UNIVERSITY
OF
CALIFORNIA
HEALTH

UC Health Strategic Investment Plan

Final Report

May 11, 2023

UNIVERSITY OF CALIFORNIA HEALTH

Contents

Working Group Charge and Membership

President Michael Drake and Executive Vice President *UC Health* Carrie Byington retained Manatt Health and charged a working group of health campus leaders to consider critical strategic priorities and establish a strategic investment plan for *UC Health*. This investment plan is intended to focus *UC Health* resources and activities on initiatives that benefit from collective action, and which will have positive impact for all health campuses and the Californians they serve. This report provides recommendations on strategic direction and priorities, the role of the Executive Vice President and division, enhancements to communications and decision-making processes, and budgetary/investment priorities and guidance.

During the planning process, Dr. Byington announced plans to transition out of the role in June 2023. In response to a request from the President, the working group also developed recommendations on the EVP job description.

The preparation of this report has included engagement across all levels of leadership of the University of California's health systems and schools and incorporated a review of the trends reshaping health care, a landscape scan of the State of California's health policy priorities, and a thorough review of *UC Health* programs.

Members:

- UC Davis: David Lubarsky (Vice Chancellor/CEO)
- UC Davis: Gary May (Chancellor)
- UC Irvine: Howard Gillman (Chancellor)
- UC Irvine: Chad Lefteris (CEO)
- UC Los Angeles: John Mazziotta (Vice Chancellor)
- UC Los Angeles: Johnese Spisso (CEO)
- UC Los Angeles: Lin Zhan (Dean - Nursing)
- UC San Diego: Steven Garfin (Interim Vice Chancellor/Interim Dean - Medicine)
- UC San Diego: Pradeep Khosla (Chancellor)
- UC San Diego: Patty Maysent (CEO)
- UC San Francisco: Sam Hawgood (Chancellor)
- UC San Francisco: Suresh Gunasekaran (CEO)
- UC Riverside: Deborah Deas (Vice Chancellor / Dean - Medicine)
- UC Merced: Juan Muñoz (Chancellor)
- UC Health: Carrie Byington (Executive Vice President)

Support:

- UC Health: Zoanne Nelson (Associate Vice President), Eileen Foster (Director)
- Manatt Health: Tom Enders, Naomi Newman, Zerrin Cetin

Findings and Recommendations

Strategic Priorities

Over the past decade, the health services delivery activities of the University of California have grown in scale and impact. Annual revenues from these activities now exceed $17 billion and represent approximately 40% of all revenues to the University of California. These revenues provide essential funding that substantially supports the cost of clinical training in the health sciences and building of the health care workforce to meet the demands for providers across our state.

The work of UC's health system is deeply intertwined with the University's academic and public service missions. UC Health is committed to delivering exceptional clinical care, especially to underserved populations, educating the future generations of health professionals, and conducting research that improves the health and quality of life for all Californians. UC Health is part of a complex health ecosystem in the US and the state and is subject to many external forces that influence our health centers. These forces include the aging population and increasing eligibility for Medi-Cal, growing disparities in access to care, extensive consolidation and vertical integration of insurers, workforce shortages and cost of labor, and consumer expectations of in-home, digital and hybrid care. The combined impact of these forces places major demands on clinical margins at a time when they are deteriorating due to the pandemic, workforce disruptions, and inflationary pressures.

Forces Reshaping the Health Care Environment

The UC health systems and health professional schools are at the forefront of innovation and workforce development, and investments will be required to maintain leadership and excellence. Simultaneously, federal and state policies are increasing access to insurance and care for Californians. However, these policies also create reimbursement challenges, with increasing regulation, desire to limit commercial price increases, and push for "accountability." In California, Medi-Cal and Medicare cover 38% of insured lives, a 10% increase in the past 10 years. Of the commercially insured lives, Kaiser now covers almost half (49%), with the remainder covered primarily by Blue Shield, Anthem and United.

Across the University, however, 71% of patient days are paid by government payers, an increase in mix from 63% government payer in 2016. Medi-Cal and Medicare days are reimbursed at a substantially lower rate per patient day as commercial/contract payers. As the payer mix across the health systems has so significantly shifted, the underlying economy of the health systems – and all the other programs and missions which depend on them – has become significantly more fragile.

These forces are occurring at an intense time of capital investment in clinical facilities which are estimated to total upwards of $13.7 billion through 2031 and include new hospital and ambulatory facilities at UC Davis, Irvine, Los Angeles, San Diego, and San Francisco. Clinical margins will also be essential for sustained leadership in research, investing in the next generation care models (including digital), expansion of educational programs to address workforce shortages, and improving access to care for vulnerable populations.

A comprehensive review of *UC Health* programs was completed[1] in the context of the landscape assessment. The *UC Health* division of the UC Office of the President has a budget of $37.8M of which approximately $25M or 66% is funded by the collaborative health systems. Of that amount, $11.5M is passed back to the campuses to fund personnel working on *UC Health* programs. The division includes 86 full time FTEs and 22 FTEs hired by other UC Health locations.

