

The Regents of the University of California

HEALTH SERVICES COMMITTEE

April 9, 2019

The Health Services Committee met on the above date by teleconference at the following locations: Luskin Conference Center, Los Angeles campus; Lote H-4, Carretera Federal 200 Km. 19.5, Punta Mita, Mexico; 1301 Catherine Street, 7300 Medical Science Building 1, Ann Arbor, Michigan.

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

In attendance: Regents Graves, Pérez, and Sures, Faculty Representatives May and Bhavnani, Secretary and Chief of Staff Shaw, and General Counsel Robinson

The meeting convened at 10:10 a.m. with Committee Chair Lansing presiding.

1. PUBLIC COMMENT

Committee Chair Lansing explained that the public comment period permitted members of the public an opportunity to address University-related matters. The following persons addressed the Committee.

- A. Atreyi Mitra, UCLA student, urged the University not to engage in a partnership with Dignity Health (Dignity), citing concern for the rights of transgender patients. She described a student-led initiative called UC Speaks Up, in collaboration with departments at UCLA, UC San Diego, and UC Santa Barbara, for research on and prevention of sexual violence on campus.
- B. Sharon Kramer expressed concern about bad living conditions for families living on U.S. military bases and health hazards associated with mold. These hazards should not be downplayed or discounted.
- C. Daniel Grossman, M.D., professor in the Department of Obstetrics, Gynecology, and Reproductive Sciences at UCSF, expressed dismay regarding the proposed affiliation between UCSF and Dignity and Catholic Health Initiatives (CHI). Affiliation with this religious healthcare system would not be in line with UCSF's values. Health care provided at Dignity and CHI discriminates against lesbian, gay, bisexual, and transgender people. He urged the Regents to ask probing questions about the proposed affiliation.

- D. Eduardo Pérez-Preciado, UCLA student, urged the University to end its consideration of partnership with Dignity, which discriminates against transgender people and denies them reproductive healthcare services.
- E. Alan Fogelman, M.D., Chair of the Department of Medicine at UCLA Health, observed that many hospitals in California are owned and operated by faith-based organizations, that many of these are the only hospitals in their communities, and that these hospitals often care for the most vulnerable patients. He cited the example of a collaboration between UCLA Health and a Dignity hospital in Los Angeles that had improved patient care. It would be unwise to take any action that would make it difficult for UC faculty to help vulnerable patients.
- F. Shay Strachan, UCSF Vice President – Strategic Partnerships, identified herself as black and queer and expressed support for the affiliation between UCSF Health and Dignity. She stated that UCSF and Dignity could work together to balance differences and create value for the community they serve. She noted that she had worked for Dignity for ten years. In her experience, Dignity had been an inclusive work environment with leaders who were women, people of color, and openly LGBTQ+ people. She affirmed her support for reproductive and LGBT healthcare rights. The affiliation with Dignity would be an opportunity to improve quality of care and for UCSF to create positive and incremental changes in the standard of care across all communities served.
- G. Nanette Mickiewicz, M.D., President and Chief Executive Officer of Dominican Hospital in Santa Cruz, observed that UCSF and Dignity had been long-time partners in the San Francisco Bay Area. Dignity cares for more Medi-Cal patients than any other private healthcare provider in California. Dignity has partnerships with multiple academic institutions and public agencies. Dignity is a Catholic health system, but many of its hospitals are not Catholic, and all its hospitals provide high-quality, evidence-based care. Physicians who practice in Dignity hospitals may discuss all treatment options with patients.
- H. Lori Dangberg, Vice President of the Alliance of Catholic Health Care, noted that hospitals are highly regulated at the State and federal levels, with longstanding laws on treatment of patients with emergency medical conditions. Over a period of 46 years, there had not been one instance noted by the government or the court system in which a pregnant woman received inappropriate emergency treatment at a California Catholic hospital, or treatment outside the standard of care. Physicians at these hospitals are not prohibited from discussing all options and alternatives. Many Catholic hospitals are rape treatment sites, providing emergency contraception. Catholic-affiliated hospitals provide a larger share of key medical services than all other California acute care hospitals combined, and have provided decades of service to the most vulnerable communities.
- I. Rhea Shetty, UCLA student, urged the University to drop its patent claim in India for the cancer drug enzalutamide, marketed as Xtandi. This would allow

development of a more affordable generic form of the drug, which could save the lives of many people suffering from late-stage prostate cancer. She urged UCLA and the UC system to do what is morally right when faced with the choice between profits and saving lives.

- J. Michael Cahn, UCLA Bicycle Academy representative, stressed that use of automobiles brings about negative health outcomes, such as obesity, diabetes, cancer, and global warming. The University is a car-centric organization. UC medical centers should inform patients about alternative transportation. He noted an upcoming event that would bring together bicycle advocates and hospital executives.
- K. Lori Freedman, sociologist and associate professor in the Department of Obstetrics, Gynecology, and Reproductive Sciences at UCSF, expressed concern about relying on workarounds to meet patient needs in affiliations with faith-based organizations. She cautioned that while procedures such as tubal ligation are sometimes permitted in Catholic hospitals, this is subject to change by bishops who set the rules. Dignity had merged with CHI, which might be more conservative and less progressive, to form CommonSpirit Health.
- L. Paula Tavrow, associate adjunct professor in the UCLA School of Public Health, stated that she was troubled by the possible consequences of an affiliation with Dignity, a hospital system that intended to adhere to Catholic teachings regarding contraception, abortion, and other aspects of reproductive health care. She related her experience as a researcher in sub-Saharan Africa and observations of how Catholic hospitals there treated women who needed post-abortion care.
- M. Cass Cole, UCLA law student, expressed concern about the proposed UCSF affiliation with Dignity because Catholic hospitals routinely do not provide contraception, abortion, and transgender health care. Workarounds, especially when patients are forced to go to a different facility and find a new doctor for contraception or gender-affirming care, are discriminatory and not acceptable.
- N. Aneri Suthar, UCLA student, enumerated incidents in 2016 and 2017 when Dignity hospitals refused to perform tubal ligation and provide transgender care. Dignity had been sued by the Equal Employment Opportunity Commission for firing a disabled employee. Catholic hospitals are obligated to follow religious directives established by the U.S. Conference of Catholic Bishops, which prohibit hospitals from providing a range of reproductive health services. She stressed that there is no dignity in exclusionary health care.
- O. Ann Thomas stated that transgender people experience neglect and disrespect and receive bad service at Catholic hospitals nationwide. Being transgender is a biological anomaly, but the Catholic Church continued in its denial regarding established facts about transgender identity. Priests are not scientists or medical

professionals, but are in control of policies and treatments available at Catholic hospitals.

- P. Kendra Neuberger observed that procedures that are medically necessary for many people might differ from the ideas of the Catholic Church. She urged the University not to consider a partnership with Dignity.
- Q. Alana Francis-Crow, UCLA student, expressed concern about the denial of health care to people because of their gender. Dignity's refusal to provide abortions would lead women to undergo life-threatening at-home abortions. Dignity's refusal to provide treatment to transgender people sends a negative message. UCLA and the UC system should stand up for the lives of women and queer and transgender people.
- R. Jerilyn Stapleton, past president of the California National Organization for Women, strongly urged the University to drop the proposed partnership with Dignity. Dignity had a history of discrimination with regard to providing full access to reproductive health care, especially for women of color. She stated that Catholic hospitals forced providers to give patients inaccurate and incomplete information. She anticipated that, as more Californians learned of the proposed partnership, opposition would grow. Discriminating against patients is not a California value.
- S. Jessica Parral, Los Angeles LGBT Center representative and UC alumna, described Dignity as a repeat offender in not providing health care to LGBT people. She asked what message the University would send to its students if it partnered with Dignity, an organization that states that not everyone deserves the right to health care. She urged the University to reconsider this partnership.
- T. Joseph Bristow, professor in the UCLA Department of English and Chair of the UCLA Academic Senate division, stated that the University of California's values are not those of Dignity and CommonSpirit Health.
- U. Yalda Afshar, M.D., UCLA Health physician in Obstetrics and Gynecology, emphasized the value of providing complete care for women throughout their lives. She stated that she had trained at a Dignity hospital. While Dignity provides excellent care, it has different values than UC, and she asked that the University not partner with Dignity.
- V. Phyllida Burlingame, American Civil Liberties Union (ACLU) representative, expressed concern about the proposed partnership with Dignity. UCSF had stated that UCSF doctors would not have to sacrifice their values or their responsibility to patients in this partnership. ACLU clients Rebecca Chamorro and Evan Minton, and other patients like them, were denied care in Dignity hospitals, and physicians could not overrule these decisions, which were made by administrators and based on Catholic doctrine. UCSF representatives had stated that as long as there is transparency with patients about the care that would be denied at Dignity hospitals,

UCSF would have acted in accordance with its values and obligations. In fact this would be acceptance of discrimination. While the ACLU defends religious freedom, this is the freedom to exercise one's religious beliefs, not to impose them on others. The University of California is a governmental entity that is not permitted to discriminate or to support religion. By partnering with Dignity, which restricts patient care and discriminates based on religion, UC would be violating its charge as a public institution.

- W. Joshua Avila, UCLA student, identified himself as queer and Catholic. He stated that the Catholic Church is not an ally for LGBT people and the proposed affiliation with Dignity would hurt queer and transgender students, who are susceptible to hate crimes and would be denied coverage.

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

Upon motion duly made and seconded, the minutes of the meeting of February 11, 2019 were approved, Regents Guber, Kieffer, Lansing, Makarechian, Napolitano, Park, Sherman, and Zettel voting "aye."¹

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

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

Executive Vice President Stobo briefly presented a financial summary chart for fiscal year 2019, January year-to-date, and reported that the medical centers were all financially stable. Days' cash on hand at UC San Diego was just below the 60-day threshold. Dr. Stobo and Executive Vice President and Chief Financial Officer Brostrom had discussed this with UCSD leadership and were confident that UCSD was on solid financial footing and that days' cash on hand would rise above the 60-day threshold.

Regent Makarechian referred to figures shown for UCLA and asked why, from 2018 to 2019, there had been an increase in modified operating income and modified earnings before interest and depreciation, while debt service coverage had decreased. Dr. Stobo responded that he would provide this information.

