

The Regents of the University of California

HEALTH SERVICES COMMITTEE

February 16, 2022

The Health Services Committee met on the above date at the UCLA Luskin Conference Center and by teleconference meeting conducted in accordance with California Government Code §§ 11133.

Members present: Regents Guber, Lansing, Park, Pérez, Sherman, and Sures; Ex officio members Drake and Estolano; Executive Vice President Byington; Chancellors Block, Hawgood, and Khosla; Advisory members Marks and Ramamoorthy

In attendance: Regents Leib, Makarechian, Reilly, Torres, and Zaragoza, Regents-designate Blas Pedral and Timmons, Faculty Representatives Cochran and Horwitz, Secretary and Chief of Staff Shaw, Deputy General Counsel Nosowsky, Vice President Nation, Chancellor Gillman, and Recording Secretary Johns

The meeting convened at 10:15 a.m. with Committee Chair Pérez presiding.

1. APPROVAL OF MINUTES OF PREVIOUS MEETING

Upon motion duly made and seconded, the minutes of the meeting of December 15, 2021 were approved, Regents Drake, Estolano, Guber, Lansing, Park, Pérez, Sherman, and Sures voting “aye.”¹

2. PUBLIC COMMENT

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

- A. Brad Jones expressed opposition to the University’s COVID-19 vaccine mandate. He stated that students did not want toxic substances in their bodies, that this was a violation of civil rights, that he would not consent to injections, and that one has a natural right to deny medical treatment and psychological indoctrination.
- B. Robert Byrd expressed his strong objection to medical research at UCSF that made use of organs and body parts from aborted fetuses, despite the existence of alternative tissue sources. He stated that UCSF had failed to demonstrate compliance with California Health and Safety Code Section 123435. The

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

University must put oversight and safeguards in place to prevent and uncover malpractice.

President Drake remarked that the University had now entered the third year of the COVID-19 pandemic. The compliance of UC campuses with public health and safety measures was impressive. More than 99 percent of students and 98 percent of employees were in compliance with the UC vaccine mandate. More than 77 percent of Californians had received at least one dose of the vaccine. UC campuses, considered as communities in the pandemic, had fared as well as any communities in the world in terms of the numbers of cases, hospitalizations, and deaths. Compliance with UC's mandate had kept people healthy and safe. The U.S. must look at how it has dealt with this pandemic, share best practices, and find a better way to respond to the next wave of the COVID-19 pandemic and to future pandemics. The University must be a learning community as it moves forward in order to do a better job responding to future challenges. Many of the actions taken by UC would be examples for the wider world.

3. **UPDATE FROM THE EXECUTIVE VICE PRESIDENT OF 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 Byington began her discussion by noting that the United States had now surpassed 900,000 deaths from COVID-19. She was certain that there would be one million or more deaths in the U.S. About one-third of these deaths, or 328,000, had occurred since May 1, when vaccines were widely available, and 100,000 deaths were due to the Omicron variant. The U.S. led the world in number of deaths, and one out of every four deaths from COVID-19 occurred in the U.S. Over 200,000 children in the U.S. have lost a parent or caregiver to COVID-19.

In early December, the Omicron variant began to appear in the U.S., and, within four weeks, it became the predominant the variant. Dr. Byington expressed concern about a sister variant of Omicron, BA.2. The trajectory of this variant and whether it would prolong the pandemic was unknown. The evolution of variants of concern had not been sequential. In the family tree of SARS-CoV-2, the Alpha variant was separate from the Delta variant, and Omicron did not evolve from Delta. These were spontaneous and distinct evolutionary results. The differences between Omicron BA.1 and BA.2 were almost as great as the differences among Alpha, Beta, and Gamma. At this moment, there was debate about whether BA.2 should be considered a new variant of concern and named differently from Omicron. One did not know where the next variant of concern might come from and whether it would be related to any of the variants experienced so far.

