UNIVERSITY OF CALIFORNIA

COMMUNITY TIES

UC Health Report on Affiliation Impacts

MAY 2020

TABLE OF
CONTENTS

SECTION I

EXECUTIVE SUMMARY

In August 2019, President Napolitano convened the Working Group on Comprehensive Access (**WGCA**), which was charged with developing policy recommendations for affiliations with health systems that have policy-based restrictions on care to "ensure UC's values are upheld" and "to ensure that UC personnel will remain free, without restriction, to advise patients about all treatment options and that patients will have access to comprehensive services." In late December 2019, the Chair of the WGCA prepared a report that outlined two options discussed by the WGCA members.

Upon review of the WGCA Chair's report, President Napolitano asked Dr. Carrie L. Byington, the Executive Vice President of UC Health, to provide an analysis of the impacts of ending all existing agreements between UC's academic health centers or health professional schools and organizations that have non-evidence-based policy restrictions on care. The President also requested an analysis by Dr. Byington in her role as Chair of the Executive Steering Committee for the UC health benefits program of the potential impact that prohibiting affiliations with these types of health care providers would have on access to health care for our employees, retirees, students, and their families covered by UC's health plans.

The following report is submitted by UC Health in response to these requests from the President. The report evaluates the impact of a ban on affiliations with institutions that have policy-based restrictions on care on 1) patients across California who are served by UC Health, 2) UC employees, retirees, and students who receive health benefits through the UC System, 3) the education and training programs of our

health professional schools, and 4) the finances of UC Health. During the creation of the report, a global pandemic caused by the novel coronavirus SARS-CoV-2 began, and California was one of the first states in the nation to report cases. We have included a section that describes the role of affiliations during the pandemic and what we believe will be the continuing importance of affiliations after the pandemic in addressing health disparities.

Overall, our findings provide evidence of the importance of affiliations for UC Health in:

1. Delivering UC's public service mission to care for all the people of California, including the most vulnerable and patients in underserved areas of the state.

2. Providing access to care in areas that are otherwise underserved for all types of health services.

3. Increasing access to specialized services on-site that are often not otherwise available at community-based institutions.

4. Providing access to hospital services for UC employees, retirees, and students in California communities where other options are not available.

5. Fulfilling the educational mission of our academic health systems, especially UC Riverside's community-based medical school, with a mission to improve the health of the people of California and, principally, to serve inland Southern California by training a diverse workforce of physicians and by developing innovative research and health care delivery programs that will improve the health of the medically underserved in the region and become models to be emulated throughout the state and nation.

INTRODUCTION

A. THE IMPORTANCE OF AFFILIATION

UC Health affiliates with many organizations in California and beyond in service of our mission. Affiliations with institutions that have policy-based restrictions on care are an important part of UC's executing its mission to serve all the people of California. In California, Catholic facilities are often the most likely to provide care to medically underserved populations, because of their commitment to serve the poor. With 1 in 7 patients in the U.S. being cared for in a Catholic hospital, UC's isolating itself from major participants in the health care system would undermine our mission.

More broadly, affiliations between UC's academic health centers and other health systems are important for a number of reasons. Despite the size of the UC Health System, access to our health facilities is limited by capacity and geography; therefore, affiliations with other institutions allow UC's academic health centers to improve quality of care and expand options for people living in California, including in underserved areas of the state.

Specifically, affiliations with other health systems offer UC's high-quality services in lower-cost settings closer to patients' homes. Many UC hospitals operate at capacity and need to turn away patients that are seeking our care. Affiliations with lower-cost facilities that care for lower-acuity patients help preserve the limited capacity at UC facilities that is needed to treat patients who truly need UC's expertise and specialized services, while facilitating access to UC services for patients in facilities that are not close to our health centers.

Affiliations are also an essential component to the fulfillment of the educational mission of our academic health systems. UC's own facilities do not have sufficient capacity to place all of our clinical trainees in UC settings to gain necessary field experience. Placement options outside of UC are based on geography, as well as the competitive framework and relationships among health care organizations in the regions surrounding our health professional schools.

Other health systems are also important parts of UC's employee health benefits plans' provider networks. Many UC employees, retirees, and students live in areas without direct access to a UC academic health center. Our UC health plans' networks therefore include many non-UC clinicians and facilities so that our plan members can access care locally.

UC's academic health centers are also operating in a rapidly evolving, highly competitive marketplace that threatens the viability of unaffiliated health care entities. Federal funding for our education and research missions is rapidly decreasing. At the same time, public and private payors are seeking to reduce reimbursement rates and are increasingly emphasizing value-based payment models that require networks with more physicians, lower-cost facilities for lower-acuity patients, and a broader geographic footprint. In the current environment, academic health centers must seek to complement the offerings of other institutions in collaborations with them—to deliver patient care in the most appropriate settings and to address gaps in the services offered by our community hospital partners.

The Association of American Medical Colleges has emphasized that academic health centers have four options in the face of the current environment: "form a system; partner with others in a collaborative network model; merge into a system; or be prepared to shrink in isolation."[1] While UC's academic health centers have increasingly sought to coordinate as a system to take advantage of their collective scale, these efforts alone are not enough for our health centers to succeed in the face of current challenges. This is another reason why affiliations are imperative for UC Health.

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1. AAMC. **Advancing the Academic Health System for the Future.** 2014.

B. THE WORKING GROUP ON COMPREHENSIVE ACCESS

Because of the importance of affiliations to UC Health, as well as the valid concerns raised about the negative consequences for patients that can ensue from non-evidence-based policy restrictions on care, such as those imposed by the Ethical and Religious Directives (ERDs) of the Catholic Church, President Napolitano convened the Working Group on Comprehensive Access (WGCA) in August 2019. The WGCA was charged with developing policy recommendations to "ensure UC's values are upheld" when its academic health centers collaborate with other health systems, and "to ensure that UC personnel will remain free, without restriction to advise patients about all treatment options and that patients will have access to comprehensive services."[2] The WGCA was comprised of a UC Regent, Chancellors, Deans, faculty, Academic Senate representatives, and UC Health System leadership.

In late December, the Chair of the WGCA prepared a report that attempted to summarize the viewpoints of the WGCA members, and that outlined two options discussed by the WGCA members. One option would, in essence, prohibit patient care and training agreements with institutions that have policy-based restrictions on care; the other option would allow such affiliations, but conditioned upon the implementation of certain protections, monitoring, and compliance protocols.

Upon review of the WGCA Chair's report, President Napolitano noted the Chair's observation that "the WGCA has not conducted a full analysis of all the implications, including financial implications" associated with the report's recommendations. Accordingly, the President asked Carrie Byington, the Executive Vice President of UC Health, to provide an analysis of the impacts of ending all existing agreements between UC's academic health centers or health professional schools and organizations that have non-evidence-based policy restrictions on care. The President also requested an analysis of the potential impact that banning affiliations with these types of health care providers would have on our ability to provide comprehensive, accessible, affordable, and quality health care to our employees.

This report is submitted by UC Health in response to these requests from the President. The report describes the impact of a ban on the following areas of focus:

A. Patients Across the State

B. Employees, Retirees, and Students in UC Health Plans

C. UC Health Sciences Education

D. Efforts to Combat COVID-19

E. UC Health System Finances

2. Janet Napolitano. **Working Group on Comprehensive Access.** August 2019.

IMPACT ON **PATIENTS**

A PROHIBITION ON AFFILIATIONS WOULD IMPACT PATIENT ACCESS TO HIGH-QUALITY AND SPECIALIZED CARE FROM UC CLINICIANS

A ban on UC affiliations with institutions that have policy-based restrictions on care would hinder and often eliminate access to UC clinicians for tens of thousands of patients. Currently, UC clinicians provide services to patients at facilities owned and operated by institutions that have policy-based restrictions on care. Also, a significant number of patients are referred by these institutions to a UC clinician or a UC facility for highly specialized—i.e., tertiary or quaternary—services that require clinical expertise or facility and technological capabilities that are not available elsewhere. UC clinicians and health centers have many types of affiliations that facilitate these interactions. These include professional services agreements where UC clinicians provide services to these non-UC institutions, as well as provider network agreements in which non-UC institutions have preferred provider arrangements with UC facilities and clinicians for specialty care. A ban on such affiliations would therefore limit patients' ability to access UC's high-quality care and specialty expertise. Such a ban would be especially difficult for patients who are uninsured or who are covered by Medi-Cal.

A. PROFESSIONAL SERVICES AGREEMENTS WHERE UC CLINICIANS PROVIDE SPECIALTY MEDICAL SERVICES AT ANOTHER INSTITUTION

All UC health centers have professional services agreements where UC clinicians are providing services at institutions that have policy-based restrictions on care. Under these arrangements, the UC clinicians/faculty practice group bill payors and collect reimbursement for the services provided to patients. The presence of UC clinicians in these settings improves the quality of care delivered; increases access to services that are often not otherwise available in those facilities; and presents patients with options and connections to UC clinicians when the care they need is not available where they are being seen. In the last fiscal year, under these professional services agreements, **UC clinicians treated over 35,000 patients whose access to those services at their local facilities would otherwise be terminated if these affiliations were to be prohibited.** UC provides other facilities with a wide array of services, including the following specialty and sub-specialty services under these affiliations:

- Radiation Oncology
- Hematology/Oncology
- Cardiology
- Pediatrics (including neonatal intensive care)
- Neurology/Neurosurgery
- Medicine (includes pulmonology, nephrology, gastroenterology, etc.)
- Pathology
- Ob-Gyn (including sub-specialty care that includes maternal and fetal care and gynecology oncology)

Figures 1 through 3 on the following pages illustrate the patients served and the services provided in Fiscal Year 2019 under existing agreements where UC clinicians are providing services at institutions that have policy-based restrictions on care.

Of note, a number of these agreements allow UC health centers to care for underserved populations. For example, these numbers capture patients served by the **UC San Diego** School of Medicine's student-run free clinics. With sites based in local churches and other community organizations, the free clinics create unique and invaluable learning opportunities for medical, pharmaceutical, dental, and integrative medicine students. In these settings, our students develop knowledge and skills around the social determinants of health and provide vital services for populations living in poverty.

Each year:

- Over 2,000 patients are served (most of whom lack any other access to health care)

- 250+ medical students are trained in underserved medicine

- 200+ doctors, dentists, and pharmacists serve as clinic volunteers and student advisors

Also included are primary care services provided by **UC San Diego** at the St. Vincent de Paul clinic (also known as "Father Joe's Clinic") in a joint family medicine and psychiatry residency program. The program at Father Joe's allows UC San Diego students, trainees, and faculty members to care for thousands of patients annually, including uninsured, homeless, and medically indigent patients. Both of these programs stand to be disrupted if blanket prohibitions are enacted on affiliations with institutions that have policy-based restrictions on care.

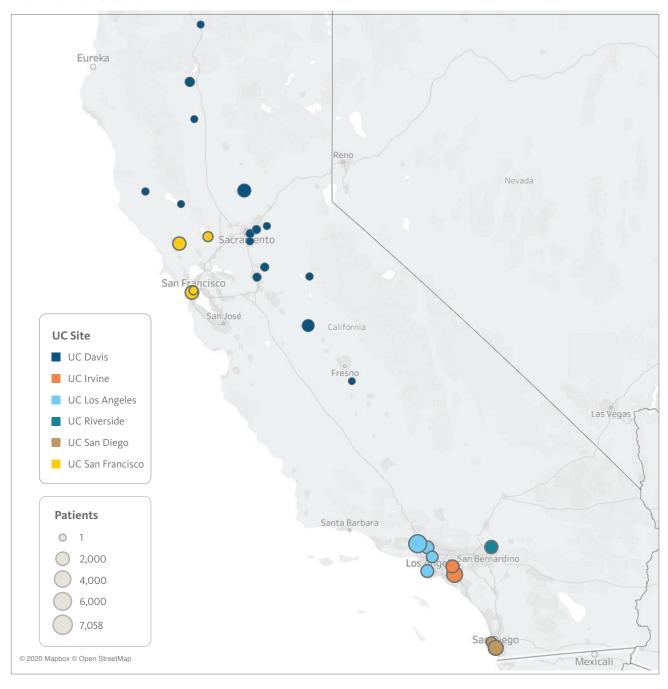**FIGURE 1:** PATIENTS SERVED BY UC CLINICIANS AT FACILITIES THAT HAVE POLICY-BASED RESTRICTIONS ON CARE — STATEWIDE

UC Site

- UC Davis
- UC Irvine
- UC Los Angeles
- UC Riverside
- UC San Diego
- UC San Francisco

Patients

- 1
- 2,000
- 4,000
- 6,000
- 7,058

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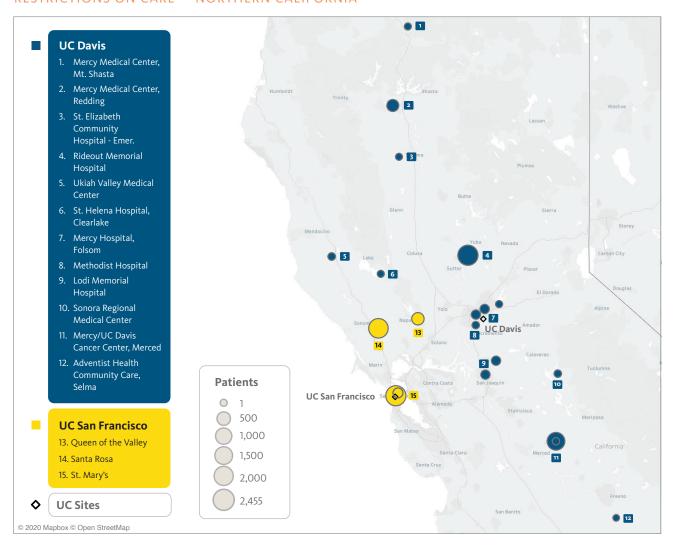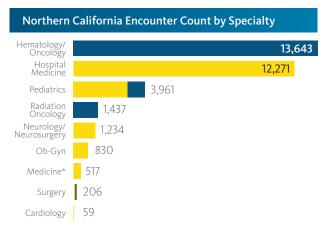**FIGURE 2:** PATIENTS SERVED BY UC CLINICIANS FACILITIES THAT HAVE POLICY-BASED RESTRICTIONS ON CARE — NORTHERN CALIFORNIA

TABLE 1: PATIENTS SERVED BY UC CLINICIANS FACILITIES THAT HAVE POLICY-BASED RESTRICTIONS ON CARE — NORTHERN CALIFORNIA

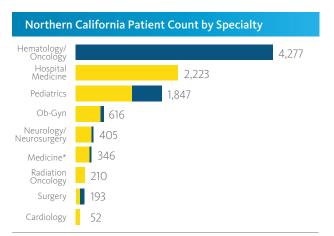### Northern California Encounter Count by Specialty

Specialty	Count
Hematology/Oncology	13,643
Hospital Medicine	12,271
Pediatrics	3,961
Radiation Oncology	1,437
Neurology/Neurosurgery	1,234
Ob-Gyn	830
Medicine*	517
Surgery	206
Cardiology	59

Northern California Patient Count by Specialty

Specialty	Count
Hematology/Oncology	4,277
Hospital Medicine	2,223
Pediatrics	1,847
Ob-Gyn	616
Neurology/Neurosurgery	405
Medicine*	346
Radiation Oncology	210
Surgery	193
Cardiology	52

*Includes pulmonology, nephrology, ID, etc.

