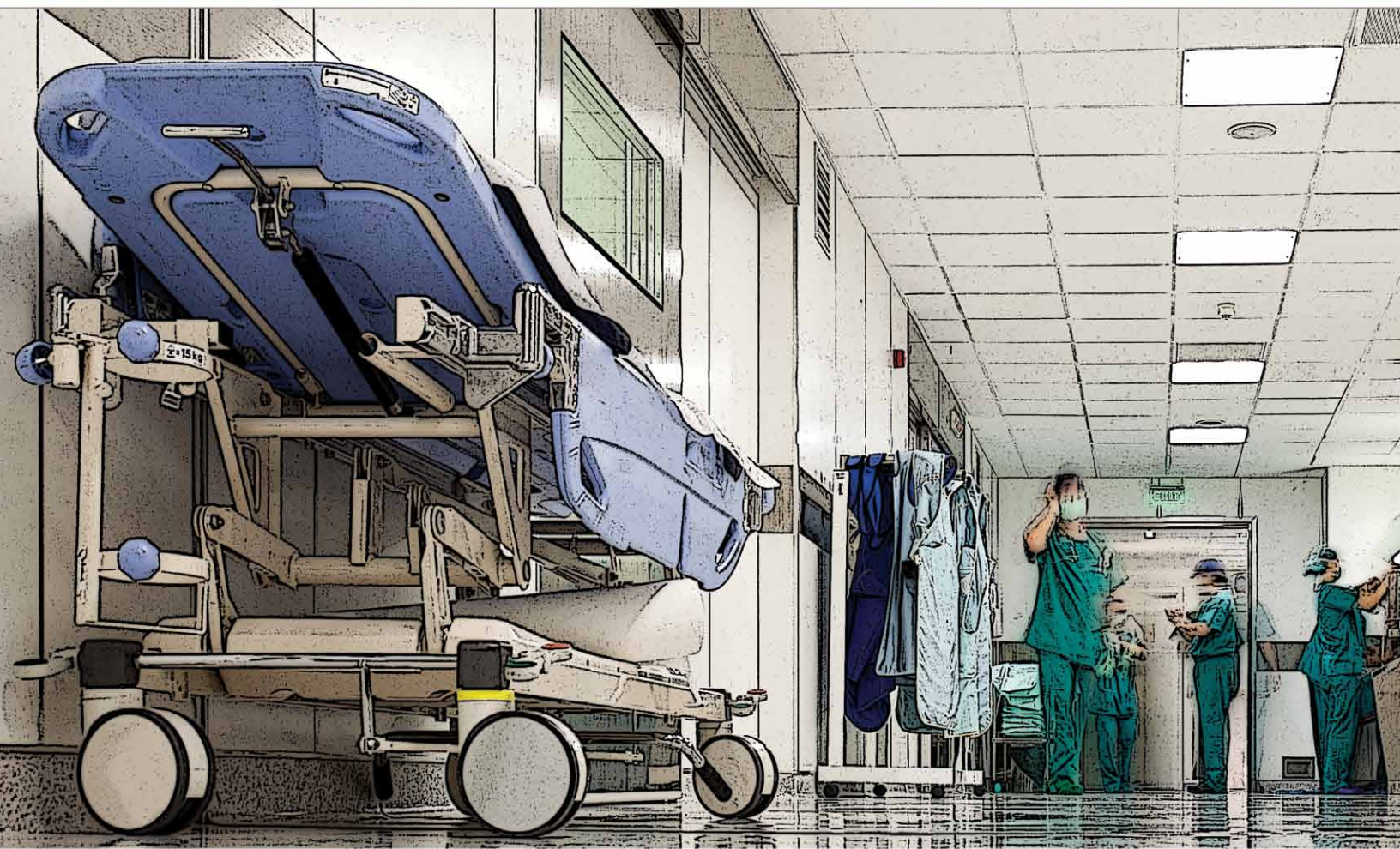


# A QUESTION OF PRIORITIES



**PROFITS, SHORT STAFFING,  
AND THE SHORTCHANGING OF  
PATIENT CARE AT UC MEDICAL CENTERS**



This report was written by AFSCME Local 3299 over the course of several months in 2012 and 2013. It is based on interviews with Local 3299 members employed at UC Medical Centers, reports by the California Department of Public Health, inpatient discharge data from the State of California's Office of Statewide Health Planning and Development, as well as additional sources.

# A QUESTION OF PRIORITIES: Profits, Short Staffing, and the Shortchanging of Patient Care at UC Medical Centers

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## EXECUTIVE SUMMARY

The public sees University of California Medical Centers as premier, world-class facilities. We rely upon them when our loved ones face the most serious illnesses because we expect them to provide the highest level of care. With the UC Medical System earning \$6.9 billion in operating revenues and hundreds of millions in profits, it has the resources to do just that.

But recently, patient care advocates have witnessed something else: administrative decisions that prioritize UC's profit margins over patients' health. These decisions reflect a shift in values that reached a tipping point with a system-wide policy in 2011 that decentralized UC budget practices, and turned each medical center into an independent profit center.

This culture change is evidenced by a sharp rise in management salaries and compensation, excessive management costs, and unprecedented borrowing to construct new buildings.<sup>1</sup> Since 2009, management at UC Medical Centers has grown by 38 percent, adding \$100 million to the annual payroll cost of management.<sup>2</sup> Debt service payments have almost quadrupled since 2006.<sup>3</sup> This diversion of patient care dollars results in management's need to capture "efficiencies" to bolster profit margins.

While "efficiencies" can be positive, they can also have serious negative consequences. Often taking the form of aggressive cost-cutting measures, some translate into chronic short staffing, over scheduling of operating rooms, prioritizing "VIP" patients over everyone else, shortchanging charity care, and outsourcing essential services. These degrade the medical centers' core mission.

Care providers are painfully aware of administrative priorities that too often leave them unable to provide the care that patients deserve. Patient care workers suffer unnecessary stress and fatigue, and at times work without adequate training on the use of hazardous materials used to sterilize patient care areas. Some report being so rushed in their work that dirty patient care areas may not be properly sanitized before new patients arrive.

While workers are already feeling squeezed, the University is threatening to cut staff. At UCSF Medical Center, management recently announced its plan to reduce 300 hospital workers, or 4 percent of its full-time workforce. These reductions are being proposed at a time when the medical center is only just recovering from having to ration respiratory care services in January 2013 because of inadequate staffing levels. To make matters worse, the hospital's CEO admits that, in his view, these cuts are needed, at least in part, to free up resources for new construction.<sup>4</sup>

**Patient care is suffering while subsidizing excessive management costs and rising debt service payments—a diversion of hundreds of millions of dollars that could go towards direct patient care each year.**

Evidence of significant deficiencies in patient care at UC Medical Centers is emerging from a variety of sources, including an independent evaluation by a healthcare buyers group, investigations by the California Department of Health, inpatient discharge data, and interviews with frontline care providers. Some of the incidents may be attributable, in whole or in part, to short staffing; others reflect a systemic breakdown of proper checks and balances. All call out for more oversight of the UC Health system.

When frontline care providers—members of AFSCME Local 3299—point out some of these problems, managers’ unsettling advice is to “just do your best.” UC management has responded with a mix of unfamiliarity, doubt, and at times, outright denial. To date, UC management has rejected all union proposals that UC take basic steps to improve staffing standards.

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At the time of this writing, the California Department of Public Health announced two fines totaling \$200,000 against **UCSF Medical Center, described in the press as part of the “state’s effort to penalize hospitals for errors serious enough to cause major injury or put patients’ lives at risk.”**<sup>5</sup> Both fines were the maximum amount given to repeat offenders. The two cases involved foreign objects left inside the patients, resulting in additional surgeries and other complications.<sup>6</sup>

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### **Frustrated, these workers are coming forward as whistleblowers to tell their story with the hope that it can bring about some corrective action.**

Given UC’s unresponsiveness to its frontline employees, this report recommends more state oversight, and an audit of UC staffing, management, and financial practices before more taxpayer dollars are committed to the UC Health system. The goal should also be to ensure that UC not only utilize safe staffing standards but also exhibit the leadership expected of such a renowned and prestigious healthcare system. Without guarantees of safe staffing, UC’s drive for “efficiencies” could have far-reaching consequences that put care providers and patients at risk.

### **Independent reports and inpatient discharge data raise questions about the quality of care at UC Medical Centers.**

- ▶ In November 2012, Ronald Regan UCLA Medical Center received an “F” for patient safety from the Leapfrog Group, a healthcare buyers organization that publishes an annual “Hospital Safety Score.”<sup>7</sup>
- ▶ In 2012, the California Department of Public Health uncovered a systemic breakdown of internal checks and balances that contributed to two UC Davis Medical Center physicians engaging in a controversial experimental treatment for brain cancer patients, with tragic results.<sup>8</sup>
- ▶ Since October 2008, the California Department of Public Health has made eleven formal findings of immediate jeopardy at two UC facilities: UC Irvine Medical Center and UCSF Medical Center.<sup>9</sup>
- ▶ UC Irvine Medical Center has one of the highest rates for hospital-acquired pressure sores among elderly patients in the State of California.<sup>10</sup>
- ▶ The California Department of Public Health found ten violations at UCSF related to hospital-acquired pressure sores.<sup>11</sup>
- ▶ UC Irvine Medical Center has the worst rate of hospital-acquired Urinary Tract Infections among female patients in Orange County and the 10th worst in California after adjusting for case mix.<sup>12</sup>

## Frontline care providers give examples of how UC policies degrade safe staffing and patient care.

- ▶ Patients often fall trying to go to the bathroom by themselves because short staffing delays staff response times. In one instance, a patient classified with “altered mental status” did not receive one-on-one attention and was found standing on a windowsill.<sup>13</sup>
- ▶ Chronic short staffing creates excessive workloads and stress. One nurse’s aide reports being afraid to take breaks because it would increase the ratio of patients to CNAs from 10:1 to 20:1.<sup>14</sup>
- ▶ Care providers are forced to give special treatment to VIPs—so-called because of their wealth or relationship to UC administrators—at the expense of other patients.<sup>15</sup>
- ▶ The UC health system seeks to “re-align” Medicare and Medicaid patients to non-UC hospitals under the assumption that they often do not require the level of care UC provides.<sup>16</sup>
- ▶ Care providers complain about dirty patient care areas. An operating room assistant sees dried blood and fluids in the crevices of an operating table month after month.<sup>17</sup>
- ▶ Care providers complain that an emphasis on cutting costs undermines patient care quality. One operating room assistant frequently hears that she must “hustle” because the operating room “costs \$260 a minute.”<sup>18</sup>
- ▶ Profitable high-level procedures get overscheduled, causing stress and exhaustion for care providers and delays for patients.<sup>19</sup>

## Payroll data shows UC Medical Centers increasingly outsourcing patient care.

- ▶ UCSF increased its outsourcing of various classifications (including Sitters, Licensed Vocational Nurses, Sterile Processing Technicians, and Anesthesia Technicians) from 135 patient care hours in 2008 to over 75,000 patient care hours in 2011 — 500 times greater than in 2008.<sup>20</sup>
- ▶ A patient care assistant at UCSF Medical Center describes “scary and stressful” situations when temporary employees work in an operating room but don’t know the protocol.<sup>21</sup>
- ▶ UC Medical Centers are relying more on temporary workers and less on career patient care providers. Although just 13 percent of the patient care technical workforce, per diem appointments accounted for nearly a third of patient care positions added this last year.<sup>22</sup>

## Practices at UCLA Medical Center raise questions about UC’s commitment to charity care.

- ▶ Despite being the second most profitable hospital in the Los Angeles market, in 2011, UCLA Medical Center only dedicated 1.29 percent of operating expenses for charity care to low-income patients. Over 77 percent of hospitals in the market dedicated more. The average general acute care hospital in Los Angeles dedicated over four times more of their operating expenses for charity care to low-income patients than UCLA.<sup>23</sup>

## At the same time, patient care dollars are being diverted to pay for a skyrocketing number of managers and their exorbitant salaries.

- ▶ Between 2008 and 2011, total UC workforce grew by 2 percent, faculty increased by 2 percent, but the number of managers and administrators grew by 9 percent.<sup>24</sup> Twenty-eight percent of all new employee positions were for managers.<sup>25</sup> And individuals earning more than \$200,000 grew by 44 percent.<sup>26</sup>

- ▶ At UC Medical Centers, between 2009 and 2012, management growth swelled by 38 percent and payroll costs for managers grew by 50 percent. It is estimated this added \$100 million to the annual cost of management, bringing total yearly salary costs for managers to an estimated \$298 million.<sup>27</sup>
- ▶ UCLA Medical Center doubled the number of its administrators between 2009 and 2012, adding 430 full-time managers at a cost of \$62 million.<sup>28</sup>
- ▶ UCSF Medical Center CEO Mark Laret received \$300,000 in bonus pay in 2011, for nearly \$1.2 million in total compensation.<sup>29</sup>
- ▶ UCLA Hospital System CEO David Feinberg’s hourly rate grew from \$354 to \$431 between 2009 and 2012.<sup>30</sup>
- ▶ UC Irvine Medical Center CEO Terry Belmont took home \$775,000 in pay and bonuses in 2011, a 40% increase from his predecessor.<sup>31</sup>

### **Patient care dollars are being diverted to pay for ballooning debt loads to finance new construction, further squeezing UC Medical Centers’ operating budgets.**

- ▶ UC medical system’s total outstanding long-term debt and financing obligations increased from \$1 billion in 2006 to \$2.6 billion in 2012, overwhelmingly due to new construction.<sup>32</sup>
- ▶ Between 2006 and 2011, outstanding hospital revenue bond debt tripled at UC Medical Centers—from \$787 million to \$2.4 billion. At UCSF alone, hospital revenue bond debt increased nearly 900 percent.<sup>33</sup>
- ▶ At the same time, annual debt service to pay for these revenue bonds almost quadrupled, from \$46.3 million to \$175.9 million.<sup>34</sup> These millions of dollars could be going to direct patient care.

