

UC San Diego

AUDIT & MANAGEMENT ADVISORY SERVICES

Sexual Violence and Sexual Harassment (SVSH)
Protections in Clinical Settings
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FINAL REPORT

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I. EXECUTIVE SUMMARY

Audit & Management Advisory Services (AMAS) has completed a review of Sexual Violence and Sexual Harassment (SVSH) Protections in Clinical Settings as part of the approved audit plan for Fiscal Year 2022-23. The objective of our review was to perform an overall assessment of SVSH protections in clinical settings, related administrative processes and internal control environment, and determine whether protocols provide reasonable assurance that SVSH monitoring practices in clinical settings have been appropriately implemented and are in compliance with University policy requirements.

Based on our review, we concluded that UCSDH completed the initial rollout of SVSH protections in ambulatory clinical settings, however certain administrative processes and internal controls in the specialty areas we reviewed were not operating consistently to provide assurance of full compliance with University policy. The Workgroup Guidance, UCH Guidance, UCSDH Chaperone Policy and the training bundle and resources established by Ambulatory Nursing and Professional Development and Ambulatory Nursing Operations provided a strong framework, and we observed that new processes related to provider credentialing were effective. Additional improvement is needed to ensure full and consistent compliance with policies and procedures.

We identified several opportunities for improvement with development and implementation of the Workgroup Guidance, UCH Guidance and Chaperone Policy at UCSDH including enhanced chaperone standards; processes for chaperone policy development and implementation; documentation, training, auditing and use of scribes; trainee education, training and guidelines; and acquisition and affiliation due diligence practices. Management Action Plans to address these findings are summarized below.

A. Enhanced Chaperone Standards

1. The UCSDH Chief Medical Officer's Office is coordinating with UCSDH leadership, Legal, and the Title IX Office to develop an inpatient chaperone policy.
2. Management has facilitated the rebuilding of a Chaperone Policy Implementation Workgroup and will ensure there is appropriate representation from all impacted specialties, as well as OGME, as appropriate, for guidance on trainee requirements.
3. Management will ensure the Chaperone Policy Implementation Workgroup and their delegates reinforce standardized processes and best practices for all service areas with sensitive exams related to use and documentation of Chaperones, training and patient education with continued monitoring. These processes and best practices should be disseminated through established communication methods and reviewed on an on-going basis.
4. Management will consider adding a standardized process for auditing and/or a template as part of the monthly responsibilities of all service areas to ensure routine compliance and reporting.
5. Management has worked with UCLC to assign the chaperone training for 2023 and will ensure that it is done automatically on an annual basis.
6. Management will ensure that any clinics with non-UCSDH employees incorporate all the required training elements in alignment with the Workgroup Guidance, UCH Guidance and UCSDH Chaperone Policy. This should extend to ensuring that any external training provided to non-UCSDH personnel who may provide care to UCSDH patients requiring the use of a Chaperone incorporates all required UCSDH elements.

7. Management has updated the UCSDH Chaperone Policy to clarify that scribes must not be used as chaperones for patient care.
8. UCSDH Management is updating the Use of Scribes for Clinical Documentation Policy to clarify that scribes must not be used as chaperones for patient care.

B. Trainee Education, Training and Guidelines

1. OGME Management will work with Ambulatory Leadership and Legal to assess methods to roll out all training on SVSH protections to UCSD Trainees as appropriate.
2. OGME Management will participate in the UCSDH Chaperone Policy Implementation Workgroup in order to determine required training for all types of Trainees, stay updated and current on the needs of the Trainees and assisting with the implementation of standard practices for Trainees in all specialties.

C. Acquisition, Affiliation and Joint Venture Due Diligence

1. UCSDH Legal has obtained clarification from UC Health Legal specifying under which types of joint ventures, physician acquisitions or healthcare affiliations the due diligence requirements would apply; in particular, in those cases where there is a minority ownership / interest or control is not defined, or when an existing agreement is being restructured.