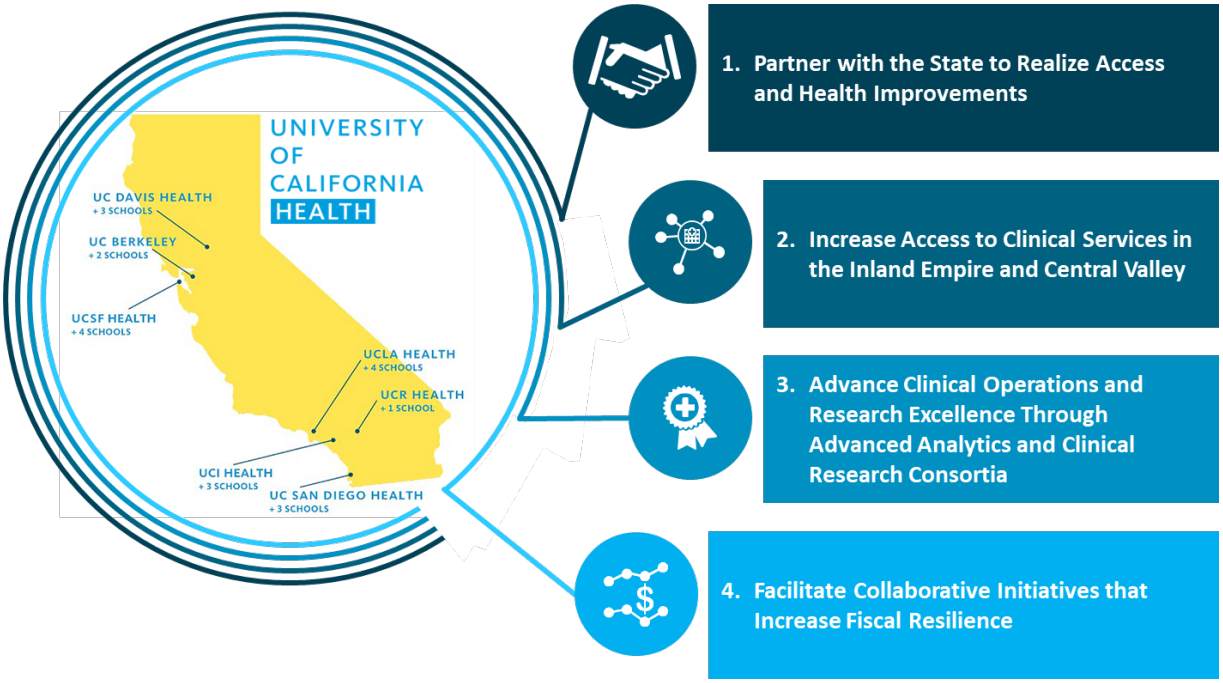
UC Health Division FY22-23 Budget by Fund Source

UC Health Department	Campus Assessment	Collaborative	Other Designated	Restricted	TOTAL
Academic Health Sciences	1,853,049	-	1,284,499	2,044,511	**$ 5,182,059**
Center for Data-Driven Insights & Innovation	-	7,372,301	-	-	**$ 7,372,301**
Clinical Strategy and Operations	629,590	3,985,593	6,000	57,660	**$ 4,678,844**
Leveraging Scale for Value	-	9,510,279	-	-	**$ 9,510,279**
Finance & Administration	1,657,508	3,354,490	317,229	68,757	**$ 5,397,984**
Health Policy & Regulatory Affairs	201,163	686,511	-	-	**$ 887,673**
Self-Funded Health Plans	-	-	2,102,821	3,083,319	**$ 5,186,139**
Vacancy Factor	(258,287)	-	-	(116,209)	**$ (374,496)**
UC HEALTH DIVISION TOTAL	**$ 4,083,022**	**$24,909,173**	**$ 3,710,549**	**$ 5,138,038**	**$ 37,840,783**
% of Total Budget	*11%*	*66%*	*10%*	*14%*	***100%***
Pass-through funding to Campus/MC	*190,880*	*11,593,795*	*873,799*	-	***$ 12,658,474***
Full-Time UCOP FTE	14	55	8	9	**86**
Full-Time Staff Hired by UCH Location	-	22	-	-	**22**
Location Experts Funded by UCH	3	60	11	-	**74**

A central theme of this planning process has been recognition that trade-offs across priorities must be made due to resource constraints and the *UC Health* agenda will need to be highly focused. Four priorities have resulted from the working group's review of the current and anticipated landscape and the collective needs of the health campuses.

[1] The working group did not discuss the following programs: the willed body program, Global Health Institute, the GME program, Student Health Services

UC Health Strategic Investment Priorities



Priority #1: Partner with the State to Realize Access and Health Improvements. The California Department of Public Health and the Department of Health Care Services have designated their priorities on reducing health disparities, improving health care affordability, improving maternal and behavioral health, reducing workforce shortages, and providing whole-person care across the lifespan. The State is investing $18.8 billion over the next five years to address these health priorities. Executing on a multi-part strategy to integrate the University's health service priorities with those of the State and the counties will require new collective action and competencies, such as a deepened knowledge of Medi-Cal financing, workforce development for different types of healthcare workers, and enhanced policy advocacy. With under 3% of the collaborative *UC Health* budget devoted to health policy and a limited presence in Sacramento, the health campuses are not well positioned to work in partnership with the State to advance mutual interests. Framing the University's health-related policy asks in alignment with the state's objectives will be critical.

Initiatives to support this priority include:

1.1 Engage with the State on CalAIM and Medi-Cal Access Strategies

1.2 Augment Workforce Development and Retention Strategies for Underserved Geographies and Shortage Disciplines

1.3 Pursue Other State and Federal Policy Priorities

See Appendix A for more detail.

Priority #2: Increase Access to Clinical Services in the Inland Empire and Central Valley. The President articulated the priority of "Promoting Health Across California, Including Its Most Vulnerable Communities" with the aspiration of improving the health of Californians now and in the future by promoting health equity across the state and expanding access to UC provided care. All UC health systems currently engage in activities to advance this goal in their local markets and will continue to do so. The need for high quality health services across the state is greater than the University alone can meet. However, the University is present in two high need Health Professional Shortage Areas: UC Riverside in the Inland Empire, and UC Merced in the Central Valley. The UC Riverside and proposed UC Merced schools of medicine are community-based medical schools, with the significant disadvantage of not having an owned or highly affiliated ambulatory or inpatient clinical service. This important limitation prevents the full realization of the potential of each medical school campus. Developing clinical resources and services plans in the Inland Empire and Central Valley in coordination with campus development will be required to meet the long-term requirements of each campus while also increasing needed access to healthcare services and advancing the University's equity goals. Developing clinical services, including primary care, specialty services delivered in ambulatory settings, and potentially inpatient hospital services, will require coalition building to bring together county, State, and University resources to bear in novel partnerships. Recent hospital closures in these and adjacent markets accentuate the need for a coordinated strategy.