## **RECOMMENDATIONS**

The State of California provides significant funding for the University’s Health System. In the fiscal year 2012-2013, it will provide approximately \$300 million in public dollars for health sciences instruction.<sup>35</sup> In addition, UC is currently requesting another \$15 million in taxpayer dollars in 2013-14 to support the new UC Riverside Medical School, as well as permanent core funding to support the school’s future needs.<sup>36</sup> Before additional taxpayer dollars are committed to UC Health or its affiliated medical centers, AFSCME Local 3299 calls for an investigation into the following:

- ▶ **Legislative Hearings on Management “Efficiencies”:** California state legislators should question UC executives on current policies for cutting costs, reducing staff and maximizing revenue. This includes UC management’s admission that reductions of frontline staff are needed to pay for new expansion projects. As the Affordable Care Act comes online—which will give healthcare coverage to 7 million Californians for the first time—public hospitals should be expanding, not decreasing, their frontline workforce.
- ▶ **Audit Management Bloat & Salaries:** A State audit should examine the increasing number of administrator positions and their compensation at UC Medical Centers and UC campuses.
- ▶ **Investigate UC Staffing Practices:** The California Department of Public Health should audit current staffing practices at all five UC medical centers to identify potentially dangerous employment practices, such as workers’ inability to take breaks and worker fatigue.
- ▶ **Investigate Short Staffing of Non-Nurse Staff:** Investigate and assess hazards stemming from the absence of mandated staffing ratios and exam time standards\* for non-nurse staff. These are two of the primary causes for workers not taking breaks and worker fatigue in a setting where being rushed and short staffing could cost lives.

\* There are currently no mandated standards for the amount of time non-nurse staff are to spend with patients.

- ▶ **Investigate UC Medical Centers' Provision of Care to the Poor:** Investigate the level of charity care provided by all five UC Medical Centers in their communities. The state legislature should explore whether the subsidies and related tax exemptions UC enjoys are justified, in particular by the level of charity care provided to the poor. At the very least, UC medical centers should be required to conduct a community needs assessment every three years like other non-profit hospitals in the state.
- ▶ **Reconsider UC's Constitutional Immunity:** The California State Legislature should reconsider the University of California's constitutional status that grants the system autonomy from basic employment standards in the State Labor Code and local ordinances. This includes immunity from state law requirements governing overtime, missed meal and rest breaks, and prevailing wage requirements, as well as municipal ordinances that require employers to pay part-time workers sick pay.
- ▶ **Audit Increasing Debt Load at UC Medical Centers:** The State should audit UC Medical Centers' current and projected debt load to assess how increasing debt service to pay for new development and expansion relates to UC's aggressive cost-cutting measures, as well as re-evaluate current and future new building projects.
- ▶ **Follow Safe Staffing Standards:** UC Medical Centers should lead their peers in safe staffing, and not outsource essential services, rely on staff to work through breaks, ration care, or cut staff. UC has repeatedly rejected bargaining proposals that improve staffing standards. These include:
  - Offer long-term per diem workers career positions after they meet a basic threshold of hours worked;
  - Commit to keeping essential services in-house and insource those currently contracted out;
  - Guarantee breaks or compensate frontline care providers when they miss their breaks; and
  - Ensure frontline care providers have a real voice in staffing decisions through a staffing committee that includes a third party dispute resolution process.
- ▶ **Provide Health & Safety Training to Patient Care Providers:** Care providers who frequently come into contact with hazardous chemicals used to prevent the spread of infectious diseases should receive adequate training, regardless of their classification. Temporary workers performing the same duties as career providers should also receive the same training.

**UC workers are committed to providing the best care to their patients. Brave workers have come forward as whistleblowers to tell their story in the hope that they can bring about some positive change.**

For more information, contact [patientcare@afscme3299.org](mailto:patientcare@afscme3299.org).

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# INTRODUCTION

This investigation into the quality of patient care at University of California Medical Centers was born out of growing concerns from the patient care advocates employed by the medical centers. These frontline patient care providers—admitting patient assistants, clinical care partners, respiratory therapists, emergency medical technicians, and sonographers, to name a few—came together from across the state to share their observations about workplace conditions that put themselves and patients at risk.

While the issues covered in this report are complex, frontline care providers offer a crucial perspective because they experience firsthand the impact that high-level policies can have on the hospital floor. Advocates' complaints center around chronic short staffing that degrades patient care and increases worker fatigue; workers' inability to take breaks; inadequate training on how to handle hazardous sterilizing chemicals; and dirty patient care areas.

When frontline providers point out these problems, managers' unsettling advice has been to "just do your best."<sup>40</sup>

These patient care workers—members of AFSCME Local 3299 employed at each of the UC medical centers—have also raised safe staffing and patient care concerns at the bargaining table, to which UC management has responded with a mix of unfamiliarity, doubt, and at times, outright denial. In fact, UC management has rejected all union proposals for UC to follow basic safe staffing standards, such as the conversion of long-term temporary workers, guaranteed breaks, and a staffing committee that can meaningfully address unsafe staffing levels.

Patient care workers take pride in their work and want to provide the best possible care to the millions of people treated at UC medical centers each year.<sup>41</sup> After spending years developing personal relationships with patients, their roles as caregivers are essential to their identities. Disturbed by what they perceive as slipping patient care standards at UC Medical Centers, brave frontline workers have chosen to come forward as whistleblowers and tell their stories with hope for corrective action.

Hospital workers' experiences reflect a broader cultural change already noted by observers of the University of California system.<sup>42</sup> This change in management culture envisions the University more as a private corporation than an institution of public service, as evidenced by a sharp rise in management salaries, growth in administrative positions relative to the number of students,<sup>43</sup> unprecedented borrowing to construct legacy buildings, outsourcing, rising tuition, and the subsequent increase in student debt.

This shift in management priorities has emerged as a national issue for higher education,<sup>44</sup> but the impact on patient care at teaching hospitals has received far less attention.

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*"For several years, the UC medical centers have enjoyed double digit net patient revenue increases and only 6 percent annual cost increases without any increase to total caseload volume, due to an increasingly complex caseload mix, and higher insurance reimbursements."<sup>37</sup>*

**—John Stobo, Senior Vice President for Health Sciences and Services, University of California, Office of the President**

*"[...] UCSF Medical Center will implement labor cost improvements and identify improved methods for setting labor standards... We are taking a proactive and thoughtful approach to optimizing financial performance and are targeting a reduction of approximately 4% of our full-time budgeted positions (approximately 300 FTE)..."<sup>38</sup>*

**—Mark Laret, CEO, University of California San Francisco Medical Center**

*"I want to tell UC: if all you see is a dollar sign, go work at a bank. That's your calling."<sup>39</sup>*

**—Annette Norwood-Dunlap, Clinical Care Partner and Unit Secretary at UCLA Medical Center in Santa Monica**

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At the University of California, the addition of two former Wall Street bank executives—Nathan Brostrom and Peter Taylor—to UC’s leadership team exemplifies this change.<sup>45</sup> The two men were hired in 2009 under the leadership of UC President Mark Yudof. Their appointments were approved by the UC Regents, the University’s governing body who are primarily culled from leaders of private industry rather than from education, health, or public service. As the Executive Vice President of Business Operations and the Chief Financial Officer, respectively, Brostrom and Taylor are responsible for designing and implementing revenue models for the University of California. In 2011, two years into their tenure, the UC Office of the President implemented the Funding Streams Initiative, a system-wide policy change that decentralized UC’s budget practices and had far-reaching implications.<sup>46</sup>

Campuses and medical centers now retain the funds they generate locally (including tuition, patient care revenues, auxiliary revenues), and pay a flat assessment fee to the UC Office of the President.<sup>47</sup> The new policy affords more local discretion and control over individual campus revenues and spending, as well as greater decision-making and priority setting.<sup>48</sup> This new policy incentivizes cost-cutting “efficiencies” that allow more money to be retained at the local level. At the same time, a growing number of executives cash extravagant paychecks and receive other forms of compensation.

### **Fundamentally, this is a problem of management priorities.**

Since 2009, management at UC Medical Centers has grown by 38 percent, adding \$100 million to the annual payroll cost of management.<sup>49</sup> At the same time, revenue bond debt since 2006<sup>50</sup> has tripled, further diverting resources to finance new construction. This diversion of patient care dollars results in managements’ drive to capture “efficiencies” to bolster profits.

Frontline patient care providers are being told they must “do their part”<sup>52</sup> to help pay for capital investments through reduced schedules, announced layoffs, chronic short staffing, and increased use of temporary staff. This type of “cost sharing” raises deep concerns around UC’s ability to provide quality patient care.

Is there a connection between the proposed reduction of 300 hospital workers at UCSF scheduled for 2013 (to capture \$30 million in savings annually) and the 19 percent growth in management at UCSF since 2009 (at an estimated additional annual cost in salaries of \$16 million)?<sup>53</sup> Or between the shortfall in the number of respiratory therapists (limiting the availability of respiratory therapy services recently outside of UCSF’s critical care units) and the \$1.52 billion price tag for Mission Bay Medical Center at UCSF currently under construction?

Patient care is suffering while subsidizing management bloat and rising debt service—a diversion of hundreds of millions of dollars annually that could go towards direct patient care.

October 16, 2012

Dear Colleagues<sup>51</sup>

As national healthcare leaders, UCSF Medical Center and UCSF Benioff Children’s Hospital are expected to excel in these efforts. We must strategically invest our dollars to improve care, grow our market share, plan for reduced payment increases, and lower our total costs overall. And, all of this must be achieved while we deal with increased pension costs, the rising cost of clinical technology and the expense of building our new hospitals at Mission Bay.

To this end, UCSF Medical Center will implement labor cost improvements and identify improved methods for setting labor standards over the next several months. We are taking a proactive and thoughtful approach to optimize financial performance and are targeting a reduction of approximately 4% of our full-time budgeted positions (approximately 300 FTE) and \$4 million of savings by June 2013 which will equate to more than \$30 million annually thereafter.

Sincerely,

**Mark R. Laret, CEO**

*UCSF Medical Center and UCSF Benioff Children’s Hospital*

**Ken Jones, COO**

*UCSF Medical Center and UCSF Benioff Children’s Hospital*

The first half of this report examines the quality of care at UC Medical Centers. It begins with a review of public reports, state data related to patient care, and deficiencies already known to regulators. That review is followed by a series of examples from care providers of how management policies impact safe staffing and patient care, which has to date escaped public oversight or intervention.

The second half looks at the various cost-cutting trends and revenue-generating “efficiencies” already adopted by UC. It begins with an examination of the considerable rise in temporary workers at the expense of long-term career workers. This is followed by an analysis of how revenues are diverted from patient care to pay for increases in administration and management compensation, and to service rising debt that largely finances new construction. While the effects of the system-wide culture change have been visible for some time, in many instances they became most pronounced in 2011.

Without greater public scrutiny of what is at stake, these trends threaten to jeopardize both worker and patient safety. AFSCME Local 3299 members are blowing the whistle, hopeful that their stories can help restore patient care as the top priority. AFSCME Local 3299 believes the findings in this report warrant immediate attention to ensure that patients at UC receive the level of care we all expect from one of the most prestigious institutions in the country.

# Part I: PATIENT CARE AT RISK

## I. QUESTIONS ABOUT PATIENT CARE QUALITY AT UC MEDICAL CENTERS

The University of California is a state-owned system comprised of ten campuses and five medical centers throughout the state. The medical centers are located in Davis, Irvine, Los Angeles, San Diego, and San Francisco, and make up the fourth-largest health care delivery system in California<sup>56</sup> with \$6.9 billion in operating revenue.<sup>57</sup>

In recent months, independent reports have questioned the quality of patient care at some of the UC medical center campuses. While these reports often focus on issues different than those raised by care providers, both show a need for an improved system of checks and balances. Some of the recent scandals at UC Medical Centers cited below highlight the need for better oversight, whether to prevent an egregious incident or address deficiencies in routine patient care.

In November 2012, Ronald Regan UCLA Medical Center received an “F” for patient safety from the Leapfrog Group, which administers the Hospital Safety Score.<sup>58</sup> Only 25 hospitals in the U.S. received a failing grade.<sup>59</sup> According to the Leapfrog Group, the assigned grades reflect the risk that a patient will suffer from a preventable medical error, an injury, an accident, or an infection while hospitalized.<sup>60</sup> Specifically, D and F grades “represent the most hazardous environments for patients in need of care,” states Leah Binder, CEO of the Leapfrog Group.<sup>61</sup> UCLA disputed the failing grade and pointed to one patient death in 2010 that unfairly lowered its grade from a C to an F.<sup>62</sup>

In December 2012, the California Department of Public Health conducted an investigation<sup>63</sup> at UC Davis Medical Center prompted by complaints about “non-standard, experimental treatments” by two neurosurgeons who placed “live bowel bacteria” into surgical sites of three critically ill brain cancer patients. Investigators concluded that UC Davis’ internal administrative system did not prevent these “experiments” and determined that deficiencies were severe enough to “put all surgical patients at risk for injury and harm, including death.”<sup>64</sup> The Center for Medicare and Medicaid services determined that deficiencies “substantially limit the hospital’s capacity to render adequate care to patients or are of such character as to adversely affect patient health and safety...”<sup>65</sup> UC Davis refuted these claims, calling them “unreasonable.”<sup>66</sup> While UC Davis administrators responded by putting in place a plan of correction, this remains a shocking example of a breakdown of internal oversight systems that required external intervention.

Direct care workers believe that more routine problems that impact patient care should receive similar attention. While not as extreme or sensational, problems with the delivery of routine care can also put both workers and patients at risk.

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### UC Health — At A Glance:

UC’s health sciences schools and medical centers are collectively referred to as UC Health.

The state-owned system includes five UC Medical Centers that provide 144,000 inpatient admissions and 3.9 million outpatient visits, including approximately 290,000 emergency room visits a year. Overall, the Medical Centers employ approximately 5,000 physicians and more than 36,000 hospital staff throughout the state.<sup>55</sup>

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What follows is information from administrative inpatient discharge data and state investigation reports. The interwoven stories from frontline patient care workers provide context to some of the technical findings. The intent is to draw attention to how deficiencies in safe staffing impact workers' ability to care for patients, and affirm their belief that UC can do better. Medical errors and other state-documented deficiencies may have multiple and complex underlying causes. In some, but not necessarily all cases, the problem may stem from short staffing.

## Findings of Immediate Jeopardy at UC Irvine and UCSF

Since October 2008, state investigators have made eleven formal findings of immediate jeopardy at two facilities — UC Irvine Medical Center and UCSF Medical Center.<sup>67</sup>

A finding of “immediate jeopardy” is defined by the State of California as “a situation in which the licensee’s noncompliance with one or more requirements of licensure has caused, or is likely to cause, serious injury or death to the patient.”<sup>78</sup> These are egregious incidents that command regulators to intervene. Although these are the incidents that draw the most attention from regulators, patient care providers also report daily problems that deserve prompt attention and corrective action because they should not be acceptable for a premier hospital system.