Observations and related management action plans are described in greater detail in section V. of this report.

II. BACKGROUND

Audit & Management Advisory Services (AMAS) has completed a review of Sexual Violence and Sexual Harassment (SVSH) Protections in Clinical Settings as part of the approved audit plan for Fiscal Year 2022-23. This report summarizes the results of our review.

On December 19, 2019, University of California (UC) President Napolitano issued a letter to all Chancellors, Medical Center Chief Executive Officers, Health Sciences Vice Chancellors and Human Health Sciences School Deans regarding the prevention, detection, and response to SVSH in the context of Patient Care. She convened a Working Group at the UC Office of the President (UCOP) with systemwide representation on May 31, 2019, to address the unique complexities that the clinical setting presents with regard to SVSH. This Working Group was charged with reviewing UC's current policies and helping to develop a presidential policy addressing SVSH in the clinical setting. The Working Group has developed interim guidance entitled *Guidance on Investigation Prohibited Conduct in the Context of Patient Care (Workgroup Guidance)*. In addition, UC Health has issued directives and guidance (UCH Guidance) that address clinical mandates and reporting, including the following:

1. Enhanced chaperone standards;
2. Supplemental credentialing application questions;
3. Acquisition and Affiliation due diligence;
4. Model website notice; and
5. Education, training and guidelines.

Both the Workgroup Guidance and the UCH Guidance documents are effective February 15, 2020. Guidance and directives regarding SVSH in patient care include the following:

Implementation Date	Action
February 15, 2020	<ul style="list-style-type: none"> • Implement Guidelines on Prohibited Definitions in the Context of Patient Care. <i>(All Locations)</i> • Implement Guidance on Investigating Prohibited Conduct in the Context of Patient Care. <i>(All Locations)</i> • Include website notice on Main Splash pages. <i>(Academic Medical Centers (AMCs))</i> • Revise credentialing and re-credentialing applications. <i>(AMCs and non-AMC clinics)</i> • Apply due diligence requirements. <i>(AMCs)</i>
March 15, 2020	<ul style="list-style-type: none"> • Submit protocols for responding to allegations arising from patient care to Systemwide Title IX Office. <i>(Locations without AMCs)</i> • Complete Incident Response Team (IRT) training for IRT members, consultants and related staff. <i>(AMCs)</i>
July 1, 2020	<ul style="list-style-type: none"> • Implement Chaperone Policy (Phase I). <i>(AMCs - Ambulatory Clinics in Primary Care, Urgent Care, Obstetrics & Gynecology, Urology, Rehabilitation Medicine)</i>
August 15, 2020	<ul style="list-style-type: none"> • Complete initial Boundaries training. <i>(All locations – All physicians, physician assistants and advance practice nurses)</i>

Implementation Date	Action
January 1, 2021	<ul style="list-style-type: none"> • Implement Chaperone Policy (Phase II). <i>(Ambulatory Clinics in all specialties)</i> • Approve standardized procedural guidelines. <i>(All locations – for routine sensitive exams and procedures, corresponding patient education materials)</i>
January 1, 2022	<ul style="list-style-type: none"> • Implement Chaperone Policy (Phase III). <i>(All locations)</i>

The UC SVSH Policy was also revised, effective January 1, 2022¹, to comply with Senate Bill 493, which amended California Education Code Section 66262.5 and added Section 66281.8. Provisions added specifically address prohibited conduct in a clinical setting, provide important new protections for potentially vulnerable populations in clinical settings, and increase accountability for those who engage in prohibited conduct.