	UC Davis	UC San Francisco	Total
Patients	4,936	5,233	10,169
Encounters	15,469	18,689	34,158

FIGURE 3: PATIENTS SERVED BY UC CLINICIANS AT FACILITIES THAT HAVE POLICY-BASED RESTRICTIONS ON CARE — SOUTHERN CALIFORNIA
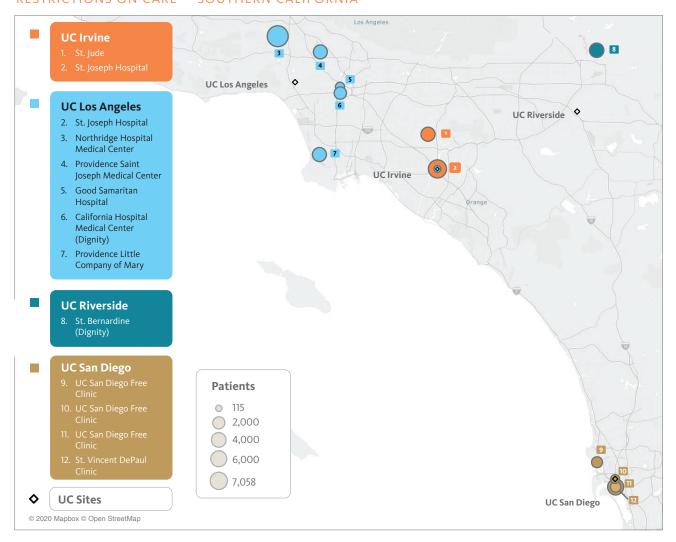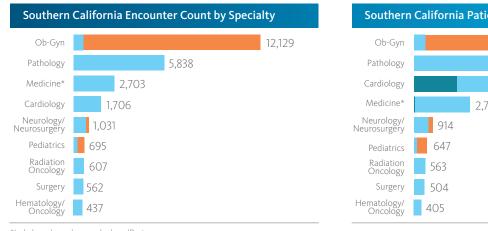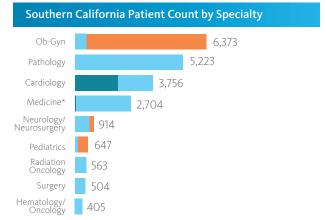

UC Irvine
1. St. Jude
2. St. Joseph Hospital

UC Los Angeles
2. St. Joseph Hospital
3. Northridge Hospital Medical Center
4. Providence Saint Joseph Medical Center
5. Good Samaritan Hospital
6. California Hospital Medical Center (Dignity)
7. Providence Little Company of Mary

UC Riverside
8. St. Bernardine (Dignity)

UC San Diego
9. UC San Diego Free Clinic
10. UC San Diego Free Clinic
11. UC San Diego Free Clinic
12. St. Vincent DePaul Clinic

◇ UC Sites

Patients
○ 115
○ 2,000
○ 4,000
○ 6,000
○ 7,058

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TABLE 2: PATIENTS SERVED BY UC CLINICIANS AT FACILITIES THAT HAVE POLICY-BASED RESTRICTIONS ON CARE — SOUTHERN CALIFORNIA

Southern California Encounter Count by Specialty

Specialty	Count
Ob-Gyn	12,129
Pathology	5,838
Medicine*	2,703
Cardiology	1,706
Neurology/Neurosurgery	1,031
Pediatrics	695
Radiation Oncology	607
Surgery	562
Hematology/Oncology	437

Southern California Patient Count by Specialty

Specialty	Count
Ob-Gyn	6,373
Pathology	5,223
Cardiology	3,756
Medicine*	2,704
Neurology/Neurosurgery	914
Pediatrics	647
Radiation Oncology	563
Surgery	504
Hematology/Oncology	405

*Includes pulmonology, nephrology, ID, etc.

	UC Irvine	UC Los Angeles	UC Riverside	UC San Diego	Total
Patients	6,530	12,446	2,109	4,583	25,668
Encounters	12,334	13,388		17,270	42,992

B. OTHER PROFESSIONAL SERVICES AGREEMENTS WHERE UC CLINICIANS PROVIDE SERVICES TO ANOTHER INSTITUTION

In addition to professional services agreements where we send our clinicians to other locations and bill for services, UC academic health centers also have a number of agreements where UC clinicians provide professional or administrative services at other facilities that are critical to promoting high-quality care and access to specialty services, but that are not separately billed to payors as professional medical services. These include agreements for call coverage, telemedicine, consultation services, and hospitalist services. In addition, UC clinicians serve as medical directors for certain types of services at these other facilities, which means that UC clinicians are responsible for oversight of the quality of care of those services at those facilities. Since UC does not bill payors directly for the services provided for each patient under these types of arrangements, we do not have the data on the number of patients served. These agreements provide another important mechanism whereby **UC expertise is provided to patients at locations outside of the UC Health System, many of whom (e.g., in rural and underserved areas) wouldn't have access to those services.**

Examples of agreements with faith-based facilities include the following:

- **UC San Diego** has agreements with Loma Linda University Health for a cardiothoracic surgeon to provide on-call coverage and to serve as medical director of TAVR (transcatheter aortic valve replacement), thoracic surgery, and cardiac rehabilitation services. UC San Diego also has agreements with Scripps Mercy Hospital for on-call services for complex hand vascular surgery patients and acute stroke on-call services for the emergency department. These agreements provide UC San Diego services to underserved patients in San Diego's inner city.

- **UC Riverside** provides cardiac imaging interpretation services to St. Bernardine's, a facility located in the underserved "Inland Empire" in California, which would not otherwise have access to those services.

- **UC Davis** has placed pediatric hospitalists with telehealth advanced support at Adventist Health Lodi Memorial which has allowed children to receive specialty care locally and has facilitated transfers to UC Davis for those patients requiring the specialty services not available at their facility.

- **UC San Francisco** provides hospitalist services at St. Mary's in San Francisco, which enables UC San Francisco to more quickly address the needs of those who do not have true emergency medical conditions and who could otherwise spend hours waiting in UC San Francisco's overcrowded emergency room.

C. JOINT VENTURES

Several of our health centers have entered into joint ventures with other health systems in which they combine their resources and expertise to form a separate entity for the purposes of delivering a defined scope of health care services collaboratively. These types of affiliations allow our health centers to expand their geographic reach and capacity where we would not have the resources to do so on our own. Following are existing joint ventures between UC and institutions that have policy-based restrictions on care.

- **UC Davis** has a long-standing joint venture agreement with Mercy Medical Center in Merced to operate a cancer center. For almost 20 years, this joint venture has been an important health care specialty service resource for central California, serving a growing population in Merced, Atwater, Winton, and Livingston and enabling patients in the Central Valley to obtain complex cancer care closer to their homes. Under this arrangement, Mercy Merced Cancer Center receives extensive clinical and operational support from UC Davis, including virtual tumor boards, oncology pharmacy consults, access to UC Davis's oncology clinical trials, and on-site radiation oncology. This affiliation has extensively increased the quality and depth of cancer care services in the Central Valley.

- **UC Davis** has also been in a long-standing joint venture since 1999 to establish and manage a cancer center at Rideout Hospital in Marysville, California (Rideout Hospital was acquired by Adventist Health in 2018). The cancer center serves a growing population in Yuba, Sutter, Colusa, Nevada, and Butte counties—locations where patients would otherwise have to travel long distances for specialized care. Notably, when the Camp Fire destroyed the local hospital, the joint venture opened a cancer center in nearby Chico to allow patients in the region to continue to obtain their cancer care.

- **UC San Francisco Benioff Children's Hospitals** developed a joint venture in 2016 with St. Joseph's Santa Rosa Memorial Hospital to enhance and expand neonatal and pediatric services in the North Bay region. This affiliation built upon UC San Francisco's long-standing relationship with Santa Rosa Memorial Hospital that includes the on-site operation of a UC San Francisco intensive care nursery, which is a level III neonatal intensive care unit.

Due to the structure and administration of the UC Davis joint ventures, the UC Davis team does not have data on the number of patients served by its joint ventures. Regarding the UC San Francisco joint venture with St. Joseph Health, the number of patients served is captured in **Figure 2** and **Table 1** for professional services agreements.

D. SERVICES PROVIDED AT UC FACILITIES AS A RESULT OF AN AFFILIATION

Our affiliations are often the mechanisms by which thousands of patients are able to access the specialty care they need at UC's academic health centers. Patients come to UC primarily for our specialty expertise and services, and are referred to us in a number of ways. Two common ways are:

- **Referral by their primary care physician in the community.** Exposure to UC specialists who are in non-UC facilities through professional services agreements allows primary care providers to work with UC specialists and identify physicians at UC with particular expertise. The UC clinicians on the ground are also able to facilitate access to UC clinicians and facilities, which operate at or near capacity most of the time.

- **Referral through transfer by UC hospitalists or other non-UC physicians working at an affiliated facility that cannot provide the necessary level of care.** Again, the presence of UC clinicians in these locations facilitates referral relationships and access to UC clinicians and facilities.

In other cases, another provider group or facility has contracted with a health plan (typically an HMO) and accepted responsibility for managing the costs and the care for the patients who are enrolled in that plan. The provider group or facility, in turn, has contracted with UC to ensure that those patients have access to medically necessary specialty services.

For example, **UC Davis** participates in arrangements with the Dignity Health Medical Foundation, where UC Davis has preferred status as a provider, and patients are therefore authorized to receive services at UC Davis for care that cannot be provided by Dignity physicians or facilities. In Fiscal Year 2019, over 500 patients were referred to UC Davis for specialty care under these arrangements.

UC San Francisco, UC Irvine, and **UC Los Angeles** also have these types of arrangements with providers who are managing care and costs on behalf of a health plan. The specific terms of each of these arrangements vary, depending on a variety of strategic, market, and geographic factors. As outlined in the UC Davis example above, analysis of the specific contract terms and market context of the UC Davis agreements

allowed us to identify the number of patients who were referred as a result of the affiliation. Absent an analysis of each agreement at the other campuses, we can say that the existing arrangements between UC's academic health systems and these other institutions are a key factor, but not necessarily the only factor, that enables patients to be referred from another provider or facility to access care at UC. Termination of these arrangements would mean that many of the patients who are referred or transferred to a UC clinician or facility under these arrangements would be discouraged and/or prevented from seeking treatment from a UC facility.

More broadly, the leadership and clinical faculty members of UC's academic health systems all attest that their affiliations are an important way to facilitate access to UC's specialty services and expertise offered for patients of other institutions who need those services. Given multiple financial reporting systems among and within the campuses, there is not a timely way to capture with certainty whether a particular patient arrived at a UC institution solely as the result of an affiliation with another institution. Accordingly, this report does not contain comprehensive data regarding the number of patients who come to UC from other facilities, but these numbers are in the tens of thousands annually. For example, in Fiscal Year 2019, at **UC Los Angeles** alone, over 7,000 patients previously treated by a UC clinician at a UC Los Angeles affiliate institution were seen in UC Los Angeles community physician practices. Over 1,800 patients were referred or transferred to **UC San Francisco** from a Catholic institution. It is clear that, absent our affiliations, a significant subset of the thousands of patients who are referred or transferred to UC facilities from our affiliates that have policy-based restrictions on care would no longer receive care at UC.

The personal patient stories that you will see on subsequent pages underscore the significance of UC's existing affiliations to patients, and therefore the real harm that ending them could cause.

E. FUTURE IMPACT ON PATIENTS

Besides undermining access to care for patients we currently serve, a ban on affiliations with institutions that have policy-based restrictions on care would limit access to care for thousands more in the future whom UC institutions would otherwise reach through such affiliations. For example:

- **UC Davis's plans to expand access to cancer services in rural Northern California would be stifled.** As referenced in **Section D**, UC Davis has a long-standing joint venture with Adventist Health to run a cancer center in Marysville, California, and is seeking to build upon this existing affiliation to expand hospital-based cancer centers into rural and specialty-underserved areas in Northern California. An affiliation with the existing hospital system in the region would be the only way to expand needed services.

- **UC San Francisco would not be able to meet the growing demand for its specialty services.** The aim of UC San Francisco's previous effort to build upon its existing affiliation with Dignity Health was to expand access to its services in a manner that UC San Francisco could not do on its own—including to provide cancer services and clinical trials, new primary care clinics, including those uniquely designed to serve transgender patients, and adult and adolescent mental health services. UC San Francisco facilities typically operate at capacity, and UC San Francisco already has collaborations with its other viable partners in the region, such as John Muir, San Francisco General, and Marin General. While UC San Francisco has also been planning to build new facilities to expand and improve access, doing so requires significant capital, an extended period of time, and serves a limited geography. Without the ability to collaborate with Dignity Health, UC San Francisco has few, if any, viable options to expand access to its unique specialty care and expertise for the communities in the Bay Area.

PATIENT STORIES

ON-LOCATION AFFILIATIONS PROVIDE HIGH-QUALITY CARE WITHOUT THE TRAVEL

UC Davis Health physicians work with Adventist Health Lodi Memorial nurses and staff to provide world-class care at Adventist Health Lodi Memorial. It has been a formula for success since the affiliation between Adventist Health Lodi Memorial and UC Davis Health started in July of 2018. Since then, Adventist Health Lodi Memorial has seen a measurable reduction in length of hospital stay and a decreased percentage of patients needing transport to Sacramento, about 37 miles away.