Dr. Stobo recalled that on March 20 there had been a strike at the medical centers by the American Federation of State, County, and Municipal Employees (AFSCME) which caused disruption to patient care and had a significant financial impact. The centers continued to provide necessary medical services. A strike was scheduled again for the following day, April 10; the medical centers would do everything possible to ensure continuation of high-quality care.

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

Regent Sures asked if there had been third-party mediation. President Napolitano responded that the University had gone through a full mediation process. AFSCME's position had not moved. Regent Sures suggested that an informal meeting with different people might lead to a different result. Dr. Stobo added that UC Health had engaged a firm to study how other academic health centers approach labor issues to see if there are lessons UC Health can learn. UC Health had also communicated with another outside group with expertise on labor issues at academic health centers about how situations like this could be avoided in the future.

Dr. Stobo reported on a recent meeting with students to discuss two important questions regarding student medical insurance. One was to ensure that students covered by the UC Student Health Insurance Plan can access providers when they are away from campus, and the second was to ensure that students have a smooth transition to other providers when they graduate or leave the UC system. A working group including students and two UC Health representatives would study these questions.

The Committee had discussed student mental health on several occasions. Dr. Stobo recalled that in November 2014, the Regents had approved an increase in the Student Services Fee, with about half of this increase, roughly \$5 million annually, to support student mental health. UC Health used this funding to increase the number of psychologists and psychiatrists at campus student health centers, with the goal of increasing this number of personnel by 90. The previous year, the State had provided these monies, about \$5 million. It now appeared that the State would not continue this contribution. Out of the 90 positions, UC had recruited 80; 70 psychologists and ten psychiatrists. With regard to its ratio of psychologists to students, UC was at about the national average. With regard to the ratio of psychiatrists to students, UC was behind. The increase in student enrollment had outpaced UC's ability to hire more personnel. The increased demand for mental health services was due to both increased enrollment and to increased demand by existing students. Across the U.S., about twice the number of students were seeking mental health services compared to five years prior. Funding of at least \$5.1 million was sorely needed, and Dr. Stobo enumerated four ways this funding might be secured. One would be to continue with the final two years of the Student Services Fee increase; the second would be to convince the State to continue to provide this funding; the third would be for UC to provide these monies out of its existing funding; the fourth would be Proposition 63 funds, approved by voters to provide increased mental health services in California. The University had received Proposition 63 funds in the past and was currently in discussions with Sacramento, but Dr. Stobo anticipated that Proposition 63 funding for UC would be unlikely in the 2019-20 fiscal year.

Chair Kieffer asked which of the four funding sources Dr. Stobo would recommend. Dr. Stobo responded that he would recommend continued State funding in the General Funds it provides to UC. UC had approached the State about this, and State government representatives had signaled diminished enthusiasm for continuing this. The University was pursuing all four avenues.

Chair Kieffer remarked that there were many anecdotal accounts about the increased need for student mental health services across the U.S. He asked if there were studies identifying the causes of this increase. Dr. Stobo responded that the fact of increased need was clear and had been documented, while the reasons were not clear. Chair Kieffer stated that it would be helpful to learn about this research. Dr. Stobo responded that students find themselves in an increasingly frenetic environment; he would try to provide more specific information.

Regent Lansing suggested that Committee members should contact members of the Legislature. Student mental health was one of the greatest concerns of the Committee. Dr. Stobo described the paucity of behavioral health services at colleges and universities as a national scourge, as serious as a physical disease.

Dr. Stobo concluded by reporting on progress in hiring for UC Health positions. For fiscal year 2018-19, there were 35 positions that the UC Health division office was seeking to fill. Three positions had been filled, and searches for 12 positions were ongoing or had been started. Ten positions had not yet been classified. As of the last month, 43 percent of UC Health positions were filled or under active recruitment. Working with the Office of Human Resources at the Office of the President (UCOP), UC Health had developed four new titles specifically for UC Health within UCOP. UC Health was also working with Human Resources to recruit an individual dedicated to UC Health recruiting.

4. **CALIFORNIA FUTURE HEALTH WORKFORCE COMMISSION REPORT**

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

Advisory member Hernandez began the discussion by noting that the California Health Care Foundation had been documenting healthcare workforce shortages for several years. Currently there were approximately seven million Californians in designated healthcare workforce shortage areas. About two years prior, a number of organizations—the California Health Care Foundation, the California Endowment, the California Wellness Foundation, the Blue Shield of California Foundation, and the Gordon and Betty Moore Foundation—came together to try to map out and understand philanthropic interests in this arena. In these discussions it became clear that there was not yet a California roadmap for building a future workforce responsive to the state's population and to emerging technologies. These organizations agreed to convene a statewide commission, seeking out leaders of health education and workforce development in California. The California Future Health Workforce Commission had 24 commissioners as well as technical and stakeholder advisory groups. The Commission was charged with developing specific recommendations that could be enacted with the help of the Legislature. Dr. Hernandez emphasized the magnitude of California's healthcare workforce needs and gaps. The Commission's three major subcommittees focused on primary care and prevention, behavioral health, and healthy aging and care for older adults. Investments in these areas should be contemplated by everyone who plays a role in training and providing the future workforce. The Commission's funders also recognized that health care is a major driver of

economic growth in California, and the Commission's report endeavors to show, for each recommendation, the impact on addressing gaps and shortages as well as the economic impact on communities.

President Napolitano stated that the Commission members spent 18 months analyzing workforce gaps. These individuals are leaders and subject matter experts who know their communities well. There was a robust consultation process to identify the most promising strategies to bolster the state's healthcare workforce and improve access to health care. The Commission put forward three complementary strategies, along with actionable recommendations to put these strategies into practice. The strategies were (1) increase opportunity for all Californians to advance in the health professions; (2) align and expand education and training to prepare health workers to meet California's health needs; and (3) strengthen the capacity, effectiveness, well-being, and retention of the healthcare workforce. The final report includes ten priority actions and 17 additional recommendations, or 27 proposals in all. While advancing all 27 recommendations over the next ten years would be important, the Commission highlighted the ten priority actions, finding that these would have the greatest impact. President Napolitano noted, however, that all the proposed strategies and recommendations would be needed to create and sustain the future healthcare workforce of California. The cost of implementing the ten priority recommendations was estimated at \$3 billion over ten years; this amounted to less than one percent of what Californians were projected to spend in 2019 alone on health care. Successful implementation of these recommendations would require commitments by the State, private and public partners, foundations, and others.

The Commission's top ten priorities for action were to (1) expand and scale pipeline programs to recruit and prepare students from underrepresented and low-income backgrounds for health careers; (2) recruit and support college students, including community college students, from underrepresented regions and backgrounds to pursue health careers; (3) support scholarships for qualified students who pursue priority health professions and agree to serve in underserved communities; (4) sustain and expand UC Programs in Medical Education (the PRIME programs) across UC campuses; (5) expand the number of primary care physician and psychiatry residency positions; (6) recruit and train students from rural areas and other under-resourced communities to practice in community health centers in their home regions; (7) maximize the role of nurse practitioners as part of care teams to help fill gaps in primary care; (8) establish and scale a universal home care worker family of jobs with career ladders and associated training; (9) develop a psychiatric nurse practitioner program that recruits from and trains providers to serve in underserved rural and urban communities; and (10) scale the engagement of community health workers, promoters, and peer providers through certification, training and reimbursement. The goal in pursuing these recommendations is to eliminate projected shortfalls in primary care and nearly eliminate shortfalls in psychiatry; to grow, support, and sustain California's health workforce pipeline by reaching more than 60,000 students and encouraging their pursuit of careers in the health professions; to increase the number of health workers by more than 47,000 and improve diversity by producing approximately 30,000 workers from underrepresented communities; to increase the supply of health

professionals who come from and train in rural and other underserved areas. Each recommendation was analyzed for potential impact and relevant literature was reviewed.

Associate Vice President Cathryn Nation discussed the Commission's recommendations that were specific to the University. One of these was a recommendation for permanent State support for UC PRIME programs. The PRIME programs reflect a strategic initiative, started about 15 years prior, to grow class sizes at UC medical schools in a manner that would address the needs of medically underserved communities. She described the characteristics of the PRIME programs, such as outreach strategy, curriculum enhancements, and diversity, and outlined the unique focus of each PRIME location. The fact that the Commission members ranked this recommendation among the top ten priorities was a testament to the success of these programs. A formal funding request of \$8.8 million was included as part of the Regents' annual budget request to the State to fund PRIME programs; the Commission recommended \$9.4 million annually, which would fund an additional 40 students.

Another recommendation was for medical school enrollment growth of 20 percent. UC medical schools enroll slightly more than 750 medical students annually, and 20 percent growth would equate to 150 students per year and 600 over the four-year medical school curriculum. This would occur through expansion of the UC Riverside School of Medicine, development of a San Joaquin Valley branch campus of the UCSF School of Medicine, and targeted expansion in an accelerated competency-based medical student program at UC Davis, as well as targeted growth in certain PRIME programs.

The Commission recommended \$45 million in new annual operating revenues for the UCR School of Medicine in order to increase enrollment from 70 first-year students to 125 students per class and to increase the current enrollment of 260 medical residents to 500 over time. The Commission also recognized the need for additional capital investment at UCR of \$75 million to \$100 million to accommodate students and faculty.

The Commission recommended permanent State funding of \$167.5 million over ten years, including \$20 million for capital expenses, for the development and operation of a San Joaquin Valley branch campus of the UCSF School of Medicine, enrolling 50 students per year. Dr. Nation noted that there were currently two bills at various stages of progress in the Legislature calling for funding for the UCR School of Medicine. Another bill, proposed by State Assembly member Adam Gray, would provide resources for a branch campus in the Central Valley.

The Commission recognized the need for additional investment in graduate medical education at UC and other institutions. California leads the nation in the retention of medical students who remain in the state to practice; the return on investment is high. The expansion recommended by the Commission would be accomplished through several existing initiatives, such as the Song-Brown program and UC's own graduate medical education initiative, which is supported by Proposition 56 tobacco tax funds.

Dr. Nation drew attention to another one of the top ten recommendations of the Commission, a proposal developed by the UC Schools of Nursing, to offer a 12-month clinical training program online and in residence for 300 already qualified nurse practitioners; the program would add a qualification for psychiatric and mental health. Such a program would benefit UC in addressing student mental health needs and bring benefit to parts of California where nurse practitioners are employed but might lack this additional training.