UC San Diego Health (UCSDH) created a Chaperone Policy Implementation Workgroup that led UCSDH in creating a location-specific UCSDH Chaperone Policy for Ambulatory Care (UCSDH Chaperone Policy) effective February 2021, which was last revised March 23, 2021. Training was rolled out initially to managers and physicians in February 2021 to areas identified with sensitive exams, and then to all ambulatory service areas and urgent care locations. A training video and training bundle were developed and disseminated to all ambulatory service areas with the Chaperone training. The Chaperone training was assigned through the UC Learning Center (UCLC) for 2021 and 2022. Training is tracked automatically. The Physician Boundaries Training was also available in the UCLC for UCSDH medical staff and via an online video and post-test for community physicians, including volunteers. UCSDH requires all community physicians and volunteers to complete the video training and post-test with the additional supplemental credentialing questions prior to the application being accepted for credentialing and/or privileges.

In addition, the presence or refusal of a Chaperone must be documented in the patient’s Epic Electronic Health Record (EHR) along with the name and title of the Chaperone. The Chaperone Policy Implementation Workgroup met with the Ambulatory leadership management team and requested that internal audits be conducted of this process in all service areas. Initially, audits were required on a weekly basis for a month, on a monthly basis for a quarter, and then quarterly for a year.

[UCSDH Chaperone Policy](#)

The UCSDH Chaperone Policy was developed to ensure the comfort and safety of patients, providers and staff. According to the UCSDH Chaperone Policy, “A chaperone must be present in an examination room during sensitive examinations and procedures (examinations and procedures involving the genital or rectum in all individuals, or breasts in females) performed by a Licensed Health care Provider (LHP), unless an exception is met as detailed in the policy. A “LHP” refers to Physicians, Nurse Practitioners, Nurse Midwives, Clinical Nurse Specialists, Nurse Anesthetists, Physician Assistants, Medical Residents, and Interns”.

¹ The revised UC SVSH Policy is an interim policy.

The UCH Guidance identified the following Ambulatory Clinics in the Phase I implementation of the Chaperone Policy:

- Primary Care;
- Urgent Care;
- Obstetrics & Gynecology (OB/GYN);
- Urology; and
- Rehabilitation Medicine.

There are multiple clinic locations for each service area. The UCSDH Physician Group Ambulatory Services leadership team led the implementation of the policy and training across the UCSDH enterprise.

III. AUDIT OBJECTIVE, SCOPE, AND PROCEDURES

The objective of our review was to perform an overall assessment of SVSH protections in clinical settings, related administrative processes and internal control environment, and determine whether protocols provide reasonable assurance that SVSH monitoring practices in clinical settings have been appropriately implemented and are in compliance with University policy requirements. In order to achieve our objective, we performed the following:

- Reviewed the following:
 - UCOP Interim Guidelines and Directives to Improve Prevention, Detection, and Response to Sexual Misconduct in the Clinical Setting including the Workgroup Guidance and UCH Guidance;
 - UCSDH Chaperone Policy;
 - UCSDHP 562.3 Use of Scribes for Clinical Documentation;
 - UCSDHS Office of Compliance, Student Health Site Visit Report;
 - UC Policy Sexual Violence and Sexual Harassment;
- Interviewed the following:
 - Associate Chief Operating Officer (COO), UCSDH Physicians Group;
 - UCSDH Senior Risk Manager, Risk Management;
 - UCSDH Chief Quality Patient Safety Officer; and
 - UCSDH Chief Administrative Officer, Operations;
 - UCSDH Assistant Director, Ambulatory Nursing and Professional Development;
 - UCSDH Senior Director, Ambulatory Nursing Operations;
 - UCSDH Director, Medical Staff Administration;
 - UCSDH Medical Staff Administration Database Analyst;
 - UCSD Associate Director (Health), Deputy Title IX Officer;
 - UCSDH Service Area Management for four selected Ambulatory service areas;
 - Management Services Organization Physician Management Services (MSO²) Manager and Supervisor;
 - UCSDH Chief Health Counsel and Contract & Legal Specialist;
 - UCSD Associate Dean for Graduate Medical Education;
 - UCSD Assistant Director and House Officer Administrative Program Manager, Office of Graduate Medical Education (OGME);

² The MSO provides non-physician clinical staff and management to three specific UCSDH-owned clinics for Service Area D.