When Stockton resident Tyana Raya-Paderes's twins arrived early at 36 weeks at nearby Adventist Health Lodi Memorial, both babies needed immediate care in the hospital's level II neonatal intensive care unit (NICU).

Thankfully, NICU care was available close to home because of an affiliation that began in 2018 between Adventist Health Lodi Memorial and UC Davis Medical Center in Sacramento, where UC Davis Health physicians work with nurses and staff to provide world-class care at Adventist Health Lodi Memorial.

It has been a formula for success since the affiliation started. Adventist Health Lodi Memorial has seen a measurable reduction in length of hospital stay and a decreased percentage of patients needing transport to Sacramento, about 37 miles away.

Adventist Health Lodi Memorial was licensed as a level II NICU by the California Department of Health in December of 2018, a designation that demonstrates the level of advanced specialty care available in the NICU, which was not available in the Lodi area before the UC affiliation.

"When I think of what it would be like if we had to go to Sacramento for my daughter's care, I think of traffic, the additional cost of gas, time spent driving. We have a 3-year-old at home as well, and we would have to find someone who could take care of him while we were there," said Raya-Paderes, who is grateful that she didn't have to face these additional challenges.

But beyond the geographic convenience, Raya-Paderes has been grateful for the compassionate care she received from her daughter's NICU physician, Moina Snyder, a UC Davis hospitalist assigned to Adventist Health Lodi Memorial.

"I'm glad that we can help patients like Tyana directly in their community. No one plans for their child to be in the NICU so we want to bring our expertise to help families during this difficult time—and being close to home can make a world of difference," Snyder said.

Source: **https://health.ucdavis.edu/health-news/contenthub/care-close-to-home/2020/02**

MERCY SAN JUAN MEDICAL CENTER AND UC DAVIS COLLABORATE TO SAVE A YOUNG LIFE

UC Davis pediatric cardiothoracic surgeon Amy Rahm was called to perform a closure of two-month-old Brooklyn's heart vessel. "I have to commend Mercy San Juan Medical Center for reaching out. This was a wonderful collaboration for the sake of patient care," said Rahm. After a series of tests and with the assistance of the Mercy team, the surgery proceeded without any complications. Mercy San Juan Medical Center is part of Dignity Health's Sacramento region and has long-standing training, data sharing, and patient care agreements with UC Davis Medical Center.

In 2017, Mark and Melanie Payne bought a house in El Dorado Hills and Melanie became pregnant with their first child, due in October. But in July, Melanie began having contractions. At only 25 weeks, Brooklyn Payne was born at Mercy San Juan Medical Center, weighing 1 pound, 4 ounces. "We didn't think she was going to make it," said Mark Payne. "It was brutal."

After a whirlwind of tests, Brooklyn was diagnosed with patent ductus arteriosus (PDA), a heart condition that affects 10% of all congenital heart anomalies. Left untreated, PDA can lead to obstructive pulmonary diseases and heart failure.

UC Davis pediatric cardiothoracic surgeon Amy Rahm was called by Mercy San Juan Medical Center to perform a PDA ligation—a surgical closure of the vessel.

"I have to commend Mercy San Juan Medical Center for reaching out. This was a wonderful collaboration for the sake of patient care," said Rahm. After a series of tests and with the assistance of the Mercy team, the surgery proceeded without any complications.

Since Brooklyn needed the higher level of care that only a level IV neonatal intensive care unit (NICU) could provide, following her surgery, she was transported and admitted into the UC Davis NICU at UC Davis Children's Hospital where she and the Paynes spent two and a half months.

"She was so vulnerable," says Mark Payne. "At first it was overwhelming. The nurses were unbelievable. The way they handle crisis situations is amazing. Plus, they really care."

In December, Brooklyn was discharged from UC Davis Children's Hospital and finally went home. It was the happy ending everyone had been hoping for.

At 10 months old, Brooklyn was developmentally on track—grabbing, giggling, scooting, and smiling. "It's a miracle she's here with us and doing so well. It's unbelievable, really," said Mark Payne. "UC Davis Children's Hospital will always be part of our story … one we are proud to tell."

Source: **https://health.ucdavis.edu/health-news/newsroom/micro-preemie-pediatric-cardiology-and-eye-surgery-patient-is-familys-miracle/2018/05**

SUPPORTING A VILLAGE

"I'd like the Regents to know that our clinic does provide access to comprehensive services. Although we may not provide a particular service here, we will get them to where they need to go for that service. Our approach is to talk about options, hear what the patient desires, and support their informed choice."

— Dr. Jeffrey Norris, Medical Director of Father Joe's Villages since 2016

"Some of our patients haven't had consistent care for years. They've been living on the streets, which takes a toll rapidly on their health and well-being," says Dr. Jeffrey Norris, Medical Director of Father Joe's Villages. "Maybe they've had episodic care through repeated trips to emergency rooms and hospitals but they don't remember which ones or they've been arrested and had limited care through the correctional system, or they were once in a psychiatric facility. You have to do some detective work to put together their history."

The patients treated at the Village Health Center run by Father Joe's Villages face multiple, complex challenges: severe mental illnesses, substance abuse, and chronic physical conditions like diabetes, hypertension, or COPD. None of it is well controlled. And the chaos of living on the streets or in various shelters makes keeping these patients connected to the care system a continual challenge.

It's that complexity that makes the hands-on support from UC San Diego Health providers so important. Many of the UC San Diego clinicians who care for patients at the Village Health Center are in a unique, five-year residency program that combines family medicine and psychiatry. That's critically important because, as Dr. Norris says, "If you have a serious mental illness, what you are experiencing is your reality. If you tell a person they need to see a psychiatrist, there's a good chance they will refuse. These 'combo doctors' can connect with a patient by providing that person with the primary care they know they need and then weave in psychiatric care elements as trust is built."

Father Joe's Villages grew under the leadership of President Emeritus Father Joe Carroll, who saw the need to create a one-stop shop to address its clients' needs for shelter, food, clothing, child care, job training, and health services. The charity's major campus is in downtown San Diego, about five miles from the UC San Diego Medical Center in Hillcrest, with satellite facilities in various parts of the city. Although its roots began in Catholic-sponsored charity care, it routinely refers patients to other facilities.

"I'd like the Regents to know that our clinic provides access to comprehensive services. Although we may not provide a particular service here, we will get them to where they need to go for that service," Norris says. "Our approach is to talk about options, hear what the patient desires, and support their informed choice."

Dr. Norris views a rupture in the relationship with Father Joe's Villages and UC San Diego Health as harmful for everyone involved. For patients, a sudden break in the doctor-patient relationship may discourage that patient from returning. The Village Health Center would never be able to pay for the number of psychiatrists needed by its clients. And for UC San Diego Health, the field experience gained by working at Father Joe's Villages helps prepare psychiatrists to work in any health center and with underserved populations.

UC RIVERSIDE
DELIA BAUTISTA

For Bautista, who celebrated her 82nd birthday in February 2020, the significance is simple. The innovative surgery returned her health and ability to be an active senior. In fact, she is doing so well that her family sometimes has to remind her to slow down and take it easy.

About seven months after undergoing a second aortic valve replacement, then-79-year-old Delia Bautista was admitted to St. Bernardine Medical Center. She had never fully rebounded from the surgery and had recently begun to feel worse.

"It was hard to breathe, and I couldn't walk without thinking that I might fall down," she recalled.

Ramdas Pai, MD, FACC, FRCP, Professor and Chairman of Internal Medicine, and Director of the Cardiovascular Fellowship Training Program at the UC Riverside School of Medicine, examined Delia and discovered that she had a perforation of the heart's anterior mitral leaflet that was allowing blood to flow backward into the left atrium. The blood backed up into her lungs, making it difficult to breathe.

Because of her age, frailty, and other health complications, Bautista wasn't a candidate for open heart surgery. So Dr. Pai and his colleagues, Associate Clinical Professor Dr. Ashis Mukherjee and Clinical Professor Dr. Mohammad a Kanakriyeh, began considering other options for repairing the perforation. The best solution seemed to be to make a small incision in the groin and deliver a plug via a catheter.

The plug eliminated the mitral regurgitation, and Bautista quickly improved. Her case is an example of what can be accomplished by a team of clinicians with diverse expertise and a background in academic medicine.

"I feel strong, I feel O.K.," she said. "I love to do things and I don't want to just sit down while others are doing things."

UC SAN FRANCISCO
STEVEN

In addition to receiving St. Mary's patients at UC San Francisco, UC San Francisco neurosurgeons provide on-call consults and care for patients at Saint Francis Memorial Hospital's emergency room.

After a fall at home, Steven was taken to Dignity Health's St. Mary's Medical Center, where a CT head scan revealed a brain bleed.

After discovering that Steven had been sick during the two weeks prior to the fall, doctors at St. Mary's called specialists at UC San Francisco to review the scan. At UC San Francisco, Steven was cared for by neurosurgeon Manish Aghi, MD, who removed the hematoma and found a malignant brain tumor.

"The affiliation between St. Mary's and UC San Francisco enabled immediate recognition of the potential for a brain tumor in the cerebellar bleed, which led to transfer of the patient to UC San Francisco and prompt treatment," said Dr. Aghi.

This is one example of the benefits of UC San Francisco's neurosurgery affiliation with Dignity Health hospitals. In addition to receiving St. Mary's patients at UC San Francisco, UC San Francisco neurosurgeons provide on-call consults and care for patients at Saint Francis Memorial Hospital's emergency room.

Steven has since been treated with radiation and continues to receive chemotherapy, and his latest scan showed no disease progression.

A **QUICK REFERRAL** FROM **DIGNITY HEALTH** **SAVES** A MAN'S FOOT

After visiting many doctors and coming up short on answers, Gordon visited Joie Dunne, MD, a vascular surgeon at Dignity Health's Mercy Medical Center in Redding. While Dr. Dunne said that she could restore the femoral flow in his leg, she didn't have the team required to tend to the complex wound on his right foot, which would require the expertise of vascular and podiatric surgeons working together to save the foot. But she knew who could help: Alexander Reyzelman, DPM, Co-Director of the UC San Francisco Center for Limb Preservation, which is based both at UC San Francisco Helen Diller Medical Center at Parnassus Heights and at Dignity Health's St. Mary's Medical Center in San Francisco.

For Gordon Metcalfe and his wife Doreen, treatment from a UC San Francisco specialist is so valuable that they drove more than 200 miles one way from Redding, California, to get it. The value of this care became even more apparent to the Metcalfes after Gordon's minor corrective foot surgery at a non-UC San Francisco facility went seriously wrong.

Shortly after surgery, a huge pressure wound opened up on Gordon's ankle. After visiting many doctors and coming up short on answers, Gordon visited Joie Dunne, MD, a vascular surgeon at Dignity Health's Mercy Medical Center in Redding. Dr. Dunne said that she could restore the femoral flow in his leg, but didn't have the team required to tend to the complex wound on his right foot, which would require the expertise of vascular and podiatric surgeons. But she knew who could help: Alexander Reyzelman, DPM, Co-Director of the UC San Francisco Center for Limb Preservation, based at UC San Francisco Helen Diller Medical Center at Parnassus Heights and at Dignity Health's St. Mary's Medical Center in San Francisco.

"It's a big blessing to live in Redding and have access to physicians in UC San Francisco," says Gordon. "If I wasn't allowed to have this care, I would have lost my foot." Since the surgery, Gordon has been receiving regular follow-up care from Dr. Reyzelman and UC San Francisco's Monara Dini, DPM, at both UC San Francisco and St. Mary's, most recently receiving a Stravix graft.

Gordon says that UC San Francisco and St. Mary's always seem well-staffed with care providers who are happy to be there. "Happy employees make for happy patient care," he says, adding that his care team members always have time to attend to his needs and never seem rushed.

"Another advantage of going to UC San Francisco and St. Mary's has been the efficient diagnostic and treatment process," he said. "When you live far away and have pressing health needs, every minute counts. Where we're from, you have to wait for weeks," Gordon says. "I am grateful that these facilities were able and willing to collaborate to provide the care I needed."

UC SAN FRANCISCO DOCTOR PROMOTES SPECIALIST TRANSITIONS TO FIND LONG-AWAITED DIAGNOSIS

Lauren's rock-climbing accident led to a life-changing encounter with UC San Francisco physician Ari Hoffman at St. Mary's Medical Center, leading to a discovery that changed the trajectory of her life.

At age 15, Lauren experienced her first serious sports injury, which resulted in hip surgery, followed three years later by a cardiac ablation for heart rhythm problems, then knee surgery. While each procedure went well, Lauren acquired multiple, mysterious skin infections that caused her to be systemically ill and hospitalized twice, with no definitive answer about the cause.

After college graduation, Lauren was bouldering on an indoor climbing wall, when she slammed her elbow against a rock and tumbled to the mat below. The injury exacerbated an existing cut on her elbow. "I couldn't move my arm at all," she says. This was a turning point in Lauren's life and future health.

In considerable pain, Lauren arrived at the UC San Francisco emergency room and was admitted to the UC San Francisco Medicine service at St. Mary's Medical Center, where she met Ari Hoffman, MD, a UC San Francisco hospitalist and St. Mary's attending physician. Hoffman says Lauren's case initially seemed straightforward, but her recurrent infections were concerning.

What presented as a simple trauma took on a new dimension, thanks to Hoffman's thorough collection and assessment of Lauren's medical background that uncovered a more serious chronic illness.

After treating Lauren's injury and underlying infection, Hoffman referred her to the UC San Francisco Allergy and Immunology clinic for genetic and allergy tests to explain her unusual medical history. She learned that she is allergic to the common antibiotic skin ointment she was frequently using for athletic injuries, among other surprising allergies.

For those around her, the experience made it clear that, while you can go to the doctor a number of times, it's all about going to the *right* doctor. In Lauren's case, it was a UC San Francisco doctor working at a Dignity Health facility who connected the dots to solve the underlying issue. And, "Our presence at St. Mary's helped ensure a smooth transition of care, from her acute care stay here to UC San Francisco specialty outpatient care," Hoffman says. Lauren continues to follow up with UC San Francisco specialists.