Advisory member Lipstein recalled a study of health workforce needs by the National Academy of Medicine a few years prior. The task force involved with this study struggled with the question of where chronic disease management and care should be placed. Typically, people with chronic illnesses such as diabetes and hypertension do not have enough interaction with their primary caregivers in order to manage their conditions adequately. People with incurable conditions such as Parkinson's disease and multiple sclerosis are also not receiving adequate attention. He asked what kind of future healthcare workers the Commission envisioned would manage patients with chronic illnesses and conditions that are not curable, but need to be treated in a much more interactive way than they were currently treated. Dr. Hernandez responded that some of the Commission's recommendations addressed this question. Currently, peer support and "promotores de salud" programs were funded by grants, often targeting a particular disease or intervention. One recommendation would be to codify this by certifying institutions that train volunteers and promotores, including them in payment mechanisms, and incorporating them in a team-based care model. The bulk of the Commission's recommendations assumed outpatient-based care. A number of the Commissioners operated Federally Qualified Health Centers, which are focused on primary care, prevention, chronic disease management, and population-based health. California would never address all its primary care needs only by training physicians; team-based care, community-based care, and peer support were essential. She referred to one of the Commission's top ten recommendations, to establish and scale a universal home care worker family of jobs. This would involve taking a workforce that was currently informal and ad hoc and making it part of a team-based care model.

Regent Graves asked if admission to PRIME programs differed from general admission to a UC medical school. Dr. Nation responded that all the educational content completed by medical students is also completed by PRIME students. Supplemental elements enrich the PRIME curriculum, and there is great care in the placement of students in their clinical clerkships at sites that will best prepare them. Regent Graves wished UC to ensure that the PRIME program was not the only program focused on equity and underrepresented minority students. In seeking funding for this program from the Legislature, the University should stress that this is an equity-minded program.

Regent Park expressed concern that the Commission's recommendations, which implied a long-term investment, might be too reliant on State funding. The State's fiscal condition varies, and there was a question of how to begin this program and how to sustain it. She challenged the Health Services Committee members to think about changes the University could contemplate in health education. She raised questions of what health care would look

like in ten years' time and how changes in technology, animation, and artificial intelligence might affect the length of time required for training and the effectiveness of this workforce. The University should try to arrive at a more effective cost structure for health education and training and present a compelling model that would receive funding. Dr. Hernandez responded that the Commission's report did not envision these recommendations as being supported only by public or State General Funds. Currently, hospitals, hospital associations, and health plans in California were all working to try to address workforce gaps. The Commission viewed this as a public-private endeavor, and the Commission included providers who serve communities where there were gaps today and where more extreme gaps were projected in the future. The Commission did not explicitly try to identify General Fund obligations for specific recommendations. The task was to understand access needs and the diversity of the population, to take into account how care should be provided in the future, given trends in medicine, and, based on this, to identify priority actions that should be taken first. The report includes a recommendation for increased leveraging of technology. Dr. Hernandez emphasized that all players, public and private, must be involved in this effort in order to meet funding needs. Dr. Nation added that the Commission's work was forward-looking, in considering demographics, aging, use of technology, the high cost of medical education, student debt, and the fact that only a small percentage of medical students come from low-income families. The focus was on debt, access, opportunity, and creating new generations and types of workers, in addition to meeting physician and advanced practice needs.

Faculty Representative May observed that there was a dire need for clinical psychologists. The American Psychological Association, through its accreditation process for graduate programs, internships, and licensing, controls the pipeline. He asked if the Commission had had discussions with the American Psychological Association about its licensing criteria and developing the pipeline to increase the number of clinical psychologists. Dr. Hernandez responded that she did not know of a discussion with the American Psychological Association, but noted that the Commission's behavioral health subcommittee thoroughly examined the obstacles in this area, the pipeline problem, and ways to accelerate the response to this tremendous need.

Regent Makarechian remarked that some potential students might choose a career path other than medicine because of the high cost of a medical school education and the debt burden upon graduation. He asked what the University was doing to lower the cost of medical education through scholarships, tuition reductions, or other means, and if the report addressed this. Dr. Nation responded that with State budget cuts that began in 2008, the University experienced disproportionate cuts for its professional degree programs. At that time, regrettably, UC medical schools went from being among the most accessible in terms of cost to being among those with the fastest-increasing mandatory charges. Mandatory charges for UC medical students were currently \$30,000 to \$35,000 per year. UC medical schools are located in cities where the cost of living is high, making the total cost of attendance very high. The rate of student debt had increased. UC Health was seeking to address the cost of instruction. One of its model programs was an accelerated program at UC Davis for well-prepared students which combines medical school education with residency training. For students who can manage the intensity of this curriculum, it saves

them a year of time and debt. The Commission's recommendations call for targeted increases in programs like this one at other locations as well as for scholarship support for the ten percent of the neediest students enrolled across the health professions, to cover mandatory charges only.

Regent Zettel emphasized the need to encourage an interest in science among students at an early age, as early as grade school. She recalled that UC medical centers help fund education at UC medical schools, and asked if some of these monies could help with workforce planning. Dr. Nation responded that the first two of the Commission's top ten recommendations focus on pipeline programs, with the goal of reaching a total of 7,000 students, targeting math and science preparation in middle school and high school, with a particular focus on low-performing schools. The estimated cost of replicating some of the state's best practices in this area would be \$11,000 per student.

Regent Sherman asked about the amount of support that PRIME students receive. Dr. Nation responded that medical students pay to attend medical school. PRIME students pay tuition and do not graduate debt-free. Some medical schools have successfully raised funds for scholarship support.

Regent Sherman referred to the recommendation for increased enrollment at the UCR School of Medicine. He asked if there were plans for expansion at other UC medical schools as well. Dr. Nation responded that one of the 17 additional recommendations, mentioned earlier, called for a 20 percent increase in annual medical student enrollment, or approximately 150 additional students. UC Health considered where this would be feasible and aligned with campus goals and infrastructure capacity. Of the 150 additional students, 50 would study at UCR, 50 at the UCSF branch campus, and the remaining 50 dispersed across existing medical schools, in programs that are targeting growth.

Regent Sherman asked if the increased enrollment of medical students would equal the increase in residency positions within California. Dr. Nation responded that the proposed growth in graduate medical education was much greater than the proposed growth in medical student education. This was based on recognition of the high return on investment and of the fact that UC medical schools are not the only medical schools in the state. She noted that private medical schools in California had few plans for growth. One matter of concern was the development of new, for-profit medical schools. The Commission's report has an important focus on growth in graduate medical education to ensure that the state can accommodate graduating students from UC and other institutions.

Regent Sherman asked how telemedicine and developments in precision medicine would affect workforce needs. Dr. Hernandez responded that the Commission considered the use of telemedicine to leverage the existing workforce. There was less consideration of artificial intelligence and precision medicine. One of the report recommendations is for more communication with technology companies to gain a better understanding of the direction of medical technology.

UCLA Health Sciences Vice Chancellor John Mazziotta reported that the UCLA School of Medicine enrolls 175 students annually. Since their inception, the David Geffen Medical Scholarships cover the total cost of attendance for 50 students. The number of applicants had increased to about 14,000. The cost of supporting 175 students over four years would be \$1.65 billion.

Committee Chair Lansing remarked that there was a large segment of the population, retirees who wish to continue working, who can be trained as healthcare volunteers. There are programs for retired doctors who work part-time in free clinics. In considering health workforce needs, one should consider this pool of people to address current service gaps.

Student observer Ashraf Beshay praised the Commission's report for prioritizing diversity as much as it prioritizes workforce expansion. The first of the top ten recommendations, "to expand and scale pipeline programs to recruit and prepare students from underrepresented and low-income backgrounds for health careers," was a noble objective, and the University could do much in this area. Currently, the six UC medical schools accepted about 770 students annually, California residents and nonresidents. The acceptance rate at UC medical schools ranged between three and five percent. For every 20 to 30 California residents who wish to attend a UC medical school, one is accepted. Such low acceptance rates also make it difficult for students of color and low-income students to see themselves successfully navigating the rigorous admissions process. There are many barriers to getting into medical school that disproportionately affect students from underrepresented communities. Applying to medical school includes the costs of primary and secondary applications, interview travel, sending of transcripts and letters of recommendation, and professional attire for interviews. These costs sometimes exceed \$5,000 for the normal medical school application cycle; low-income students cannot afford this, and this should be part of UC Health's considerations. The Medical College Admission Test (MCAT) requires several months of study and costs more than \$300 to take. Low-income students are more likely to have to work at a job, with less time for test preparation. An applicant's financial status can have an impact on this important criterion for admission. Mr. Beshay hoped that UC would look to other selection criteria that are less influenced by financial status and resources and more reflective of academic talent and personal drive.

The second of the Commission's top ten recommendations focuses on the recruitment of minorities for health careers. About 42 percent of UC undergraduates are first-generation students. The University had focused its attention so much on the capacity for undergraduate enrollment that it lost track of the objective of college education, which is to equip students with the tools to pursue their life goals and ambitions. Mr. Beshay urged the Health Services Committee and the Commission to prioritize undergraduate preparation for graduate studies; this was the root cause of the current crisis under discussion. There was not insufficient interest in health careers. Interest was impeded and hindered by financial factors. UC Health should pursue and address this problem, because far too many students obtain an undergraduate degree at UC but are not able to take the next step to fulfill their goal of a career in medicine.

[At this point Chair Kieffer left the meeting.]

5. **STRATEGIC AFFILIATION WITH A FAITH-BASED HEALTH SYSTEM, UCSF HEALTH, SAN FRANCISCO CAMPUS**

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

UCSF Health Chief Executive Officer Mark Laret provided a context for the discussion, recalling that for decades, UCSF Health has had relationships with a wide range of other healthcare providers in Northern California, including public hospitals, private hospitals, for-profit hospitals, and Catholic and other faith-based hospitals. UCSF Health has entered into these relationships because its role as a regional tertiary and quaternary care provider requires this, as do the goals of long-term viability in a population health delivery model and the ability to support the care of the mentally ill and the medically underserved. This has resulted in a patchwork quilt of providers, with each hospital and health system contributing in a unique way to the overall system. Catholic and other faith-based hospitals have played an especially important role in this system of care, delivering a significant portion of all health care delivered in Northern California. These faith-based systems closely share UCSF's commitment to care for underserved populations. The Dignity Health system (Dignity), comprised of both Catholic and non-Catholic hospitals, provides more care to Medi-Cal patients than any other system in the state. In San Francisco, Dignity is the only private hospital providing gender affirmation services to the transgender community.