Initiatives to support this priority include:

2.1 Develop Clinical Resources in Inland Empire

2.2 Develop Clinical Services Plan for Central Valley

See Appendix A for more detail.

Priority #3: Advance Clinical Operations and Research Excellence through Advanced Analytics and Clinical Research Consortia. Over the past decade, UC Health has launched several collaborative initiatives on clinical and research excellence:

- **The Center for Data-driven Insights and Innovation (CDI2)** was started five years ago as a UC-wide data asset which includes data from nearly 9 million patients and UC self-funded health plan claims. This data now provides the basis for powerful analytical capabilities which CDI2 is delivering and enables *UC Health* to be the collaboration hub for a data-driven learning health system. CDI2 has reached a critical mass of data and capability whereby it can inform and support care quality, patient safety, population health, health equity and enable the next generation of clinical research. Importantly, CDI2 served an essential role during the COVID pandemic by providing rapid data to support *UC Health* and state level decision makers. Thus CDI2 is well positioned to support the state in future endeavors developing real-word evidence and informing state policy. CDI2 is also well positioned to support clinical research efforts across all UC campuses and locations including large scale surveillance of drug outcomes. To enhance the return on investment to the investing campuses, CDI2 should function as a core resource and facilitate access to its data and tools by researchers at each health location.
- **The UC Cancer Consortium** remains an early but promising initiative to improve cancer outcomes by leveraging expertise and shared resources. Return on investment will be

augmented by a results-oriented emphasis on clinical data infrastructure for precision oncology, multi-campus clinical trials coordination, and specialized support for pharmacy, reporting, and other selected services.

- **Consortia on population health and clinical quality** have driven improvements in diabetes and hypertension care, cardiac surgery outcomes, and information-sharing and best practice development in areas of emerging science such as long-COVID – to name just a few of the results. Continuing to foster cross-system expertise sharing supports each health system's objectives of being a "learning health system."

Initiatives to support this priority include:

3.1 Expand the Center for Data-Driven Insights & Innovation (CDI2)

3.2 Support Cancer Consortium Collaboration Agenda

3.3 Continue Population Health and Clinical Quality and Operations Consortia

See Appendix A for more detail.

Priority #4: Facilitate Collaborative Initiatives that Increase Fiscal Resilience. As noted, fiscal resilience in the face of escalating revenue and cost challenges will be critical to each of the health campus's operating performance.

- *To optimize revenues,* the Managed Care Contracting Collaborative negotiates $8B (and increasing) of managed care contracts on behalf of the UC health systems – Anthem, Blue Shield and United are the largest payers. The contracting initiative has worked well and there is value in continuing to work together on commercial contracting, with additional yield from integrating the commercial contracting strategy with the self-funded plan's TPA strategy, and other strategies that interface with commercial payers (e.g., Revenue Cycle). Attention to pursuing new contracting opportunities, such as promoting greater use of the UC health systems by CalPERS plans, and strategic partnerships with Kaiser, will also be important. As a revenue diversification strategy, the health systems are interested in exploring together entry into the Medicare Advantage market – including evaluating opportunities to leverage common risk and population health management infrastructure.
- *To optimize cost management,* the Leveraging Scale for Value (LSfV) collaboration has produced consistently positive returns. Further gains can be made through efforts to address contract labor strategies, share scarce human resource specialty services, and optimize capital spending. Systemwide contingent labor spend in CY22 was over $400M, and nursing represented the largest category. There is currently variation in rates of up to 67% by campus, and the goal is to narrow campus rate variation to 10-15%. There is also an important opportunity to generate savings by creating systemwide capital equipment forecasts and group buy initiatives. Medical equipment replacement averages about $125M annually, and new medical equipment requirements are expected to be about $1B+ over five years.
- T*o optimize access to capital*, the health systems have benefited from going to the debt markets as a single obligated group. Sustaining the integrity of the obligated group will be critical as the

health systems bring $13B of major capital projects online over the next decade. These projects will ensure health systems meet seismic requirements and better serve their communities.

Initiatives to support this priority include:

4.1 Enhance Integrated Commercial Payer Strategy

4.2 Explore Medicare Advantage Entry

4.3 Launch Next Wave of Cost Savings Collaborations

4.4 Enhance Integrity of Health Systems' Obligated Group

See Appendix A for more detail.

Strategic Investment Considerations

Notwithstanding these important opportunities for collective action, several of which require incremental investment to pursue, due to financial constraints the FY24 Collaborative Budget Proposal reflects no increase. Any new investment commitments will be discussed with the incoming *EVP UC Health* and in the context of the FY25 and subsequent budgets.

The initiatives with high potential financial return include:

- Engaging with the State to facilitate enhanced Medi-Cal access and commensurate reimbursement through increases in the Enhanced Payment Program Rates. Positive results in this effort could yield substantially increased reimbursement for Medi-Cal inpatient, outpatient, and professional services and support the initiatives to improve access to the underserved in the Inland Empire and Central Valley.
- Aligning workforce development and education agenda with State priorities, with the potential for additional funds for PRIME and grants for training initiatives.
- Enhancing an Integrated Commercial Payer Strategy.
- Implementing the next wave of cost savings initiatives with emphasis on capital optimization, and contract labor spend.

When prioritizing investments, consideration should be given to increasing and/or reallocating the general campus assessment to support health-related initiatives that meet a Presidential priority that require seed funding and do not support a near-term financial ROI. Examples of such initiatives include:

- Collaborative priorities that can yield significant research benefit, such as a clinical trials network.
- Feasibility assessment of Medicare Advantage start up.
- Prototyping of artificial intelligence capabilities with CDI2.
- Investments in the clinical enterprises of UCR and UCM.