IMPACT ON UC EMPLOYEES, RETIREES, AND STUDENTS IN UC HEALTH PLANS

The University has a commitment to ensure that UC health plan members (including employees, retirees, and students) have access to high-quality, appropriate care at the right time and in the right setting. Not allowing affiliations with institutions that have policy-based restrictions on care could impact the University's ability to continue to meet these commitments to covered members and their families by requiring members to travel significantly farther to facilities that might offer lower-quality care.

There are areas of the state where institutions that have policy-based restrictions on care are the only option for care in a community, and members would have to drive significant distances, often an hour or more, to the next closest in-network (INN) hospital. While members have the ability to seek care in an out-of-network (OON) facility, the financial impacts could be substantial, depending on which health plan a member is enrolled in.

UC Blue & Gold HMO (Health Net) members have a defined network of providers they must obtain care from in order for the plan to cover the services. If a member receives care at an OON provider, the member is responsible for 100% of the costs for non-urgent/non-emergency services. Because the provider is not INN and therefore has no negotiated rates with Health Net, the provider's billed charges are typically based on its standard fee schedule, usually substantially higher than rates that an insurer negotiates.

While the UC PPO plans (UC Care, Health Savings Plan, and CORE with Anthem) have OON coverage, members will have to pay more for care received at OON providers. The UC Care plan, for example, has a member coinsurance of 50% of the Anthem allowed amount for most services received from an OON provider. In comparison, the coinsurance for an INN Anthem preferred provider is 20%.

The UC Care plan also has maximum plan payments for facility-based care received at an OON provider (e.g., for inpatient non-emergency services in an OON hospital, the maximum plan payment amount is $300 per day). There is financial protection through an out-of-pocket maximum for the plan, but the amount is $8,600 for an individual and $19,200 for a family. So, while the UC PPO plans do have coverage for OON services, the potential for the member to have high OON costs is real for non-emergency services. Two examples of member cost impact and exposure are highlighted on pages 31 and 32 in the section that discusses the Merced community.

The exclusion from UC provider networks of institutions that have policy-based restrictions on care will also undermine the UC Health commitment to the UC Academic Senate, the Health Care Task Force, the Health Benefits Advisory Committee, and leadership of the campuses that do not have local UC health systems to locate UC physicians on every campus. Since her arrival, Executive Vice President Byington and UC Health leaders

have been working across the campuses to identify opportunities for UC Health to serve the health care needs of our employees and retirees in the communities surrounding all UC campuses.

Efforts for UC Health providers to serve all UC campuses would be hindered by a ban on affiliations. UC Health has committed to serving every campus, with a focus on UC Merced, UC Santa Cruz, and UC Santa Barbara. It is essential that UC physicians practicing in ambulatory settings be able to admit and follow the care of their patients at a nearby hospital. In Merced and Santa Cruz, the only community hospitals are Catholic and follow the ERDs of the Catholic Church. A policy of disengagement from these hospitals would make it very difficult to deliver on UC Health's commitment to these campuses and communities. Patients cared for by UC providers would experience significant disruptions in their continuity of care if hospital care was needed.

In Merced, for example, UC Health intends to open a primary care clinic staffed by UC doctors and nurses in order to increase access to care for UC Merced and the surrounding community in an area that has severe access problems to providers of all types. Physicians need assurance that, if they join the practice, there will be a hospital nearby to refer patients to for services. They will also want to ensure they can fully monitor and manage the medical needs of their patients, which requires access to care across multiple settings. Dignity Health-owned Mercy Medical Center (Mercy Merced) is the only hospital in the area. If UC is not allowed to affiliate with Mercy Merced, or if Mercy Merced is excluded from the UC provider network, it will be difficult to recruit providers to practice at the new clinic, because they will not want to travel an hour or more to do patient follow-up. It will also greatly impede a UC Health goal to

enhance access in the community and to create a more robust, functional, and effective health care ecosystem there.

To assess the potential impact of a policy change on members' access to care, we reviewed geographic areas across the state, focusing on those in which UC campuses are located and where UC Health operates and provides services. Metropolitan statistical areas (MSAs) in California were used to analyze the utilization of institutions that have policy-based restrictions on care, including those that follow Catholic ERDs, compared to those who do not. MSAs are areas that contain a substantial population nucleus and, together with adjacent communities, have a high degree of economic and social integration with that core. We reviewed utilization over a two-year period from July 1, 2017 to June 30, 2019. We identified patterns of practice for health care within each area to inform our conclusions on how access to care might be impacted if our health plan networks were to exclude institutions that have policy-based restrictions on care. The health plan enrollment figures noted include members in the UC PPO plans (Anthem), the UC Blue & Gold HMO plan (Health Net), and the Kaiser Permanente HMO plan for active employees and retirees. We included Kaiser because it refers members to non-Kaiser providers for specific services not offered by its facilities in certain areas.

Once we completed our analysis, we then identified "at-risk UC communities." At-risk UC communities are those we concluded 1) would have substantial disruption in the local market due to reduced health care resources or capacity and 2) whose members could be substantially impacted in their continued ability to access high-quality care at the right time and in the right setting. We identified four communities as at-risk.

AT-RISK UC COMMUNITY 1:
MERCED AREA

The Merced MSA is located in the San Joaquin Valley and has a population of around 550,000 residents.[1] It is a mostly rural and sparsely populated area, with a large Spanish-speaking population, that includes small towns such as Chowchilla in the south, Livingston and Atwater in the north, and Los Banos in the southwest. The city of Merced, the county seat, has over 83,000 people[2] and is where the UC Merced campus is located.

UC Merced currently does not have UC providers on or around the campus. Merced County is severely underserved by health providers of all types, a situation that has caused significant problems in attracting and retaining faculty and staff to the campus. There is only one hospital in the city of Merced, the Dignity Health-owned Mercy Medical Center (Mercy Merced) that is currently used by about 3,650 UC health plan employee and retiree members. Nearly 40% of members (over 1,100 members) in the area that seek care receive it at Mercy Merced. Our members' heavy utilization of Mercy Merced and its affiliated physicians would be disrupted if the hospital were to be removed from the UC provider network. Many of these members would have to choose new doctors and travel farther to receive care.

Two other community hospitals are located in the MSA: Emanuel Medical Center in Turlock (a Tenet Healthcare facility) and Memorial Hospital Los Banos in Los Banos (a Sutter Health facility). Emanuel Medical Center is about 30 miles/40 minutes from UC Merced, and Memorial Hospital in Los Banos is even farther at over 40 miles/one hour away. Most members that don't receive care at Mercy Merced have specific health care needs. More than three-quarters of the 10% of members who travel to Emanuel Medical Center receive cancer-related services. A similar number of members travel to UC San Francisco Medical Center for more specialized cancer and heart-related conditions. Other facilities utilized include Stanford Medical Center, Children's Hospital, and Doctors Medical Center of Modesto. **Mercy Merced is a key full-service provider in the community, and the additional distance to potential alternate facilities would impact access to care, assuming those facilities could even provide the same level, mix, and quality of services.**

In addition to impacting members' access to care by eliminating Mercy Merced from the network, there would be significant costs to members if they chose to receive care at Mercy Merced on an OON basis. For example, if a pregnant UC Care member gives birth at Mercy Merced today, the member pays a $250 copayment for the inpatient stay (the hospital is in the plan's UC Select provider network tier). Mothers generally remain in the hospital for about two days following a normal delivery (i.e., without complications). Prenatal and postnatal care requires a $20 copayment that is only paid once for the initial visit (all subsequent visits are at no cost to the member).

However, if Mercy Merced were OON, the member's out-of-pocket costs would be substantially higher. **Accounting for all the plan's coverage parameters, the member would be liable for approximately $36,750 just for the delivery, versus about $270 out-of-pocket if Mercy Merced remains INN.[3]** Since any amounts above the allowed amount do not count toward the out-of-pocket maximum, the member would very likely be liable for more than the $8,600 individual out-of-pocket maximum.

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1. 2018 UC Census Bureau.

2. Ibid.

3. The assumed billed charge the member would receive is approximately $44,000. The estimated allowed amount would be about $30,000 (assuming a 30% discount). The member is 100% responsible for any amount above the allowed amount, or $14,000, which does not count toward the annual out-of-pocket maximum. After the $500 deductible, the plan would normally pay 50% of the remaining $29,500 ($30,000 allowed amount minus the $500 deductible). However, OON hospitals are subject to a maximum plan payment of $300 per day. Assuming this was a typical two-day stay in the hospital, the maximum amount the plan would pay is $600.
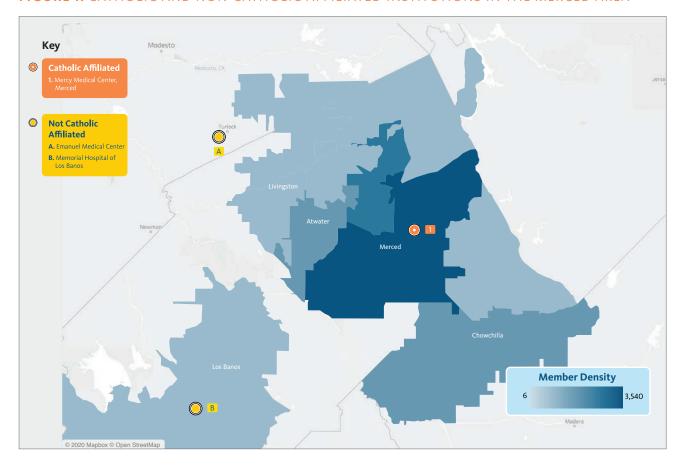
A member receiving cardiovascular surgery at Mercy Merced would have a similar experience. Currently, the member would pay the $250 copayment for the inpatient facility stay. If Mercy Merced were OON, the assumed billed charge would be approximately $37,000.[4] The same plan parameters would apply and this member would be liable for approximately $31,050 for the surgery.[5] See **Table 1** for key UC Care plan design features that would apply to an individual for services received at Mercy Merced as an INN facility versus an OON facility.

Members that decide to receive care at an OON hospital have the daunting task of accurately estimating what their potential out-of-pocket costs will be. UC Care was designed to make member out-of-pocket costs for care received at UC Select providers, like Mercy Merced, simple and straightforward. Coverage for OON care is complex at best and frustrating and overwhelming at worst. Members also have the administrative burden of having to manually submit claims to Anthem for processing and reimbursement—a responsibility that does not exist for INN care. For these reasons, very few of our members currently choose to receive care OON.

The student population would also be impacted. Nearly 50% of UC Merced students that need facility-based care receive it at Mercy Merced. Most of the remaining half likely requiring a higher level of care than could be provided at Mercy Merced or other facilities in the area receive those services at UC San Francisco Medical Center and Stanford Medical Center. Just 0.2% of students that need facility-based care receive it at either Memorial Los Banos or Emanuel Medical Center. **Generally, students are less mobile than older populations, and requiring them to go farther to receive treatment could be very disruptive to their lives, given the academic and other demands on their time that already exist.**

FIGURE 1: CATHOLIC AND NON-CATHOLIC AFFILIATED INSTITUTIONS IN THE MERCED AREA

4. Out-of-network providers will generally charge "retail" rates for services since no contract with the health plan exists, so there is no negotiated amount for services. Hospital fee schedules (also known as chargemasters) are now publicly available on their websites. The estimated allowed amount on the $37,000 billed charge is about $25,000 (assuming a 30% discount).

5. The assumed length of stay in the hospital is six days.

TABLE 1: UC CARE PLAN DESIGN FEATURES FOR SERVICES RECEIVED AT MERCY MEDICAL CENTER

Plan Benefit Parameter	In-Network Member Costs (UC Select tier)[6]	Out-of-Network Member Costs (Anthem non-preferred tier)
Pregnancy Services		
Deductible	None	$500
Copayment	$250 per hospital stay $20 for initial pre/postnatal visit	N/A
Coinsurance Amount	N/A	50% of allowed amount (plus 100% of amount above allowed amount)[7]
Maximum Plan Payment	N/A	$300 per day (ALOS is 2 days)
Plan Out-of-Pocket Maximum	$5,100	$8,600
Total Member Cost	$270	$36,750[8]
Cardiac Surgery		
Deductible	None	$500
Copayment	$250 per hospital stay	N/A
Coinsurance Amount	N/A	50% of allowed amount (plus 100% of amount above allowed amount)[7]
Maximum Plan Payment	N/A	$300 per day (ALOS is 6 days)
Plan Out-of-Pocket Maximum	$5,100	$8,600
Total Member Cost	$250	$31,050[8]

6. Mercy Medical Center is currently in the UC Select tier.

7. Any amount above the allowed amount does not count toward the annual out-of-pocket maximum.

8. The total includes both the out-of-pocket costs, which count toward the annual out-of-pocket maximum, and the amount above the allowed amount, which does not count toward the out-of-pocket maximum.

NATHAN BROSTROM & CHARLES NIES

Interim Chancellor & Vice Chancellor of Student Affairs

"Our health center relies on being able to refer to Dignity Health. If we had to sever ties with them, we'd have no partner in our area. That means no continuity of care for our students because there aren't other good options. Although many people focus on medical-surgical services, we also rely on them when our students are in psychiatric crisis."

— Charles Nies, Vice Chancellor of Student Affairs

The newest UC campus is in Merced, a community of 83,000 people midway between Fresno and Modesto. The only inpatient care in the area is a children's hospital and the 186-bed Mercy Medical Center, a Dignity Health facility.[9]

"If Mercy Merced were no longer available, it would be devastating to student health, faculty recruitment and retention. It would limit the opportunity to bring UC Health services to the community, and the development of future academic programs in the health sciences at Merced," said Nathan Brostrom, Interim Chancellor. "Our goal is to expand health care access in Merced. If you cut off an affiliation with the only hospital in the area, you effectively put an end to that effort," Brostrom says.

When students have inpatient health care needs, they are referred to Mercy Medical Center, so the prospect of ending that relationship alarms Charles Nies, UC Merced's Vice

Chancellor of Student Affairs. "If we had to sever ties with them, we'd have no health care partner in our area. Although many people focus on medical-surgical services, we also rely on them when our students are in psychiatric crisis," says Nies.

Because there are already so few doctors, nurses, and other health professionals in the area, UC Merced hopes to build upon its popular programs in biology to create a pre-med path with UC San Francisco at Fresno. However, that plan requires access to clinical settings even as a pre-med student. "The highest percentage of first generation college students in the entire UC system is at UC Merced. We want to open their eyes to careers that not only lift them up, but their community as well. The highest predictor of where someone will open a practice is where they went for their undergraduate, medical school and residency. Mercy Merced is integral to all three phases of career development."