UCSF Health has successfully partnered with Dignity for decades for a host of services, including adolescent mental health and neurological and gynecological surgery. This collaboration has helped UCSF recruit and retain faculty who otherwise would not have had adequate support and space at UCSF's core locations. UCSF believed that it was now imperative to expand this historical relationship with Dignity in order to better serve the healthcare needs of its diverse community, and to ensure UCSF's ability to continue to fulfill its patient care, community service, education, and research missions. One of UCSF's and the UC system's greatest assets is an engaged, thoughtful, and diverse community of faculty and staff. Some in the UCSF community strongly object to this public university having a relationship with Catholic healthcare providers because of the Ethical and Religious Directives for Catholic Health Care Services and the Statement of Common Values that, for religious reasons, forbid the delivery, in Catholic hospitals, of certain medical services; this differs from UC and the community's standards of medical practice. Recognizing this diversity of views, over the past three years, the UCSF administration has engaged in multiple consultations at UCSF with faculty, including the Academic Senate, clinical department chairs, and outside consultants who have facilitated similar affiliations between other public universities and Catholic healthcare systems. UCSF has developed guidelines for how it, as a public university, enters into these relationships. These guidelines had been discussed several times at meetings of the Committee. The guidelines include transparency with patients about which services are or are not offered at individual hospital locations; ensuring that UCSF faculty practicing in

any of these facilities are absolutely free to discuss all available healthcare options with patients; and never requiring UCSF faculty or staff to participate in any care to which they have an objection. Considering the experiences of other public universities in partnering with Catholic healthcare systems, UCSF's own experience, and the consultative process with UCSF faculty over the past three years, Mr. Laret expressed confidence in UCSF's ability to protect its fealty to UC values in these relationships. By engaging with Dignity and other faith-based organizations, UCSF would improve the quality of care for all patients and in fact increase the clinical options available to women and the LGBTQ community. This had been UCSF's experience in working with the patchwork quilt of providers that makes up its healthcare system. The issues related to UCSF partnering with Catholic and other faith-based organizations are important and concern the core values of the University. Consequently, it was important for the Regents to hear directly from UCSF faculty about these issues.

UCSF Professor Jody Steinauer, M.D., of the Department of Obstetrics, Gynecology, and Reproductive Sciences and Director of the Bixby Center for Global Reproductive Health, expressed strong opposition to the proposed partnership with Dignity and Catholic Health Initiatives (CHI). She noted that 1,500 UCSF faculty, staff, trainees, and alumni had signed a letter to UCSF leadership stating that this partnership would be misaligned with UCSF values. She stated that she had chosen to train and work at UCSF because of the core value of providing evidence-based, high-quality care, based on the best available science, to all patients.

UCSF Associate Professor Vanessa Jacoby, M.D., of the Department of Obstetrics, Gynecology, and Reproductive Sciences, recalled statements made by UCSF leadership to the effect that in any partnership, UCSF would uphold its values. In a partnership with Dignity/CHI, by definition, UCSF would not be able to uphold its values because women and LGBT patients are denied basic health services, based on religious doctrine. At times, UCSF might choose to partner with an entity that does not share all of its values because the benefits would outweigh the misalignment. But in this case, it appeared that forgoing comprehensive care for women and LGBT people was not considered a strong enough risk that would outweigh potential benefits. She urged the Regents to consider restrictions on the care of women and LGBT people as an insurmountable obstacle that required disapproval of this partnership. Based on religious directives, certain services are specifically prohibited at Dignity/CHI hospitals. Contraception is explicitly prohibited in all Dignity/CHI Catholic facilities, including outpatient facilities. While physicians can prescribe contraceptives, the most effective and commonly used methods of contraception must be placed by a provider in a hospital or clinic; they cannot be received in a pharmacy, by prescription. UCSF leadership had stated that no UCSF faculty would be required to participate in obstetric, gynecological, or reproductive services at Dignity. The care concerns at CHI were not limited to obstetrics and gynecology. Access to contraception and abortion is critical to the overall care of women. Women with cancer, treated with chemotherapy that is toxic to pregnancy, need contraception. Women who receive organ transplants must avoid pregnancy to prevent complications. Women with severe pulmonary and cardiac disease, in which pregnancy would hasten death, need contraception. This is a problem not limited to reproductive health providers. Techniques

to assist reproduction, such as use of a sperm or egg donor, or in vitro fertilization, are also prohibited at all Dignity/CHI facilities. While this directive applies to all patients, it disproportionately affects lesbians and gay men, because these are the only methods for these people to have biological children.

Dr. Steinauer stated that abortion is a critical aspect of comprehensive reproductive health care, including during hospitalization. Women with desired pregnancies sometimes experience obstetric tragedies that could not have been expected and that require abortion services. UCSF leadership had stated that the prohibition on contraception and abortion could be mitigated with workarounds, within restrictive care models. For example, a woman at a Dignity hospital who needs an urgent abortion can be transferred to the main UCSF campus. In Dr. Steinauer's view, this idea was misguided and not supported by the medical literature or medical ethics. Women in faith-based hospitals with restrictive care who need abortion services experience delays in diagnosis, transfer, and treatment that can worsen health. In these cases, patients would be transferred not because a physician did not have the skills or a hospital did not have the resources, but only because of religious doctrine. Workarounds might also require physicians to use unethical or fraudulent practices in order to provide appropriate care for patients. For example, a physician might need to purposely miscode a diagnosis in the medical record to obtain contraception for a patient. In 90 percent of Dignity/CHI hospitals, gender-affirming care for transgender patients is prohibited. These are standard services such as hormone treatments or common surgeries such as hysterectomies.

Dr. Jacoby stated that UCSF has clear policies to ensure that equitable care is delivered to its diverse patient population. The Dignity/CHI care model cannot uphold this UC standard, because women and transgender people are prohibited from receiving services. These Dignity/CHI policies discriminate based on sex, gender, and gender identity, which is in direct conflict with the policies and values of the University. Dignity policies also create an environment where discrimination is condoned, supported, and accepted. A partnership with Dignity would send a clear message to the UCSF community and the public, to the effect that UCSF supports restrictive health care for some but not all of its patients. UCSF leadership has stated that UCSF and Dignity share the common value of caring for low-income patients. The restrictive reproductive services at Dignity actually worsen health outcomes for low-income women. When contraception and abortion are not provided for underserved patients, these patients often lack the resources needed to obtain these services outside their local community.

While UCSF leadership had explained that UCSF would focus on transparency, providing patients with information about which services are or are not provided at Dignity facilities, Dr. Steinauer stressed that transparency does not mitigate discrimination. Telling a woman patient who is admitted with a kidney infection that her birth control pills are not stocked at the pharmacy due to religious directives does not eliminate the discriminatory care she receives. While not taking birth control pills during her hospital stay, she increases her risk of an undesired pregnancy when she returns home. Certain healthcare services are prohibited at Dignity based on two religious doctrines. One is the Ethical and Religious Directives for Catholic Health Care Services (ERDs), a set of rules issued by the U.S.

Conference of Catholic Bishops; the other is the Dignity Statement of Common Values, also a religious doctrine that prohibits abortion and in vitro fertilization. UCSF leadership has asserted that the ERDs affect less than one percent of hospital admissions. It was not clear how this number was calculated, but she expressed confidence that it was incorrect. The vast majority of women of reproductive age use contraception, and 52 percent of OB/GYN physicians working in Catholic facilities report conflict with their employer over its religious policies for patient care. If less than one percent of patient care was affected by the ERDs, it seems unlikely that half of these physicians would report these problems. In the past, UCSF leadership has made clear statements about the harms of restrictive care for women. In 2016, a non-religious community hospital in the Central Valley affiliated with UCSF communicated its intention to newly prohibit abortions. Mr. Laret, Chancellor Hawgood, and Dean Talmadge King took a stand against this restrictive policy, writing in a letter, “We do not support any limits on abortions. Our expectation is that hospital policy will align with UCSF’s commitment to comprehensive reproductive health care.” Dr. Steinauer agreed wholeheartedly with this strong statement by UCSF leadership and believed that the same standard should apply to the current proposal with Dignity.

Dr. Jacoby noted that 90 percent of Dignity/CHI’s approximately 140 hospitals follow the ERDs. Ten percent are Catholic-affiliated hospitals and follow the Statement of Common Values. UCSF leadership had stated that this partnership is critical to address UCSF’s need for more space to accommodate high patient volume. But no solution to address UCSF’s operational challenges should include partnership with a healthcare system that restricts care for women and LGBT people. She encouraged the Regents to consider other options to manage high patient volume that would not compromise patient care or threaten UCSF values. UCSF leadership had stated that a benefit of this partnership would be an expansion of reproductive health services for patients who currently received restrictive care at Dignity. She stated that this viewpoint was flawed. In order to expand reproductive services to Dignity patients, UCSF would need to partner in a collaborative care model. This partnership would support a restrictive model of care that harms women and is at odds with UCSF’s core values.

Dr. Steinauer observed that UC faculty have long been advocates for comprehensive women’s health care and high-quality care for LGBT people. Faculty at UCSF have spent decades fighting harmful restrictive reproductive health policies across the U.S. and around the world. They never expected that they would have to oppose these policies within their own institution. She reported that her and her colleagues’ concerns about the proposed affiliation increased following the merger of Dignity and CHI. She stated that the proposed affiliation was misaligned with the University’s commitment to comprehensive reproductive health care and to diversity, equity, and inclusion, and expressed concern that this relationship would diminish UC’s reputation for excellence.