- Evaluated the following:
 - Implementation of the Workgroup Guidance and UCH Guidance, including the implementation of the new UCSDH Chaperone Policy and the process and monitoring in Ambulatory for four specialties;
 - Ambulatory Chaperone Policy Staff Education Bundle including, but not limited to Patient Education Materials, Epic Tip Sheet, FAQ Sheet, Team-Based Training Template, Video Resources and Sample Agenda;
 - The Manager Chaperone Standards Implementation Readiness Tool for ten specialty clinics to understand how clinical directors were ensuring their clinical areas were appropriately staffed to accommodate the implementation of the UCSDH Chaperone Policy and how they would develop a staffing and communication plan for related workflows;
 - Procedures to expand and track supplemental credentialing application questions;
 - Education, training and guidelines for boundaries training, monitoring and tracking course completion through UCLC and online for physicians, advanced practice nurses or physician assistants with patient care responsibilities;
 - Current acquisitions and affiliations since February 15, 2020, and the inclusion of due diligence practices;
 - Patient Education tools;
- Analyzed the following:
 - Chaperone documentation compliance for 38 appointments; 15 in Service Area A, 10 in Service Area B, and 13 in Service Area C;
 - Boundaries training verification and completion dates for 25 Providers;
 - Completion status of the Medical Chaperone training for 15 Chaperones;
 - Five Medical Staff applications for inclusion of new supplemental questions and answers and completion of training for credentialing and/or privileges;
 - Twenty-one (21) total patient appointments that had been audited internally in Service Area A, Service Area B, Service Area C and Service Area D; and
 - Documentation available for four acquisition and/or affiliation agreements to determine if due diligence practices to address unprofessional conduct had been included, as appropriate.

This audit did not include a review of processes for receiving, evaluating, and investigating reports of misconduct, or compliance with the SVSH Policy and Guidance on Investigating Prohibited Conduct in the Context of Patient Care. We also did not evaluate policy and procedures in non-UCSDH owned clinics.

IV. CONCLUSION

Based on our review, we concluded that UCSDH completed the initial rollout of SVSH protections in ambulatory clinical settings, however certain administrative processes and internal controls in the specialty areas we reviewed were not operating consistently to provide assurance of full compliance with University policy. The Workgroup Guidance, UCH Guidance, UCSDH Chaperone Policy and the training bundle and resources established by Ambulatory Nursing and Professional Development and Ambulatory Nursing Operations provided a strong framework, and we observed that new processes related to provider credentialing were effective. Additional improvement is needed to ensure full and consistent compliance with policies and procedures.

We identified several opportunities for improvement with development and implementation of the Workgroup Guidance, UCH Guidance and Chaperone Policy including enhanced chaperone standards; processes for chaperone policy development and implementation; documentation, training, auditing and use of scribes; trainee education, training and guidelines; and acquisition and affiliation due diligence practices.

These opportunities for improvement are discussed in greater detail in the balance of this report.

V. OBSERVATIONS REQUIRING MANAGEMENT ACTION

A.	Enhanced Chaperone Standards
Aspects of the required enhanced chaperone standards have not been fully implemented in all locations, including the use of a chaperone annual training for staff and residents, documentation, auditing and the use of scribes as chaperones. A policy addressing inpatient protections has not yet been developed.	
Risk Statement/Effect	
Lack of full compliance with the policy minimizes the organization's ability to prevent, detect, and respond to sexual violence and sexual harassment.	
Management Action Plans	
A.1	The UCSDH Chief Medical Officer's Office is coordinating with UCSDH leadership, Legal, and the Title IX Office to develop an inpatient chaperone policy..
A.2	Management has facilitated the rebuilding of a Chaperone Policy Implementation Workgroup and will ensure there is appropriate representation from all impacted specialties, as well as OGME, as appropriate, for guidance on trainee requirements.
A.3	Management will ensure the Chaperone Policy Implementation Workgroup and their delegates reinforce standardized processes and best practices for all service areas with sensitive exams related to use and documentation of Chaperones, training and patient education with continued