### Basic Patient Services at Risk

A look at routine indicators reveals problems with basic patient care practices, especially when UC medical centers are compared to their market peers.

Each year, acute care hospitals self-report inpatient discharge data to the State of California’s Office of Statewide Health Planning and Development (OSHPD). The data provided by UC’s Medical Centers reflect worrying rates of hospital-acquired pressure sores and hospital-acquired urinary tract infections. Both are potential indicators of inadequate basic patient care services that may be attributable, at least in part, to insufficient staffing levels.

Patients at UC medical centers should not suffer from pressure sores—particularly if they might be avoided by ensuring that hospitals are adequately staffed. But UC patients do suffer from pressure sores, some of them severe.<sup>79</sup> Severe pressure ulcers are such a serious problem that they are considered “never events,” which are “particularly shocking medical errors... that should never occur.”<sup>80</sup>

### Pressure Sores

Over the last three years, UC Irvine has been cited by the California Department of Health for deficiencies related to the development of hospital-acquired pressure ulcers on nine separate occasions.<sup>81</sup> Esther Flores, Senior Hospital Assistant at UC Irvine Medical Center, explains, “Patients need to be

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## IMMEDIATE JEOPARDY FINDINGS AT UC

### Immediate Jeopardy findings at UCSF involved serious incidents with specific patients:

- A patient received an antibiotic she was allergic to and spent several days in intensive care on a ventilator.<sup>68</sup>
- A preterm baby received an overdose of a blood-thinning agent.<sup>69</sup>
- A comprehensive validation survey of UCSF uncovered problems in six areas of operation.<sup>70</sup>
- A small clip was left inside a patient during brain surgery.<sup>71</sup>
- A sponge was left inside a patient during an operation in two separate incidents.<sup>72</sup>
- A surgical incision was made on the wrong eye of the patient.<sup>73</sup>

### At UC Irvine, DPH investigations found that:

- Patients were given potentially ineffective vaccines.<sup>74</sup>
- A patient died after choking on food that did not follow their prescribed diet.<sup>75</sup>
- Five patients received medication overdoses.<sup>76</sup>
- A sponge was left inside a patient during an operation.<sup>77</sup>

After state regulators intervened the medical centers took corrective action, albeit without “admitting” wrongdoing. Nonetheless, in several cases, the state imposed fines of up to \$100,000 per incident. Too often, however, regulators are not aware of other more routine hospital practices that may also place patients at risk.

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turned every two hours, and they can't do it themselves. The staff at UC Irvine is overwhelmed. Too often, workers\* don't have enough time, and the registry workers don't know the routine."<sup>82</sup>

A review of deficiency reports at other UC medical centers during the same approximate time period found ten violations at UCSF involving hospital-acquired pressure ulcers on twelve patients.<sup>83</sup>

Pressure ulcers occur when a patient stays in one position for too long, and the constant pressure and reduced blood flow to an area of skin causes the tissue to die.<sup>84</sup> Pressure ulcers are painful and may increase the risk of serious infections, such as sepsis, a life-threatening blood infection that can lead to organ failure, and squamous cell carcinoma, a type of aggressive cancer that develops in chronic, non-healing wounds.<sup>85</sup>

OSHPD's inpatient discharge data tracks the incidence of all hospital-acquired pressure sores, stages 1 through 4. Data submitted by UC Irvine Medical Center shows it has one of the highest rates of hospital-acquired pressure ulcers among elderly patients in California.<sup>86</sup> From 2009 through 2011, UC-Irvine had a pressure sore rate of 1.6 percent among patients 65 and older—the fifth highest in the State of California among hospitals with at least 2,000 qualifying discharges.<sup>87</sup> The data suggests this high rate of pressure ulcers is not explained by case mix.<sup>88</sup> **UC Irvine's rate is 3 times higher than the expected rate even after controlling for case mix**, one of the highest observed-versus-expected ratios among hospitals in the State of California.

It doesn't have to be this way. Care providers want to be able to give the best care possible.

## Urinary Tract Infections

A urinary tract infection (UTI) is the most common type of hospital-acquired infection. Women and older patients are at higher risk for UTIs.<sup>89</sup> Urinary tract infections are painful and, if left untreated, can cause permanent damage to the bladder and kidneys.<sup>90</sup> Additionally, elderly patients suffering from UTIs may experience confusion, agitation, hallucinations, and an increased risk for falls.<sup>91</sup>

The majority of UTIs are associated with the use of indwelling urinary catheters: infection may occur when urinary catheters are left in the body for too long or if a bacterium enters the body on the catheter.<sup>92</sup> While OSHPD administrative discharge data indicates whether a patient had a urinary catheter inserted or replaced, it does not specify how many days the catheter was in the patient. Without this latter piece of information, it is impossible to establish the catheter-associated nature of the UTI. For this reason, the analysis below looks only at patients who did not have urinary catheterizations. These patients should be at a reduced risk for UTIs compared to those with indwelling catheters.

Prevention of UTIs, whether catheter-related or not, calls for a number of interventions potentially made more difficult when the hospital is short staffed. These include: making sure the patient is getting plenty of fresh fluids, ensuring the patient is able to urinate often, and cleaning the patient regularly to prevent skin contact with urine and fecal matter.<sup>93</sup>

The state's data is troubling: from 2009 through 2011, among female patients who did not have urinary catheters at UC Irvine Medical Center, 1.8 percent developed a UTI that was not present on admission.<sup>94</sup> Statewide, UC Irvine's rate is 21st out of 242 California hospitals with at least 2,000 qualifying discharges. Out of 15 hospitals in Orange County with at least 2,000 qualifying discharges, UC Irvine's rate of UTIs among female patients is the second highest.

As with its high rate of pressure sores, UC Irvine's high rate of hospital-acquired UTIs is not explained by case mix.<sup>95</sup> The differences between UC Irvine's observed rate and its expected rate are among the worst in the county and the state. Female patients at UC Irvine developed UTIs at a rate 45 percent higher than expected.

\* Registry workers are temporary staff employed through a subcontractor.

**This difference between the observed and expected rate is the highest in Orange County, and the 10th highest in all of California.** Among UC Irvine’s female patients 65 and older, the rate of hospital-acquired UTIs is 19 percent higher than expected—the second highest in the county and the 37th highest in the state. Among UC Irvine’s female patients under 65, the rate of hospital-acquired UTIs is 52 percent higher than expected—the highest in the county and the seventh highest in the state.

### Hospital-Acquired UTIs: Observed Rate vs. Expected Rate at UC Irvine

| Female Age Group | Difference between observed and expected UTI rate | Rank among 15 hospitals in Orange County with at least 2,000 qualifying discharges | Rank among 242 hospitals in California with at least 2,000 qualifying discharges |
|------------------|---|--|--|
| All              | 44.7%   | 1  | 10   |
| 65-plus          | 19.0%   | 2  | 37   |
| Under 65         | 52.0%   | 1  | 7  |

Leonor Orozco, Senior Custodian at UC Irvine, recounts an incident in which a patient unable to use the bathroom on his own had evacuated in his bed the night before and laid in his own feces. It had dried so it was clear that the patient had been there for a long time. The registry nurse the night before hadn’t gotten to the patient. “This was partly because of being short on time but in my opinion, it’s also because registry workers just aren’t as invested in their jobs.”

We offer one solution to reduce the risk of UTIs: maintain better staffing to help patients to the bathroom and keep them clean — a solution that requires a greater number of patient care workers on a shift as well as the hiring of long-term career workers invested in patient outcomes.

## II. PATIENT CARE STORIES FROM FRONTLINE CARE PROVIDERS

### Short Staffing Threatens Patient Care and Safety

**T**odd Perez, a Senior Emergency Medical Technician (EMT)\* with UCLA Medical Center, points out that EMTs are already staffed “at bare minimum,” which means that “if someone’s sick or someone calls out, then we become short-staffed.” When ambulance crews, already pushing the limits, have to do more than their share of work because of skeleton staffing, it “can really affect patient care if you have something urgent. We work 12-hour shifts and if someone doesn’t show up or we don’t have our full crew you end up having to pick up more work, having to pick up the slack.”<sup>96</sup>

Annette Norwood-Dunlap, Clinical Care Partner and Unit Secretary at UCLA Medical Center in Santa Monica, tells of a patient suffering from “altered mental status.” Norwood-Dunlap, a frontline worker with five years of experience dealing with dementia, thought the patient required direct one-on-one care, but her manager assigned her several patients. “So, I went to clean up [another] patient with incontinence problems,” Norwood-Dunlap says, “and five minutes later, the patient with altered mental status had slipped out of the belt and was standing on the window sill. After that, they put me with her one-on-one.”<sup>97</sup>

Short staffing adds insult to injury because of its effects on care and patients’ basic dignity. Brenda Sweeney, Hospital Unit Service Coordinator at UC San Diego Medical Center, points out that patients fall when there is no one there to assist them. This happens all too often. “The patient gets anxious and they try to use the bathroom by themselves and then they fall. They don’t want to wet the bed, so they try to go themselves. It’s interfering with the dignity of the patients.”<sup>98</sup>

Esther Flores, a UC Irvine Medical Center Senior Hospital Assistant, recalls a deaf patient who suffered humiliation because of short staffing. “He needed help and to be cleaned up, but he was unable to communicate. We set up an alarm for him to call us but by the time someone came to answer, he was already on the floor. He needed to go to the bathroom and tried to get out of bed and he fell. . . . When the family came, they were very upset.”<sup>99</sup>

Short staffing may also place patients and staff in harm’s way. Security staff is charged with preventing people with aggressive behavior from becoming a danger to patients or care providers. Insufficient staff at UC medical centers means security officers sometimes have to leave certain dangers unattended. Patrick Mitchell, Senior Security Officer at UCLA Medical Center, says, “More often than not, I show up to work to find that we are staffed at the minimum level or even below minimum.” During a recent short-staffed shift, Mitchell reports, “we had three holds\*\* in the back with the officer... Then two more patients walk in, who are either dangers to themselves or a danger to others.

\* Emergency Medical Technicians (EMT) are trained and certified to provide basic care and assessment of patients in emergency medical situations, such as defibrillation, resuscitation, and controlling severe bleeding. EMTs have a variety of roles, including ambulance technicians and members of rescue squads.

\*\* A “hold” in this instance is when a doctor, a law enforcement official, or a social worker has ruled that the patient should not be left alone because they represent a danger to themselves or others, or they are gravely disabled.

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### Interviews with AFSCME Local 3299 members at the five UC Medical Centers revealed troubling patterns of:

- ▶ Risks to the safety and care of patients resulting from short staffing
  - ▶ Burnout, fatigue and stress on the part of overworked patient care staff
  - ▶ Outdated and unreliable equipment
  - ▶ Unequal patient care, including special treatment for so-called “VIP” patients
  - ▶ Unsanitary patient care areas and inadequate training
  - ▶ Over-scheduling of revenue-generating complex procedures
-



**They put them on a hold, so I had to leave the waiting room to go watch those two patients, leaving no one in the front to protect the admitting area and triage staff.”<sup>100</sup>**

## Short Staffing Leads to Worker Burnout, Fatigue and Stress

Todd Perez, the Senior EMT at UCLA, paints a frightening picture of the worker fatigue that can result from short staffing and what that can mean for patients. Perez explains that when the hospital is short-staffed, there aren't enough people to cover when something unexpected happens, such as worker illness or injury. When this happens, an ambulance team may reach the end of a twelve-hour shift, find there is no one to relieve them, and have to stay on the road for another several hours. “Sometimes, you've already been driving all day and there are bad weather conditions,” says Perez. “When you're short-staffed, it's much more tiring to be on the road. It's not safe for us, for other drivers on the road, or for the patients. You're risking an accident.”<sup>101</sup>

Priscilla Zollicoffer, Senior Admitter at UCSF, misses her break two to three times a week because there's no one to cover for her. She misses many of her final fifteen-minute breaks. “You're working under pressure because you're short of staff. Your electrolytes are super low. You're doing two jobs and even three jobs all by yourself. The phones never stop ringing at the nurses' station. You're the only one keeping track of a lot of information.”<sup>102</sup>

When workers approach management about the challenges arising from insufficient resources, the response seems to reflect a lack of understanding or concern about the quality of care they're delivering. Annette Norwood-Dunlap of UCLA complains about missing breaks because she is so busy bathing patients. “Management's suggestion is to get the other CNA to cover, but this doesn't work because they're also bathing patients. Management tells us to work it out among ourselves.”

Esther Flores of UC Irvine Medical Center also hears dismissive responses from managers about missed breaks. “When there are 20 patients, there are just two CNAs, and then one goes on break, and you end up having 20 patients by yourself.” **She can't imagine taking a break with 20 patients under her care, so she often doesn't.** But even when she is able to get a break, she still has to “answer those calls, be on the lookout for the 20 patients. It's not safe.” Management's response, according to Flores? “Well, do your best.”<sup>103</sup> Flores also reports that at her hospital, there is only one custodian to cover five floors during some shifts.<sup>104</sup>

Wendy Tan, a Senior Custodian at the UCSF Medical Center breast cancer clinic, says she chooses every day to finish her work rather than take breaks. “Generally, I don't take breaks at all, just my lunch. I don't want to take breaks because if I do, I can't do any details – like spot cleaning the wall, patient tables, the desk, taking out the trash. It makes me tired. I just work, work, work. But, if I take my break, I can't finish my work.”<sup>105</sup>

An appropriate managerial response would be to hire more workers. But the problem of short staffing and overwork also sets up many new hires for failure. According to Marlon Gliane, a Biomedical Equipment Technician at UCLA Medical Center, “Many new hires don't get past probation because they get overwhelmed by the workload.”<sup>106</sup> For Gliane and other care providers, short staffing taxes their ability to take care of patients and makes work unnecessarily intense and difficult.