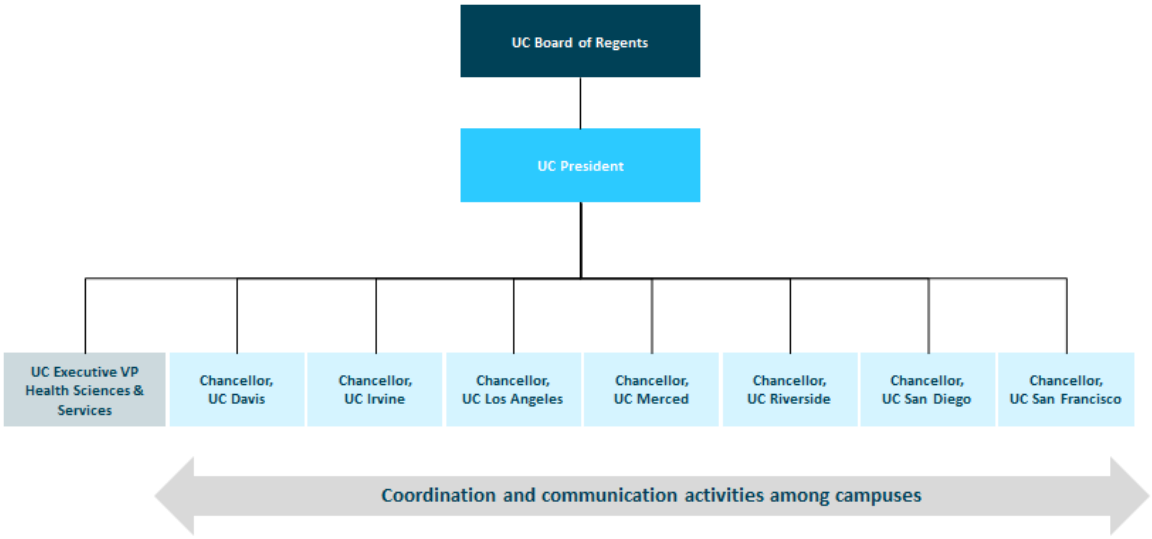
Collaborative funding for *UC Health* today comes from health system contributions. Consideration should be given to also including funding from the Deans and Vice Chancellors to support educational and research priorities.

Organization and Operation of UC Health

The UC President reports to the Board of Regents. The health systems report up through their respective campus Chancellors who in turn report to the President. The Chancellors have responsibility for all the health services and related activities which occur on their campus. They oversee the cross-subsidies from clinical activity which support the education and research functions.

UC Health is a division of UCOP that provides certain functions to the health campuses and also serves to coordinate activities across them. The EVP does not have authority over the health system operations, nor do they have budget authority beyond that of the UC Health Division of UCOP itself.

Health Services Management Model



The Health Services Committee (HSC) of the UC Board of Regents has primary governance jurisdiction over the strategic plans and budgets for the clinical services of the respective campuses, as well as oversight for patient care quality, cost, and access. The HSC also has purview of executive appointments and compensation for health-related clinical and academic Senior Management Group members and can delegate authority to the President within specified parameters.

In addition to their other responsibilities, the EVP of *UC Health* serves as a spokesperson for health system activity and collaborative initiatives at the HSC meetings and reports on the patient quality, safety, and financial status of the health campuses.

Role of the EVP

In the preparation of this report, and at the request of the President, the working group and Manatt reviewed the EVP role in the context of the strategic priorities enumerated above, prepared a summary job description as input to the search process, and considered the qualifications required.

Reporting to the President of the University of California, the Executive Vice President (EVP) is a responsible member of the executive leadership team in the Office of the President and supports the President's goals, objectives, and priorities in health areas. The EVP maintains collaborative relationships

with the Chancellors, Vice -Chancellors of Health, health professions Deans, and Academic Medical Center CEOs.

The EVP has the following responsibilities:

- Represent UC Health and serve as spokesperson for the health campuses to the UC Regents and external stakeholders.
- Lead an effective coalition across the UC's health campuses for solutions and initiatives which position UC as a partner to the State on public health and health care priorities.
- Facilitate collaboration amongst the campuses, advance distinctive programs, and increase access to the underserved.
- Oversee and maintain an effective organization, directing the selection, employment, compensation, and evaluation of employees in areas of direct responsibilities.

The EVP serves a pivotal role in developing the strategies for collective action and in their execution. Their role includes:

- Provide government relations leadership, contracting expertise and facilitation, and select shared services implementation for the collective health enterprise.
- Represent UC in State and Federal health care forums.
- Cultivate coordination amongst the campuses to improve health sciences education, research, patient care, and community collaboration.
- Ensure the facilitation and execution of a UC Health strategy to stabilize and sustain the clinical enterprises at UC Riverside and UC Merced.
- Develop and ensure the implementation of the UC Health Strategic Plan.
- Catalyze transformational change, linking stakeholders and finding common needs and goals to create alignment and achieve superior results.
- Represent the health campuses in UCOP Labor Relations strategies and initiatives.
- Coordinate a UC Health obligated group and develop strategies for optimal capital/debt allocation among campuses.

The relevant experience of the EVP should include the following:

- A proven physician leader in an academic medicine environment with relevant health care financing, policy, and advocacy expertise.
- A visionary and strategic thinker with demonstrated ability to work collaboratively with faculty, staff, and administrative leadership.
- A senior leader with first-hand experience in, knowledge of, and appreciation for the research, education, clinical, and community missions of a preeminent academic health system.
- Extensive knowledge and experience with the complexities of health care financing including Medicaid and Medicare.
- Proven experience with complex contracting negotiations and commercial payer relationships.
- Experience building coalitions and establishing effective working relationships with legislatures, State health officials, associations, and other external stakeholders.

Communication Channels and Processes

The EVP and the *UC Health* team interface with myriad stakeholders who govern, oversee, are accountable for, or operate within UC's extensive health enterprise. To fully implement the strategic priorities outlined in this report, robust management systems and communications channels will be critical to success.