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9. **https://oag.ca.gov/sites/all/files/agweb/pdfs/charities/nonprofithosp/dignity-chi-merced-county-health-impact-report.pdf**

Mercy Merced already has strong ties to UC students through a volunteer program, which has grown from nine students in 2007 to more than 50 today. "It provides a first-hand look at career options they might not have thought possible. They start to seriously imagine themselves in these roles of doctor, nurse, pharmacist or other health professional," Nies says.

The impact of ending the affiliation doesn't end there. "How are we going to recruit faculty if the only hospital in the area is out-of-network? Would you accept that job offer?" Brostrom asks.

Indeed, ending the affiliation also would end efforts by UC Health to bring its primary care physicians and specialists to serve the campus and community. "They have to be able to admit patients somewhere."

But what about the debate about values? "Without question it is important to lead with values," Nies says. "But we have to think first and foremost about the safety and well-being of our students, faculty and staff. The loss of immediate access to high-quality inpatient care would be extremely concerning. I'm thinking about situations that are life and death, things that are unpredictable. An hour-long drive simply isn't feasible."

AT-RISK UC COMMUNITY 2:
SANTA CRUZ-WATSONVILLE AREA

The greater Santa Cruz metropolitan area has about 275,000 residents.[10] In addition to the city of Santa Cruz, the area is home to the UC Santa Cruz campus. The area also includes the smaller towns of Aptos, Capitola, and Watsonville in the south and Boulder Creek in the north, near Big Basin Redwoods State Park.

UC Santa Cruz does not have a UC medical center on the campus. Santa Cruz area health plan members will be highly impacted if institutions that have policy-based restrictions are no longer accessible to the UC community. The area has just one major hospital—Dominican Santa Cruz (a Dignity Health facility), located in the city of Santa Cruz—that provides most services in the area. One-third of Santa Cruz area members

receive care at Dominican Hospital. Less than 2% of members receive care at Watsonville Community Hospital, a potential alternate facility that is a 15-mile/20-minute drive from Santa Cruz. Members from Santa Cruz do not typically travel to alternate facilities in the San Jose area to receive care. The remaining two-thirds that don't obtain care at Dominican Hospital receive services from 30 other hospitals, including UC medical centers in Northern and Southern California. If members have tertiary or quaternary specialty care needs (about 20% of the two-thirds), they primarily seek care at either Stanford or UC San Francisco medical centers. **Eliminating Dominican Hospital from the UC network would cause access and quality issues and would disrupt current practice and referral patterns.**

FIGURE 2: CATHOLIC AFFILIATED INSTITUTIONS IN THE SANTA CRUZ-WATSONVILLE AREA

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10. https://datausa.io/profile/geo/santa-cruz-watsonville-ca-metro-area

Similar to UC Merced, the student population at UC Santa Cruz would also be impacted. Nearly 50% of UC Santa Cruz students that need facility-based care receive it at Dominican Hospital. Also similar to the experience at UC Merced, many of the remaining half receive care at UC San Francisco and Stanford medical centers. These members are likely those that require a higher level of care than could be provided at Dominican

Hospital. Less than 2% of students that need facility-based care receive it at Watsonville Community Hospital, an alternate facility in the area. **This utilization also implies a pattern of practice that could be highly disruptive to the student population if Dominican Santa Cruz Hospital were to be excluded from the network.**

UC SANTA CRUZ

SARAH LATHAM

Vice Chancellor, Business and Administrative Services

"Of course we have to take multiple viewpoints into account, but making health care difficult to access for all people doesn't improve access for anyone."

On a map, Santa Cruz looks close to Silicon Valley. Behind the wheel, however, those 32 miles can take well over an hour. Highway 17, the primary route, was first built in the 1930s, and its tight curves, lack of shoulders, frequent accidents, and mudslides have earned it the nickname "Blood Alley." It's even listed as one of the nation's most dangerous roads.

For UC Santa Cruz, with more than 20,000 students, faculty, and staff, the only nearby full-service hospital is Dominican, a Dignity Health facility. Other options are limited to a small surgical facility operated by Sutter Health, and a community hospital 18 miles away just off Highway 1 in Watsonville.

"We don't have a plethora of other hospitals, like some communities do," says Sarah Latham, who has been a Vice Chancellor at UC Santa Cruz for more than seven years. "We are more geographically isolated than most people think."

Latham recalls a recent experience with her mother, who went to a doctor's appointment only to be told she needed to be admitted to the hospital immediately. She stayed at Dominican for a week.

"That was stressful enough," Latham says. "I can't imagine an ill person trying to make that winding drive toward San Jose in a hurry. And it's not just the patient. Family members want to visit. That back and forth commute can take almost half a day. Would a single parent or an hourly employee have that much child care support or the ability to take so much time off from work?"

For Regents considering their decisions, Latham offers this perspective: "Of course we have to take multiple viewpoints into account, but making health care difficult to access for all people doesn't improve access for anyone. The idea of not being able to use the only nearby hospital would be devastating for many."

AT-RISK UC COMMUNITY 3:
GREATER SACRAMENTO AREA

The Greater Sacramento area includes cities such as the city of Sacramento, Davis, Roseville, and Folsom, and has a population of approximately 2.4 million residents.[11] The area includes the UC Davis campus and the UC Davis Health enterprise, including the UC Davis Medical Center located in Sacramento.
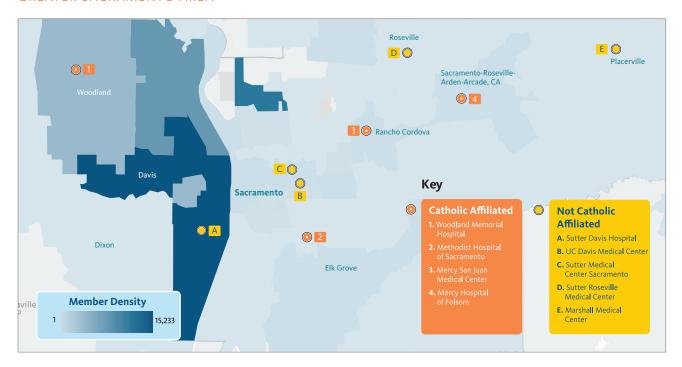
Four of the nine hospitals in the Sacramento MSA are Catholic-affiliated, representing over a third of the area's 1,400 licensed beds.[12] While the Sacramento area is not typically known for access or care capacity issues, it would be greatly impacted by the exclusion of providers subject to policy-based restrictions on care. UC Davis Medical Center, for example, is at capacity and could not accommodate repatriating impacted members. The most impacted areas would be Woodland (where Woodland Memorial Hospital is located), the southern part of Sacramento (Methodist Hospital of Sacramento), and Folsom (Mercy Hospital of Folsom). Travel times would increase by at least 10 to 15 miles/15 to 30 minutes. Many of the routes to alternate facilities (e.g., UC Davis Medical Center or Sutter Davis) would require driving near or through central/downtown Sacramento, which is known for its heavy traffic and traffic-related delays. Exclusion of the providers that have policy-based restrictions

on care may impact access of not just UC health plan members but also the larger community. The impact on the larger community is important to highlight since the University's mission includes not just a direct focus on the UC community, but also a commitment to the public and service to all California communities.

Of the 53,000 UC health plan members in the Sacramento area, about 4,000 received care at a Catholic facility over the two-year review period. Of these, about 1,800 are retirees living in the area that received care at a Catholic facility. Retirees are typically a population that requires more services, has closer relationships with their providers, and may be more mobility-limited. **Eliminating a significant portion of the network would particularly impact retirees because of the greater distances many would need to travel to receive care.**

In addition to the extra travel time and the disruption to provider relationships with their patients, **the alternatives to Dignity Health are Sutter facilities, which are more costly to the UC health plans and to the members who pay coinsurance or have higher health plan deductibles.**

FIGURE 3: CATHOLIC AND NON-CATHOLIC AFFILIATED INSTITUTIONS IN THE GREATER SACRAMENTO AREA

Key

Catholic Affiliated
1. Woodland Memorial Hospital
2. Methodist Hospital of Sacramento
3. Mercy San Juan Medical Center
4. Mercy Hospital of Folsom

Not Catholic Affiliated
A. Sutter Davis Hospital
B. UC Davis Medical Center
C. Sutter Medical Center Sacramento
D. Sutter Roseville Medical Center
E. Marshall Medical Center

Member Density

1   15,233

11. https://www.statista.com/statistics/815313/sacramento-metro-area-population
12. California Office of Statewide Health Planning & Development (OSHPD) Annual Financial Disclosure Reports (December 2019).

AT-RISK UC COMMUNITY 4:
SAN LUIS OBISPO-PASO ROBLES-ARROYO GRANDE AREA

The San Luis Obispo area has a population of about 284,000 residents.[13] Major cities in the area include Paso Robles and Atascadero in the north, Morro Bay on the coast, centrally located Arroyo Grande and the city of San Luis Obispo, and Santa Maria in the south. The area has no UC Health providers, and no University campuses are located there. The area has five hospitals, three of which are Catholic. Forty percent of members in the area (almost 800 members) received care at the three Catholic facilities. The two alternate facilities are Twin Cities Community Hospital (in the city of Templeton) and Sierra Vista Regional Medical Center (in the city of San Luis Obispo). Though Sierra Vista Regional is located in San Luis Obispo city, the most populated city in the area, most members that receive care at a non-Catholic facility traveled to Twin Cities Community, which is 20 miles/25 minutes away. Interestingly, almost 20% of services received at Twin Cities Community are related to maternity care. Sierra Vista utilization for UC members is less than half that of Twin Cities Community, which likely means that Twin Cities Community offers a greater mix and higher-quality services.
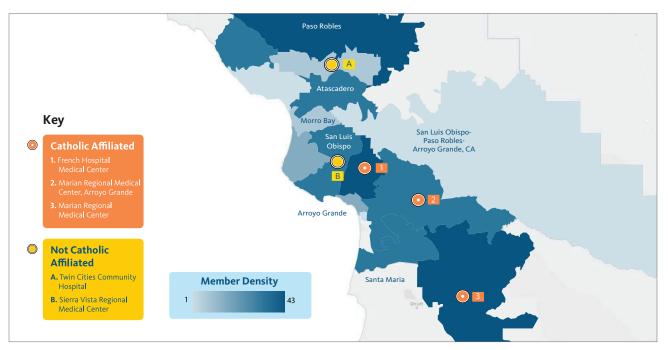
Many members in the San Luis Obispo area travel south to Marian Regional Medical Center, a Catholic facility located in the city of Salinas, which is about halfway between San Luis Obispo and Santa Barbara. **Excluding Marian Regional from the UC network would significantly impact members because it is the most utilized facility of residents from both San Luis Obispo and Santa Maria (considering usage of all facilities).**

Without access to Marian Regional, Santa Maria residents would need to drive an additional 30+ miles/35 minutes to Sierra Vista Regional or 50+ miles/50 minutes to Twin Cities Community. However, it is not clear that the alternate hospitals could provide the appropriate level of care or service mix that members may need and that only the facilities excluded from the network could provide. What is clear is that the hospital capacity to care for patients would be substantially reduced. The total number of medical/surgical hospital beds for all five hospitals is 470, of which the institutions with policy-based restrictions on care provide about 250.[14] Excluding the Catholic facilities would reduce capacity by more than half (54%).

Similar to the Sacramento area, exclusion of the Catholic-affiliated providers may impact access of not just UC health plan members but also the larger community. **As a public institution with a mission of public service, funneling UC health plan members into the remaining hospitals could negatively impact the ability of those providers to provide quality and timely care to the community as a whole.**

FIGURE 4: CATHOLIC AND NON-CATHOLIC AFFILIATED INSTITUTIONS IN THE SAN LUIS OBISPO-PASO ROBLES-ARROYO GRANDE AREA

Key

Catholic Affiliated
1. French Hospital Medical Center
2. Marian Regional Medical Center, Arroyo Grande
3. Marian Regional Medical Center

Not Catholic Affiliated
A. Twin Cities Community Hospital
B. Sierra Vista Regional Medical Center

Member Density
1   43

13. 2018 UC Census Bureau.
14. California Office of Statewide Health Planning & Development (OSHPD) Annual Financial Disclosure Reports (December 2019).

IMPACT ON **UC HEALTH SCIENCES EDUCATION**

PROHIBITION ON AFFILIATIONS WOULD NEGATIVELY IMPACT UC'S MEDICAL AND NURSE TRAINING PROGRAMS

In keeping with the public service mission of the University, and to enhance our educational mission, UC medical and nursing programs are responsible for educating and preparing health care providers to serve every member of our community, including those who are uninsured or who have coverage through Medi-Cal. Core aims of UC clinical training programs include diversity, equity, and inclusion to ensure that our graduates are prepared to care for all patients fairly and equitably, regardless of the site of care or type of health system where care is provided. In view of the growing diversity of the California population, UC health sciences schools have a mission and responsibility to teach future health professionals about different cultures and values across California's diverse communities and delivery systems. UC medical and nursing schools instill in our trainees the idea and expectation that advocating for patients and protecting the provider-patient relationship is the professional responsibility of the clinician. At the same time, our broad educational aims are to train health care providers who understand and are well prepared to care for patients in the broad array of settings where care is provided. Ending educational affiliations with community institutions that have policy-based restrictions on care would thus undermine core aspects of our educational mission and limit valuable regional partnerships that often must work together to meet public health needs.

Many types of clinical training sites are required to provide patient experiences for our students and trainees that represent the diversity of California and that are necessary to prepare them for future practice. Across the University's health sciences instructional system, our medical students, nursing students, and medical residents and fellows have experiences in UC-owned and operated ambulatory and hospital settings and in other settings, including public hospitals, Veterans Administration facilities, and a broad array of community sites across the state. Institutions that have policy-based restrictions on care are also among the sites that are important for the clinical education of our students. These facilities enable UC students to gain relevant community experience working outside the academic setting. Students gain experience that reflects and encompasses the practice of health care as it is delivered for a majority of patients in California and the nation. This is also important given that, when our students complete their training, the majority of them will practice in a broad range of community sites rather than exclusively in academic settings. Within a statewide context, it is important to note that data published by the Association of American Medical Colleges (AAMC) in its 2019 Physician Workforce Profile shows that California is among the leaders of all states in the retention of medical students who attend public medical schools (i.e., those operated by the University of California).