## Underinvesting in Medical Equipment Risks Compromising Patient Care

Challenges to patient care caused by short staffing are exacerbated by equipment failures, especially when workers are operating at maximum capacity. Juan Campos-Ochoa, Patient Care Assistant at UCSF Medical Center, portrays a chaotic scene

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Beverly Simpson, an Operating Room Assistant at UC Davis Medical Center, tells of “Stools with legs that fall off, back tables with legs that fall off, operating tables that are always not working. It's shocking how often the hospital beds are broken — again and again we put a sign and write ‘broken’ on them ... **You'd think because it's UC Davis, we'd have nice new equipment, but we don't. A lot of it is really old.**”<sup>107</sup>

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in the middle of surgery: **“The surgical bed in the middle of the surgery wouldn’t respond. It was very scary. The anesthesiologist was very scared because there was no way to move the patient.** We had to get a bed from another room and transfer the patient. We had to get two to three people to push the locked bed against the wall, the whole weight, with the wheels locked. It was a circus. **Everyone was concerned. . . Someone came later to check it, to fix it, but they said that some tables are 20 years old. They’ve had them forever.”**

Workers complain that management does not invest in maintaining and upgrading the computers and machines that play a critical role in patient care. In the experience of Campos-Ochoa, “There is no day where you get there in the morning and you have all the tools you need working. It’s over and over, every day, calling, calling. For computers, oxymeters.” On a recent day, Campos-Ochoa says, “There were three computers that weren’t working, and these are computers we need for surgical cases. We need this equipment to provide care to the best of our ability.”<sup>108</sup>

Stuck wheels, legs falling off stools and tables, broken beds, and broken computers are symptomatic of a healthcare system that fails to invest in the tools and technology workers need to deliver quality care to their patients.

### Valuing Some Patients More than Others

Differential treatment in hospitals is shameful because all lives should be valued equally and anyone who comes to a hospital deserves the best quality care available. Yet workers report that “VIPs” receive special treatment. These VIPs are often donors, celebrities, or friends and relatives of UC administrators.<sup>109</sup> Todd Perez, UCLA EMT, says of the Hollywood celebrities that come to UCLA Medical Center, “All those people get special treatment.” Annette Norwood-Dunlap of UCLA points out that this special treatment actually comes at the expense of caring for other patients: “VIPs get special treatment all the time. **I’m often interrupted while helping one patient to help a VIP patient because they come first.** They say, ‘Well this person is VIP, so we have to give them special treatment.’”<sup>110</sup>

Brenda Sweeney, UC San Diego Hospital Unit Service Coordinator, is rightly disgusted by this unequal treatment. “I’ve seen them move a patient out of a room so they could make a suite for a VIP and it really ticked me off. And when a VIP comes in, we’re all told about it . . . **Staff is told that the VIP’s requests should be expedited above others. I’ve never thought that was right. I hate it.**”<sup>111</sup>

Diana Robles, the UC Davis dietary worker, once saw a note that read “VIP.” “So I had to go over there and make sure he got all his choices. I had fifty other people to call, but I had to make sure he got his choices.”<sup>112</sup>

Leonor Orozco, Senior Custodian at UC Irvine Medical Center, has seen this unequal treatment at her hospitals: “They receive immediate attention and they get everything they need. They tell us to come clean their rooms very quickly because they’re a VIP. They get preference on care. If they need something, everyone comes running.”<sup>113</sup> Time and again, workers complain that orders to provide special treatment to VIPs interfere with their work and violate their belief that all patients are equally deserving of the highest quality care.

In contrast to treatment of VIPs, UC Medical Centers seek to “realign” Medicare and Medicaid patients to other facilities under the assumption that they often do not require the level of care that UC Medical Centers provide.<sup>114</sup> Santiago Muñoz, Associate Vice President for Clinical Services Development, was asked how the medical centers could improve services if reimbursement rates were to decline in the future. He replied that **“as part of the realignment of the delivery of health care services, some Medicaid and Medicare patients currently seen at UC Health might be more appropriately served at other facilities.”**<sup>115</sup>

## Cutting Corners on Training and Sanitizing Patient Care Areas

Patients and visitors to any hospital expect a clean and sterile facility. Among other critical tasks, patient care support staff work hard to meet these expectations. However, inadequate staffing and unrealistic time pressures undermine these standards.

Hospital workers are exposed to all sorts of diseases but are regularly rushed through—and receive conflicting information about—sterilization procedures. “Management tells us that the disinfectant we use, H-25, has to air-dry for 8 minutes,” reports Sandra Ramirez-Curci, Operating Room Assistant (ORA) at UC Davis Medical Center. But the manufacturer’s own instructions require a full ten minutes drying time.<sup>116</sup> “They don’t give us any special kind of class or training on the chemical we’re using. All I know is that the chemical is called H-25.” Andrea Whaley, also a UC Davis ORA, agrees that she is also being rushed: “When we clean the rooms, they’re not dry, and a lot of times they’re coming into the room already.”<sup>117</sup>

Inadequate staffing further compounds the impact of time pressures upon patient and staff safety. Ramirez-Curci reveals, “When isolation patients go into the OR, they get transferred to the table, and the bed gets pushed back out into the hallway. It sits there until ORAs get a chance to clean it and redress it. The Fire Department complains because it’s like a pinball machine to get through these hallways.”

Beverly Simpson, another UC Davis ORA, describes how blood and fluids seep into the hydraulics of operating tables. In order to properly disinfect them, they need to be rotated out, disassembled, cleaned and put back together. “Month after month, I see what appears to be blood and fluids dried in the crevices of the tables. I’m concerned about my health and safety, and that of the patients.” Simpson adds, “Training is provided online but we do not have time for it during our work hours, and it is not correct training for the work we do. We need one-one-one or group training.”<sup>119</sup>

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Beverly Simpson, Operating Room Assistant at UC Davis, is also concerned that emphasizing profit margins of operating rooms impacts patient care. She says, “We’re constantly told to do things fast, do it quickly—instead of do it carefully, do it right. Our manager goes around telling us ‘hustle, hustle, hustle, this room costs \$260 a minute.’”<sup>118</sup>

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## Adopting Policies to Maximize Profits from High-End Procedures

Patient care workers describe how the monetary value of high-end procedures dictates hospital practices and policies. “They keep saying that time is money so they want to herd these people through, in and out, in and out, like cattle,” says Sandra Ramirez-Curci of UC Davis.<sup>120</sup>

Whaley, also from UC Davis, concurs. “We’re told if an operating room is sitting there empty, it costs money. Their goal is to get us in cleaning the room and out, and get the patient on the table within thirty to forty-five minutes.” Whaley complains that short staffing makes this goal especially difficult. She also warns that this emphasis harms patient care. “What they care about is getting the patients in because the OR makes a lot of money. And when you put the emphasis on that, you risk making a lot of mistakes.”<sup>121</sup>

Workers at UC hospitals express concerns that the pace of services does not prioritize patients. Tim Thrush, Diagnostic Medical Sonographer at UCSF, says, “About once or twice a week, they try to schedule too many high-level difficult procedures in a row, usually on the days when we have the most difficult procedures.” Thrush worries this makes it difficult and stressful for the workers as well as for the patients who end up waiting in the lobby a half hour to two hours extra.<sup>122</sup> Too often, workers skip their meals and breaks on these days.

### III. PATIENT CARE, SHORT STAFFING EXPLAINED

All five University of California Medical Centers are ranked among the 25 top grossing public hospitals in the country,<sup>126</sup> and the UCSF and UCLA Medical Centers are the two highest revenue generators for the University of California Health System. In the most recent three-year period, operating revenues for all five medical centers increased by 16 percent to \$6.9 billion dollars in 2012.<sup>127</sup>

John Stobo, Senior Vice President for Health Sciences and Services, oversees health education and clinical functions at the five medical centers. In 2012, he explained UC's financial success:

*"For several years, the UC Medical Centers have enjoyed double digit net patient revenue increases and only 6 percent annual cost increases without any increase to total caseload volume, due to an increasingly complex caseload mix, and higher insurance reimbursements."<sup>128</sup>*

UC Medical Centers' successes surely cannot be explained solely by higher reimbursements from health insurers. Frontline workers say that UC Medical Centers are extracting as much money from each patient and worker as they can, and they experience that squeeze first hand.

Furthermore, Mr. Stobo's commitment to finding new ways to increase "efficiencies" and generate more revenue makes them even more wary.<sup>129</sup> While certain efficiencies can benefit a hospital's operations, others call the hospital system's mission into question.

In light of emerging reports around patient care deficiencies at UC Medical Centers, at what point does striving for too much "efficiency" put patient care at risk? When efficiency means short-staffing conditions that leave a hospital area without a security guard; when there is only one custodian at UC Irvine Medical Center to clean five hospital floors; or when the hydraulics of a UC Davis Operating Room table appear stained with blood and fluids month after month, the drive for "efficiency" may have become hazardous.

#### The Wrong "Efficiencies": Cutting Frontline Workers

Frontline patient care advocates witness firsthand how inadequate staffing levels and increasing workloads adversely affect their work. "There was an internal survey a while ago and the managers told us in a meeting that [the efficiency experts] said we need at least three people to clean an operating room," says Andrea Whaley, Operating Room Assistant at UC Davis. "About twice a week, I'm working and we only have two people to clean a room, and then you get rushed. You can only cover so much in a certain amount of time."<sup>130</sup>

Marlon Gliane, Biomedical Equipment Technician at UCLA Medical Center, reports that staffing in his unit has not increased since layoffs in 2006 when they lost three positions. "On top of that, three positions in the unit remained vacant until recently, when two of them were eliminated. But the equipment inventory continues to increase. So our workloads keep getting bigger."<sup>131</sup>

Brenda Sweeney, Hospital Unit Service Coordinator at UC San Diego Medical Center, was cut from 40 hours a week to 24 hours a week. "The hospital ordered that each unit be cut back a certain percent because of the budget. With the cuts, you can't keep the floor running smoothly anymore."<sup>132</sup>

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#### Efficiency Pays... If You Are the Boss

On top of a \$580,000 base salary, Senior Vice President John Stobo was awarded \$130,500 additional compensation as part of the Clinical Enterprise Management Recognition Plan (CEMRP) in 2012.<sup>123</sup> Intended to "encourage and reward quality patient care and operational efficiency,"<sup>124</sup> the payment was to recognize Stobo's "success in meeting systemwide goals" including improving patient care, reducing expenses, and increasing revenue.<sup>125</sup>

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These management decisions interfere with the ability to simply complete routine duties and add to the frustrations of care providers facing increasing workloads, eliminated positions, and reduced hours.

A recent announcement of upcoming staff reductions at UCSF raises especially deep concerns. Already, UCSF Medical Center management had to ration respiratory therapy services for a period of time in January 2013, prioritizing those patients in critical care units, because of a shortage of respiratory therapists.<sup>133</sup> With hospital staff already stretched thin, CEO Mark Laret has announced the reduction of 300 hospital positions—or 4 percent of its workforce—in 2013. At a time when 7 million Californians are expected to receive healthcare coverage for the first time thanks to the Affordable Care Act, public hospitals should be increasing their frontline patient care staff, not reducing their ranks.

## Contracting Out Essential Services

AFSCME members also complain that the use of temporary workers causes delay and takes time away from regular duties. “Registry workers are not being adequately trained—each floor is different. We have to take time to show them how to do charting of vital signs on the computer and it’s a waste of time. A lot of the time, they are given a temporary password but if they don’t have it, they have to wait for the office to give it to them, which can sometimes take one to five hours. And then the nurses need vitals, so you end up doing the vitals for the whole unit,” says Esther Flores, Senior Hospital Assistant at UC Irvine Medical Center.<sup>134</sup>

Reports by the Institute of Medicine (IOM) and US Department of Health and Human Services’ Agency of Healthcare Research and Quality (AHRQ) find that “adverse patient outcomes associated with the use of contingent nurses” occur, in part, because temporary nursing staff are less familiar with a nursing unit or medical center’s policies, practices, critical pathways, information systems, and other work elements.<sup>135</sup>

While the existing research within the medical field has focused principally upon nursing staff, we should expect similar results for other patient care and support positions. Indeed, numerous studies across a wide range of industries have found that increased use of contingent workers can lead to higher accident rates and other adverse effects.<sup>136</sup>

The IOM and AHRQ reports specifically caution that risks arise from less familiarity with the local facility or patient care unit since temporary employees are not accustomed to the organization. These risks are “compounded when temporary workers do not receive the same level of orientation and training.”<sup>137</sup>

Juan Campos-Ochoa, Patient Care Assistant (PCA) at UCSF Medical Center, often sees temporary workers filling in for other PCAs in his unit. These workers do not stay long enough to become familiar with a given operating room. “They don’t know the protocol, and they’re inside an operating room during an operation. They just rotate through so they don’t learn anything and become the responsibility of the permanent employees. It’s scary and stressful.”

Temporary workers’ lack of training, experience, and investment in their work are common complaints from career employees. “When I worked in radiology, we had some travelers—and they never scanned at the level that we could do,” says Tim Thrush, Diagnostic Medical Sonographer at UCSF Medical Center.<sup>138</sup> “Sometimes, patients complain to us that registry nurses are too rough with them,” says Esther Flores, Senior Hospital Assistant at UC Irvine Medical Center.

Sometimes, volunteers are used to make up for short staffing. Danielle Bailey, Hospital Unit Secretary Coordinator at UC San Diego Medical Center, is sent home when her floor’s patient census reaches 25 patients or lower.<sup>139</sup> The hospital has student volunteers from local high schools and UC San Diego take her place. **“Volunteers are there for a couple of months to get their volunteer hours. They’re only responsible for the basics, but it scares me that a volunteer is thrown into that position. How would they respond to a Code Blue?”\***

\* Code blue generally indicates that a patient requires resuscitation, usually due to respiratory arrest or cardiac arrest.

Registry workers save UC money because they are not provided benefits other than wages. To assess how much UC Medical Centers rely on registry workers, AFSCME

Local 3299 submitted a public records request to UC for all five of the medical centers. At the time of writing—nine months after the request—only UCSF Medical Center had responded, providing information for nine patient job titles from 2008 to April 2012. Although limited in scope, the available information demonstrates a clear increase in the use of registry workers. The most significantly impacted titles include Licensed Vocational Nurses, Senior Vocational Nurses, Patient Care Assistants, and Sitters.

In 2008, the UCSF Medical Center reported contracting out a total of only 135 hours, all within the “Sitter” job class, and no reliance on registry for Licensed Vocational Nurses, Sterile Processing Technicians, or Anesthesia Technicians. By 2011, however, UCSF had hired registry workers in all these classifications for a total exceeding 75,000 patient care hours. **This represents more than a 500-fold increase, equivalent to an expansion from one employee working less than three weeks to nearly 36 full time employees working the entire year.** Hours reported for subcontracted License Vocational Nurse and Sitter positions during the first four months of 2012 are on pace to exceed the numbers from 2011.<sup>140</sup>

## A Growing Reliance on Per Diem Employees

Another area for achieving “efficiencies” is UC’s increasing reliance on Per Diem employees. Per Diems may work for a couple of hours per week for short intervals, or work close to full-time for years. Their increasing numbers provide UC significant cost savings. While they are members of AFSCME 3299, UC does not provide them with the same level of benefits as UC career workers. They are not eligible for sick pay, nor are they provided health insurance or retirement benefits. **In fact, unlike virtually any other California employer, the University of California’s special status in the state constitution exempts the UC system from following locally mandated sick pay ordinances.** For example, in San Francisco, temporary and part-time workers are provided paid sick leave, but workers at UCSF Medical Center are left out.