UCSF Professor Dana Gossett, M.D., of the Department of Obstetrics, Gynecology, and Reproductive Sciences, Division Director, and Vice Chair for UCSF Health Regional Women’s Health Strategy, stated that the proposed partnership was important for the survival of UCSF Health. She disagreed with the depiction of women’s health as a casualty in this agreement. As much as other clinical areas in UCSF Health, women’s health needed

this affiliation, and would benefit from the affiliation as much as any other department. UCSF currently could not serve its patients as well as it wants to. UCSF is forced to divert patients whom it has cared for during their pregnancy to other hospitals to have their babies. But UCSF not only cannot appropriately care for the women already under its care, it has no way of reaching other women in the community who need UCSF because it lacks the capacity. There are not enough obstetric beds in San Francisco. On some days, all four delivery hospitals are simultaneously at capacity, and there is nowhere to divert patients. UCSF has a moral obligation to help solve this problem for the women of San Francisco. Dr. Gossett expressed her belief that UCSF and UC in general share more values with Dignity than with any other health system in the area. UCSF and Dignity are both committed to serving in the community. Dignity focuses on care of the underserved to a greater degree than UCSF. She stressed that her own position was pro-choice, that she supported LGBTQ rights, and that she would be unwilling to compromise on these positions. In her view, UCSF's unique position and role as a leader and champion for women's reproductive rights obligates UCSF to engage with individuals and institutions whose views differ. She was confident that UCSF would improve access to reproductive health services through transparency and collaboration. At the present time, there was no disclosure of which services are or are not available at any Dignity/CHI facility. With this partnership, UCSF would provide this proactive transparency at the outset and alternatives for receiving care that currently did not exist for an entire population of patients. Dr. Gossett noted that her own department was diverse and had diverse views on this relationship. Fewer than half the faculty in her department had signed the petition objecting to the affiliation. Polarization had made discussion of this matter difficult. She stated her belief that the proposed affiliation would benefit the UCSF Department of Obstetrics, Gynecology, and Reproductive Sciences and would allow UCSF to improve care for the women UCSF currently served, to expand services to women UCSF currently did not reach, women who might not be aware of which services they lack, and to be part of the solution to the inadequate number of obstetric beds in San Francisco. She concluded by observing that if UCSF did not engage with Dignity and CHI, it would lose the opportunity to have any influence on how Dignity and CHI deliver health care; engagement was morally correct.

UCSF Assistant Professor Ari Hoffman, M.D., explained that he serves as Medical Director of the UCSF Hospital Medicine Service at St. Mary's Medical Center, which is located about a mile from the UCSF Parnassus campus and is a Dignity/CommonSpirit hospital. He took on this role in 2017. The UCSF Division of Hospital Medicine is part of the Department of Medicine. The Division cares for hospitalized adults with conditions such as pneumonia, organ failure, diabetes, and cancer. Advanced care planning and end of life care are part of the Division's daily work. In late summer 2017, the Division was asked to begin service at St. Mary's. The Division considered the implications and decided that this expansion would be beneficial to UCSF Health, and that the impact on patient care would be positive. The Division was reassured by the partnership principles, and by the fact that UCSF could practice evidence-based medicine, regardless of the site of care. The Division hoped to bring improvements to the existing medical care and residency programs at St. Mary's, and to help UCSF address its census difficulties, which have become the new norm. In early 2018, UCSF began an independent service for hospitalized adults admitted

through the Parnassus emergency department, and cared for at St. Mary's. This arrangement was expanded in October, when UCSF assumed contract staffing for the entire hospital medicine program at St. Mary's. UCSF faculty hospitalists were now the attending physicians of record for both direct care services, without any trainees or students, and teaching teams, with supervision of St. Mary's internal medicine residents and some visiting students from other programs. This program has cared for hundreds of patients since its inception, from the Parnassus emergency department as well as from the St. Mary's patient population. With regard to ERDs, Dr. Hoffman stated that he was unaware of any restrictions placed on the care provided by any UCSF doctors at St. Mary's. Given that the average age in this patient population is close to 70, UCSF, when it began this medical service, naturally focused its attention on the ERDs related to end of life care. The Division found that the directives are very much in line with UCSF's palliative care practices at the Parnassus hospital, with an emphasis on risks, benefits, and patient preferences.

UCSF's work with Dignity in this program had resulted in gains in quality, access, and education. The UCSF Division of Hospital Medicine prides itself on providing quality improvement and education in addition to clinical care. UCSF's work with other health systems is characterized by close engagement, and this was no different at St. Mary's. UCSF hospitalists currently populated most of the St. Mary's hospital committees. UCSF had worked with Dignity to effect changes such as enhancements to interpreter services at St. Mary's, upgrades to electronic medical records, and patient experience initiatives. The Division was also proud of its work in education and the professional development of trainees, in this case the graduate medical education program at St. Mary's. Dr. Hoffman reported that patients were being appropriately referred from the UCSF and St. Mary's emergency departments to subspecialty services within UCSF Health's broader system. UCSF hospitalists at St. Mary's are able to access expert consultation from UCSF colleagues to serve as a second opinion. There were challenges in this undertaking. Dr. Hoffman had found that the chief operational challenge was the navigation of a different system and different electronic health records. Efforts to create a health information exchange between the UCSF and Dignity patient records systems now allowed some flow of information in both directions, but there were still inefficiencies.

Referring to the concerns expressed earlier by Drs. Steinauer and Jacoby, Dr. Hoffman presented an example of the reality on the ground from a case that had occurred that week. A 27-year-old woman patient had a severe sexually transmitted infection. Dr. Hoffman stabilized her medical condition and advised her on options for contraception and her need for protection from recurrent infections. He and the patient agreed on a plan of care, and this was documented in the record. Dr. Hoffman stressed that he was not restricted or prevented from providing this advice and documenting it in the record. This was not in keeping with ERD no. 52, which states that Catholic health institutions may not promote or condone contraceptive practices, but it was in keeping with UCSF's partnership principles, according to which UCSF physicians should be able to practice and counsel patients on the full range of services. One could see this as an example of a workaround or an example of a UCSF doctor acting on UCSF principles at St. Mary's.

Advisory member Hetts recalled that in June 2016, many UCSF faculty first became aware of a partnership between UCSF and Santa Rosa Memorial Hospital, part of the St. Joseph Health System, a faith-based organization. The affiliation focused on pediatrics, neonatology, and obstetrics, and was known to faculty in these departments, but not more broadly. The UCSF Division of the Academic Senate then formed a Task Force on Clinical Affiliates and Quality of Care in order to make recommendations regarding how UCSF forms affiliations between its Medical Center and other healthcare institutions. This first Task Force reviewed the faculty's initial concerns regarding the involvement of faculty in vetting of affiliations, the impact of ERDs, and the teaching and practicing of evidence-based medicine. The Task Force engaged in fact-finding regarding "discernment," a process to review potential clinical scenarios that could present conflict with the ERDs, "carve-outs" made when secular or public hospitals interact with faith-based organizations, including the details of billing and the flow of funds, which might be segregated to ensure that ERDs are not violated by certain procedures. The Task Force identified potentially problematic areas and estimated that these amounted to 0.4 percent of inpatient admissions at Santa Rosa Memorial Hospital at that time. There were additional faculty concerns about the effects on UCSF's reputation, UCSF's commitment to diversity and inclusion, curriculum development for trainees, and UCSF's public service mission.

The first Task Force presented recommendations for clinical affiliations in a number of areas. With regard to the process of affiliations, faculty felt that this process should be standardized, inclusive of faculty, and modeled on best practices from other states. With regard to standards of care, faculty felt that the evidence-based care of diverse populations is a core value of UCSF that must be adhered to. When UCSF contemplates an affiliation, it must consider the effects on education and training and take account of public perception. Naming conventions should clearly delineate the nature of an affiliated facility. Patients must be given clear information about the services available and the values of the organization, and the public at large should receive clear information about the nature of an affiliation.

The findings of this first Task Force were discussed, and in January 2017, a joint task force or review committee of the UCSF Academic Senate and UCSF administrative leadership was formed. This group reviewed UCSF's Administrative Policy 100-10 on affiliation agreements, the principal affiliation policy, which had been developed in the 1980s. Historically, most affiliations consisted of professional services agreements between individual departments. The Affordable Care Act changed the healthcare landscape. It became clear that UCSF, in forming an accountable care organization, could also initiate affiliations, which might be on the departmental level or more broad and strategic in scope. The joint task force considered training and curriculum content and reaffirmed that curriculum content falls under faculty and Academic Senate authority.

The recommendations of this second joint task force were that UCSF establish a Central Affiliation Office; establish a standing Affiliation Review Committee with representation from UCSF Health, the School of Medicine, and clinical faculty from the Academic Senate; and make changes to campus Administrative Policy 100-10: the same process should be used for affiliations driven by the health system as for those established for other reasons,

teaching affiliations should remain under the purview of each school's Dean, and a review of guidelines or "alignment of values" must be performed to determine each potential affiliate's entry point.

Dr. Hetts briefly reviewed UCSF Academic Senate Clinical Affairs Committee town hall meetings and UCSF-Dignity discussions. The Clinical Affairs Committee met with Senior Vice President Shelby Decosta regarding Phase I of the Dignity Health Partnership, including the draft of the UCSF Health Partnership Principles. In July 2018, the Academic Senate Executive Council was presented with the draft UCSF Health Partnership Principles, and in October to December 2018, Mr. Laret and Ms. Decosta discussed Phase II of the Dignity Health Partnership with Academic Senate leaders and clinical department Chairs. In November 2018, the Academic Senate Executive Committee received an update on the Dignity affiliation, including clarifications regarding the obligations of full-time versus part-time OB/GYN faculty and regarding procedures offered at certain facilities and alternate access offered at other facilities. The Clinical Affairs Committee received further updates in early 2019.

Among UCSF faculty, there was a broad range of awareness and concerns, significant questions about the relationship of UCSF's values to those of faith-based organizations, and widespread acknowledgement that UCSF is operating at capacity and needs additional capacity to serve patients. According to UCSF's transfer center for adult patients, the previous year there were about 7,800 requests for transfers to UCSF. This had increased in the first half of fiscal year 2019, with about 4,200 requests. Over 50 percent of these requests are cancelled, and in fiscal year 2018 over 1,800 cancellations were due to lack of medical or surgical necessity. There had been 248 cases in the prior year and 149 in the current year so far of transfers cancelled due to lack of beds. UCSF must turn away stroke and brain aneurysm patients on a weekly basis due to lack of beds. Dr. Hetts noted that these data are not captured when the transfer center is closed, and delays in transfers are not included in the data.