	monitoring. These processes and best practices should be disseminated through established communication methods and reviewed on an on-going basis.
A.4	Management will consider adding a standardized process for auditing and/or a template as part of the monthly responsibilities of all service areas to ensure routine compliance and reporting.
A.5	Management has worked with UCLC to assign the chaperone training for 2023 and will ensure that it is done automatically on an annual basis.
A.6	Management will ensure that any clinics with non-UCSDH employees incorporate all the required training elements in alignment with the Workgroup Guidance, UCH Guidance and UCSDH Chaperone Policy. This should extend to ensuring that any external training provided to non-UCSDH personnel who may provide care to UCSDH patients requiring the use of a Chaperone incorporates all required UCSDH elements.
A.7	Management has updated the UCSDH Chaperone Policy to clarify that scribes must not be used as chaperones for patient care.
A.8	UCSDH Management is updating the Use of Scribes for Clinical Documentation Policy to clarify that scribes must not be used as chaperones for patient care.

A. Enhanced Chaperone Standards – Detailed Discussion

Chaperone Documentation

The UCSDH Chaperone Policy states that “A Chaperone must be present in an examination room during sensitive examinations and procedures, for all locations effective January 1, 2022. The presence or refusal of a Chaperone must be documented in the patient’s” EHR. According to UCSDH Chaperone Policy the presence or refusal of a Chaperone must be documented in the patient’s EHR. The documentation must include:

1. Name and title of the Chaperone.
2. Presence or absence of the chaperone based on either the Chaperone being present/required, the Chaperone is not required due to the age of the patient and parent/legal guardian presence, or a Chaperone is refused by the patient.

There are two ways in Epic for a chaperone to be documented; either the provider can note it in the visit notes, or it can be documented in the rooming tab when the patient has arrived to the appointment room.

We performed an evaluation of 38 judgmentally selected patient appointments from three ambulatory service areas, referred to as Service Area A, Service Area B and Service Area C, for chaperone policy compliance. The following results are based on our review of these three service areas. We did not include Service Area D for this test since it does not utilize UCSDH’s Epic instance. We found that 17 were compliant with chaperone usage and documentation, and 11 were not compliant. We noted that 10 appointments were partially compliant. Chaperones were noted but there were inconsistencies in how these chaperones were documented. Our results are summarized in the following table.

Specialty	Number of Clinics	Patient Appointment Review Results			
		Compliant	Not Compliant	Partially Compliant ³	TOTAL
Service Area A	3	5	5	5	15
Service Area B	1	8	-	2	10
Service Area C	6	4	6	3	13
TOTAL	10	17	11	10	38
% Compliant		45%	29%	26%	

Currently, not all ambulatory service areas are consistently requiring Chaperones to be present in an examination room during sensitive exams, since service areas have not uniformly implemented the standards.

Auditing

When the Workgroup Guidance, UCH Guidance and UCSDH Chaperone Policy were implemented in March 2021, Ambulatory service areas were instructed to do an internal audit of their processes. The original requirements were weekly audits for a month, monthly audits for a quarter, and quarterly audits for a year. Audits were to be done by the Manager or Nurse Supervisor. If there was an issue, the responsible reviewer was directed to inform the Medical Director. Completed audits were not collected and were just retained in their respective areas.

There does not appear to be any other specific guidance outlined on the frequency, standards, reporting requirements and/or record retention standards for auditing chaperone documentation in the EHR on an ongoing basis. As a result, responsible service areas are requesting specific guidance and a standardized process.