The U.S. was currently on a rapid downhill trajectory of average reported cases. Less than a month earlier, there had been more than 800,000 cases per day. There were now 254,000 patients per day as a seven-day average. This represented an approximately 75 percent decline. While this was a favorable trend, the current rates were equal to the highest points of the pandemic.

California was also on a steep downward trajectory. The prior week, the state had about 75 cases per 100,000 population; today the rate was 50 cases per 100,000. There had been a decline of about 75 percent in one month. There were higher rates of vaccinations and booster vaccinations in California than in the U.S. overall. In most states, there were fewer hospitalizations this winter than last winter; in California, there were 49 percent fewer hospitalizations than last winter. This was a direct result of vaccinations, booster shots, and immunity generated by infection.

UC Health had not experienced the same decline in hospitalizations in its facilities. This winter, UC hospitals had a higher number of COVID-19 patients than last winter. Dr. Byington believed that this was due in part to the fact that UC medical centers are referral centers and treat some of the sickest patients in California. These numbers included patients hospitalized with COVID-19 rather than for COVID-19; UC Health would soon begin to distinguish these patients in its reporting.

Statistics on cumulative deaths in the U.S. compared to other high-income countries (Europe, Australia, Canada, and Japan) indicated that, early in the pandemic, other countries had higher rates of mortality per 100,000. Since implementation of vaccines, the U.S. has had the highest per capita mortality rate of these countries. During the Omicron wave, there was a significant difference between the U.S. and other developed countries.

Dr. Byington emphasized the importance of the following statistic on deaths by vaccination status. Unvaccinated people in the U.S. were 97 times more likely to die from COVID-19 than people who were vaccinated and had received booster shots. All Americans should know this fact and use this information to protect themselves and their families.

On February 11, the Centers for Disease Control and Prevention (CDC) published a study on the waning of effectiveness of the second and third doses of the mRNA vaccine. Two months following a booster shot, the likelihood of an emergency department visit was reduced by 87 percent and of hospitalization by 91 percent, compared to being unvaccinated. This was during a period when the Omicron variant was predominant. At four months, the protection against emergency department visits declined to 66 percent and against hospitalizations declined to 78 percent. These data were critical in planning for the future and trying to project the decline by the winter of 2022–23. One needed to prepare for that now, in particular for the healthcare workforce.

The U.S. Food and Drug Administration had postponed an evaluation of data for authorization of use of the Pfizer vaccine for the youngest children, six months to four years of age. This was disappointing news for parents, but Dr. Byington believed that this was the right scientific decision, allowing time for further study. It also demonstrated the fact that vaccine trials for children should have begun earlier than they had begun in this pandemic.

The CDC had released a report about a week earlier in its Morbidity and Mortality Weekly Report series on the effectiveness of wearing a mask to prevent COVID-19 infection. This study also compared the effectiveness of cloth masks, surgical masks, and respirator masks.

Wearing a cloth mask lowered the odds of testing positive for COVID-19 by 56 percent, wearing a surgical mask by 66 percent, and a respirator mask by 83 percent. This study was published at about the same time when many states were lifting their masking requirements. These contradictions in messaging would be difficult for the general public to reconcile. Masks would continue to be required in a number of settings, and for the unvaccinated. Some local jurisdictions would maintain mask orders for the time being.

The UC system had done well in protecting faculty, staff, and students and had developed its own guidance, which sometimes was more detailed and went beyond CDC guidance. On February 7, the CDC issued new guidance for institutions of higher education, and it was very much like UC's guidance, including an emphasis on vaccination, entry testing, and wearing a mask during periods of high and substantial transmission. Most of the U.S. currently remained in a state of high and substantial transmission. UC Health believed that the time had come to align its recommendations with those of the CDC and to have recommendations allowing individual campuses to assess COVID-19 transmission in their communities and to address this by using the infrastructure they had developed. There would be a discussion of new guidance at the meeting of the Council of Chancellors the following week and Dr. Byington anticipated that this new guidance would be posted soon.