The following are recommendations to enhance current processes:

1. *Augment opportunity for leadership discussion on critical health services strategic and operational oversight issues*. Given the scale of the health services, regular meetings amongst the Chancellors, the Vice Chancellors, the CEOs, and the EVP as a group will support greater alignment on important strategic issues. This change from current practice can be achieved by instituting a monthly meeting for this purpose.
2. *Align campus-based initiative leads more closely with UC Health.* Where there is advantage, initiative leaders should be campus-based, thus drawing on and leveraging campus resources while also knitting together the collective actions of *UC Health*. In these instances, there should be clear and documented expectations and lines of dual reporting to both the campus leadership and to a designated *UC Health* leader, whether the EVP or a member of the *UC Health* team.
3. *Formalize calendar of reporting on UC Health initiatives*. Initiative owners should report out at least quarterly to the leadership team during the monthly meetings with Chancellors. This will ensure that Chancellors, Vice Chancellors, and CEOs have visibility into the value *UC Health* is delivering, surface concerns about reporting and/or performance, and foster greater alignment around shared strategic objectives.
4. *Increase engagement between the EVP, AVP Academic Health Sciences, and deans to implement workforce and training initiatives.* The health professions deans expressed a desire to convene both within and across disciplines around a bold vision responding to the State's healthcare workforce development and training challenges.
5. *Maintain existing forums for communication and coordination on UC Health initiatives,* including
    - Bi-weekly EVP-President meetings
    - Monthly EVP-UCOP Government Affairs lead
    - Monthly EVP Managed Care Contracting Chair, Vice Chair, and Outside Counsel
    - Weekly EVP-UC Health direct reports meetings and bi-weekly one-on-one meetings.
6. *Establish an annual review and update to the UC Health strategic priorities.* The three-year strategic planning process is the formal vehicle for surfacing and discussing opportunities for collaborative action. Given the rapid pace of change in the health arena, augmenting this formal process with an annual update and retreat of leadership is recommended. Establishing an annual review of priorities and progress will allow tighter alignment between *UC Health* activities and health system leadership and can support the annual budget process. An annual review of priorities should have representation from the Chancellors, Vice Chancellors, CEOs, Deans, and the EVP and should result in recommendations to the President to maintain, augment or pivot *UC Health's* priorities.

Appendix A: Detailed Recommendations

Priority #1: Partner with the State to Realize Access and Health Improvements

Strategies	Rationale	Tactics
1.1 Engage with the State on CalAIM and Medi-Cal Access Strategies	With Medi-Cal now covering one in three Californians, the state engaging in major reform efforts aimed at advancing whole-person care for people with Medi-Cal, and the health systems experiencing significant Medi-Cal funding shortfalls, a focused Medi-Cal access and reimbursement strategy will be critical to the UC's mission to advance equity in a financially sustainable manner. UC Health needs to articulate to the State what investments in the UC system will do for Californians' health and demonstrate that it will provide a good return on investment.	**1.1.1 Develop whole-person care models and pursue CalAIM contracts** (e.g., establish the contracts and competencies to serve as Enhanced Care Management (ECM) providers, and coordinate with Medi-Cal managed care plans, including those that serve dual-eligibles.) **1.1.2 Engage with the state to optimize Medi-Cal revenue opportunities in conjunction with increased access initiatives** – areas of focus include the following supplemental payment and other opportunities: ▪ Increases in Enhanced Payment Program (EPP) Rates for UC Health Provider Class, resulting in the potential for adjustments in Medi-Cal inpatient, outpatient, and physician service payments to enhanced rates ▪ Quality Incentive Program (QIP) ▪ Graduate Medical Education (GME) ▪ Rate range ▪ Physician Upper Payment Limit (UPL) **1.1.3 Design and launch a communications campaign and legislature engagement plan**, including working with the Regents to identify key stakeholders and messaging regarding the health systems' safety net role, case studies of engagement (e.g. Homeless health initiatives; subspecialty access initiatives), and commitment to serving Medi-Cal beneficiaries under the Cal-AIM reform initiative.

Strategies	Rationale	Tactics
1.2 Augment Workforce Development and Retention Strategies for Underserved Geographies and Shortage Disciplines	The California Future Health Workforce Commission estimates that 7 million Californians—one in five residents—live in a Health Professional Shortage Area (HPSA), a federal designation for counties experiencing a shortage of primary care, dental or mental health care providers. And these shortages disproportionately impact communities of color. As a major source of training for medical, nursing, and allied health professions, the University of California is well-positioned to work with the state to develop innovative programs to tackle this challenge.	**1.2.1 Expand PRIME program:** ▪ Develop proposals to secure full funding for and expand Medicine program ▪ Expand PRIME model to other health professions (Dentistry, Nursing, Public Health, Optometry, Pharmacy, Veterinary Medicine) **1.2.2 Implement workforce development and retention initiatives in shortage geographies and disciplines.** ▪ **Primary Care:** Expand training sites and positions in healthcare workforce shortage areas ▪ **Behavioral Health:** Increase the number of state-funded trainee positions in public health and mental health to address the State's needs, particularly those of vulnerable populations ▪ **Reproductive Care:** Expand the training opportunities in public health and services dedicated to improving access to comprehensive, evidence-based reproductive healthcare ▪ Implement evidence-based policies, programs and resources to promote recruitment and retention of diverse faculty, trainees and staff ▪ Advocate for investments to expand and strengthen UC training infrastructure – space & facilities, recruitment & retention, clinical placements & preceptorships **1.2.3 Coordinate response to state grant opportunities:** ▪ Actively disseminate information about the state's workforce grants to promote all eligible schools to apply ▪ Work with the Department of Health Care Access and Information (HCAI) to