The diversity of affiliations with community health facilities is particularly critical for medically underserved regions across the state, including the San Joaquin Valley and the Inland Empire. The UC Riverside School of Medicine was specifically created to recruit students from the region and to prepare them as future providers who will work in medically underserved regions of the state. The UC Riverside School of Medicine is reliant on community-based affiliations, including the Dignity Health St. Bernardine Medical Center in San Bernardino, California, which is regionally accessible for the Riverside campus.

A. IMPACT OF AFFILIATIONS ON UC RIVERSIDE SCHOOL OF MEDICINE

UC Riverside is a community-based medical school program, which, as defined by the AAMC, is a non-federal medical school, accredited after 1972, and which does not have an integrated teaching hospital. There are 36 community-based medical schools in the nation, and they are frequently in rural or underserved areas and have a mission to train providers that will serve in these areas.

As a community-based school, the UC Riverside program does not own or operate a UC hospital. The UC Riverside School of Medicine must therefore rely on multiple affiliations to build its clinical teaching platform for training medical students and residents. If the school, which was founded for the purpose of bringing medical services to the underserved "Inland Empire" in Southern California, were unable to affiliate with regional health systems that adhere to policy-based restrictions on care, its clinical platform for training would be severely compromised. The school would lose approximately one-third of its total training capacity, as well as the only existing opportunity for clinical training that provides care to the underserved populations of San Bernardino County.

Currently, fourth-year students do clinical electives at Dignity Health's St. Bernardine Medical Center in San Bernardino. The internal medicine residency program, a backbone of the medical school training program, relies on training sites at St. Bernardine Medical Center, Riverside County Hospital, and Kaiser in Fontana. If the relationship with St. Bernardine Medical Center were to be terminated, tremendous strain would be placed on the County and Kaiser. In addition, the only interventional cardiology program in the region is at St. Bernardine Medical Center. Training in this specialty is integral and important for both our students and internal medicine residents.

More broadly, as a community-based medical school, UC Riverside must consider its full, regional community base, which includes a large Catholic health system, institutions that are Seventh Day Adventist, and others. As the first public medical school to open in California in more than 40 years, the school must embrace and work with all of its community partners in this medically underserved region.

Importantly, UC Riverside School of Medicine is not the only institution competing for these regional partnerships. The California University of Science and Medicine (CalMED) is a new medical school located in San Bernardino, California, less than 20 miles from UC Riverside. The school is provisionally accredited by the Liaison Committee for Medical Education (LCME) and accepted its first class in 2018. It has 120 students per class, and this school will continue to compete with UC Riverside for clinical affiliations to support medical student education. The ability of community-based medical schools to provide the clinical curriculum required for an accredited medical program depends on maintaining stable and collaborative clinical affiliations and partnerships. There are a limited number of health systems within a reasonable distance from the UC Riverside campus that are deemed appropriate and permissible by the LCME. The St. Bernardine Medical Center is an important affiliate, and the loss of this affiliation would force UC Riverside to decrease the size of the medical school class at the time it is trying to increase capacity. Significant reduction in clinical training sites and access to accredited residency programs would potentially threaten the accreditation and viability of the UC Riverside School of Medicine.

B. DATA REGARDING CURRENT AFFILIATIONS

Tables 1 through 4 provide summary data regarding the clinical training agreements for UC Health medical and nursing schools. This data has been provided by the Deans of our six UC medical schools and four UC nursing schools and reflects current training agreements. These educational affiliation arrangements are the means by which UC schools approve and manage clinical clerkships and elective rotations for students and for medical residents who are participating in specialty-specific graduate medical education (GME) programs. The data is provided for 1) nursing, 2) medical students, and 3) medical residents (or GME trainees). For each category, the Deans have provided information to help demonstrate the anticipated impact of ending affiliations with systems that have policy-based restrictions on care.

The total proportion of clerkship rotations and training experiences at Catholic-associated health systems is ~5.5% for UC nursing students, ~5.6% for medical student rotations, and ~6.8% of GME trainees. Although these overall proportions may seem small, in specific programs, the proportions of students or trainees impacted may be far greater. Examples include advanced practice nursing programs and those operated by the **UC Riverside** School of Medicine, and specific disciplines, such as behavioral health. These programs have been identified in the health professional Deans' comments in the next section.

TABLE 1: SUMMARY FOR UC SCHOOLS OF NURSING STUDENT PLACEMENTS (NOT FTE)

Affiliate Type	Current Estimated Student Placements
UC-owned hospitals and clinics	1,050
VA facilities	169
County facilities	549
Community facilities	3,163
For profit/private	908
Not for profit – no religious affiliations	1,952
Catholic-associated health systems	175
Other faith-based health systems	128
TOTAL	**4,931**

IMPACT ON UC NURSING EDUCATION PROGRAMS OF A PROHIBITION ON AFFILIATIONS

- The **UC Irvine** School of Nursing relies heavily on community affiliations. Ending affiliations with systems that have policy-based restrictions on care would create overcrowding at remaining clinical facilities, potentially jeopardizing students' ability to graduate on time and UC Irvine's capacity to admit new nursing students.

- In the past year, **30% of UC Davis family nurse practitioner (NP) and physician assistant (PA) students** fulfilled their required two- to four-week clinical rotations in primary care, behavioral health, emergency medicine, surgery, and cardiology in Catholic-affiliated facilities. Eliminating or reducing these affiliations would negatively impact training for these advanced practice clinical programs.

- The **UC Los Angeles** School of Nursing would be negatively impacted beyond loss of placements. Institutions that have policy-based restrictions on care with which UC Los Angeles collaborates provide a high-caliber educational experience, are flexible in accepting students (in the Southern California region where placements are difficult to find), have excellent clinical preceptors, and engage UC Los Angeles clinical faculty to improve student success.

- The **UC San Francisco** School of Nursing would be minimally impacted based on data, though the academic Deans recognize, support, and value the importance of community partnerships for other health professional schools in the UC System.

TABLE 2: SUMMARY FOR MEDICAL STUDENT AFFILIATIONS (NOT FTE)

Affiliate Type	Current Estimated Student Rotations
UC-owned hospitals and clinics	5,621
VA facilities	1,412
County facilities	1,863
Community facilities	2,870
For profit/private	846
Not for profit – no religious affiliations	1,640
Catholic-associated health systems	163
Other faith-based health systems	221
TOTAL	**11,766**

IMPACT ON UC UNDERGRADUATE MEDICAL EDUCATION PROGRAMS OF A PROHIBITION ON AFFILIATIONS

- The community-based **UC Riverside** School of Medicine is almost entirely dependent upon community affiliations for undergraduate medical education. UC Riverside School of Medicine's affiliation with Dignity Health's St. Bernardine Medical Center complements a substantial graduate medical education presence and provides clerkship rotations for one-third of students. Another UC Riverside training affiliate, Loma Linda University (a Seventh Day Adventist Health Sciences University), is a significant employer of physicians who want to stay in the Inland Empire, which is also aligned with UC Riverside's mission to improve access to medical services for this region. Reducing affiliations would leave far fewer options for student rotations and far less flexibility. It is important to emphasize that UC Riverside residency and fellowship programs form the foundation for medical student education because students work and learn in team settings with residents, fellows, and attending faculty physicians. Further, the LCME requires medical students to work with residents as part of the accreditation of medical schools. (See next section for details on UC Riverside residency and fellowship training programs.)

- At the **UC Irvine** School of Medicine, scaling back or ending relationships with providers that have policy-based restrictions would result in overcrowding of students at other clinical sites in order to accommodate required clinical experiences. Students would be impacted throughout their first through third years.

- Scaling back or ending affiliations with systems that have policy-based restrictions on care would have a negative effect on the student learning experience for **UC Davis** School of Medicine's primary care/family medicine clerkships. Faith-based health systems have been longtime partners, with reliable educators who are well-rated by students.

- For the **UC Los Angeles** School of Medicine, systems that have policy-based restrictions on care provide important community placements for medical student core clerkships in neurology and family medicine. Any future changes to these arrangements would require identifying new clinical rotation sites, which has been increasingly challenging for many educational training programs, which compete for limited placement sites in communities.

- Although there would not be a major impact on the **UC San Francisco** School of Medicine's educational training program, UC San Francisco medical students often seek and benefit by having elective experiences in a diverse array of community settings.

TABLE 3: UC HEALTH GRADUATE MEDICAL EDUCATION AFFILIATIONS

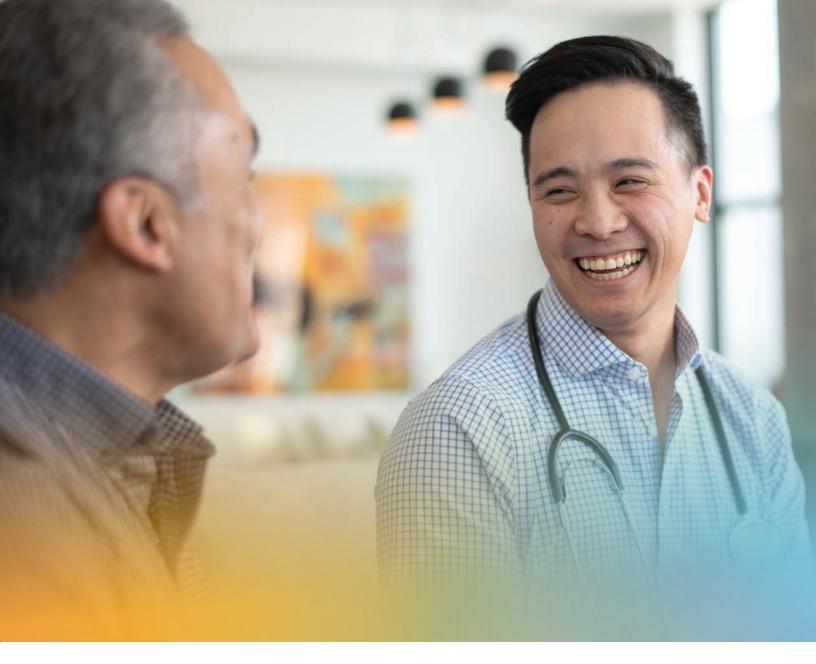| Affiliate Type	Current Estimated FTE
UC-owned hospitals and clinics	2,545
VA facilities	770
County facilities	386
Community facilities	674
For profit/private	105
Not for profit – no religious affiliations	494
Catholic-associated health systems	46
Other faith-based health systems	29
TOTAL	4,375

IMPACT ON UC GRADUATE MEDICAL EDUCATION (GME) PROGRAMS OF A PROHIBITION ON AFFILIATIONS

- A prohibition on affiliations with institutions that impose policy-based restrictions on care would most substantially and adversely impact **UC Riverside** as one of three medical schools in the Inland Empire that are all vying for community-based placements for training of residents.

- The UC Riverside School of Medicine has a total of seven GME programs (residencies and fellowships). If affiliations were prohibited, four of the programs would likely be terminated, and one other would be severely impacted.

  o The UC Riverside-sponsored family medicine residency program will be based 100% at Dignity Health's St. Bernardine Medical Center beginning in July 2020. If this affiliation is prohibited, it is unlikely this residency program could continue.

  o In addition, St. Bernardine Medical Center is one of three locations for the UC Riverside-sponsored internal medicine residency program. Without this location, accreditation for this program is at risk.

  o The UC Riverside-sponsored fellowships in cardiovascular disease, interventional cardiology, and gastroenterology are based 100% at Dignity Health St. Bernardine Medical Center. These three programs would no longer be able to continue if that affiliation is prohibited.

- Details for UC Riverside-sponsored programs are shown below. **Seventy-seven trainees would be impacted by eliminating the affiliations with providers that have policy-based restrictions on care.**

- In San Francisco, the only burn center and the only adolescent inpatient behavioral health beds in the city are at Dignity Health facilities. **UC San Francisco's** training programs in these fields are completely dependent upon affiliations with these institutions—as is the ability of UC San Francisco to care for patients needing these services. Eighty-three UC San Francisco residents and fellows from seven medical specialties currently train at these sites as part of required rotations each year.

TABLE 4: UC RIVERSIDE SCHOOL OF MEDICINE-SPONSORED GME PROGRAMS

Program	Location(s)	Number of Trainees	Positions Offered Each Year
Family Medicine Residency	St. Bernardine Medical Center	26	8
Internal Medicine Residency	St. Bernardine Medical Center, Riverside University Health System, Kaiser	37	12
Psychiatry	Riverside University Health System, VA, Kaiser, Patton State, Pacific Grove	18	8
Child & Adolescent Psychiatry Fellowship	Riverside University Health System	4	2
Cardiovascular Disease Fellowship	St. Bernardine Medical Center	10	3
Gastroenterology Fellowship	St. Bernardine Medical Center	3	2
Interventional Cardiology Fellowship	St. Bernardine Medical Center	1	1

- More broadly, a prohibition would also raise the following concerns for UC's GME programs:

    o   In some instances, there are no alternatives to replace the GME rotations that are currently in place at health systems that have policy-based restrictions on care.

    o   These clinical settings present unique learning opportunities (e.g., palliative and hospice care discussions and decisions). Preparing our trainees to navigate these types of situations will be difficult to replicate in other locations.

UC trainees provide critical care in subspecialties that are otherwise not available to these facilities, especially for the vulnerable patients they serve, including the uninsured, homeless, and Medi-Cal populations. Beyond the adverse impact on UC's training programs, a ban on affiliations for GME would reduce both the care that UC provides to patients and the longer-term public benefits of preparing our students and residents across the full array of training sites that serve California's diverse communities.

The personal stories from UC trainees that you see on these pages underscore the significance of UC's existing affiliations to our health sciences education program.

RESIDENT AND **MEDICAL STUDENT** STORIES

DR. CATHERINE PEONY KHOO

Catherine Peony Khoo, MD, has a broad perspective on studying and training within institutions that have policy-based restrictions on care. As a medical student, she attended St. Louis University, a Jesuit school. During her residency training in family medicine at UC Los Angeles, she did labor-and-delivery rotations in her first and second years at California Hospital Medical Center, a Dignity Health facility in downtown Los Angeles. In both settings, she says, "There is an emphasis on outreach to the community and helping the underserved, and I think that really has ingrained in me a strong passion for service."