With regard to the views of the systemwide Academic Senate, there were significant concerns about alignment between UC's values and those of faith-based organizations or any non-UC organization, and questions about the scope and governance of the affiliation with Dignity following Dignity's merger with CHI to form CommonSpirit in 2019. There were challenges for expanding access to UC Care for faculty, students, and the public. There is a substantive difference between department-to-department affiliations and institution-wide affiliations. There is a difference between renting beds to accommodate overflow of services from UC hospitals and entering into a mission-driven partnership with a non-public entity, which raises issues of shared values to a higher level. Many faculty would comment that workarounds are not an ethical solution when reproductive health, LGBT patient care, and end of life care are involved. The Academic Senate's University Committee on Faculty Welfare had recently issued an interim report on non-discrimination in health care. This report raises concerns about differences in values between a public university and a non-public, faith-based institution; the sufficiency of UC Care's network, given the prevalence of Catholic hospitals included as providers; requests for exemptions by individual providers from treating certain groups of patients; the potential for providers

to offer unsolicited prayer with patients or to seek accommodation to pray with patients. In part because faculty have not seen a draft of the proposed contract with CommonSpirit Health, there was a general feeling of uneasiness at a lack of transparency in the process. There is an essential need to have a high-level dialogue about the nature of affiliations between the University and non-public organizations whose values may differ from UC's. If UCSF proceeds with this type of affiliation, this potentially could set a precedent for the entire UC system. This affiliation would affect access to UC Care for UC Santa Cruz faculty, staff, and others at Dominican Hospital. This affiliation would involve multiple UC campuses and therefore, voices from beyond UCSF should also participate in defining the appropriateness, nature, and extent of this proposed partnership.

UCSF School of Medicine Dean Talmadge King stated that the School's clinical department Chairs were acutely aware of the issues raised by faculty. After much discussion, they decided that pursuing an affiliation with Dignity would help address many of the challenges UCSF faces. The clinical department Chairs supported the affiliation and believed that it would allow UCSF to provide better service to the community.

Faculty Representative Bhavnani emphasized that access to health care is not expressed only by numbers of patients admitted to a hospital. The situation of a woman having a cesarean section and not receiving a tubal ligation was a limiting of access to tubal ligations. Access is not measured in numbers. If bishops choose to change the ERDs, the Catholic Church accepts this; this is quite different from how the University operates. UC should not accept bishops taking away or adjusting directives. Hospitals might post signs informing patients that abortions are not performed there, but this is not enough to ensure the good health of patients. There was no question that the University needs to serve more patients, and she suggested that the University explore other possibilities to allow UC to serve more patients.

Committee Chair Lansing asked if it was true that not all Dignity hospitals are Catholic. Mr. Laret responded in the affirmative. Of the four hospitals UCSF was considering affiliating with, two are Catholic and two are non-Catholic. All four abide by the Statement of Common Values. Saint Francis Memorial Hospital provides gender affirmation surgery; it is a Dignity hospital in San Francisco, but it is not Catholic. St. Mary's Medical Center is a Catholic hospital and does not provide gender affirmation surgery. Mr. Laret also confirmed for Regent Lansing that none of these hospitals provide abortions.

Committee Chair Lansing asked if it was true that all these Dignity hospitals have LGBT employees. Ms. Decosta responded in the affirmative and quoted a non-discrimination statement from a ministry alignment agreement between Dignity and CHI. Dr. Jacoby added that one of the lawsuits pending against Dignity was by an employee for employment discrimination, a transgender nurse who was not allowed to use health insurance to receive gender affirming surgery.

Committee Chair Lansing remarked that this contradicted the information about one Dignity hospital that performs this surgery. Dr. Jacoby recalled that there were two relevant religious doctrines. Of the 140 Dignity/CHI hospitals, 90 percent follow the ERDs, which

include all restrictions. About ten percent of the hospitals are less restrictive, but have restrictions on abortion and in vitro fertilization.

Committee Chair Lansing asked if it was true that a UC doctor at a Dignity hospital could provide any information to a patient, counsel the patient in any way, although the service being discussed might not be performed at the hospital. Ms. Decosta responded in the affirmative. There was no gag order.

Committee Chair Lansing presented a hypothetical situation in which a patient would need an abortion and would die otherwise, and asked if a Dignity hospital would perform this abortion. Dr. Gossett responded that the ERDs prohibit what is termed a “direct abortion.” A direct abortion, in the understanding of the Catholic Church, is an abortion performed to terminate the life of the fetus. It is permissible to perform an abortion to save the life of the woman; in that case it is not considered a direct abortion. The death of the fetus is considered an unfortunate side effect of life-saving treatment. Dr. Gossett noted that the execution of this determination has varied by bishop and jurisdiction. She recalled a case in a Catholic Healthcare West hospital outside California where an abortion was performed for a woman with right-sided heart failure. This case resulted in excommunication by the bishop and Catholic Healthcare West became Dignity Health.

Committee Chair Lansing asked if Dignity hospitals can terminate a life in order to save a life. Dr. Jacoby explained that the case mentioned by Dr. Gossett occurred in a Catholic hospital under the ERDs in Arizona. The patient was so ill that she was going to die, and terminating her pregnancy at 11 weeks would save her life. The ethics board of the hospital believed that it was appropriate to terminate the pregnancy to save the patient’s life. The Church hierarchy found that this action was inappropriate and stripped the facility of its Catholic name. Catholic Healthcare West changed its name to Dignity. The bishop, in confrontation with the chief executive officer of this hospital, stated that the hospital had violated the ERDs. The chief executive officer stated: “Our first priority is to save both patients. If that’s not possible, we always save the life we can.” The University’s values are to always save the life of UC’s patient, the mother. In the Arizona case, the focus was not on saving the life of the woman, but on saving whichever life one could save. The woman in this case did not die, but most definitely would have died if the hospital had adhered in full to the ERDs, as the bishop wanted. It was very fortunate that the woman did not die, because there was a significant delay in her care while the ethics board met.

Committee Chair Lansing observed that this type of delay should not occur in the proposed affiliation because a patient in this situation would be immediately transferred to a UCSF hospital. She asked about an emergency situation in which a patient was dying, and if these Dignity hospitals would terminate the pregnancy to save the patient’s life. Mr. Laret responded that this raised an essential question, namely, whether the quality of medical care in these facilities would be better or worse with the engagement of UCSF. UCSF strongly feels that the quality will be better. UCSF faculty in a Dignity hospital would transfer the patient to ensure that proper care is delivered.

Committee Chair Lansing reiterated her question about a dying patient who needs an abortion to save her life, and if a Dignity hospital would perform this. Dr. Gossett responded in the affirmative and explained that if this patient came to the emergency department at St. Mary's Medical Center, where there was currently no women's health care provider, she would be transferred to a place where that care could be provided. At Saint Francis Memorial Hospital, a secular hospital governed by a different standard, she would receive that care. There are gynecologists at Saint Francis who care for those conditions.

In response to another question by Committee Chair Lansing, Dr. Jacoby explained that one reason why this severe emergency scenario was complicated was because, in Catholic hospitals, bishops have oversight regarding abortion. In severe cases like the one in Arizona, it is up to the local bishop to determine whether the hospital can perform the abortion or not. This varies a great deal across the U.S.

Committee Chair Lansing asked if there would always be a UC doctor in the emergency department. Mr. Laret responded that this would be a goal of UCSF in this affiliation. Dr. Gossett added that a patient would have access to a higher level of care because of UCSF's presence in that facility.

Committee Chair Lansing asked if it would be possible to inform patients when they enter the hospital about the services available and not available, and where other services can be obtained. Mr. Laret responded in the affirmative. This was part of UCSF's commitment to transparency, and Dignity agreed with this.

Regent Sures presented a specific scenario of a woman with a life-threatening miscarriage, when it is unclear if the baby will survive. He asked what would happen in this case. Dr. Gossett responded that UCSF wished to structure the affiliation in a way that would limit the number of challenging situations. The patient would be taken to a facility that provides this obstetric care; this would be no different than the current situation.

Regent Sures asked if a situation might arise in which a doctor was capable of providing the service, but would choose not to because of his or her religious views, or due to fear of violating a policy. Mr. Laret responded that this could occur now at a UCSF hospital, because UCSF does not require any faculty or staff member to participate in care to which he or she has a moral objection. Dr. Jacoby commented that UCSF often transfers patients, but there was a difference between transferring patients because resources or necessary personnel are not available at a particular facility and transferring patients because the religious practice of the hospital will not allow the procedure to occur, which is misaligned with UC's policy of providing evidence-based care, care based on science rather than religious doctrine. Ms. Decosta added that these situations have been discussed with Dignity. She stated that emergency care would always be provided. Contraception can be provided. There was nothing in the ERDs that would prevent physicians from saving a life. In these hypothetical situations, Dignity physicians would save the patient's life. Dignity physicians had done this in Arizona and would do so in the affiliation with UCSF.

Regent Sures elaborated on the scenario of a patient with a miscarriage. If the woman in this case needed a tubal ligation because a future pregnancy would place her at risk of dying, he asked if the tubal ligation would be performed. Dr. Gossett responded that this depended on the hospital. Dr. Jacoby added that this procedure could not be performed in a Catholic hospital. Dr. Gossett stated that the procedure could not be performed at St. Mary's Medical Center, but could be performed at Saint Francis Memorial Hospital. Of the four hospitals under consideration in the affiliation, two are Catholic—Dominican Hospital and St. Mary's Medical Center, and two are Catholic-affiliated—Saint Francis Memorial Hospital and Sequoia Hospital. Tubal ligations can be performed at the Catholic-affiliated hospitals.

Committee Chair Lansing stated her understanding that a patient at a Catholic hospital who wished to have a tubal ligation could be transferred to another site for the procedure, since this was not a life-threatening situation. Dr. Steinauer stated that women are denied tubal ligations in Catholic hospitals immediately following delivery. They would have to wait for an interval sterilization. Studies had shown that women who are denied tubal ligation at the time of delivery are at high risk of becoming pregnant again soon.

Regent Sures referred to statements made earlier during the public comment period about discrimination against LGBTQ patients in Dignity hospitals. He asked specifically what type of discrimination this was. Dr. Jacoby responded that there was a difference between the ten percent of hospitals that follow the Statement of Common Values and the 90 percent of Dignity hospitals that follow the ERDs. For those that follow the ERDs, the Catholic Church has made it very clear that it does not recognize the existence of transgender people.