Strategies	Rationale	Tactics
		shape future workforce development opportunities related to shortage disciplines (e.g., behavioral health, primary care, and reproductive care) **1.2.4 Assess opportunities and support related business planning to develop training programs that align with the state's needs for a lay workforce** (e.g., CHWs)
1.3 Pursue Other State and Federal Policy Priorities	The University of California developed a strong working relationship with the state during the COVID pandemic and can build on it to expand collaboration on health security and public health preparedness. A targeted Federal health policy agenda is also critical considering the growing importance of government payers.	**1.3.1 Coordinate with State on health security & public health preparedness** **1.3.2 Sharpen federal advocacy agenda on health topics, with a focus on Medicare and Medi-Cal reform initiatives**

Priority #2: Increase Access to Clinical Services in the Inland Empire and Central Valley

Strategies	Rationale	Tactics
2.1 Develop Clinical Resources in Inland Empire	Developing clinical resources and services plans in the Inland Empire and Central Valley in coordination with campus development will be required to meet the long-term requirements of each campus while also increasing needed access to healthcare services and advancing the University's equity goals. Developing clinical services, including primary care, specialty services delivered in ambulatory settings, and potentially inpatient hospital services, will require coalition building to bring together county, State, and University resources to bear in novel partnerships.	**2.1.1 Formalize UCR-UCI-UCLA-UCSD collaboration** and potentially joint-venture on clinical services to develop multispecialty ambulatory care and other services **2.1.2 Build out UCR FQHC network** **2.1.3 Innovate a county and State funding model** for developing and sustaining physician and clinical services in Inland Empire (inpatient and outpatient)
2.2 Develop Clinical Services Plan for Central Valley		**2.2.1 Develop Clinical Services Plan, educational infrastructure and faculty for Central Valley**, to augment placement opportunities for trainees in the UC Merced and UCSF Fresno programs.

Priority #3: Advance Clinical Operations and Research Excellence Through Advanced Analytics and Consortia

Strategies	Rationale	Tactics
3.1 Expand the Center for Data-Driven Insights & Innovation (CDI2)	CDI2's clinical database and the team's advanced analytics have already demonstrated value in clinical care (promoting standardization to best practice and supporting quality reporting), cost management (identifying opportunities to better manage inpatient drug spend, medical device purchases), and research (supporting researchers in securing over $60M in NIH funding, supporting 17 COVID-related research publications). With continued investment, it can augment its advanced analytics capabilities to ensure the University of California stays at the forefront of the rapidly evolving application of analytics and artificial intelligence in health care.	**3.1.1 Enhance Advanced Analytics Capabilities to Support Clinical and Research Priorities:** ▪ **Quality Reporting:** Develop Vizient dashboards for CMO/CNOs and other resources ▪ **Operational Initiatives:** Address reference lab send-out practices and other efficiency opportunities ▪ **Clinical Strategies:** Build out cancer data points – such as tumor stage and genomic test results – into the data warehouse; support lung cancer consortium on screening program ▪ **Local Population Health Strategies:** Augment Medicare Advantage claims analytics ▪ **Research Initiatives:** Pilot use of data warehouse for clinical trial participant recruitment; deepen relationship with CDPH; facilitate access to data, services, and tools for researchers across the University and develop education materials to augment self-serve use of data warehouse ▪ **Data Governance**: Complete systemwide recommendations for responsible and safe large-scale data collaborations; create centralized resources **3.1.2 Launch Real World Evidence (RWE) Strategy** ▪ Create a forum for knowledge sharing ▪ Invest in business development capability to foster research and

Strategies	Rationale	Tactics
		commercialization partnerships with external stakeholders ▪ Create RWE products/services ▪ Evaluate national data aggregators (Optum, nFerence, Truveta) **3.1.3 Launch Radiology Initiatives** ▪ Establish cross-credentialing to enable cross-reads, with goal of addressing staffing challenges and reducing dependency on third parties ▪ Launch AI proof-of-concept pilot focused on chest X-rays, including developing "sandbox" for R&D to build the best chest X-ray AI algorithm.
3.2 Support Cancer Consortium Collaboration Agenda	The University of California Cancer Consortium (UCCC) is a collaboration across the University's five NCI-designated cancer centers, launched as response to then Vice President Biden's "cancer moonshot." Investment is required for the consortium to execute on its strategic agenda: • **Data & Precision Oncology:** Strengthen UC-wide cancer data infrastructure and precision oncology to benefit patients. • **Systemwide Collaborations:** Foster systemwide consortia, team science, and multi-campus clinical trials to advance clinical care for specific tumor types and patient populations. • **Cancer Clinical Business:** Enhance cancer clinical	**3.2.1 Data & Precision Oncology:** ▪ Enhance UC-wide clinical data infrastructure: genomics, cancer registry ▪ Support UCCC Molecular Tumor Board ▪ Support User engagement and data exploration **3.2.2 Systemwide Collaborations:** ▪ Develop multi-campus clinical trials infrastructure and launch operations ▪ Launch strategic projects in quality and clinical care **3.2.3 Cancer Clinical Business:** ▪ Conduct business analysis and planning for virtual second opinion network ▪ Develop marketing plan to market UC Health systemwide cancer care message ▪ Launch cost-saving projects in pharmacy and procurement

Strategies	Rationale	Tactics
	business operations through marketing collaborative outcomes, developing business cases for systemwide initiatives such as virtual second opinion. • **Centralized Operations:** Enhance organizing function to implement initiatives and coordinate systemwide opportunities, including policy activities.	**3.2.4 Centralized Operations:** ▪ Support operational and programmatic coordination ▪ Provide specialized support: pharmacy, business ▪ Conduct policy and advocacy support for the campuses ▪ Conduct centralized reporting and administration
3.3 Continue Population Health and Clinical Quality and Operations Consortia	*UC Health*-supported consortia on population health and clinical quality have driven improvements in diabetes care, cardiac surgery outcomes, and information-sharing and best practice development in areas of emerging science such as long-COVID – to name just a few of the results. Continuing to foster cross-system expertise sharing supports each health system's objectives of being a "learning health system."	**3.3.1 Maintain support for population health and clinical quality and operations consortia**