## UCSF Labor Relations On the Record: UCSF Medical Center Does Not Have to Follow Ordinances or Employment Statutes

An analysis of UC personnel data over the past three years shows that the University of California Health System is relying more heavily on Per Diem workers, while the number of long-term career employees is growing at a much slower rate.<sup>141</sup> The most significant increase occurred in the last year alone:

- ▶ Among the patient care technical unit workforce, from September 2011 to September 2012, UC increased the number of Per Diem employees by 13 percent, three times the rate of increase for career appointments which grew by only 4 percent.
- ▶ Per Diem appointments represent 13% of the workforce, but account for nearly a third of patient care positions added this last year.<sup>142</sup>

The increased reliance on Per Diem employees is most pronounced at UC Davis and UC San Diego. Between 2009 and 2012, the number of Per Diems grew by 34 percent and 28 percent, respectively. During the same period, career employment grew by only 1 percent and 2 percent, respectively. In just the last year, on both campuses, the number of Per Diem patient care employees increased while the number of career employees actually fell.<sup>143</sup>

While a formal pathway exists to allow conversion to career employee status, the threshold for conversion is kept intentionally out of reach for many Per Diem workers. Among other criteria, a Per Diem employee applying for conversion to career status must have worked “no less than 50 percent time” in any given month during the contract year. At UCSD Medical Center, the number of Per Diems assigned at 49 percent appointment time has grown from 60 percent in 2009 to 80 percent in 2012.<sup>144</sup>

## UCSF Medical Center

Human Resources  
3360 Geary Boulevard, Ste. 301  
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www.ucsfhealth.org

University of California  
San Francisco

September 24, 2010

Dan Harper, Organizer  
AFSCME 3299  
1360-9<sup>th</sup> Avenue, #240  
San Francisco CA 94122

Subject: Paid sick days for per diem employees

Dear Dan:

We have reviewed your email dated August 17, 2010 and have consulted with our legal counsel to ensure that our understanding was accurate. The Ordinance to which you refer does not apply to the University of California. As you are likely aware, this Ordinance, like other labor statutes and ordinances, does not expressly indicate that it covers public entities nor does it indicate that it specifically identifies the University of California.

Should you have information to the contrary, please advise.

Sincerely,

*for Shelley Nielsen*  
Shelley Nielsen  
Director of Employee Relations  
*by S. Henderson*

## IV. UC SHORTCHANGING ITS COMMUNITY: A LOOK AT UCLA MEDICAL CENTER

While UC Medical Centers record hundreds of millions in profit each year, the medical centers do not pay federal, state or city taxes on their earnings. Both private and public sector non-profit hospitals, in exchange for their tax-exempt status, are expected to provide free and discounted charity care to eligible, low-income residents. However, there is no federal requirement quantifying the amount they must provide.

As state-owned public teaching hospitals, UC Medical Centers also receive additional state funding not available to other private sector non-profits, such as clinical teaching dollars to help pay for the costs of teaching programs. Unlike their non-profit counterparts, however, UC Medical Centers are not required to conduct community needs assessments or submit reports to the state describing their provision of care to the poor.<sup>145</sup> The health system is exempt from California's SB 697, the Hospital Community Benefit Program, which requires non-profit hospitals to perform a community needs assessment every three years, develop a plan in consultation with the community, and submit the plan to the Office of Statewide Health Planning and Development (OSHPD), who makes it available to the public.<sup>146</sup>

UC Medical Centers nonetheless advertise the benefits they provide to local communities. In 2012, UC claims that its medical centers provided \$560.7 million in charity care and unreimbursed care to their surrounding communities.<sup>147</sup> Such benefits can include free medical services for patients who have no source of payment for urgently needed care, the unpaid cost of Medicare, Medi-Cal, State Children's Health Insurance Program, as well as the unpaid cost of indigent programs and other safety net programs.

A review of charity care data for Los Angeles hospitals, however, reveals that UCLA Medical Center is not doing its fair share to care for the poor, despite enjoying the tax benefits and funding afforded to it as a public hospital. Perhaps not coincidentally, UC Health's website provides links to only two medical center "community benefit reports." UC Health does not indicate whether UCLA prepared such a report, and if it did, does not include it on the system's website.<sup>148</sup>

According to the most recent financial data submitted by UCLA to the State, UCLA Medical Center—the largest of the five UC medical centers—reported the second highest net income in the Los Angeles market in 2012, a profit of \$222.4 million. At the same time, the medical center only dedicated 1.29 percent of its operating expenses for charity care to low-income patients.\* This is far below other general acute care hospitals in the Los Angeles market, which averaged 5.35 percent.

**In other words, the average general acute care hospital in the market dedicated over four times more of their operating expenses for charity care to low-income patients than UCLA Medical Center. In fact, 77 percent of other general acute care hospitals in the county dedicate a higher percentage of operating expenses to charity care than UCLA Medical Center.**<sup>149</sup>

\* Throughout this report, charity care refers to data that is reported by the medical centers to OSHPD and published in the agency's 2011 Annual Financial Data Pivot Profiles; it includes the sum of "Charity-Other," "Bad Debt," and "County Indigent Programs Contract Adjustments" multiplied by the cost-to-charge-ratio.



Moreover, UCLA Medical Center only provides 1.8 percent of the charity care provided in the local market.<sup>151</sup> This means other Los Angeles hospitals must shoulder the burden. According to state data, UCLA Medical Center provided \$240 million less in charity care in the Los Angeles market than the highest provider, LAC/USC Medical Center.

### Charity Care Provided By Los Angeles County General Acute Care Hospitals in 2012<sup>152</sup>

| Hospital                              | Percentage of Operating Expenses Dedicated to Charity Care | Amount of Charity Care Provided |
|---------------------------------------|--|---------------------------------|
| UCLA Medical Center                   | 1.29%  | \$17,151,292                    |
| Hospital County Average               | 5.35%  | \$11,440,005                    |
| Los Angeles County/USC Medical Center | 23.92%   | \$256,765,759                   |

# Part 2: MONEY DIVERTED FROM DIRECT PATIENT CARE

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These disturbing trends beg an explanation: After studying how patients, workers and communities are being shortchanged, the next question is: Why? And where is the money going?

## V. UC'S CULTURE CHANGE: DECENTRALIZATION CREATES INDEPENDENT PROFIT CENTERS

The culture change taking place at University of California Office of the President has implications for the entire UC system. There is growing public concern that UC is behaving more like a private corporation than a public service and educational institution.<sup>153</sup> The change not only impacts the quality and affordability of a UC education, and the students, faculty and staff throughout UC, but also the millions of patients seen at UC's medical centers.

One system-wide policy change in 2011 appears to have had far-reaching implications: UC's budget practices and authority were decentralized, allowing all ten campuses and five medical centers to retain the funds they generate rather than forwarding the money to the UC Office of the President (UCOP) for centralized distribution.<sup>154</sup> The intention was to return much of the money previously held by Office of the President to the campuses without restrictions on how the money should be spent, allowing more decision-making and priority setting by local administrators.<sup>155</sup>

With more control over local revenues, local administrators now have a greater incentive at the individual campus level to achieve "efficiencies." While some of these may be positive, other so-called "efficiencies"—as this report has demonstrated—may lead to serious negative consequences. The result is an institutional structure of individual profit centers rather than an integrated structure accountable to the public these institutions are supposed to serve.

This culture change has been years in the making, particularly at UCSF Medical Center. Randy Johnson, MRI technician at UCSF Medical Center, remembers, "When CEO Mark Laret first arrived at the medical center, he repeatedly told me and other staff that, 'When you see patients, you should see dollar signs.' He finally stopped after a group of outraged doctors confronted him."<sup>156</sup>

With greater discretion, administrators are diverting hundreds of millions of dollars away from patient care to pay for extravagant management salaries and an unprecedented increase in debt service to finance new construction. In turn, "efficiencies" are being implemented to pay for these misguided management priorities.

## VI. EXECUTIVE COMPENSATION AT MEDICAL CENTERS

California Governor Jerry Brown recently called “for greater efficiency, greater elegance, modesty” from UC officials. This insistence came in response to the hiring of new UC Berkeley Chancellor Nicholas Dirks at an annual salary of \$486,800, a \$50,000 increase over the outgoing chancellor.<sup>157</sup>

Swelling administrator salaries at public universities across the country have prompted lawmakers to scrutinize how the institutions spend their money.<sup>158</sup> Public outcry around UC’s lack of “modesty” emboldened California State Senator Leland Yee to reintroduce a bill to control executive pay increases at the University of California.<sup>159</sup>

**Attention in Sacramento has largely focused on the ten campuses of the University of California system, but this eclipses a similar phenomenon taking place at the five UC Medical Centers.** Given that the UC Health System, which includes the teaching arm of the five medical centers, will receive approximately \$300 million this year in state funds for health sciences instruction,<sup>160</sup> and that UC officials are asking for \$15 million in taxpayer dollars for a new medical school at UC Riverside<sup>161</sup> along with core permanent state funding in the future,<sup>162</sup> it is within the public interest that state officials take a closer look at questionable and potentially harmful spending practices at the medical centers.

There is a disturbing story to be told that exposes the exorbitant salaries paid to executives at UC Medical

Centers. This modesty problem at UC is not just diverting money from students and instruction, but also from patients at UC Medical Centers. In the balance is the safety of patients and their caregivers.

### Management Bloat in the University of California System

UC payroll data shows that top administrators continue to enjoy compensation far above that of the best-paid state employees outside of higher education.<sup>163</sup> In recent years, the number of administrators, managers, and other highly paid employees at the University of California system has grown at a much higher rate than the general workforce.

Between 2008 and 2011, at a time when the University of California system faced declining state support, the total University workforce grew by 2 percent, faculty increased by 2 percent\* —but the number of managers and administrators within the university system’s ranks grew by 9 percent. Twenty-eight percent of all new employee positions were for new managers.<sup>165</sup>

At the same time, the number of individuals receiving more than \$200,000 in base pay grew by 44 percent.<sup>166</sup> Employees grossing more than \$200,000, while only 2.6 percent of the total workforce, accounted for 13.8 percent of total payroll payments. This came at a cost to the University of nearly \$1.5 billion in 2011.<sup>167</sup>

### Management Growth Systemwide: 2008 vs. 2011

| Type of Employee                   | 2008           | 2011           | Total Change | Percentage Change |
|------------------------------------|----------------|----------------|--------------|-------------------|
| Faculty, Ladder- and Acting-Rank   | 8,860          | 8,663          | - 196        | - 2%              |
| All Faculty                        | 13,765         | 14,078         | 312          | 2%                |
| Management Position                | 8,230          | 8,956          | 725          | 9%                |
| <b>Total University Employment</b> | <b>134,912</b> | <b>137,545</b> | <b>2,633</b> | <b>2%</b>         |
| Gross Pay >\$200k                  | 3,646          | 4,889          | 1,243        | 34%               |
| Base Pay >\$200k                   | 1,051          | 1,511          | 460          | 44%               |

\* During this time period, ladder-rank faculty actually decreased by 2 percent. This category includes professorial series faculty, agronomists, astronomers, acting faculty, faculty on sabbatical leave and lecturers with security of employment or potential security of employment.

## Management Growth at UC Medical Centers

This trend is even more pronounced at UC's medical centers. **Between May 2009 and May 2012, management growth swelled by 38 percent**, contributing significantly to a 50 percent growth in payroll costs for managers. This is estimated to have added \$100 million to the annual cost of management, bringing total yearly salary costs to an estimated \$298 million.<sup>168</sup>

Specifically, UCLA Medical Center doubled its administrators during this period, adding 430 full-time managers at a cost of \$62 million.<sup>169</sup> At UCSF Medical Center, management grew by 19 percent, while the associated costs of management payments grew by 27 percent, an estimated additional annual cost of \$16 million.<sup>170</sup>

## Hiring More and More Managers Does Not Translate into Greater Productivity

Despite the increase in managers, workers report that management policies often impede the delivery of care and waste money. "We often have to sit around and wait for the go-ahead from supervisors to give the call for which team he or she wants to dispatch to which room," says Sandra Ramirez-Curci, an Operating Room Assistant at UC Davis Medical Center. Ramirez-Curci also complains that inconsistent policy-making makes work more difficult, "UC Davis paid high-priced efficiency consultants to evaluate our OR. Their reorganization doesn't make sense. Rules are now changing on a weekly basis," she explains. "I try to follow the rules and then they say, 'Oh we don't do that anymore.' No one even knows the rules because they are changing so often."<sup>178</sup>

New policies can waste operating dollars. Isaac Seckora, a Senior Surgical Tech at UC Davis, describes new policies implemented in anticipation of an inspection from the Center for Medicare and Medicaid Services. "We knew they were coming because they had already been to UCSF and UCLA. So our management threw together this broad policy that you have to wear blue jackets over scrubs in the operating room because our skin cells were causing infections," says Seckora. "The jackets cost our department \$3 a piece and we burned through roughly 1,100 in a day. Months later, we stopped using them because, according to research, skin cells are not directly related to surgical site infections."<sup>179</sup>

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### CEO PAY SKYROCKETS (2009 to 2012)

- David Feinberg, CEO of the UCLA Hospital System, saw his hourly rate grow from \$354 to \$431.<sup>171</sup>
- Mark Laret, CEO of UCSF Medical Center, received a \$94 hourly raise, bringing his hourly rate to \$448.<sup>172</sup>
- Ann Rice, CEO of UC Davis Medical Center, saw her regular pay grow by 37 percent, from \$584,300 to \$800,000. Base pay for the COO, Vincent Johnson, grew by over \$100,000—to \$553,500.<sup>173</sup>

### BONUSES AND OTHER PERKS

On top of these rates, top executives were eligible for an \$8,916 auto allowance, bonus compensation, and other perks:

- In 2011, Feinberg received nearly \$500,000 in bonus pay on top of his \$900,000 salary.<sup>174</sup>
- Laret received over \$300,000 in bonus payments, raking in a total of nearly \$1.2 million.<sup>175</sup>

### PAYMENTS TO NEW HIRES

- At UC Irvine, CEO Terry Belmont took home \$775,000 in pay and bonuses in 2011, a 40% increase from what his predecessor Maureen Zehntner received just three years earlier.<sup>176</sup>
  - Paul Viviano, the new CEO at the UC San Diego Medical Center, is expected to receive \$180,000 to \$252,000 in bonus pay on top of his \$720,000 salary.<sup>177</sup>
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## VII. COSTLY NEW DEVELOPMENT AT UC MEDICAL CENTERS DRAINS OPERATING BUDGETS

### Increasing Debt Load Diverts Money From Patient Care

As more and more patient dollars are diverted to pay for lucrative salaries for UC’s top executives and managers, patient care revenues are also being used to build new facilities with a price tag that will impact UC’s financial resources for decades to come. Exponentially higher debt loads driven by expansion goals direct resources towards the construction of new buildings rather than patient care. The two newest clinical facilities are the \$664 million Jacobs Medical Center at UC San Diego<sup>180</sup> and \$1.52 billion Mission Bay Medical Center at UCSF.<sup>181</sup> Increasing debt is overwhelmingly funding these types of expensive new projects, rather than seismic retrofit or repair of existing buildings.