In response to another question by Regent Sures, Dr. Jacoby confirmed that a transgender patient can receive other services, but may not receive gender affirming services, because the Catholic Church does not recognize this as a medical condition that needs treatment. Regent Sures asked if most gender affirming services are emergency services or elective services. Dr. Jacoby responded that these are services commonly performed for non-transgender people. Hysterectomies may not be performed for a transgender patient. This had given rise to lawsuits alleging discrimination.

Regent Sures asked if there were other forms of discrimination that the Regents should be aware of. Dr. Jacoby responded that the prohibition on all assisted reproductive technologies applies to all patients. A heterosexual couple may not receive these services, but the denial of these services disproportionately affects lesbians and gay men, because these are the only methods by which these people can have biological children. Regent Sures noted that these are not emergency but elective services, and supposed that in this affiliation, these patients would be able to receive these services at one of the other available facilities. Mr. Laret observed that these are usually outpatient procedures. Dr. Jacoby noted that the ERDs apply to outpatient facilities owned by Catholic hospitals.

Regent Sures stated his concern that a transgender or gay patient with one or another illness might be turned away because of his or her sexual orientation. Dr. Jacoby confirmed that this could not happen, but commented that it is an extremely demeaning experience for a

patient to receive the message that “we don’t recognize you” or “we don’t believe that you exist as a transgender person.” The hospital might treat this patient’s pneumonia but not recognize the patient’s transgender identity.

Regent Pérez referred to Ms. Decosta’s mentioning of the Arizona case as an example of how Dignity would operate. In that case, a group of doctors decided to move forward with a medically necessary abortion. This was evidence that the Regents should consider. Ms. Decosta stated that one should look at the real actions of Dignity.

Regent Pérez recounted a real life situation in California concerning a woman in her early 30s with cerebral palsy, personally known to him. She had a high-risk pregnancy, went into emergency labor, and was taken to a hospital with obstetric services in its emergency department. It was medically necessary for her to have a tubal ligation. The physicians at this facility performed a cesarean section. The patient was intubated although she did not support intubation well. The physicians refused to perform a tubal ligation because this was inconsistent with their Catholic values. The patient was stabilized and had to be transferred to another hospital, intubated again, and undergo a high-risk procedure. She nearly died twice. Regent Pérez stated that he was willing to accept the Arizona case as evidence. He asked if UCSF would accept this California case as evidence. Ms. Decosta indicated that she would accept this case as evidence.

Referring to the bishop’s intervention in the Arizona case, Regent Pérez asked if many decisions in Catholic hospitals are subject to consultation, intervention, and discussion informed by the feelings of a bishop. Ms. Decosta confirmed that these hospitals are subject to consultation.

Regent Pérez observed that the Archbishop of San Francisco, Salvatore Cordileone, was a conservative theologian who performed the Extraordinary Form of the Roman Rite in Latin. Mr. Cordileone’s conservative positions would be relevant if he were a player in making healthcare decisions. Regent Pérez stressed that Archbishop Cordileone had no medical training and expressed concern about his having a role to play in healthcare decision-making. With respect to non-discrimination, he cautioned against making the assumption that the existence of a non-discrimination policy in an organization means that the environment is free of discrimination. Policy, in and of itself, does not create environments that are free of discrimination. Many openly gay, lesbian, and bisexual patients do not disclose their sexual orientation to their doctors because they might feel that it is not a safe environment to make that disclosure, and this can result in negative health outcomes. He requested confirmation that in a current case at Dignity, a transgender employee had been denied coverage for procedures that would otherwise have been covered if this individual were not transgender. Dr. Jacoby confirmed this.

Regent Pérez disclosed that he personally intervened in this case. A transgender man was going through the process of aligning with his identity, and was scheduled to have a hysterectomy. The procedure had been approved by the doctor and the health insurance company, but had involved a long and demanding process for the patient. The day before the scheduled procedure, the patient was informed that the hospital would not perform the

hysterectomy because the patient was transgender. This patient was moved to another facility, but not without having experienced physical and emotional hardship. In Regent Pérez's view, this did not align with UC values. He asked if UCSF would accept this second California case as evidence. Ms. Decosta responded in the affirmative, but stated her understanding that Dignity had not lost the discrimination case. While she appreciated and understood the example, she did not have enough information to comment further.

Regent Pérez noted that for the Regents, this legal case would be informative rather than dispositive. The questions of alignment of values, the University's public role, and the University's public obligation are important. Regent Pérez stated his view that if the University entered into this affiliation, overall healthcare outcomes would be better for the community in general. An important question now was whether the University would be satisfied with this outcome at the expense of alignment with some positions that go against UC's values as a public institution.

Committee Chair Lansing expressed the hope that, if UC entered this affiliation, patients like the transgender patient mentioned by Regent Pérez would be immediately transferred to a UC facility. If the affiliation would improve the experience of Dignity patients, this would be a positive development.

Regent Pérez remarked that when there is no obstetrician on site at a hospital, an ambulance driver knows not to take a patient there for an emergency delivery. Emergency medical technicians can assess the need for an emergency delivery, but cannot assess whether there will be a need for tubal ligation, in which case it would be desirable to take a patient to a non-Catholic hospital. If UCSF enters the affiliation and has obstetricians on site, ambulances will come to these hospitals for emergency deliveries, and this can lead to more complicated matters like the one described.

Dr. Jacoby addressed the question of whether UCSF can improve care through this affiliation with Dignity. For care of women and LGBT patients, UCSF cannot improve care at facilities bound by the ERDs. These facilities would never provide contraception or perform an abortion. The only way to improve service is to transfer patients. There is substantial evidence indicating that transferring patients decreases quality and increases morbidity. Using a workaround is inappropriate and puts UC doctors in the uncomfortable position of acting unethically or illegally. Mr. Laret countered that this was one position; this was not the position of the UCSF administration.

Dr. Gossett commented that UCSF wished to build structures that would protect UCSF and its patients from these types of problems. One example of this was UCSF's intention not to locate any obstetric care at St. Mary's Medical Center because it is a Catholic facility. The obstetric receiving hospital that would be added through this affiliation would be Saint Francis Memorial Hospital, where tubal ligation was currently performed and part of routine care. The affiliation would address reproductive health needs in San Francisco but not outside the city. Sequoia Hospital provides full reproductive services, including tubal ligation and contraception. Dominican Hospital is a Catholic institution. Dr. Gossett hoped that, if an acutely ill woman with a complex condition like the case described by Regent

Pérez came to Dominican Hospital and it was recognized that she should receive tubal ligation, the patient would be brought to a UCSF facility. If UCSF did not have an affiliation with Dominican, this option would not be available to her.

Advisory member Lipstein referred to the point that had been made about considering the actual experience or practice at Catholic hospitals. He encouraged the Regents to examine affiliations of Catholic hospitals with other academic medical systems in the U.S. He recalled his own experience of presiding over a health system that was the merger of a Lutheran hospital, a Jewish hospital, a Baptist hospital, a Christian hospital, and a children's hospital. None of these hospitals adopted the ethical or religious directives of the other hospitals. All the other hospitals in the St. Louis metropolitan area that were not a part of BJC (Barnes Jewish-Christian) were Catholic hospitals. In the examples that Mr. Lipstein knew of around the U.S. where Catholic hospitals have worked with secular hospitals, they have worked together to achieve better outcomes for patients. He encouraged the Regents to review a case study of a merger between CHI and Jewish Hospital of Louisville. There were examples of Catholic hospitals working with academic medical centers not on workarounds but on new systems and procedures for patients who would be affected by ERDs. He stated that, if UCSF did not affiliate with Dignity, women and transgender patients at Dignity would be in the same situation, no better off than at present. But if one created an environment in which Catholic hospitals work with academic medical centers, one would create a dynamic in which new things become possible. Mr. Lipstein anticipated that in ten years, Catholic doctrine regarding health care would not change, but patients served by Dignity hospitals would be in a better situation than now. This affiliation would open opportunities for these patients that currently did not exist.

Faculty Representative May asked Dr. Hoffman about his personal views on collaboration with Dignity/CHI and how his views had developed over the past year. Dr. Hoffman responded that this was a complicated question. He believed that everyone deserves the best care and that UC faculty need to be able to practice in line with UC values. He was very proud to be a UCSF faculty member and aligned himself with UCSF whether at the Parnassus hospital or at St. Mary's. The essential question was how UCSF could accomplish its goals, addressing the need for capacity and upholding its values. This was a difficult matter with many nuances. From the standpoint of hospital medicine, he believed that a workable solution could be found for this situation, but he was mindful of conflict.

Mr. May noted that the discussion had touched on the fact that affiliating with Saint Francis and St Mary's would add capacity for UCSF. He asked why affiliating with Sequoia Hospital and Dominican Hospital was desirable and about the reasons for including them in this affiliation. Mr. Laret responded that the Affordable Care Act was moving the world of health care toward population health management and away from episodic, fee-for-service care. One of UCSF's objectives is to be able to take care of Medicare patients through the Medicare Advantage program, and this requires a regional network of healthcare providers. This was one reason for the affiliation with Dominican and Sequoia Hospitals. Dominican is the primary hospital near the UC Santa Cruz campus. One of the responsibilities of UC Health is to find a way to provide more care for UC faculty, staff, retirees, and dependents at all UC locations. This was an opportunity to bring UC faculty,

standards, and quality oversight to this community. Dominican and Sequoia were successful hospitals that could manage without UCSF, but they would benefit greatly from this relationship with regard to population health and service to UC Santa Cruz.

Mr. May stated his understanding that under the University's current health plan, UC Santa Cruz employees already had full access to Dominican Hospital, which is a provider for the UC Care and Health Net Blue and Gold plans. Affiliation with Dominican would not increase access for UC employees. Mr. Laret responded that UCSF intended not merely to affiliate with Dominican, but contemplated new programs there, such as expanding cancer treatment options and building a physician network in the Santa Cruz area, which might include an on-campus facility. Mr. May observed that having a clinic on campus would not require an affiliation with Dominican. Mr. Laret recalled three essential problems that UCSF was trying to solve. The foremost problem was capacity. UCSF currently had to turn away patients with severe conditions and was not meeting the needs of the community. The second problem was the movement toward population health. UCSF must have a network and, through the Canopy Health network, UCSF was trying to position itself in the region to become a Medicare Advantage provider. The partnership with Dignity was required in order to achieve this goal. The third issue was UCSF's commitment to serving mentally ill patients and the underserved in the community. Mr. Laret underscored the important role of Dignity hospitals in providing mental health services and service to Medi-Cal patients in Northern California. In San Francisco, there is only one place to take a child with severe mental illness who needs hospitalization—the adolescent psychiatric services department at St. Mary's.