Priority #4: Facilitate Collaborative Initiatives that Increase Fiscal Resilience

Strategies	Rationale	Tactics
4.1 Enhance Integrated Commercial Payer Strategy	Supporting negotiations for over $8 billion in managed care contracts, *UC Health's* coordination of payer negotiations on behalf of the health systems has yielded great value over the past decade, with potential for continued upside. With such a highly consolidated payer landscape, establishing strategic relationships with payers is a critical strategic priority.	**4.1.1 Develop an Integrated Commercial Payer Strategy** ▪ Assign executive leader reporting to the EVP to develop and execute an integrated commercial payer strategy across the Managed Care Contracting Collaborative, Revenue Cycle, and Systemwide HR Benefits functions. ▪ Support the EVP and CEOs in executive-level discussions with payer partners, as needed. **4.1.2 Continue Collaborative Contracting Model** ▪ Re-affirm principles of the all-UC Commercial Contracting strategy ▪ Continue work on increasing data transparency in the contracting process. **4.1.3 Strengthen Strategic Relationships with Commercial Payers** ▪ Initiate system-system discussions on partnership opportunities to serve the Tertiary/ Quaternary out-referral needs of Kaiser members (with initial focus on UC employee care). **4.1.4 Align Self-Funded Plan Strategy with Commercial Contracting Strategy & Health System Objectives:** Collaborate with UC Systemwide Human Resources Office on the following priorities: ▪ **Strategic alignment on vendor management:** • Coordinate TPA strategy with broader Commercial contracting strategy; • Align TPA networks with regional ACO/CIN networks;

Strategies	Rationale	Tactics
		▪ **Benefit design and employee incentives:** • Enhance cost competitiveness of self-funded plan options; • Market self-funded plan options to new hires; ▪ **Enhancing program infrastructure**: • Retain executive level health plan expertise; • Augment financial risk management capabilities; • Develop financial and operational data tools for risk management
4.2 Explore Medicare Advantage Entry	Currently Medicare Advantage represents 58% of Medicare lives in the counties with UC locations, but only 12% of health systems' patient population. Becoming effective at managing population health and financial risk is critical to evolving towards the value-based payment models of the future and ensuring market relevance in a market that is migrating towards managed care.	**4.2.1 Support Medicare Advantage Direct Entry Feasibility Assessment and Business Planning:** Coordinate business planning and best practice sharing for direct entry into Medicare Advantage and evaluate opportunities to leverage common risk and population health management infrastructure.
4.3 Launch Next Wave of Cost Savings Collaborations	The LSfV program is an existing collaborative effort targeting cost management strategies. The program is currently able to target 30% of UC Health's $17.1B expense base – medical supplies, other supplies, and	**4.3.1 Supply Cost Management:** Continue current LSFV supply cost savings initiatives with emphasis on "best price" and standardization of contracts for large spend commodity items **4.3.2 Capital Equipment Spend Management**: Coordinate on capital equipment contracting opportunities, including

Strategies	Rationale	Tactics
	purchased services. The working group recommends launching the next wave of savings collaborations in the areas of capital equipment purchasing, oncology drug purchasing, contract nursing, coding FTEs, and cross-credentialing.	synchronization of major equipment purchases for new hospital and ambulatory replacements and expansions at Davis, Irvine, Los Angeles, San Diego, San Francisco, Riverside, and Merced. **4.3.3 Contract Labor Spend Management:** Engage in select labor purchasing coordination activities, starting with agency nursing, focusing on achieving health system rate cards within 10% of each other and securing savings on agency fees **4.3.4 Shared Services for Select Back-Office Functions:** Explore coordination of resources such as a shared pool for billers/coders and/or other high value scarce resources.
4.4 Enhance Integrity of Health Systems' Obligated Group	The health systems have benefited from going to the debt markets as a single obligated group. Sustaining the integrity of the obligated group will be critical as the health systems bring $13B of major capital projects online over the next decade.	**4.4.1 Enhance Integrity of Health Systems' Obligated Group** to support major capital projects that ensure health systems meet seismic requirements and better serve their communities – including revisiting the "first-come-first serve" approach to debt allocation and including health campus Chancellors in decisions related to the obligated group.

Appendix B: Working Group Process

The Working Group met seven times from December 2022 through March 2023. The table below highlights discussion topics by meeting.

Date	Agenda
12/5/22 (3 hours)	Review national and California health care trends, define requirements for success of health enterprise, articulate a vision for the future for UC Health, identify highest priority areas for collective action
12/14/22 (1.5 hours)	Discuss evolution of UC Health priorities and programs in relation to requirements for the future: ○ Leveraging Scale for Value (Dougie Graham) ○ Other Cost Savings Opportunities (Dougie Graham)
1/11/23 (3 hours)	▪ Discuss evolution of UC Health priorities and programs in relation to requirements for the future: ○ Cancer Consortium (Anne Foster) ▪ Discuss policy priorities and how best to advance them with the State ○ Medi-Cal Access & Reimbursement Strategy (Santiago Muñoz) ▪ Engagement Update from the President and Discussion (Michael Drake)
1/30/23 (3 hours)	▪ Introduce emerging strategic framework and investment considerations ▪ Discuss evolution of UC Health priorities and programs in relation to requirements for the future ○ Operationalizing Access to Care in the Inland Empire and Central Valley (Deborah Deas, Juan Muñoz) ○ Integrating the Commercial Payer Contracting Strategy with the Self-Funded Plan Strategy (Zoanne Nelson)
2/15/23 (3 hours)	▪ Review EVP role survey results ▪ Discuss evolution of UC Health priorities and programs in relation to requirements for the future: ○ Academic Health Sciences: Workforce and Education (Deena McRae) ○ Integrated Commercial Payer Strategy (Zoanne Nelson) ○ Population Health and Care Management Models, MA Plan Development (Anne Foster, Sam Skootsky) ▪ Review updates to the Strategic Framework
3/03/23 (3 hours)	▪ Report-outs on areas of emerging strategic priorities (investments required / anticipated return): ○ Leveraging Scale for Value (Dougie Graham) ○ UC Riverside Clinical Strategy (Deborah Deas) ○ Medi-Cal Strategy (Santiago Muñoz) ○ Cancer Consortium (Michael Teitell) ▪ Updated Strategic Framework ▪ Discussion on Role of the EVP and UC Health ▪ Collaborative CY22 Performance & FY24 Budget Proposal Updates
3/10/23 (1 hour)	▪ Current State and Future Directions for Center for Data-Driven Insights and Innovation (CDI2) ▪ Input to President on EVP Job Description