From 2006 to 2012, the UC Medical system’s total outstanding long-term debt and financing obligations grew from \$1 billion to \$2.6 billion.<sup>182</sup> The increase was driven by issuance of hospital revenue bonds, the primary source of debt financing for construction projects.

Patient care spending competes with revenue bond debt service since both are funded from operating revenue. In other words, these millions of dollars could be going to direct patient care.

**Between 2006 and 2011, outstanding hospital revenue bond debt at UC Medical Centers tripled from \$787 million to \$2.4 billion. Changes were most dramatic at UC Irvine and UCSF.**<sup>183</sup>

- ▶ At UC Irvine, hospital revenue bond debt increased from \$0 in 2006 to \$295 million in 2011.
- ▶ UCSF’s outstanding hospital revenue bonds increased nearly 900 percent from \$95 million to \$851 million.
- ▶ This debt tripled at UC San Diego from \$58 million to \$180 million.
- ▶ At UCLA Medical Center, it increased 239 percent, from \$287 million to \$686 million.

### Total Outstanding Hospital Revenue Bonds (In Thousands) 2006 vs. 2011<sup>184</sup>

|              | 2008           | 2011             | % Change    |
|--------------|----------------|------------------|-------------|
| UCLA         | 286,585        | 685,784          | 239%        |
| UC SAN DIEGO | 58,153         | 180,167          | 310%        |
| UCSF         | 94,895         | 850,599          | 896%        |
| UC DAVIS     | 347,295        | 345,264          | - 1%        |
| UC IRVINE    | 0              | 294,900          | —           |
| <b>Total</b> | <b>786,928</b> | <b>2,356,714</b> | <b>299%</b> |

UC Medical Centers also have more planned construction projects. For example, the Mission Bay campus at UCSF will need to take on additional debt for an outpatient cancer building, faculty office space, parking, and a second major expansion that will add as many as 261 beds, expanded outpatient services, and even more parking.<sup>185</sup>

## Existing Debt Service Payments' Impact on Medical Center Budgets

**Annual debt service payments have almost quadrupled since 2006 in sync with overall debt load, from \$46.3 million to \$175.9 million in 2011.**<sup>186</sup>

- ▶ In 2012, UCLA and UC San Diego paid \$42.3 million and \$52 million, respectively, in debt service for hospital revenue bonds. Compared to 2006, these figures represent increases of 280 percent and 796 percent, respectively.
- ▶ At UCSF, debt service for these bonds nearly quintupled, from \$6.6 million to \$31.6 million.
- ▶ At UC Davis, debt service increased 179 percent from \$18.1 million to \$32.4 million.
- ▶ UC Irvine had no hospital revenue bond debt to service in 2006, but paid \$17.6 million in 2011.

### Hospital Revenue Bonds Total Debt Service (In Thousands) 2006 vs. 2011<sup>187</sup>

| MedicalCenter | 2006          | 2011           | % Change    |
|---------------|---------------|----------------|-------------|
| UCLA          | 15,120        | 42,307         | 280%        |
| UC SAN DIEGO  | 6,541         | 52,042         | 796%        |
| UCSF          | 6,559         | 31,552         | 481%        |
| UC DAVIS      | 18,084        | 32,421         | 179%        |
| UC IRVINE     | 0             | 17,608         | —           |
| <b>Total</b>  | <b>46,304</b> | <b>175,930</b> | <b>380%</b> |

## VI. RECOMMENDATIONS

In light of these findings, AFSCME Local 3299 calls for greater public oversight of University of California Medical Centers to ensure quality of care for UC patients. At stake are the lives of millions of patients, and thousands of frontline patient care providers who take pride in giving the best care possible. “Efficiencies” that lead to short staffing, worker fatigue, potentially unsanitary patient care areas, over-scheduling procedures or a management bias toward wealthier patients unfairly impact the quality of care patients receive.

Rather than continue to be led astray by the culture change occurring throughout the University of California system—whether at the ten campuses or five medical centers—these excesses must be contained. UC’s “modesty problem” must be stopped.

This charge is within the purview and responsibility of state elected officials. UC Health, including its medical schools and affiliated medical centers, will receive approximately \$300 million this year in taxpayer dollars to fund instruction at UC medical schools. Additionally, UC is asking Governor Brown for \$15 million in state support in fiscal year 2013-14 for UC Riverside’s medical school. Pledged taxpayer dollars must come with more government oversight.

### **Before taxpayer dollars are committed to UC Medical Centers for 2013-14, AFSCME Local 3299 calls for an investigation into the following:**

- ▶ **Legislative Hearings on Management “Efficiencies”:** California state legislators should question UC executives on current policies for cutting costs, reducing staff, and maximizing revenue. This includes UC management’s admission that reductions of frontline staff are needed to pay for new expansion projects. As the Affordable Care Act comes online, giving healthcare coverage to 7 million uninsured Californians for the first time, public hospitals should be expanding—not decreasing—their frontline workforce.
- ▶ **Audit Management Bloat & Salaries:** A State audit should examine the increasing number of administrator positions and their compensation at UC Medical Centers and UC campuses.
- ▶ **Investigate UC Staffing Practices:** The California Department of Public Health should audit current staffing practices at all five UC Medical Centers to identify potentially dangerous employment practices, such as workers’ inability to take breaks and worker fatigue.
- ▶ **Investigate Short Staffing of Non-Nurse Staff:** Investigate and assess hazards stemming from a lack of mandated staffing ratios and exam time standards\* for non-nurse staff. These are two of the primary causes for workers not taking breaks and worker fatigue in a setting where being rushed and short staffing could cost lives.
- ▶ **Investigate UC Medical Centers’ Provision of Care to the Poor:** Investigate the level of charity care provided by all five UC Medical Centers in their communities. The state legislature should explore whether the subsidies and related tax exemptions UC enjoys are justified, in particular by the level of charity care provided to the poor. At the very least, UC medical centers should be required to conduct a community needs assessment every three years like other non-profit hospitals in the state.
- ▶ **Reconsider UC’s Constitutional Immunity:** The California State Legislature should reconsider the University of California’s constitutional status that grants the system autonomy from basic employment standards in the State Labor Code and local ordinances. This includes immunity from state law requirements governing overtime, missed meal and rest breaks, and prevailing wage requirements as well as municipal ordinances that require employers to pay part-time workers sick pay.

\* There are currently no mandated standards for the amount of time non-nurse staff are to spend with patients.

- ▶ **Audit Increasing Debt Load at UC Medical Centers:** The State should audit UC Medical Centers' current and projected debt load to assess how increasing debt service to pay for new development and expansion relates to UC's aggressive cost-cutting measures, as well as re-evaluate current and future new building projects.
- ▶ **Follow Safe Staffing Standards:** UC Medical Centers should lead their peers in safe staffing, and not outsource essential services, rely on its staff to work through their breaks, ration its care, or cut staff. UC has repeatedly rejected bargaining proposals that improve staffing standards. These include:
  - Offer long-term per diem workers career positions after they meet a basic threshold of hours worked;
  - Commit to keeping essential services in-house and in-source those currently contracted out;
  - Guarantee breaks or compensate frontline care providers when they miss their breaks; and
  - Ensure frontline care providers have a real voice in staffing decisions through a staffing committee that includes a third party dispute resolution process.
- ▶ **Provide Health & Safety Training to Patient Care Providers:** Care providers who frequently come into contact with hazardous chemicals used to prevent the spread of infectious diseases should receive adequate training, regardless of their classification. Temporary workers performing the same duties as career providers should also receive the same training.

**UC workers are committed to providing the best care to their patients. Brave workers have come forward as whistleblowers to tell their story in the hope that they can bring about some positive change.**

For more information, contact [patientcare@afscme3299.org](mailto:patientcare@afscme3299.org).



## END NOTES

- 1 Douglas Belkin and Scott Thurm, "Hiring Spree Fattens College Bureaucracy—And Tuition" *The Wall Street Journal*, December 28, 2012, <http://online.wsj.com/article/SB10001424127887323316804578161490716042814.html>
- 2 UC Office of the President, Corporate Personnel System Data, May 2009 and May 2012.
- 3 University of California Report on Audit of Financial Statements and on Federal Awards Programs in accordance with OMB Circular A-133, 2011 and 2007.
- 4 Mark Laret, (UCSF Medical Center CEO,) "Update from the CEO and COO," email to UCSF Medical Center staff, October 16, 2012.
- 5 Victoria Colliver, "UCSF, St. Mary's hospitals fined by state," *The San Francisco Chronicle*, February 7, 2013, <http://www.sfgate.com/health/article/UCSF-St-Mary-s-hospitals-fined-by-state-4261351.php>
- 6 California Health and Human Services Agency, Department of Public Health, "CDPH Issues 10 Penalties to Hospitals," February 6, 2013, <http://www.cdph.ca.gov/Pages/NR13-005.aspx>
- 7 For the Hospital Safety Score, hospitals were given a grade of A, B, C, D or F using data from the Leapfrog Hospital Survey, the Agency for Healthcare Research and Quality (AHRQ), the Centers for Disease Control and Prevention (CDC) and the Centers for Medicare and Medicaid Services (CMS). Information from the American Hospital Association's Annual Survey was also used to add bonus percentage points for safety. (Michelle Castillo, "Study on safest hospitals shows some surprising results," CBS News, November 28, 2012, [http://www.cbsnews.com/8301-204\\_162-57556061/study-on-safest-hospitals-shows-some-surprising-results/](http://www.cbsnews.com/8301-204_162-57556061/study-on-safest-hospitals-shows-some-surprising-results/).) The Leapfrog Group relied on Medicare claims data, presented online at <http://www.medicare.gov/hospitalcompare.gov>.
- 8 According to the investigative report, the deficiencies discovered at UC Davis Medical Center were severe enough to "put all surgical patients at risk for injury and harm, including death." The hospital made changes as a result, but refuses to accept the independent regulators' conclusions, calling them "unreasonable," and maintaining that the physicians' actions were akin to "innovative care." California Health and Human Services Agency, Department of Public Health, *Statement of Deficiencies and Plan of Correction for University of California, Davis Medical Center*, August 30, 2012.
- 9 California Health and Human Services Agency, Statement of Deficiencies . . . for *University of California, Irvine Medical Center and University of California, San Francisco Medical Center*, October 25, 2008; June 17, 2009; July 15, 2009; March 3, 2010; March 4, 2010; July 22, 2010; October 21, 2010; January 18, 2011; April 5, 2011; May 11, 2011; and June 30, 2011.
- 10 Based on an analysis of 2009-2011 inpatient discharge data from California Office of Statewide Health Planning and Development (OSHPD). See note 86 below and "Pressure Sores" in Part I of this report.
- 11 California Health and Human Services Agency, *Statement of Deficiencies . . . for UCSF Medical Center*, December 1, 2008; April 6, 2009; May 4, 2010; June 24, 2010; October 11, 2010; January 20, 2011; February 23, 2011; March 16, 2011; March 21, 2011; and January 20, 2012.
- 12 Out of 242 California Hospitals with at least 2,000 qualifying discharges. See note 94 and note 88 below, as well as "Urinary Tract Infections" in Part I of this report.
- 13 Annette Norwood-Dunlap, (Clinical Care Partner and Unit Secretary at UCLA Medical Center.) Interview, December 20, 2012.
- 14 Esther Flores, (Senior Hospital Assistant, UC Irvine Medical Center.) December 17, 2012.
- 15 Priscilla Zollicoffer works as a liaison for UCSF Medical Center's Concierge Services. This program provides special services to VIPs, often major donors to the medical center, such as connecting them with the most sought-after physicians and providing them with the best private suites. However, Zollicoffer notes that UC Executives—and their family and friends—also receive special treatment through concierge services: "[UC executives] will call concierge services to tell them that their family or friends are coming in, and then the message goes down to us in the ER that these people are VIP." Diana Robles, dietary worker at UC Davis, says VIPs are usually "somebody connected high up in the UC." [Patricia Zollicoffer, (Senior Admitter at UCSF Medical Center.) Interview, December 13, 2012; Diana Robles, (Dietary technician at UC Davis Medical Center.) Interview, December 11, 2012.]
- 16 At a recent UC Regents meeting, Regent William De La Peña stated, "A question remains as to which physicians will provide services to the newly insured seven million Californians (after the Affordable Care Act goes into effect), considering the level of Medicaid fees," (UC Regents Committee on Health Services, Minutes of Meeting 27 March 2012, <http://regents.universityofcalifornia.edu/minutes/2012/hs3.pdf>, p. 8.); Santiago Muñoz, Associate Vice President for Clinical Services Development, was asked how the medical centers could handle an increase in Medicare and Medicaid patients. He replied that "as part of the realignment of the delivery of health care services, some Medicaid and Medicare patients currently seen at UC Health might be more appropriately served at other facilities," (UC Regents Committee on Health Services, Minutes of Meeting 27 March 2012. <http://regents.universityofcalifornia.edu/minutes/2012/hs3.pdf>, p. 9).
- 17 Beverly Simpson, (Operating Room Assistant at UC Davis Medical Center.) Interview, December 12, 2012.
- 18 Ibid.
- 19 Tim Thrush, (Diagnostic Medical Sonographer at UCSF Medical Center,) Interview, December 14, 2012.
- 20 UC Office of the President/ UCSF Medical Center, Response to AFSCME 3299 Request for Information (EX-12-051-05), August 17, 2012.
- 21 Juan Campos-Ochoa, (Patient Care Assistant at UCSF Medical Center.) Interview, December 15, 2012.
- 22 UC Office of the President, AFSCME 3299 Membership Files for 2010-09, 2011-09, and 2012-09.
- 23 OSHPD 2011 Complete data sets and pivot tables. To calculate the average, a total of 82 general acute care hospitals in Los Angeles County populated the data set. Ronald Reagan (466 licensed beds) and Santa Monica (315 licensed beds) campuses of UCLA Medical Center were combined and removed. Kaiser Foundation hospitals were removed since they do not provide this data. Throughout this report, charity care refers to data that is reported by OSHPD in the 2011 Annual Financial Data Pivot Profiles and refers to the sum of "Charity-Other," "Bad Debt" and "County Indigent Programs Contract Adjustments" multiplied by the cost-to-charge ratio. UCLA Resnick Neuropsychiatric Hospital, a 74-licensed bed psychiatric unit housed in the Ronald Reagan facility, reports its data to OSHPD separately. Because it is not a general acute care hospital, it was not included in this analysis.
- 24 For this discussion management refers to employees classified as Senior Management Group (SMG) or MSP. Staff numbers are reported in terms of *Full Time Equivalents (FTE)*.
- 25 UC Office of the President, Corporate Personnel System: Employee Full Time Equivalent Statistics from October 2008 and 2011, accessed November 26, 2012, <<http://www.ucop.edu/ucophome/uwnews/stat/>>
- 26 AFSCME 3299 Analysis of UC Office of the President Corporate Personnel Payroll and FTE Data. (UC Office of the President, "Headcount and FTE Tables," Oct. 2008-Oct. 2011, Corporate Personnel System, accessed November 26, 2012, <<http://www.ucop.edu/ucophome/uwnews/stat/>>; UC Office of the President. "University of California Employee Pay," 2008-2011, <https://ucannualwage.ucop.edu/wage/>. Downloaded from <http://ucpayglobl.org/>.)