Mr. Laret recognized that there were tensions and problems in an affiliation with Dignity, but stressed that there were also areas of great congruence. UCSF would work with Dignity to address care for homeless people. UCSF, working with Dignity and the City and County of San Francisco, had begun, at St. Mary's, the only post-acute care program to serve discharged mentally ill patients who would otherwise have no other place to go. UCSF wants to be "inside the tent," participating in decisions about how care is delivered to these populations. UCSF needs to participate financially. Like all UC medical centers, the UCSF Medical Center is self-supporting, receiving no funds from the State or the University. UCSF loses money in caring for Medi-Cal and Medicare patients and makes money in caring for insured patients. Participating with Dignity financially would ensure a revenue flow to support some of UCSF's money-losing programs. Other than spending multiple billions of dollars to build new facilities, which would take a decade or more, there was no other option at hand to improve service to the community in San Francisco.

Mr. May observed that there was no dispute about a need for more space and that in certain areas, Dignity is aligned with the work of UCSF. The disagreement was about the differences in values. He noted that Dignity is listed as a participant in Canopy Health. He asked if Dominican Hospital was currently a participant in Canopy Health. Ms. Decosta responded that Dominican had just been approved for participation in Canopy Health. Mr. May asked about the majority view of faculty in the UCSF Department of Obstetrics, Gynecology, and Reproductive Sciences regarding the proposed affiliation. Dr. Jacoby responded that there had not been a vote, but many discussions had taken place over the

past two years. The previous summer, when it was announced that Saint Francis Memorial Hospital would be opening a birth center in partnership with UCSF, there was much discussion, and the vast majority of faculty did not support this because of the restrictions on abortion services. It was appropriate to weigh benefits and risks. One of the cited benefits of this affiliation was that care would be improved. Dr. Jacoby stressed that the care delivery model of Dignity/CHI does not improve care for women. UCSF, by partnering with Dignity, would enable this restrictive, discriminatory model of care to be sustained and expanded.

Mr. Laret acknowledged that this was an important point and one that UCSF needed to grapple with. Dignity was the largest healthcare delivery system in California. An essential question then was whether UCSF should engage with largest healthcare system or have nothing to do with it. UCSF already had a number of collaborative programs with Dignity. A logical conclusion of the argument about not enabling a discriminatory care model would be that UCSF should remove itself from all these relationships.

UC Davis Health Vice Chancellor David Lubarsky noted that Dignity has many hospitals in the Sacramento area. UC Davis has a number of shared programs with Dignity and was seeking to expand them. Dr. Lubarsky noted that he was personally engaged to have Dignity send all high-risk OB/GYN patients to the UC Davis Medical Center so that high-technology and totally responsive care is provided. In his view, at least in Sacramento, women's health would be improved through these kinds of partnerships. UC Davis operates the only transgender clinic in the region. If UC Davis is more engaged, it is more likely to be able to refer patients for hormonal therapies and gender affirming surgeries. UC Davis would take its ethics into other hospitals and treat transgender, LGBT, and all patients with the dignity that every patient deserves. By disengaging, one would allow a lesser quality of care for patients one could otherwise help. UCSF's engagement with the largest healthcare system in California was a positive step. UC Davis also faced patient census challenges and needed to engage with Dignity, just as UCSF did, to apportion its lower-acuity patients to better sites of care.

Dr. Gossett referred to Mr. May's question about the views of faculty in the OB/GYN Department. A petition opposing the affiliation was circulated in a variety of forms, and fewer than 50 percent of the faculty signed it.

Mr. May reported that the Academic Senate's Academic Council and University Committee on Faculty Welfare were overwhelmingly concerned and had grave reservations about this affiliation. He quoted from an interim report by the University Committee on Faculty Welfare Non-Discrimination in Healthcare Task Force, which recommended that UC's existing and potential affiliation agreements with entities whose values are in conflict with UC's roles as a public trust with the people of California be paused, scrutinized with increased rigor, and curtailed until any area of conflict with the University's missions and values had been resolved. Mr. May opined that this was an issue of institutional relations between the UC system, not just UCSF, and Dignity. He requested a wider discussion of this matter within the entire University. This discussion would involve the Academic Council and all divisions of the Academic Senate. He noted that the

UC Santa Cruz Division of the Academic Senate had also requested such a broad-based discussion. He emphasized the Academic Senate's serious hesitation about supporting the proposed affiliation.

Dr. King remarked that the Academic Senate did not represent many UCSF faculty who would be affected by this decision. He asked if the Academic Senate would allow these faculty to become members of the Academic Senate so that they could participate in this discussion. Otherwise, the Academic Senate would be issuing opinions on behalf of faculty who were not members. Mr. May countered that the Academic Senate would be opining on the values of the University and how they would be in conflict with the values of another institution. It is within the prerogatives of the Academic Senate to so opine. Dr. King stated that this was control without representation. Mr. May objected that the Academic Senate was not controlling; it was simply offering an opinion.

Regent Park referred to a letter from the American Civil Liberties Union, the National Center for Lesbian Rights, and the National Health Law Program to Mr. Laret and Chancellor Hawgood concerning the proposed affiliation. As an indication of how the ERDs address partnerships with secular hospitals, the letter quoted ERD no. 73: "Before affiliating with a health care entity that permits immoral procedures, a Catholic institution must ensure that neither its administrators nor its employees will manage, carry out, assist in carrying out, make its facilities available for, make referrals for, or benefit from the revenue generated by immoral procedures." She asked if the Dignity Catholic hospitals would consider this relevant with regard to UCSF physicians' ability to speak freely with patients and staff's ability to complete referrals. Deputy General Counsel Rachel Nosowsky responded that she believed that Dignity's view was that no UCSF faculty are employees at Dignity, none would be administrators, and they are not covered by this ERD. She would follow up and confirm this.

Regent Park emphasized that this was a serious matter involving important principles, and that the Regents must proceed with caution. She warned against standing on a single principle that does not exist in isolation in the real world. This was a process of negotiating many principles which the University holds dear. It was important to acknowledge the effort to extend medical care to people without access today. These people were nameless and faceless, and had not had the opportunity to attend this meeting and tell their individual stories. It was important to ask how UC can extend care and what the net benefit to all kinds of patients would be. Regent Park requested more quantitative and qualitative information about what the University would improve through this affiliation and by how much. More than one principle was involved. The University's responsibility was related to what happens in the healthcare ecosystem. When much healthcare in this ecosystem is delivered by Catholic hospitals, the University must think about where it can fill gaps and provide services not otherwise provided. The Catholic Church might not change, but the healthcare arena changes and expectations change. There had been many changes over the past 20 years. She again requested a more quantitative characterization of what would improve, and for whom.

Advisory member Hernandez observed that all the discussants shared more values than not. There was no question that every clinician present believed in the highest quality of care for every human being, regardless of financial circumstances, social determinants, sexual identity, or gender. The question was how to continue to evolve a complex ecosystem of care, with the goal of engagement. Nothing would be changed by disengagement. Dr. Hernandez recalled that during the time of the HIV epidemic, when there was little scientific knowledge and little medicine, when principally gay men were dying, the first healthcare system that stepped forward to provide comprehensive HIV care besides San Francisco General Hospital was St. Mary's Medical Center. Those HIV services were state-of-the-art, operated by infectious disease specialists who had trained at UCSF. In her view, distinguishing a UCSF clinician from a Dignity clinician was a false dichotomy. There were many painful accounts about the inefficiencies of the current healthcare system, especially concerning low-income individuals who lack access and power. She stated that, in her former role as director of public health for the City and County of San Francisco, if she had said that she would not engage with Dignity because of the ideology of the Catholic Church, there would not have been supportive housing, HIV services, and mental health services. The only way to improve care is to engage and have a common vision. She urged the Regents not to seek absolute solutions. There were many examples of disparities in care. African American women die disproportionately in birth at all institutions. It was painful to consider the cases that were brought up during the discussion, and to consider disparities in health care. The University would not address these disparities if it decided to disengage.

Regent Zettel stated that the University needs to be concerned about low-income and Medicaid patients who were currently not being served, and who would benefit from this affiliation.

Regent Makarechian asked Mr. Laret to comment on the consequences for UCSF and Dignity of not pursuing this affiliation. Mr. Laret responded regarding the consequences for UCSF. If UCSF did not pursue the affiliation, Dignity would find another partner. The UCSF School of Medicine was first in the nation for research. UCSF Medical Center was the number one hospital in California. UCSF has achieved this stature by growing and by investing in faculty, infrastructure, science, and the community. Eighteen years prior, UCSF was a small medical center; currently it was operating at capacity. This was due to changes in the market and because patients in the community choose to come to UCSF. UCSF could not grow without this affiliation. UCSF would add 30 patient beds in January 2020. The next addition of patient beds on the planning horizon would not occur until 2029. UCSF hoped that it would be in a financial position at that point to borrow \$1.5 billion, which, along with philanthropy and other sources, would finance the construction of the \$2.5 billion Hellen Diller Medical Center on the Parnassus Heights campus. Even that would only provide a small, incremental increase in the number of beds. From UCSF's standpoint, there was no good alternative to the affiliation. If UCSF were to disengage from a partnership with Dignity, this would be catastrophic for the healthcare delivery system in San Francisco.

UCLA Health Sciences Vice Chancellor John Mazziotta commented that the UCLA Medical Center is full every day. UCLA has had hospitalists and medical specialists in three Dignity hospitals and four Providence hospitals, in some cases since 2007. While the phenomenon of UC physicians in faith-based hospitals was not new, it had not risen to this level before. This debate was important. UC hospitals were full, and patients were not receiving care because of this.

Committee Chair Lansing thanked all the speakers and participants for presenting a nuanced view of this matter. Deliberation on this very important issue would continue.

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

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

This item was not discussed.

7. **UC RIVERSIDE SCHOOL OF MEDICINE UPDATE, RIVERSIDE CAMPUS**

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

This item was not discussed.

The meeting adjourned at 2:45 p.m.

Attest:

Secretary and Chief of Staff