The following provided input into the strategic planning process via interviews and focus groups conducted by Manatt Health:

- Health Services Committee, Board of Regents, University of California:
    - John Pérez (Chair)
    - Jonathan "Jay" Sures (Vice Chair)
    - Howard "Peter" Guber
    - Hadi Makarechian
    - Lark Park
    - Janet Reilly
    - Richard Sherman
- UC Office of the President
    - Michael Drake (President)
    - Rachel Nosowsky (Deputy General Counsel - Health Affairs & Technology Law)
    - UC Health
        - Atul Butte (Chief Data Scientist, Center for Data-driven Insights and Innovation)
        - Carrie Byington (Executive Vice President, UC Health)
        - Anne Foster (Chief Clinical Officer)
        - Dougie Graham (Chief Transformation Officer)
        - Tam Ma (Associate Vice President, Health Policy & Regulatory Affairs)
        - Deena McRae (Associate Vice President (Interim), Academic Health Sciences)
        - Santiago Muñoz (Lead, UC Health Medi-Cal Strategy)
        - Zoanne Nelson (Associate Vice President Of Finance & Administration)
        - Laura Tauber (Executive Director, UC Self-Funded Health Plans)
- Campus Representatives:

Campus	Chancellors	Vice Chancellors	CEOs	Health Sciences Deans
Berkeley				John Flanagan (Optometry) Michael Lu (Public Health)
Davis	Gary S. May	David Lubarsky		Susan Murin (Medicine) Stephen Cavanagh (Nursing) Mark Stetter (Veterinary Medicine)
Irvine	Howard Gillman	Steve A. N. Goldstein	Chad T. Lefteris	Michael Stamos (Medicine) Mark Lazenby (Nursing) Jan Hirsch (Pharmacy) Bernadette Boden-Albala (Public Health)
Los Angeles	Gene Block	John Mazziotta	Johnese Spisso	Paul Krebsbach (Dentistry) Steven Dubinett (Medicine) Lin Zhan (Nursing) Ronald S. Brookmeyer (Public Health)
Merced	Juan Sánchez Muñoz			

Riverside	Kim Wilcox	Deborah Deas	Donald Larsen	Deborah Deas (Medicine)
San Diego	Pradeep Khosla	Steven Garfin (Interim)	Patty Maysent	Steven Garfin (Medicine) Brookie Best (Pharmacy) Cheryl Anderson (Public Health)
San Francisco	Sam Hawgood	Suresh Gunasekaran		Michael Reddy (Dentistry) Talmadge King (Medicine) Catherine Gilliss (Nursing) Kathy Giacomini (Pharmacy)

Appendix C: Estimate of Planned Facility Investments

University of California Health | Project List ($ millions) [1]				
Medical Center	**Project**	**Spend Timing**	**Project Cost**	**Debt Financing**
Davis	Replacement Hospital Tower [2]	2024 – 2031	$ 3,700	$ 1,700
Davis	Sacramento Ambulatory Expansion	2022 – 2024	700	350
Davis	Folsom and Rocklin Health Complexes	2021 – 2022	275	275
Irvine	Irvine Campus Medical Complex	2021 – 2025	1,070	825
Los Angeles	Olympia Medical Center Acquisition and Remodel	2022 – 2024	450	450
Los Angeles	Unidentified Capital Needs	2022 – 2026	500	500
San Diego	Hillcrest Replacement Hospital [2]	2026 – 2031	1,500	1,500
San Francisco	Helen Diller Medical Center at Parnassus [2]	2021 – 2029	4,500	2,700
San Francisco	Benioff Children's Hospital Oakland Phase II	2021 – 2029	1,000	500
Total			**$ 13,695**	**$ 8,800**

(1) Excludes projects that are expected to be funded with 2020 Series N bond proceeds.
(2) Seismic projects.

Appendix D: State of California Health Priorities

State agencies are aligned on priority areas to improve health of Californians. The Department of Public Health and the Department of Health Care Services programs all focus on reducing health disparities, health care affordability, improving maternal and behavioral health, and providing whole-person care across the lifespan.

Let's Get Healthy California

- **Healthy Beginning**: Laying the foundation for a healthy life
- **Living Well**: Preventing and Managing Chronic Disease
- **End of Life**: Maintaining Dignity and Independence
- **Redesigning the Health System**: Efficient, Safe, and Patient-Centered Care
- **Creating Healthy Communities**: Enabling Healthy Living
- **Lowering the Cost of Care**: Making Coverage Affordable and Aligning Financing to Health Outcomes

"50 by 2025 Bold Goals" Initiative

- Close **racial/ethnic disparities** in well child visits and immunizations by 50%
- Close **maternity care disparity** for Black and Native Americans persons by 50%
- Improve **maternal and adolescent depression** screening by 50%
- Improve follow up for **mental health and substance use disorder** by 50%
- Ensure all health plans exceed the 50th percentile for all children's preventive care measures

CalAIM

- Identify and manage comprehensive needs through **whole person care** approaches and **social drivers of health**
- Improve quality outcomes, reduce **health disparities**, and transform the delivery system through **value-based initiatives**, modernization, and payment reform
- Make **Medi-Cal a more consistent and seamless system** for enrollees to navigate by reducing complexity and increasing flexibility