Of the four service areas reviewed in detail (Service Areas A, B, C and D) one has continued to conduct monthly audits to verify that chaperone practices remained in compliance with the UCSDH Chaperone Policy and related UC guidance and requirements. Of the other three service areas, two had completed the audits in the first one to two months of implementation but not consistently since, while one has not performed the audit process. Additional guidance on the expectations and frequency of ongoing audits may be needed to be re-communicated to UCSDH service areas to ensure they are meeting the audit requirement.

Annual Training

The UCSDH Chaperone Policy states that the “completion of initial training and annual training is required for staff to act as a Chaperone. All Chaperone training must be documented.”

On March 1, 2021, training at UCSD was first rolled out to managers in areas with sensitive exams. Managers and physicians were trained at the same time. Super users in each division were subsequently identified that would be responsible for training the staff on their team and keeping them up to date with any new guidance or implementations. On March 8, 2021, a training video was assigned

³ We noted inconsistencies in how these chaperones were documented, including missing the chaperone’s last name and/or title or there was documentation in the physician’s visit summary that stated a Chaperone was declined, but there was a Chaperone documented in the rooming tab.

to all Ambulatory staff in UCLC. From that point forward, there was team-based training that included physicians. The team-based training included the following steps:

1. Review internal workflow and planned processes;
2. Develop team-based training content;
3. Disseminate materials to staff;
4. Schedule team-based training to perform in-person review of process; and
5. Assist with the go live on April 1, 2021.

Training was completed in the month of March 2021 and the UCSDH Chaperone Policy went live at all Ambulatory service areas effective April 1, 2021.

The last required Medical Chaperone training was in March 2022. At the time of our review, we noted that the training had intentionally not been assigned in UCLC for the 2023 year so training could be consolidated for ambulatory and inpatient services. Therefore, the training was not yet rolled out to UCSDH personnel to ensure compliance with the training requirement.

UCSDH-Owned Clinics operated by a Management Services Organization (MSO)

According to the UCH Guidance, each and every clinical location shall develop or adopt standardized procedural guidelines for routine sensitive exams and procedures such as the Well Child Check, which includes a sensitive exam for every patient regardless of gender. In addition, the UCH Guidance requires each clinical location (or UC Health on behalf of all clinical locations) to identify best practices for preventing and detecting sexual misconduct perpetrated by or against special populations, such as children. We noted that Service Area D had a lack of patient educational materials, and inconsistent training, documentation, and auditing.

Per discussion with Service Area D Management, the two Service Area D sites have not fully implemented the Workgroup Guidance, UCH Guidance and UCSDH Chaperone Policy. These clinics are UCSDH-owned with UCSDH Faculty, but all other staff and the administration is managed by the MSO. The clinics utilize the MSO's version of Epic, and the staff is hired and trained by the MSO based on a Management Services Agreement with UCSDH. The non-UCSDH employees managed by the MSO were only trained in 2021 at the initial implementation of the UCSDH Chaperone Policy, using training materials generally consistent with the UCSDH standards⁴. No subsequent trainings have been performed.

Use of Scribes for Chaperones

According to feedback from management, the use of scribes, who are contracted personnel who assist providers with documenting notes during medical appointments, are not allowed to be chaperones.

We noted that one of the service areas reviewed was using scribes as chaperones. Scribes are not trained to be chaperones and they are not UCSDH employees. This restriction is not clearly defined in the UCSDH Chaperone Policy or UCSDHP 562.3 Use of Scribes for Clinical Documentation, but management has indicated that updates to the related Scribe policy specifying this restriction are in process.

⁴ The 2021 training materials were established by MSO personnel based on input and feedback from UCSDH management.

Inpatient Chaperone Policy

According to the UCH Guidance, minimum standards for all Sensitive Exams performed in part by a Health Care Provider in any specialty and each clinical location (individually or collectively with one or more) shall develop a plan to implement complementary policies or controls for inpatient, emergency room, and procedural site settings on or before January 1, 2022. However, we noted that there is no inpatient chaperone policy at this time.