- 27 UC Office of the President, Corporate Personnel System Data, May 2009 and May 2012.
- 28 Ibid.
- 29 University of California, Annual Report On Executive Compensation For Calendar Year 2011, <http://compensation.universityofcalifornia.edu/reports/2011-annual-report-executive-compensation-092012.pdf>
- 30 UC Office of the President, Corporate Personnel System Data, May 2009 and May 2012.
- 31 UC Office of the President, Payroll Data, <https://ucannualwage.ucop.edu/wage/>. Downloaded from <http://ucpay.globl.org/>
- 32 These figures do not include all debt taken on by University health sciences departments for facilities that do not provide clinical care, such as new research centers or medical student classrooms. (UC Office of the President, *Medical Center Financial Statements*, 2006, 2007, 2011, 2012, <http://www.ucop.edu/financial-accounting/financial-reports/medical-center-financial-reports.html>)
- 33 UC Report on Audit of Financial Statements and on Federal Awards Programs in accordance with OMB Circular A-133, 2007 and 2011.
- 34 Ibid.
- 35 State of California Proposed Budget for Fiscal Year 2013-14, Education, University of California (6440), p. EDU 9, <http://www.ebudget.ca.gov/pdf/GovernorsBudget/6000/6440.pdf>.
- 36 UC Office of the President, *Budget for Current Operations*, 2013-14, p. S-2.
- 37 UC Academic Senate, University Committee on Planning and Budget, Minutes of Meeting 5 June 2012.
- 38 Laret, "Update from the CEO and COO," email to staff, October 16, 2012.
- 39 Annette Norwood-Dunlap, (Clinical Care Partner and Unit Secretary), UCLA, 2012.
- 40 "I don't think it's safe to have one Nurse's Aide for 24 patients, but the manager just says 'do your best,'" (Esther Flores, Senior Hospital Assistant, UC Irvine, 2012); "My assignment is huge. I've asked for help several times but the manager just says 'do your best,'" [Wendy Tan, (Senior Custodian at UCSF Medical Center), 2012]; "There was one time when we didn't have mop sticks or wash cloths. When we don't have enough equipment or the proper equipment, we're told to just 'do our best,'" [Beverly Simpson, (Operating Room Assistant at UC Davis Medical Center) 2012.]
- 41 University of California, *Academic Medical Centers 101*, accessed January 11, 2013, <http://www.universityofcalifornia.edu/news/documents/academicmedicalcenters101.pdf>
- 42 Prominent scholars note the emergence of critical university studies, a growing body of academic work that takes as its subject a broad culture change within the university writ large. This change is described as a move to a model in which the university is run like a corporation, constructing students as consumers and faculty as contingent labor. (See: Jeffrey Williams, "Deconstructing Academe: The Birth of Critical University Studies," *The Chronicle of Higher Education*, February 19, 2012, <http://chronicle.com/article/An-Emerging-Field-Deconstructs/130791/>; Bill Readings, *The University in Ruins*, Cambridge: Harvard University Press, 1997; Christopher Newfield, *Unmaking the Public University*, Cambridge: Harvard University Press, 2011. For a critique more specific to the University of California, see: Christopher Adams, "The University of California's Two Big Mistakes: The New Logo and the Berkeley Stadium (Opinion)," *Berkeley Daily Planet*, December 12, 2012; and *Remaking the University*, <http://utotherescue.blogspot.com>)
- 43 Belkin and Thurm, "Hiring Spree Fattens College Bureaucracy," *WSJ*, 2010.
- 44 See note 42 above.
- 45 Charlie Eaton, Jacob Habinek, Mukul Kumar, Tamera Lee Stover, and Alex Roehrkasse, "Swapping Our Future, How Students and Taxpayers are Funding Risky UC Borrowing and Wall Street Profits," November 2012.
- 46 The Funding Streams Initiative was introduced and implemented by UCOP in 2011. Brostrom first mentioned this initiative in the May 19, 2010 meeting of the UC Regents Committee on Finance. (UC Regents Committee on Finance, Minutes of Meeting 19 May 2010, <http://regents.universityofcalifornia.edu/minutes/2010/fin5.pdf>, p. 4.) The committee did not revisit the matter until Brostrom presented an update at the March 2011 meeting. In his update, he noted that the purpose of the measure was to "provide high-quality services to campuses and allow them as much flexibility as possible in fulfilling their mission of teaching, research, and public service." (UC Regents Committee on Finance, Minutes of Meeting 16 - 17 March 2011, <http://regents.universityofcalifornia.edu/minutes/2011/fin3.pdf>, p. 16) See: Mark Yudof, Letter to Chancellors, September 12, 2011, [http://blink.ucsd.edu/\\_files/finance-tab/cbo/Chancellors-Funding-Streams-Initiative-091211.pdf](http://blink.ucsd.edu/_files/finance-tab/cbo/Chancellors-Funding-Streams-Initiative-091211.pdf)
- 47 Yudof, Letter to Chancellors, 2011.
- 48 UC Regents Committee on Finance, Minutes of Meeting, 16 March, 2012, <http://regents.universityofcalifornia.edu/regmeet/mar11/f3.pdf>
- 49 UC Office of the President, Corporate Personnel System Data, May 2009 and May 2012.
- 50 UC Office of the President, *Medical Center Financial Statements*, 2006, 2007, 2011, 2012, <http://www.ucop.edu/financial-accounting/financial-reports/medical-center-financial-reports.html>
- 51 Laret, "Update from the CEO and COO," email to staff, October 16, 2012.
- 52 "When I was cut from 40 to 24 hours per week, my supervisor explained to me that I have to do my part to help pay for the new Jacobs Center. With the reduced paycheck, I couldn't make my mortgage payment last month" Brenda Sweeney, (Hospital Unit Service Coordinator at UC San Diego Medical Center), 2012.
- 53 UC Office of the President, Corporate Personnel System Data from May 2009 and May 2012. Job titles reviewed include all SMG and MSP classifications, excluding physicians and dentists not in primary management roles.
- 54 In a memo circulated in January 2013 to all patient care areas at UCSF Medical Center from Respiratory Care Service, it was announced that the hospital was experiencing a high volume of respiratory care procedures relative to the number of available staff. (UCSF Medical Center, Respiratory Care Service, Notice RE: Respiratory Care of Patients in Your Area, obtained January 16, 2013.) As a result, respiratory therapy services outside of critical care units were being prioritized.
- 55 University of California, *Academic Medical Centers 101*, 2013.
- 56 Ibid.
- 57 UC Office of the President, *Medical Center Financial Statements*, 2012, <http://www.ucop.edu/financial-accounting/financial-reports/medical-center-financial-reports.html>
- 58 For the Hospital Safety Score, hospitals were given a grade of A, B, C, D or F using data from the Leapfrog Hospital Survey, the Agency for Healthcare Research and Quality (AHRQ), the Centers for Disease Control and Prevention (CDC) and the Centers for Medicare and Medicaid Services (CMS). Information from the American Hospital Association's Annual Survey was also used to add bonus percentage points for safety. (Michelle Castillo, "Study on safest hospitals shows some surprising results," *CBS News*, November 28, 2012, [http://www.cbsnews.com/8301-204\\_162-57556061/study-on-safest-hospitals-shows-some-surprising-results/](http://www.cbsnews.com/8301-204_162-57556061/study-on-safest-hospitals-shows-some-surprising-results/).) The Leapfrog Group relied on Medicare claims data, which is presented online at <http://www.medicare.gov/hospitalcompare.gov>. In contrast, data collected here for determining rates of pressure sores and urinary tract infections is provided by the state and available through the Office of Statewide Health Planning and Development upon request.

- 59 Chad Terhune, "UCLA Medical Center gets failing grade on patient safety," *Los Angeles Times*, November 28, 2012, <http://articles.latimes.com/2012/nov/28/business/la-fi-ucla-hospital-grade-20121128>
- 60 "Hospitals, A to F," *Chicago Tribune*, December 1, 2012, [http://articles.chicagotribune.com/2012-12-01/news/ct-edit-hospitals-1201-jm-20121201\\_1\\_leah-binder-hospitals-score-hospital-report](http://articles.chicagotribune.com/2012-12-01/news/ct-edit-hospitals-1201-jm-20121201_1_leah-binder-hospitals-score-hospital-report).
- 61 "Leapfrog Updates Hospital Safety Scores," *Health Leaders Media*, last accessed January 12, 2013, [http://www.healthleadersmedia.com/slideshow.cfm?content\\_id=286951&pg=1](http://www.healthleadersmedia.com/slideshow.cfm?content_id=286951&pg=1).
- 62 Terhune, "UCLA Medical Center gets failing grade on patient safety," *Los Angeles Times*, 2012.
- 63 California Health and Human Services Agency, *Statement of Deficiencies . . . for University of California Davis Medical Center*, August 30, 2012.
- 64 Idem, *Statement of Deficiencies . . . for University of California, Davis Medical Center*, August 30, 2012.
- 65 Rufus Arther, (Division of Survey and Certification, Centers for Medicare and Medicaid Services.) Letter addressed to UC Davis Medical Center Administrator, November 13, 2012. Obtained by request.
- 66 California Health and Human Services Agency, *Statement of Deficiencies . . . for University of California, Davis Medical Center*, August 30, 2012.
- 67 California Health and Human Services Agency, *Statement of Deficiencies . . . for University of California, Irvine Medical Center and University of California, San Francisco Medical Center*, October 25, 2008; June 17, 2009; July 15, 2009; March 4, 2010; July 22, 2010; October 21, 2010; January 18, 2011; April 5, 2011; and June 30, 2011.
- 68 California Health and Human Services Agency, *Statement of Deficiencies . . . for UCSF Medical Center*, January 18, 2011.
- 69 California Health and Human Services Agency, *Statement of Deficiencies . . . for UCSF Medical Center*, October 25, 2008.
- 70 These areas were Governing Body, Quality Assessment and Performance Improvement, Pharmaceutical Services, Food & Dietetic Services, Infection Control, and Surgical Services. (California Health and Human Services Agency, *Statement of Deficiencies . . . for UCSF Medical Center*, October 21, 2010.)
- 71 California Department of Public Health, *Statement of Deficiencies . . . for UCSF Medical Center*, April 5, 2011.
- 72 Idem, *Statement of Deficiencies . . . for UCSF Medical Center*, March 3, 2010 and June 30, 2011.
- 73 Idem, *Statement of Deficiencies . . . for University of California Irvine Medical Center*, May 11, 2011.
- 74 Idem, *Statement of Deficiencies . . . for University of California Irvine Medical Center*, March 4, 2010.
- 75 Idem, *Statement of Deficiencies . . . for University of California Irvine Medical Center*, June 17, 2009.
- 76 Idem, *Statement of Deficiencies . . . for University of California Irvine Medical Center*, July 15, 2009.
- 77 Idem, *Statement of Deficiencies . . . for University of California Irvine Medical Center*, July 22, 2009.
- 78 California Department of Public Health, "Hospital Facility FAQs," accessed January 15, 2013, <http://hfcis.cdph.ca.gov/faq/Hospital.aspx>; California Health and Human Services Agency, *Statement of Deficiencies . . . for University of California Irvine Medical Center*, March 4, 2010.
- 79 California Health and Human Services Agency, *Statement of Deficiencies . . . for University of California Irvine Medical Center*, April 7, 2008; July 23, 2008; September 19, 2008; April 22, 2009; July 15, 2009; July 28, 2010; October 28, 2010; February 11, 2011; August 17, 2011; and August 18, 2011; Idem, *Statement of Deficiencies . . . for UCSF Medical Center*, December 1, 2008; April 6, 2009; May 4, 2010; June 24, 2010; October 11, 2010; January 20, 2011; March 16, 2011; and March 21, 2011.
- 80 U.S. Department of Health & Human Services, Agency for Healthcare Research and Quality, "Never Events," last updated October 2012, <http://www.psnet.ahrq.gov/primer.aspx?primerID=3>
- 81 California Health and Human Services Agency, *Statement of Deficiencies . . . for University of California, Irvine Medical Center*, April 7, 2008; July 23, 2008; September 19, 2008; April 22, 2009; July 28, 2010; October 28, 2010; February 11, 2011; August 17, 2011; and August 18, 2011.
- 82 Esther Flores, (Senior Hospital Assistant), UC Irvine, 2012.
- 83 California Health and Human Services Agency, *Statement of Deficiencies . . . for UCSF Medical Center*, December 1, 2008; April 6, 2009; May 4, 2010; June 24, 2010; October 11, 2010; January 20, 2011; February 23, 2011; March 16, 2011; March 21, 2011; and January 20, 2012.
- 84 University of Maryland Medical Center. "Pressure ulcer – Overview," last updated November 22, 2010, <http://www.umm.edu/ency/article/007071.htm>
- 85 Mayo Clinic Staff. "Bed sores (pressure sores): Complications," last updated March 19, 2011, <http://www.mayoclinic.com/hewalth/bedsores/DS00570/DSECTION=complications>
- 86 Based on an analysis of 2009-2011 inpatient discharge data from California Office of Statewide Health Planning and Development (OSHPD). The analysis of OSHPD data follows, with two exceptions, AHRQ's most recent technical specifications for Patient Safety Indicator #3, Pressure Ulcers. These specifications detail which discharges to include and exclude from the analysis cohort. Among the key exclusions: patients with stays of less than 5 days; patients with paralysis or stroke; patients who underwent certain skin or wound procedures during the hospital stay; and patients transferred from another healthcare facility. The exceptions are that we look only at patients 65 and older (instead of 18 and older), and that instead of considering only patients with secondary diagnoses of "severe" (stage 3 and 4) pressure ulcer, we consider patients with secondary diagnoses of all pressure ulcers. The limitation to stage 3 or 4 pressure ulcers is intended to capture those pressure ulcers whose treatment Medicare will no longer pay for. But from a quality standpoint, any hospital-acquired pressure sore is troubling, and indeed until recently AHRQ considered all pressure ulcers, regardless of stage. (See: Harold Brem et al, "High cost of stage IV pressure ulcers," *The American Journal of Surgery*, Volume 200, Issue 4, (October 2010): DOI: 10.1016/j.amjsurg.2009.12.021; Department of Health and Human Services, Agency for Healthcare Research and Quality, "Patient Safety Indicators: Technical Specifications," AHRQ Quality Indicators, Version 3.2, March 10, 2008, [http://www.qualityindicators.ahrq.gov/Downloads/Modules/PSI/V32/psi\\_technical\\_specs\\_v32.pdf](http://www.qualityindicators.ahrq.gov/Downloads/Modules/PSI/V32/psi_technical_specs_v32.pdf), pp. 7-8; and Version 4.4. March 2012, [http://www.qualityindicators.ahrq.gov/Downloads/Modules/PSI/V44/TechSpecs/PSI\\_03\\_Pressure\\_Ulcer\\_Rate.pdf](http://www.qualityindicators.ahrq.gov/Downloads/Modules/PSI/V44/TechSpecs/PSI_03_Pressure_Ulcer_Rate.pdf));
- 87 The Collaborative Alliance for Nursing Outcomes (CALNOC; formerly known as the California Nursing Outcomes Coalition) includes all pressure ulcers in its quality indicator. ([http://www.wsha.org/files/2009\\_NSQ\\_Webcast.pdf](http://www.wsha.org/files/2009_NSQ_Webcast.pdf), slide 34)
- 88 Qualifying discharge is defined as a patient, age 65 and older, meeting AHRQ's inclusion and exclusion specifications for the pressure ulcer Patient Safety Indicator, but for all (i.e., not limited to stage 3 and stage 4) pressure ulcers (See note 86 above). There were 148 hospitals in California with at least 2,000 qualifying discharges from 2009 to 2011.
- 89 Although the AHRQ specifications are careful to exclude patients who are more likely than others to be diagnosed with pressure sores, it is still necessary to control even more strictly for a hospital's precise case mix. This is done by calculating a statewide pressure sore rate for each diagnosis-related group (DRG) and using these DRG-specific rates to arrive at an "expected" pressure sore rate at a given hospital. These expected rates are compared with the actual, or observed, rates. Consider this purely hypothetical example: patients in the more acute DRG 1 are found to have a statewide pressure sore rate of 5%, while patients in the less acute DRG 2 are found to have a statewide pressure sore rate of 0.8%. Hospital A has 10 patients in DRG 1 and 7 patients in DRG 2. Hospital B has 3 patients in DRG 1 and 13 patients