There was slow progress in world vaccination. At this point, 55 percent of the world was fully vaccinated. This amounted to approximately ten billion doses given across the world. This was a remarkable achievement, but large swathes of the world were still unprotected, especially in Africa. The University was raising its voice to advocate for vaccination across the world. It was projected that certain countries would fail to meet a target of 70 percent vaccination by mid-2022, and these countries included the U.S. The World Health Organization (WHO) had stated that reaching this target would enable the world to change the trajectory of the pandemic.

The U.S. could help world vaccination in a number of ways. One way was to scale up in-kind donations of surplus vaccines. The U.S. still needed to make good on about 60 percent of the donations it had promised. The U.S. could provide additional funding for global vaccine efforts such as COVAX and should help to expand vaccine manufacturing capability in other countries. There should be a discussion of waiving and relaxing intellectual property restrictions. Through WHO sponsorship, a laboratory in South Africa was working to create its own mRNA vaccine. This effort had financial support from France, Germany, and Belgium and would use a nucleic acid template patented by Moderna and a sequence published by Stanford University scientists. Clinical trials of this vaccine should occur later this year.

The U.S. could also support additional vaccine development. The Corbevax vaccine had been developed at Baylor College of Medicine and Texas Children's Hospital, licensed patent free, and approved for use in India. It was under review in many other countries, and cost about three dollars per dose. About 300 million Corbevax doses were expected to be delivered this year. There was also great interest in a pan-coronavirus vaccine, one which would work against all coronavirus variants. Studies in this area were ongoing at the

Scripps Research Institute and at UC San Diego. Dr. Byington presented a list of international organizations working to vaccinate the world population.

Researchers at UCLA had developed the Swab-Seq technology, and UCLA was working with the California Department of Public Health to deliver testing across the state. This technology should allow for 20,000 tests per week. It was one of the most flexible technologies and could help support a lasting, low-cost, and sustainable testing infrastructure for California.

A recent study by UCLA researcher Antoni Ribas focused on how the COVID-19 pandemic has disrupted cancer care. Cancer screenings for common cancers, such as colon and breast cancer, have decreased by about 80 percent. Cancer patients were coming in with more advanced cases of cancer and in need of more intensive therapy. Because of this disruption in care, thousands of additional cancer deaths were expected in the coming years.

Another recent study by the Department of Veterans Affairs (VA) hospital system followed about 150,000 survivors of COVID-19 in the VA system and compared them to historical and contemporary control groups for one year. The study found that adult survivors of COVID-19 were at higher risk for stroke, atrial fibrillation, ventricular arrhythmias, inflammatory heart disease, acute coronary disease, and cardiomyopathy.

Dr. Byington presented data from a study of 24,000 adolescent survivors of COVID-19 in Denmark, compared to 97,000 matched COVID-19-negative controls. For many types of complaints—chest pain, headache, fatigue, dizziness, fever, loss of appetite, trouble breathing, trouble remembering or concentrating, and dizziness while standing—the complaints were greater for adolescents who had survived COVID-19 than for control subjects who had not had COVID-19. There were major effects for adults and children who survive the disease, and there was a high mortality rate in the U.S. The U.S. health system would have to adapt. Public health literacy must improve. One must address vaccine hesitancy and misinformation, plan for care delivery for more chronic diseases, and address the needs of children recovering from COVID-19 or experiencing mental health issues and the loss of a parent or caregiver.