The UCSDH management team met on April 28, 2023 with another UC location to obtain feedback about their inpatient chaperone processes. According to UCSDH management, additional research and work is still required to determine the next steps for implementation.

B. Trainee Education, Training and Guidelines	
Trainees, including Residents, Interns and Fellows, managed by OGME have not received the Boundaries or Chaperone training since policy implementation in 2020.	
Risk Statement/Effect	
Lack of full compliance with the policy minimizes the organization's ability to prevent, detect, and respond to sexual violence and sexual harassment.	
Management Action Plans	
B.1	OGME Management will work with Ambulatory Leadership and Legal to assess methods to roll out all training on SVSH protections to UCSD Trainees as appropriate.
B.2	OGME Management will participate in the UCSDH Chaperone Policy Implementation Workgroup in order to determine required training for all types of Trainees, stay updated and current on the needs of the Trainees and assisting with the implementation of standard practices for Trainees in all specialties.

B. Trainee Education, Training and Guidelines – Detailed Discussion

The UCH Guidance requires that “every physician credentialed or otherwise permitted to practice by a UC academic medical center or medical group shall be required, within six months after employment and at least biannually thereafter to complete an in-person or online boundaries course”. Furthermore, the UCSDH Chaperone Policy requires all LHPs to receive initial Chaperone training. As referenced above, LHPs are defined as Physicians, Nurse Practitioners, Nurse Midwives, Clinical Nurse Specialists, Nurse Anesthetists, Physician Assistants, Medical Residents, and Interns.

During our review of 25 providers to determine compliance with Boundaries training we noted that one provider, who is a resident, did not have any such training documented. OGME confirmed that this resident and any of the Trainees managed by their office have not received Boundaries and/or Chaperone training. Management indicated that the policy is unclear as to whether the Boundaries Course requirement applies to trainees with the initial interpretation of the UCH guidance that trainees

were not included since they are not credentialed providers. However, UC Health Legal considers it a best practice to have all trainees receive this training, and UCSDH has previously required that trainees complete the SVSH questionnaire. Trainees will also receive the Boundaries Course moving forward.

C.	Acquisition, Affiliation and Joint Venture Due Diligence
Due diligence elements were not completed for some agreements, based on interpretation of the UC policy and guidance, which does not clearly define the specific types of agreements that require the completion of the recommended due diligence elements.	
Risk Statement/Effect	
Inconsistent due diligence could result in the University being unaware of situations related to SVSH issues prior to executing an agreement.	
Management Action Plan	
C.1	UCSDH Legal has obtained clarification from UC Health Legal specifying under which types of joint ventures, physician acquisitions or healthcare affiliations the due diligence requirements would apply; in particular, in those cases where there is a minority ownership / interest or control is not defined, or when an existing agreement is being restructured.

C. Joint Venture, Acquisition and Affiliation Due Diligence – Detailed Discussion

Per UCOP guidelines, policy standards “apply to due diligence in the acquisition of or affiliation with a physician or group practice; the acquisition in whole or in part of any health care facility, clinic, or ancillary services provider by any means; or any affiliation under which the University assumes administrative, quality, or other oversight or operational control over health care facilities or providers.”

UCSDH Legal identified three joint venture or physician acquisition agreements executed after February 15, 2020. Two agreements are joint ventures with less than 50% ownership and one agreement was for the acquisition of the physical assets from a physician’s practice; the physician subsequently joined UCSDH Medical Staff. There was also an existing agreement that was restructured.

Since the joint ventures represented a less than 50% ownership interest with no direct control and the physician acquisition was limited to the physical assets and office lease of the physician, and not any other assets or liabilities of the physician’s prior operations, due diligence was not completed. UCSDH Legal indicated their interpretation was that due diligence was not required in these instances, including the restructured existing agreement. However, this was not clear based on the language in the policy. During the review, UCSDH Legal obtained clarification from UC Health Legal to confirm that for those agreements where UC would hold a minority interest, the policy has not been applied.