance objectives for each participant in CEMRP comprised of the following: (1) Up to three objectives relating to the performance of the *Clinical Enterprise* (defined as Systemwide); (2) Up to three objectives relating to the performance of the *Institution* (defined as the participant's Health System); (3) For all participants other than those eligible for the LTI component, up to three objectives relating to *Individual* and/or *Departmental* performance. If an Individual/Departmental performance objective has three components and the Threshold, Target, and Maximum performance standards are framed as “meet one of three,” “meet two of three,” and “meet three of three,” respectively, each component must have equal importance and weighting. While this type of Individual/Departmental performance objective is

permissible, Individual/Departmental performance objectives with clear metrics for each performance standard are preferred.

Annual STI Individual/Departmental performance objectives will be established and administered by each participant's supervisor in consultation with the CEO of that Health System for all participants other than those eligible to participate in the LTI component.

The annual STI Institutional performance objectives for each Health System will be established and administered by the EVP – UC Health in consultation with the respective Chancellors in advance of the Plan year.

The annual STI performance objectives for the Systemwide Clinical Enterprise Level will be established by the President, who may consult with the Chair of the Regents' Health Services Committee.

LTI participants will also be assigned one or more LTI performance objective(s) for each three-year performance period. The LTI performance objective(s) will require longer-term, multi-year efforts to achieve. LTI performance objectives must contain details that define Threshold, Target, and Maximum performance and include metrics and benchmarks, as appropriate. The LTI performance objectives will be established by the President, who will consult with the Chair of the Regents' Health Services Committee.

All performance objectives must be SMART (specific, measureable, attainable, relevant, and time-based). Assessment of participants' performance and contribution relative to these objectives will determine their actual award amount.

Peer group and/or industry data must be used where appropriate to provide a benchmark and performance standard. Performance objectives at the Clinical Enterprise and Institutional levels are typically measured against relative peer/industry benchmarks in the market. Where an established internal or external benchmark is used, baseline metrics must be included to enable a determination of the degree to which the intended results would require stretch performance. The Chief Human Resource Officer at each Health System will be responsible for ensuring that all Individual/Departmental objectives for participants at that location meet the SMART standards before obtaining sign-off from the CEO and Chancellor. The STI and LTI performance objectives for all participants will be subject to review and approval by the AOC prior to the beginning of the Plan year or as soon as possible thereafter. The AOC will consult the Senior Vice President – Chief Compliance and Audit Officer in an independent advisory capacity during its review of Plan participants' objectives.

The participants' performance toward their assigned STI objectives may be measured across three organizational levels as noted above (Systemwide Clinical Enterprise, Institutional, and Individual/Departmental) and will be weighted according to the percentages listed in the table below.

Weighting of STI Annual Objectives

Position Level within Organization	Systemwide Clinical Enterprise Level	Institutional Level	Individual and/or Departmental Level
EVP – UC Health	100%	0%	0%
Health System Chief Executive Officers	50%	50%	0%
Other “Chief Levels” and Other Key Senior Clinical Enterprise Leadership	30%	50%	20%
Other UC Health Leadership	80%	0%	20%
Other Clinical Participants	20%	50%	30%

The supervisor of each Plan participant will provide him/her with: (a) the participant’s performance objectives for the Plan year, (b) the performance standards that will be used to measure Threshold, Target, and Maximum performance for each objective, (c) the performance weightings that will apply to the participant’s performance objectives, and (d) a copy of this Plan document.

10. PLAN FUNDING AND MINIMUM THRESHOLD FOR FINANCIAL STANDARD

Full funding of STI awards for participants at a Health System in the plan year is contingent upon that Health System’s ability to pay out the awards while maintaining a positive cash flow ~~income~~ from operations before intra-institutional transfers and depreciation. This minimum threshold financial standard is based on Modified Operating Income (Loss) which is Revenue less Expenses, excluding the non-cash portion of Other Post Employment Benefits (OPEB) as reported to the Regents’ Health Services Committee.

In the event that the Health System cannot meet that financial standard for the Plan year, and the Health System attains key Institutional non-financial objectives, the AOC may consider and approve, in consultation with the Chancellor and EVP – UC Health, partial STI award payouts for some or all of that Health System’s Plan participants based on the Award Opportunity Levels defined above and participants’ achievement of their assigned STI performance objectives for the Plan year.

11. INCENTIVE AWARD ELIGIBILITY CRITERIA

Participants must be active full-time employees of the University at the conclusion of the Plan year (i.e., as of midnight on June 30th) to be eligible to receive an STI award for that Plan year, unless the circumstances of their separation from the University entitle them to a full or partial award as set forth in the Separation from the University provision below in Section 13.

LTI participants must be active full-time employees at the conclusion of the three-year period associated with an LTI performance objective (i.e., as of midnight on June 30th of the third year) to be eligible to receive an LTI award for that period.

Participants must have at least a “Meets Expectations” or equivalent overall rating on their performance evaluation for the Plan year to be considered for an STI award under the Plan for that Plan year or an LTI award for the performance period that concludes at the end of that Plan year. A manager may reduce or eliminate an award according to the participant’s overall performance rating with the approval of the AOC. However, an overall performance rating below “Meets Expectations” will eliminate the total award for that participant for that Plan year or performance period.

A participant who has been found to have committed a serious violation of state or federal law or a serious violation of University policy at any time prior to distribution of an STI or LTI award will not be eligible for such awards under the Plan for that Plan year and/or performance period. If such allegations against a participant are pending investigation at the time of the award distribution, the participant’s award(s) may be withheld pending the outcome of the investigation. If the participant’s violation is discovered later, the participant may be required to repay awards for the Plan years and/or performance periods in which the violation occurred.