Dr. Byington then briefly reported on other UC Health developments. Regents Policy 4405: Policy on Affiliations with Healthcare Organizations that Have Adopted Policy-Based Restrictions on Care and the related President's policy require the provision of evidence-based and medically necessary care for all patients in sites where UC clinicians are working. UC Health had convened implementation working groups to promote consistent application of these policies. UC Health's affiliation agreements required new contract language. A checklist was reviewed for all new agreements, and there was an approval process to ensure that all new and renewed contracts aligned with policy. With assistance from the Office of the General Counsel, UC Health had now completed systemwide master agreements with Dignity Health and Adventist Health. UC Health was still working to amend agreements with Providence, the Department of Veterans Affairs (VA), and the Indian Health Service. The UC policies also required annual reporting. UC Health had just

completed a test run of reporting for new and extended affiliation agreements. The test run was successful and confirmed that each location was appropriately monitoring and tracking these affiliations. UC Health was also working on reporting to capture patient, employee, and trainee complaints and developing standard language for education and training about the policies and their requirements.

Dr. Byington briefly reported that UC Health received an award for “Building Climate Resilience at Essential Hospitals” from America’s Essential Hospitals and the Essential Hospitals Institute. UC Health’s effort was led by UCSF Associate Clinical Professor Seema Gandhi. This award would allow UC Health to participate in a national climate change work group. UC Health was recognized as a 2021 Climate Champion by Health Care Climate Challenge and Health Care Without Harm; specifically, UC Health was recognized for climate leadership, renewable energy, and climate resilience.

Dr. Byington recalled that there was an unprecedented blood shortage in the U.S. due to the COVID-19 pandemic and lack of donations. UC Health as a system was able to renew its contract with the American Red Cross and to implement new systemwide contracts that provided greater access to blood centers across the U.S. UCLA and UC Irvine shared blood resources across the system to allow vital surgeries and cancer treatments to continue. UC healthcare workers were also donating blood for their patients.

Regent Lansing asked about a fourth shot of the COVID-19 vaccine and if people who had received a booster shot should receive another shot after four to six months. Dr. Byington responded that she believed it was likely that one would need annual immunizations against COVID-19, like the annual influenza vaccine. It seemed clear that one could not maintain antibodies from either the vaccine or natural infection much longer than a year. She was awaiting guidance from the CDC, which would be based on national data. A recent trial of the Omicron-specific vaccine showed no improvement in antibody levels or effectiveness compared to the regular vaccine. This was one question that must be answered: was there a need for variant-specific vaccines or annual vaccines formulated for the variants experienced at that time?

Regent Lansing asked if people would receive a shot every four months. Dr. Byington responded in the negative. Even with the waning of the antibody, there was still good protection against hospitalization and severe disease. She did not believe that there would be a vaccination cycle of booster shots every four months. This would be neither possible nor necessary.

Regent Lansing asked if there would be harm in a fourth shot. Dr. Byington responded that there might be side effects and that there could be harm from receiving booster shots too frequently and not giving the immune system enough time. She anticipated that COVID-19 vaccinations would move to an annual pattern.

Regent Lansing asked if the development of a Delta- or Omicron-specific vaccine might be completed in a year. Dr. Byington responded that this might occur sooner. Trials were already underway. In the future, there might be a multi-variant vaccine. It might be possible

to combine vaccine for COVID-19 and for influenza together in one shot to make vaccination easier. These possibilities were under active investigation.

Regent Lansing asked if it was preferable not to eat indoors with others present. Dr. Byington responded that she was still avoiding eating indoors. She would like to see the case rate, currently about 50 cases per 100,000, diminish. In a few weeks, the rate might come down to 20 cases or fewer per 100,000, and she would then consider eating with others indoors.

Staff Advisor Lakireddy asked how UC could inform people in rural communities and communities without UC hospitals to seek routine checkups and other care that had been neglected due to the pandemic. Dr. Byington responded that the UC Cancer Consortium was one means of ensuring that people have access to care. There would need to be a focus on cardiovascular disease and on mental health as well. Telehealth would be part of the solution. Dr. Byington was interested in partnering with the State to find ways to serve communities that needed greater access to care.

Regent Torres asked about the waning effectiveness of the booster shot after four months. Dr. Byington explained that the effectiveness of the shot waned after four months but did not go away; the shot still had effectiveness in preventing hospitalization and severe disease. She anticipated an annual immunization cycle for COVID-19.