- 125 University of California, "Summary of individual compensation actions," September 13, 2012, <http://www.universityofcalifornia.edu/news/article/28339>
- 126 Molly Gamble, "25 Top Grossing Public Hospitals," *Becker's Hospital Review*, July 11, 2012. <http://www.beckershospitalreview.com/lists/25-top-grossing-public-hospitals.html>
- 127 UC Office of the President, *Medical Center Financial Statements*, 2011, 2012, <http://www.ucop.edu/financial-accounting/financial-reports/medical-center-financial-reports.html>
- 128 UC Academic Senate, Committee on Planning and Budget, Minutes of Meeting 5 June 2012, p.2.
- 129 Ibid.
- 130 Andrea Whaley, (Operating Room Assistant), UC Davis, 2012.
- 131 Marlon Gliane, (Biomedical Equipment Technician), UCLA, 2012.
- 132 Brenda Sweeney, (Hospital Unit Service Coordinator), UC San Diego, 2012.
- 133 See note 54 above.
- 134 Esther Flores, (Senior Hospital Assistant), UC Irvine, 2012.
- 135 Ann Page, "Temporary, Agency, and Other Contingent Workers (Chapter 27)," in *Patient Safety and Quality: An Evidence-Based Handbook for Nurses*, ed. Rhonda G. Hughes, AHRQ Publication No. 08-0043, April 2008, Agency for Healthcare Research and Quality, Rockville, MD, <http://www.ahrq.gov/qual/nursesfdbk/>; Ann Page, ed., Committee on the Work Environment for Nurses and Patient Safety, Board on Health Care Services, *Keeping Patients Safe: Transforming the Work Environment of Nurses*. Washington, DC: National Academies Press; 2004.
- 136 Michael Quinlan, Claire Mayhew C, and Philip Bohle, "The global expansion of precarious employment, work disorganization, and consequences for occupational health: a review of recent research," *International Journal of Health Services*, 31, no. 2 (2001): 335-414. <http://www.ncbi.nlm.nih.gov/pubmed/11407174>.
- 137 Page, "Temporary, Agency, and Other Contingent Workers," 2008; Idem, *Keeping patients safe*, 2004.
- 138 Tim Thrush, (Diagnostic Medical Sonographer), UCSF, 2012.
- 139 Danielle Bailey, (Hospital Unit Secretary Coordinator) UCSD2012.
- 140 UC Office of the President/ UC San Francisco Medical Center, Response to AFSCME 3299 Request for Information (EX-12-051-05), August 17, 2012.
- 141 For this analysis staff numbers reflect headcount of patient care technical workers represented by AFSCME 3299. An analysis of the existing data by Full Time Equivalency yields similar results. However the practice of some medical centers – notably UC Davis – to classify many of their Per Diem employees as 0%, regardless of the number of hours actually worked, distorts the results of such analysis.
- 142 UC Office of the President, AFSCME 3299 Membership Files for 2010-09, 2011-09, and 2012-09.
- 143 Ibid.
- 144 UC Office of the President. Corporate Personnel System Data and AFSCME 3299 Membership and Dues Files.
- 145 Senate Office of Research, State of California, *Charity Care and Nonprofit Hospitals*, 2012. [http://www.cheac.org/page/Newsletter/pdfs/SOR\\_Backgrounders\\_on\\_Charity\\_Care\\_Nonprofit\\_Hospitals\\_8-13-12.pdf](http://www.cheac.org/page/Newsletter/pdfs/SOR_Backgrounders_on_Charity_Care_Nonprofit_Hospitals_8-13-12.pdf)
- 146 California Office of Statewide Health Planning and Development, "FAQs: Hospital Community Benefits Programs," last revised August 8, 2012, <http://www.oshpd.ca.gov/HID/SubmitData/CommunityBenefit/FAQ.html>
- 147 *UCLA Today*, "UC provides communities with \$3.3 billion in health services," last accessed January 13, 2013. <http://today.ucla.edu/portal/ut/PRN-uc-hospitals-clinics-serve-communities-230951.aspx>
- 148 See <http://health.universityofcalifornia.edu/about/>. This site contains links to community benefits reports for UC Davis and UC San Diego, and a "community engagement" site for UCSF, but no reports specific to either UCLA or UCI Medical Centers.
- 149 OSHPD 2011 Complete data sets and pivot tables. A total of 82 general acute care hospitals in Los Angeles County populated the data set. Ronald Reagan and Santa Monica campuses of UCLA Medical Center were combined and removed. Kaiser Foundation Hospitals were removed since they do not provide this data.
- 150 Weighted average of: charity care + bad debt + county indigent programs contract adjustments multiplied by cost-to-charge ratio as reported in OSHPD 2011 pivot tables for hospitals included in the sample.
- 151 Charity-Other + Bad Debt + CIP Cont. Adj. times cost to charge ratio; from OSHPD pivot tables.
- 152 OSHPD 2011 Complete data sets and pivot tables.
- 153 See note 42 above.
- 154 Yudof, Letter to Chancellors, 2011.
- 155 UC Regents Committee on Finance, Minutes of Meeting, 16 March, 2012. <http://regents.universityofcalifornia.edu/regmeet/mar11/f3.pdf>
- 156 Randy Johnson, (MRI Technician at UCSF Medical Center.) Interview, February 5, 2013.
- 157 Laurel Rosenthal, "Jerry Brown criticizes UC for raising new chancellor's pay," *The Sacramento Bee*, November 27, 2012, <http://blogs.sacbee.com/capitolalert/latest/2012/11/jerry-brown-criticizes-uc-for-raising-new-chancellors-pay.html#storylink=cpy>.
- 158 Peter Orszag, "Life-Span Gap Skews Entitlements Toward the Well Off," *Bloomberg News*, December 20, 2012, <http://www.bloomberg.com/news/2012-10-02/life-span-gap-skews-entitlements-toward-the-well-off.html>.
- 159 Orszag, "Life-Span Gap Skews Entitlements," *Bloomberg News*, 2012.
- 160 State of California Proposed Budget for Fiscal Year 2013-14, Education, University of California (6440), p. EDU 9, <http://www.ebudget.ca.gov/pdf/GovernorsBudget/6000/6440.pdf>.
- 161 Ibid, p. S-2.
- 162 Ibid, p. 56.
- 163 Orszag, "Life-Span Gap Skews Entitlements," *Bloomberg News*, 2012.
- 164 For this discussion, management refers to employees classified as Senior Management Group (SMG) or Management and Senior Professionals (MSP). Employee numbers refer to "Full-Time Equivalents" (FTE).
- 165 UC Office of the President. "Headcount and FTE Tables," Oct. 2008 – Oct. 2011, Corporate Personnel System. Accessed 11/26/12. <<http://www.ucop.edu/ucophome/uwnews/stat/>>

- 166 AFSCME 3299 Analysis of UC Office of the President Corporate Personnel Payroll and FTE Data. UC Office of the President. "Headcount and FTE Tables," Oct. 2008 – Oct. 2011, Corporate Personnel System. Accessed 11/26/12. <[<http://www.ucop.edu/ucophome/uwnews/stat/;>](http://www.ucop.edu/ucophome/uwnews/stat/); UC Office of the President. "University of California Employee Pay," 2008-2011. <https://ucannualwage.ucop.edu/wage/>. Downloaded from <http://ucpay.globl.org/>.
- 167 Ibid.
- 168 UC Office of the President, Corporate Personnel System Data, May 2009 and May 2012. SMG and MSP classifications by Full Time Equivalency. In this section, "annual costs" were estimated from Gross Year-to-Date values from May of each year.
- 169 Ibid.
- 170 UC Office of the President, Corporate Personnel System Data, May 2009 and May 2012. Job titles reviewed include all SMG and MSP classifications, excluding physicians and dentists not in primary management roles.
- 171 UC Office of the President, Corporate Personnel System Data, May 2009 and May 2012.
- 172 UC Office of the President, Corporate Personnel System Data, May 2009 and May 2012.
- 173 UC Regents Committee on Compensation, Minutes of Meeting 15 September 2011, <http://regents.universityofcalifornia.edu/regmeet/sept11/c3a.pdf>, p. 6; *Idem*, Minutes of Meeting 28 November 2011, <http://regents.universityofcalifornia.edu/regmeet/nov11/c3a.pdf>, p. 5.
- 174 University of California, Annual Report On Executive Compensation For Calendar Year 2011, <http://compensation.universityofcalifornia.edu/reports/2011-annual-report-executive-compensation-092012.pdf>
- 175 Ibid.
- 176 The University of California Office of the President, Payroll Data, 2011, <https://ucannualwage.ucop.edu/wage/>. Downloaded from <http://ucpay.globl.org/>.
- 177 The Regents of the University of California, "Compensation for Paul S. Viviano as Associate Vice Chancellor—Health Sciences and Chief Executive Officer, UCSD Health System, San Diego Campus," May 2012, <http://regents.universityofcalifornia.edu/aar/viviano.pdf>
- 178 Sandra Ramirez-Curci, (Operating Room Assistant), UC Davis, 2012.
- 179 Isaac Seckora, (Senior Surgical Technician) UC Davis, 2012. Seckora reports that these numbers were quoted by management to staff in a meeting. The policy required jackets for all workers who entered the Operating Room but did not "scrub in," or undergo the sterilizing procedure required of those more directly involved in procedures, such as surgeons, nurses, and surgical technicians. The policy had been motivated by a theory that cells from these workers' exposed skin were somehow contributing to surgical site infections. The jacket policy was in place for one to two months before a panel was assembled to look for research to support this theory. The panel found no direct data that wearing a jacket would decrease surgical site infections. Because OR workers typically wash their hands every 15-20 minutes, the skin cells on their forearms should be minimized.
- 180 UC Regents Committee on Grounds and Buildings, "Approval of the Budget for Capital Improvements," March 23, 2010, <http://regents.universityofcalifornia.edu/regmeet/mar10/gb5.pdf>
- 181 UC Regents Committee on Grounds and Building and UC Regents Committee on Finance, "Amendment of the Budget for Capital Improvements," September 16, 2010, <http://regents.universityofcalifornia.edu/regmeet/sept10/joint1.pdf>
- 182 These figures do not include all debt taken on by University health sciences departments for facilities that do not provide clinical care, such as new research centers or medical student classrooms. (UC Office of the President, *Medical Center Financial Statements*, 2006, 2007, 2011, 2012, <http://www.ucop.edu/financial-accounting/financial-reports/medical-center-financial-reports.html>)
- 183 University of California Report on Audit of Financial Statements and on Federal Awards Programs in accordance with OMB Circular A-133, 2007 and 2011.
- 184 Ibid.
- 185 Cindy Lima, Executive Director of Administration, UCSF Medical Center, UC Regents Committee on Grounds and Buildings, Minutes of Meeting May 17, 2008; UC Regents Committee on Grounds and Buildings, Minutes of Meeting May 13, 2008.
- 186 University of California Report on Audit of Financial Statements and on Federal Awards Programs in accordance with OMB Circular A-133, 2007 and 2011.
- 187 Ibid.





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