Likewise, when it has been determined that a participant’s own actions or the participant’s negligent oversight of other University employees played a material role in contributing to a serious adverse development that could harm the reputation, financial standing, or stability of the participant’s Health System (*e.g.*, the receipt of an adverse decision from a regulatory agency, placement on probation status, or the adverse resolution of a major medical malpractice claim) or, with regard to the EVP – UC Health and the Clinical Enterprise overall, the AOC has the discretion to decide that the participant will either not be eligible for an STI or LTI award under the Plan that year or will receive an award that has been reduced as a result of and consistent with the participant’s role with regard to the adverse development. If the participant’s role with regard to the adverse development is still under investigation at the time of award distribution, the participant’s award for the Plan year may be withheld pending the outcome of the investigation.

If the participant’s role in the adverse development is discovered later, the participant may be required to repay awards for the years in which the actions or negligent oversight occurred.

12. INCENTIVE AWARD APPROVAL PROCESS

At the end of each Plan year, proposed incentive awards will be submitted to the Executive Director, Systemwide Compensation Programs and Strategy. Except as set forth below. Awards amounts will be reviewed and approved by the AOC. Any incentive award for the EVP – UC Health will require the approval of the Regents’ Health Services Committee in addition to the approval of the AOC. The AOC will consult the Senior Vice President – Chief Compliance and Audit Officer in an independent advisory capacity during its review of proposed incentive awards. The AOC will provide the chair of the Regents’ Health Services Committee and the President with a listing of award recommendations before awards are scheduled to be paid. On

behalf of the AOC, the Executive Director, Systemwide Compensation Programs and Strategy will provide the President and the Regents with the award details in the Annual Report on Executive Compensation.

Approved incentive awards will be processed as soon as possible unless they have been deferred pursuant to the provision set forth below.

Annual incentive awards will be payable in cash, subject to appropriate taxes and pursuant to normal University payroll procedures. The participant's total University salary (which includes base salary and any stipends, but does not include any prior year incentive award payouts or disability pay) as of June 1st of the Plan year will be used in the calculation of the incentive award amount. The assigned Description of Service code of "XCE" specific to the Plan **must** be used when paying awards to Plan participants.

This Plan may be terminated or replaced at any time for any reason upon the recommendation of the President, in consultation with the Chair of the Regents' Health Services Committee. Reasonable efforts, given all circumstances, will be made to delay Plan termination until after the current Plan year has concluded. However, if the Plan is terminated during the Plan year, awards for the current year will still be processed based on participants' performance during the portion of the Plan year prior to termination.

Notwithstanding any other term in the Plan, current year incentive awards may be deferred if the Regents issue a declaration of extreme financial emergency upon the recommendation of the President or if the Systemwide Clinical Enterprise experiences a consolidated negative cash flow/income from operations before intra-institutional transfers and depreciation based on Modified Operating Income (Loss) which is Revenue less Expenses, excluding the non-cash portion of Other Post Employment Benefits (OPEB) as reported to the Regents' Health Services Committee. In such situations, the deferral would be made upon the recommendation of the AOC and require the approval of the President and the Chair of the Regents' Health Services Committee. In such a case the current year deferred awards will earn interest at the Short Term Investment Pool rate. Award payments that have been approved, but deferred, will be processed and distributed as soon as possible. In no event will awards be deferred longer than one year.

The University may require repayment of an award that was made as a result of inappropriate circumstances. For example, if there is an inadvertent overpayment, the participant will be required to repay the overage. If the participant has not made the repayment before an award for the employee for a subsequent Plan year is approved, the outstanding amount may be deducted from the employee's subsequent award.

13. SEPARATION FROM THE UNIVERSITY

The table below indicates whether a participant who separates from the University will be eligible to receive a full or partial STI award and also specifies when forfeiture of such awards will occur. Retirement will be determined based upon applicable University policies. In order to determine the most accurate STI award for the current Plan year, partial payments will be

calculated at the end of the Plan year and issued in accordance with the normal process and schedule.

Reason for Separation	Separation During Plan Year (i.e., on or before June 30, 201920)	Separation on or after July 1, 201920
Voluntary Separation for any reason other than retirement	<ul style="list-style-type: none"> Forfeiture of STI award for 2018-192019-20 Plan year. 	<ul style="list-style-type: none"> Payout of full STI award for 2019-20 2018-19 Plan year.
<ul style="list-style-type: none"> Retirement Medical separation due to disability Death* Involuntary separation due to reorganization or restructuring 	<ul style="list-style-type: none"> Partial STI award for 2019-20 2018-19 Plan year. 	<ul style="list-style-type: none"> Payout of full STI award for 2019-20 2018-19 Plan year.
Involuntary termination due to misconduct or inadequate performance	<ul style="list-style-type: none"> Forfeiture of STI award for 2019-20 2018-19 Plan year. 	<ul style="list-style-type: none"> Forfeiture of STI award for 2019-20 2018-19 Plan year.

*In such cases, payments will be made to the estate of the participant.

LTI awards are not eligible for full or partial payment if a participant separates from the University before the conclusion of the applicable three-year LTI performance period; forfeiture will occur.

14. TREATMENT FOR BENEFIT PURPOSES

Incentive awards under this Plan are not considered to be compensation for University benefit purposes, such as the University of California Retirement Plan or employee life insurance programs.

15. TAX TREATMENT AND REPORTING

Under Internal Revenue Service Regulations, payment of incentive awards under this Plan must be included in the participant's income as wages subject to withholding for federal and state income taxes and applicable FICA taxes. The payment is reportable on the participant's Form W-2 in the year paid.