California Hospital treats a large immigrant population, and many of the patients whom Dr. Khoo saw had come to the hospital to deliver babies with limited or no prenatal care. "For me, it was important exposure to connecting with a population that needs help," she says. Many of the women Dr. Khoo saw

were reluctant to seek care during their pregnancies for a variety of reasons. One of her co-residents treated a woman who, as a child, had undergone genital mutilation. Observing how the hospital's providers managed that case with great sensitivity "raised our cultural awareness and understanding," she says.

Having earned her MD degree at a Catholic university, Dr. Khoo knew there would be limitations at a Dignity Health site on her ability to talk with patients about issues such as abortion or contraception. Still, she believes it would be detrimental to future trainees if UC were to sever its relations with institutions that have policy-based restrictions on care.

"As a resident, you want to get as much experience as possible, and I wanted more experience in labor and delivery," she says. "It can be quite challenging in Los Angeles as a resident

"**WITHOUT ACCESS** TO THESE FACILITIES, THE **OPPORTUNITIES** TO **GAIN MEANINGFUL CLINICAL EXPERIENCE** COULD BE EVEN **MORE DIFFICULT**..."

in family medicine to get adequate volume and meaningful hands-on experience in labor and delivery because of the large number of training programs there are here. We are competing for placements with trainees not only from our field in family medicine but also, of course, from obstetrics and gynecology, and not just from UC Los Angeles, but also from other training programs in the city. If there were no option to go to a facility like California Hospital, I think it would be incredibly challenging and we might have a less-meaningful experience. Having that experience was really important to me, particularly as I will be doing a fellowship in obstetrics."

"Without access to these facilities, the opportunities to gain meaningful clinical experience could be even more difficult for UC medical students and trainees outside of large urban areas such as Los Angeles, where there may be fewer training options," Dr. Khoo says. "I would hate to see future residents not have an opportunity to provide care in that setting if it is the best option for them."

And, ultimately, she says the experience that students and trainees receive in different care settings benefits them and the patients they will treat. "I think that within the comprehensive context of UC medical education and training that it's a valuable experience to have exposure to different settings and different health systems," Dr. Khoo says.

UC LOS ANGELES

JASMIN C. NEAL
FREDERICK FERGUSON

"I understand the issue the Regents are considering. But we represent UC and hold UC values even when we are away from UC. If I ever saw something that troubled me, I would feel comfortable reporting my professional concerns. You are even allowed to do so anonymously."

— Jasmin C. Neal, MD Candidate at the David Geffen School of Medicine at UC Los Angeles

Jasmin Neal and Frederick Ferguson were third-year internal medicine students at UC Los Angeles when they rotated through St. Mary's Medical Center in Long Beach, a Dignity Health facility. Although the rotation was only four weeks long, it made a lasting impression.

Frederick remembers the high number of patients with alcohol withdrawal, kidney disease, or who had suffered strokes or heart attacks. One patient, a man in his 40s, had already developed cirrhosis of the liver and needed counseling and support resources to deal with his alcoholism.

"As a medical student I was able to pre-round on my patients and have more time to talk with them. This extra time allowed me to help educate patients who may not be able to grasp the full extent of their condition," says Frederick. In the case of this patient and his family, "Just talking with them, I got a sense of some of the things that led to his reliance on alcohol. I've always taken extra time to understand patients, and this environment fostered that."

Before beginning their field experience at St. Mary's Medical Center, both Jasmin and Frederick were aware that it is a Catholic facility. Neither recalls any instances where they felt appropriate care was being denied or withheld based on hospital policies.

"I understand the issue the Regents are considering," says Jasmin. "But we represent UC and hold UC values even when we are away from UC. If I ever saw something that troubled me, I would feel comfortable reporting my professional concerns. You are even allowed to do so anonymously."

Both are concerned about what would happen to patients if UC faculty, residents, and medical students couldn't work at St. Mary's Medical Center, but they also are concerned about the loss of the educational experience for future medical students.

"Education should provide exposure to different scenarios, different patients and different settings," Frederick says. Jasmin agrees: "The experience in a variety of settings helps us figure out what environment we want to practice in in the future."

UC SAN FRANCISCO

DR. DAVID NERY

"It was the best learning and teaching experience that one could ever have. It has been a wonderful bridge in learning."

— David Nery, MD

David Nery, MD, was in his third year of residency at Dignity Health's St. Mary's Medical Center when the relationship with UC San Francisco began. From the start, he says, the new association was seamless and professional.

"The UC rigor in terms of reading, education, training, teaching—of raising the bar in general—was evident from the start," Nery says. "Our learning exploded in quality and amount. The residents knew that if you work at UC San Francisco, it is because you are excellent. That reputation won over the hearts of residents. We were very excited to learn from the physicians who taught us, and they were excited to teach us. It was a match made in heaven."

Following the completion of his residency last year at St. Mary's Medical Center, Nery, to his great joy, joined UC San Francisco Helen Diller Medical Center at Parnassus Heights as a clinical instructor and cardiology hospitalist focusing on advanced heart failure.

"It was absolutely because of the relationship between UC San Francisco and St. Mary's that I'm now doing the work I most wanted to do," he says. "It was the best learning and teaching experience that one could ever have. It has been a wonderful bridge in learning."

"IT WAS **ABSOLUTELY** BECAUSE OF THE **RELATIONSHIP BETWEEN UC SAN FRANCISCO AND ST. MARY'S** THAT I'M NOW **DOING THE WORK I MOST WANTED TO DO**."

MEDICAL STUDENTS LEARN TO HELP **UNDERSERVED POPULATIONS**

"We've never had interference about the counseling we give patients about their health care options at Scripps Mercy. For services not provided here, we refer out. I understand the strong emotions associated with reproductive health. My younger self would have said there needs to be a clear separation from religious barriers to care. Now, I've come to realize that a referral isn't always a bad thing."

— Marianne McKennett, MD, Program Director from UC San Diego Health

San Ysidro Health in Chula Vista provides much-needed care to newborns, adolescents, and adults. And for more than 20 years, family medicine residents affiliated with UC San Diego Health have been collaborating with Scripps Mercy Hospital and other community providers through the health center to reduce inequalities in access to care.

Two dozen UC San Diego residents work at the federally qualified health center, each spending three years in the community providing outpatient care at the clinic and inpatient care at Scripps Mercy Hospital. Many of the residents working at San Ysidro Health graduated from one of UC's PRIME programs, which combine typical medical student training with additional curricula focused on underserved populations.

Marianne McKennett, MD, Program Director from UC San Diego Health, says, "Our patients live in the reality of a multi-cultural, bi-national existence. They may live on one side of the border and work on the other side. Many of them have not had consistent access to care, at least not until the expansion of Medi-Cal."

The family medicine residency program is sponsored by Scripps Mercy, a Catholic facility that does not provide certain services. However, the team there has a well-developed referral process to ensure patients get the medically appropriate, patient-requested care they need. "We've never had interference about the counseling we give patients about their health care options at Scripps Mercy," says McKennett. "For services not provided here, we refer out. I understand the strong emotions associated with reproductive health. My younger self would have said there needs to be a clear separation from religious barriers to care. Now, I've come to realize that a referral isn't always a bad thing. Medical facilities make referrals for other types of care that cannot be provided at their site. Examples include cardiac care and neurological surgery. You wouldn't automatically assume that's a lower level of care just because you had to be referred."

As for what would happen if UC had to step away from these agreements? "I think that the family medicine residency program would continue under Scripps sponsorship; however, valuable opportunities such as shared faculty, medical student teaching and UC San Diego resident collaboration would be lost," McKennett says. Scripps Mercy currently provides core medicine and OB-GYN clerkships for 100 UC San Diego medical students each year. Grant writing and program development opportunities could also be negatively impacted. Dr. McKennett also sees another benefit of these affiliations: "UC may not fully realize the value that these campus/community partnerships provide back to UC. This work—these patient encounters—break down the perception of academics in an ivory tower and help foster a positive view of UC."

IMPACT ON
EFFORTS TO MANAGE
COVID-19 PANDEMIC

PROHIBITION ON AFFILIATIONS WOULD SEVERELY UNDERMINE THE COLLECTIVE, COORDINATED EFFORT TO MANAGE THE COVID-19 PUBLIC HEALTH CRISIS IN THE STATE OF CALIFORNIA

UC Health began the process of collecting and analyzing data regarding our affiliations in 2019. The health care landscape in 2020 is now facing the COVID-19 pandemic. This is a watershed moment—a dividing point from which our world will never be the same.

The COVID-19 pandemic is the most significant public health crisis in over a century. Many have referred to this pandemic as an apocalypse, given the health and economic consequences of the public health emergency. The Greek origin of the word is *apo*, which means "un," and *kaluptein*, which means "to cover." Together, *apokaluptein* means to uncover or reveal.

The COVID-19 pandemic has starkly revealed the weaknesses inherent in U.S. health care, including the lack of health care coverage for all Americans and limitations in access faced by the poor, uninsured, and other marginalized populations in the U.S. Accordingly, while the effects of COVID-19 are experienced by everyone, the poor, underinsured, and underserved are disproportionately impacted.[1]

The disproportionate burden of health disparities in poor communities existed for virtually all medical conditions in the U.S. before the pandemic. Health care providers are very aware of these disparities, and increasing health equity through the elimination of health disparities is a UC Health systemwide goal.

The COVID-19 pandemic has now uncovered or revealed these health disparities to all who live in the U.S. The visibility comes from the infectious nature of COVID-19. While the public may be unaware of the health disparities associated with asthma, cancer, diabetes, heart disease, infant mortality, and myriad other conditions, because their own health is not impacted, it is obvious that the lack of care for any individual with COVID-19 places the health of the entire nation at risk.

During COVID-19, the importance of affiliations in meeting the health needs of all the people of California has been easier to recognize. In order to manage the spread of the virus, we need to ensure that people have access to care as soon as possible across all geographic regions. During the course of the debate about UC's affiliations with institutions that have policy-based restrictions on care, UC Health has underscored that our academic health centers must collaborate with other institutions in executing our mission to serve the people of California. At no time in our history has this been more apparent. As this virus continues to spread, and millions of Americans are losing their jobs and health insurance, it is now more important than ever for UC Health to collaborate with other health systems to expand the reach of its care and research to the people of California.

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1. Sarah Collins and David Blumenthal. LA Times. Without Universal Healthcare, Coronavirus Puts us All at Risk. March 2020.

As previously underscored, the need to partner with organizations that are willing to serve Medi-Cal patients is critical—in order to offer broad access to UC's expertise and services, including to patients in rural areas and to those who may be distant from existing UC facilities. Catholic facilities governed by Ethical and Religious Directives are often the most likely to provide care to medically underserved populations because of their commitment to serve the poor, with Dignity Health providing more Medi-Cal inpatient hospital stays and outpatient hospital visits than any other provider in the state.[2] As discussed in previous sections of this report, affiliations with UC improve and expand both the care available to the patients served by those institutions and their access to UC facilities when needed. In the context of the COVID-19 pandemic, where we are collectively at risk of exposure and illness, caring for these populations is not just part of UC's mission and moral obligation, it is essential to the health and well-being of the people of California.

Consistent with our tripartite mission of education, research, and caring for patients as a public service, UC's academic health centers have been at the forefront of efforts to prevent, detect, and treat COVID-19 in California. Our testing capacity is continuing to grow, with all five UC academic health centers having in-house testing capabilities and working collaboratively to increase capacity across the system and for the communities we serve. UC researchers are leading the way to better understand and educate others about the virus and how it is transmitted, identify existing drugs that might treat it, and develop vaccines and new treatments. All of our health centers are caring for patients with COVID-19 in our facilities and in facilities with which we have long-standing affiliation agreements. Our health centers are also actively offering their communities the benefit of UC resources, services, and expertise—all as a vital asset of the Governor's response plan.
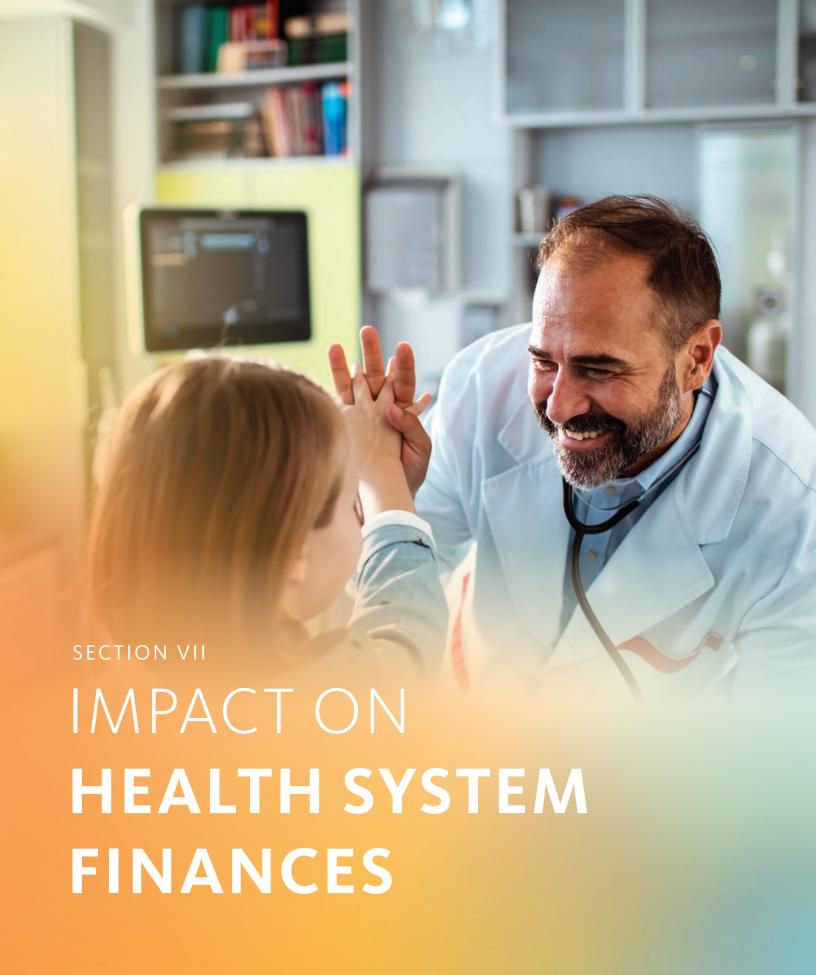
The unanimous call—from our local, regional, and state leaders, including the Governor—is for all of the state's health systems to work together to combat the threat that we collectively face from COVID-19. This coordination means that we must work across health systems within our communities to provide the best care for patients, meet staffing needs, ensure adequate distribution of critical supplies for testing and treatment, make additional beds available for an expected surge in hospitalizations, facilitate telehealth services, and arrange bilateral transfer agreements to ensure that patients are being treated in the appropriate facility for their level of acuity. For example:

- At the request of the City and County of San Francisco, UC San Francisco is collaborating with Dignity Health for UC clinicians to help staff 40 new medical-surgical beds and eight ICU beds at St. Francis Hospital for the care of COVID-19 patients.

- At the request of the California Secretary of Health and Human Services, the California Hospital Association has convened key health systems in the state, including UC Health, Sutter Health, Kaiser Permanente, Dignity Health, and Adventist Health, to serve on a surge capacity rapid response team. This group is working together to guide the state's work on hospital surge capacity, including by optimizing plans across systems and hospitals in California.

In the context of this COVID-19 epidemic, there is widespread agreement that collaboration among all health systems is an imperative. A prohibition on UC affiliations with institutions that have policy-based restrictions on care would not only hurt many of the state's most vulnerable patients served by those institutions, but would undermine the greater effort to manage the current public health crisis, causing harm to all the people of California. At UC Health, we believe this need for collaboration was also true before the pandemic and will be even more important in the world after the pandemic.

2. OSHPD Patient Discharge Data (based on 2017 data), California Data Reporting Manual.

IMPACT ON
HEALTH SYSTEM
FINANCES

A PROHIBITION ON AFFILIATIONS WOULD RESULT IN A LOSS OF REVENUE FOR UC HEALTH WITH FEWER PATIENTS ABLE TO ACCESS UC HEALTH CLINICIANS AND SERVICES

UC's academic health centers are reimbursed from a variety of payors for the services they provide to patients in connection with UC affiliations with institutions that have policy-based restrictions on care. As further illustrated below, a prohibition on such affiliations would result in a loss of tens of millions of dollars in professional services revenue that is directly attributable to current affiliation agreements. As previously discussed, a prohibition would also mean that a significant subset of the tens of thousands of patients who are referred or transferred to UC facilities from institutions that have policy-based restrictions on care would no longer receive care at UC facilities, resulting in a further loss of millions of dollars in corresponding revenue.

While significant, the estimated financial impact of a prohibition on affiliations with institutions that have policy-based restrictions on care constitutes a small portion of the revenue generated by the UC Health System:

- In Fiscal Year 2019, the total revenue generated from professional fees across the UC Health System was approximately $3.5 billion.

- In addition to professional fee revenue, total health center revenue for Fiscal Year 2019 across UC Health was approximately $13.3 billion.

Although the financial losses may be small compared with the overall financial portfolio of the health enterprise, UC's academic health centers are self-supporting. All revenue generated from clinical care delivery through these affiliations

or other means is important to ensure the financial viability of the academic health centers. The financial strength of the UC Health System enables our ability to carry out our public service mission and supports the academic mission of the University.

Like other academic health centers across the nation, UC's health centers operate on slim margins, which are greatly impacted even by relatively small losses. Moreover, within our slim margins, our health centers contribute substantially each year in support of the University's academic mission. In Fiscal Year 2019, the health centers transferred over $600 million, which was used for a variety of purposes, including to support education and research activity, such as health professional training programs, biomedical science research, and public health research.

The financial pressure on UC Health is now significantly exacerbated by the COVID-19 pandemic. The direct and indirect costs of our screening, testing, and treating all the people of California touched by this outbreak are already causing our health centers to lose millions of dollars daily, with losses that could exceed $1 billion by the end of this fiscal year. The financial impact of a loss of affiliation revenue would add to and exacerbate these losses.

In summary, the financial analysis demonstrates a modest benefit from these affiliations. The numbers only underscore that it is improving patient care and access under our public service mission—and not financial gain—that is the driving force behind the desire to preserve our ability to affiliate.

TYPES OF REVENUE GENERATED THROUGH AFFILIATION

While it is not possible for the UC health center finance teams to calculate the exact revenue generated from all of the different types of affiliations that UC has with these institutions, the following sections describe key types of revenue that UC health centers receive, with systemwide financial data provided when available and illustrative examples provided if systemwide data is not available.

A. REVENUE FROM PROFESSIONAL SERVICES AGREEMENTS WHERE UC CLINICIANS PROVIDE SPECIALTY MEDICAL SERVICES AT ANOTHER INSTITUTION

The revenue generated from services provided by UC clinicians at institutions that have policy-based restrictions on care is shown in **Table 1**. The data presented is for UC professional services agreements that are structured so that UC's academic health centers bill payors and collect reimbursement for their services. Resulting in over 77,150 patient encounters, **these arrangements generated more than $20 million in Fiscal Year 2019 revenue across UC Health.** The revenues were greatest at UC San Francisco (primarily for hospital medicine, pediatrics, Ob-Gyn, neurology, and neurosurgery services) and UC Los Angeles (primarily for pathology, cardiology, internal medicine, and neurology services). If these arrangements were to be prohibited, the UC Health System would lose, at a minimum, the revenues generated in Fiscal Year 2019, and would lose opportunities to serve additional patients that could generate additional revenue in the future.

TABLE 1: REVENUE GENERATED FROM SERVICES PROVIDED BY UC CLINICIANS AT INSTITUTIONS THAT HAVE POLICY-BASED RESTRICTIONS ON CARE

	FISCAL YEAR 2019		
	Unique Patients	Encounters	Net Revenue
UC Los Angeles	12,446	13,388	$10,522,263
UC Irvine	6,530	12,334	$2,300,756
UC San Francisco[1]	5,233	18,689	$5,100,000
UC San Diego[2]	4,583	17,270	$763,320
UC Riverside[3]	2,109		$157, 149
UC Davis	4,936	15,469	$1,687,610
TOTAL	35,837	77,150	$20,531,098

1. UC San Francisco's net revenues are estimated based on average collections per encounter.
2. UC San Diego's numbers are for calendar year 2019 versus fiscal year. Of note, UC San Diego's revenue is low relative to the number of patients served due to the inclusion of encounters at UC San Diego's free clinics located at institutions that have policy-based restrictions on care.
3. UC Riverside was not able to provide encounter data.

B. EXAMPLES OF REVENUE FROM OTHER PROFESSIONAL SERVICES AGREEMENTS WHERE UC CLINICIANS PROVIDE SERVICES TO ANOTHER INSTITUTION

Several of our health systems were able to provide the revenue generated from our professional services agreements where UC clinicians are providing professional or administrative services to other facilities at a set rate or fixed costs (and where the non-UC entity bills and collects from payors). These numbers are set forth in **Table 2.** For many campuses, the contracting for these affiliations is done at the clinical department or division level, and relevant financial data is housed in academic accounts. These accounts represent the academic faculty practices across the UC Health enterprise, which are within the financial portfolios of the Deans of the health professional schools. These accounts are separate from the clinical revenue generated with our academic health centers' hospital facilities and the corresponding accounts that are within the financial portfolios of the CEOs. A centralized contracting repository across UC Health was not available at the time of this report.

TABLE 2: REVENUE FROM OTHER PROFESSIONAL SERVICES AGREEMENTS WHERE UC CLINICIANS PROVIDE SERVICES TO ANOTHER INSTITUTION

Campus	Services Provided	Fiscal Year 2019 Revenue
UC Irvine	Medical Direction Call Coverage	$1,453,447
UC San Diego	CT Surgery Call Coverage Medical Direction Perinatology Consultation Vascular Surgery Call Coverage Acute Stroke Call Coverage	$991,662
UC Riverside	Cardiac Imaging	$122,800
UC San Francisco	Hospitalist Services Management Services	$3,950,000

C. INCOME GENERATED FROM JOINT VENTURES

As described previously, UC San Francisco and UC Davis have both entered into joint ventures with institutions that have policy-based restrictions on care. **UC Davis received $4.4 million in Fiscal Year 2019 from its two cancer joint ventures with Mercy Merced and Adventist Health.**

UC San Francisco did not receive meaningful income from its joint venture with St. Joseph's, though the relationship remains an important means of access to UC San Francisco specialty care in the North Bay.

D. REVENUE GENERATED FROM SERVICES PROVIDED AT UC FACILITIES

As described in Section III, patients are referred to UC academic health centers in a number of ways, and revenue is generated from the services that UC provides to patients who are referred or transferred to UC clinicians and facilities from institutions that have policy-based restrictions on care.

Provider Network Agreements with Providers That Have Policy-Based Restrictions on Care

UC Davis, UC San Francisco, UC Irvine, and **UC Los Angeles** all have agreements with providers that have policy-based restrictions on care that are managing care and costs on behalf of a health plan and who contract with UC to provide services that aren't available at the referring institutions. **UC Davis alone received over $11.5 million in revenue for comprehensive specialty services provided to patients under these arrangements.** Depending upon the scope of a prohibition on UC's affiliations with these institutions, these arrangements may be prohibited and revenue lost as many of the patients who are referred or transferred to UC under these arrangements would be discouraged or prevented from seeking treatment at a UC facility. Even if these particular arrangements are deemed permissible, we can anticipate that they may be disrupted or not continue in a scenario where UC has instituted a ban on clinical and training agreements with these same institutions that have policy-based restrictions on care.

Referrals and Transfers from Providers with Policy-Based Restrictions on Care with Whom We Affiliate

Affiliations facilitate access to specialty services and expertise at UC academic health centers for patients of institutions that have policy-based restrictions on care. Although we do not have a method to identify with certainty whether a particular patient arrived at a UC institution solely as a result of an affiliation, we do know that our affiliations develop the infrastructure, processes, and clinician relationships that impact the referral and transfer of patients to the UC System. These referrals and transfers are typically for highly specialized care that is not available at the referring institutions. The referral or transfer of patients to UC's academic health systems from our affiliates is a significant source of revenue for all UC academic health centers. An example for **UC San Francisco** is shown in **Table 3**.

Table 3 shows the contribution margin generated from treatment of patients that were transferred to UC San Francisco from Dignity Health facilities. Notably, these numbers are relevant to patient transfers only, not referrals. The table illustrates the increase in revenue from Fiscal Year 2016 (before UC San Francisco had an affiliation with those institutions) to Fiscal Year 2019 (after an affiliation had been in place for three years). Following affiliation, UC San Francisco documented an increase in contribution margin of over $2 million in Fiscal Year 2019 compared to Fiscal Year 2016. This increase is attributed to a change in case mix to include more patients transferred for higher acuity tertiary and quaternary care.

TABLE 3: EXAMPLE OF UC SAN FRANCISCO REVENUE FROM PATIENTS TRANSFERRED TO UC SAN FRANCISCO FROM DIGNITY HEALTH

UC San Francisco Affiliate	Fiscal Year 2016 Contribution Margin	Fiscal Year 2019 Contribution Margin	Increase
St. Mary's Hospital and Medical Center	$1,195,169	$1,917,931	$722,762
St. Francis Memorial Hospital	$1,681,478	$3,029,384	$1,347,906
Sequoia Hospital	$204,231	$415,790	$211,559
TOTAL	$3,080,878	$5,363,105	$2,282,227

CONCLUSION

This report underscores that a prohibition on affiliations with institutions that have policy-based restrictions on care would have significant adverse impacts across UC Health and would be disruptive to our education and public service missions.

The primary effects of banning affiliations with health systems that have policy-based restrictions on care will be borne by UC Health patients, including those we serve in communities across California, and our own employees, retirees, and students who receive health benefits through UC plans. Tens of thousands of patients today would experience care disruptions. Many would have limited access to both primary and specialty care, and in some cases, access to specialty care would be eliminated. Future affiliations that would increase access, for example, to state-of-the-art cancer care would be jeopardized. Importantly, our ability to expand UC Health services to all campus communities would be impeded by the lack of community hospital partners in Merced and Santa Cruz. **In no case would the banning of affiliations increase comprehensive access for patients in California.**

The COVID-19 pandemic has made clear to all the inequities in U.S. health care that result in health disparities for poor and marginalized communities. As a public, land-grant institution, the University of California and UC Health have a public service mission that is central to our purpose and existence. The elimination of affiliations with institutions that have policy-based restrictions on care would have impeded our successful response to the COVID-19 pandemic and would have jeopardized the readiness of the state. We believe that following the pandemic, the state and the nation will place greater emphasis on the elimination of health disparities as a way to strengthen our readiness for public health emergencies that may arise in the future. Our commitment and duty to partner with the state in achieving health equity is clear. Isolation will not help to achieve the goals of health care for all. Our ability to partner with all health systems in the state will be more important than ever.

Our students and trainees are another important group that will suffer through the banning of affiliations. Our ability to sustain several of our key training programs, particularly those programs associated with UC Riverside, would be weakened. UC Riverside is of particular concern because it is a community-based

medical school designed to increase training opportunities for those underrepresented in health care and to encourage them to practice in the most underserved regions of our state. As a community-based program, UC Riverside depends on affiliations, and a key affiliation is with a Catholic facility. Banning these affiliations would likely result in the closure of several GME residency programs at UC Riverside. The loss of these programs and this training site could force the UC Riverside School of Medicine to decrease class size and could threaten the accreditation and viability of the program, which is vitally important for eliminating health disparities in the state.

Finally, the report outlines the financial consequences on UC Health of banning affiliations. Though small, all declines in income are significant to the self-funded health centers and to the academic programs the health centers support. Declines in revenue also impact our public service mission.

At UC Health, we are committed and aspire to 1) improve the health of all people living in California now and in the future; 2) promote health equity through the elimination of the health disparities; and 3) reduce barriers to access our clinical, education, and research programs by creating more inclusive opportunities for employees, students, and trainees. Affiliations across California and beyond are an important mechanism for meeting our systemwide goals.

UC Health would like to thank President Napolitano for the opportunity to provide analyses of the impacts of ending existing affiliations between the University of California and institutions that have policy-based restrictions on health care. We urge the President and Regents to consider strongly the points herein, as well as the unanimous opinion of the leaders of our health centers, health professional schools, and health plans: These affiliations are core to our education and public service missions to offer access to high-quality care to all the people of California. A policy of disengagement would undermine our mission and weaken our health care infrastructure, and not one patient would be better served as a result.