Regent Torres asked when one should receive another shot, following the booster shot. Dr. Byington responded that she did not know what the CDC would recommend or authorize, but expected guidance to be issued soon because, if there was a plan for fall COVID-19 vaccinations, now was the time to prepare.

Chancellor Block asked if there were any grand strategies to improve vaccination rates. He noted that vaccination rates in Los Angeles were not as high as they should be. Dr. Byington responded that it was necessary to increase public health literacy and public understanding of the pandemic, and UC, as an educational institution, could play a role in this. It was also necessary to address vaccine hesitancy, which would require not just providing facts but listening to people's concerns.

President Drake commented that, in recent polls of Americans, 30 to 40 percent expressed a low level of belief in science. However, none of those people consistently act on the basis of this viewpoint. Overwhelmingly, these people get on elevators and drive across bridges, entrusting their safety to structures based on science and engineering. Even after contracting COVID-19 or losing a family member to COVID-19, some people were still resistant to vaccination, and this was perplexing. The fact of 900,000 deaths from COVID-19 should be sufficient data. President Drake referred to the CDC study mentioned earlier on the relative effectiveness of different types of masks. He asked if this study had surveyed vaccinated or unvaccinated people, and if there was a difference between these populations. Dr. Byington responded that the study surveyed a mix of people and only focused on wearing a type of mask or not.

President Drake suggested that the effectiveness of COVID-19 prevention among the masked and vaccinated population would be higher than among the masked and unvaccinated population. The University might consider such data for its own masking policies. Dr. Byington concurred and noted that every campus would now be dealing with masking policy.

Regent Reilly asked about the latest variant of Omicron. Dr. Byington responded that the BA.2 variant was similar to Omicron. It did not appear to be more or less deadly than Omicron, but more infectious. People in the U.S. were unmasking when a new variant was appearing. This variant was a matter of concern.

Regent Sures referred to the increases in heart disease attributed to COVID-19. He suggested that UC Health send out mass email messages to patients encouraging them to schedule appointments and tests for conditions that might have been neglected during the pandemic. Dr. Byington responded that UC Health was continually communicating with patients to remind them and to make them confident that it was safe to come into the hospital. There was an enormous patient backlog.

Regent Zaragoza asked when campuses might lift mask mandates and how one would ensure safety. Dr. Byington responded that each campus had to work with its county or city public health entity, the local authority. She expected that mask mandates would be lifted on the campuses over the next several weeks. Just because the mandate was lifted did not mean that one should stop wearing a mask. A person with underlying risk factors or someone who was unvaccinated should continue wearing a mask. Even when the requirement was lifted, the campuses should be a mask-friendly environment.

Regent-designate Timmons asked about filtration and air quality in UC's planning and messaging. Dr. Byington responded that filtration had been important since the beginning of UC's response to the pandemic. Engineering controls came before masks and vaccines. All campuses and medical centers had worked on their buildings to ensure that their heating, ventilation, and air conditioning (HVAC) quality was good and that there was good air circulation in the buildings.

Regent-designate Timmons asked if good air quality was being taken into consideration along with the mask mandate. With good air quality, wearing a mask might be less critical. Dr. Byington responded that each of these elements was a separate layer of protection for individuals. In her view, the most significant factor was the level of community transmission. In January, the level in some places was as high as 1,000 cases per 100,000 in the population, and one needed to implement every possible protection. As the level of transmission decreased, and the lowest in California had been 0.7 cases per 100,000, one could be more comfortable with relying on engineering controls and vaccination as protective measures.

Committee Chair Pérez noted that the Coachella and Stagecoach music festivals would not require vaccination or masking this year. It seemed unwise to withdraw all levels of protection at once. Dr. Byington expressed agreement. The U.S. had ample resources and should have been able to deliver better outcomes.

Committee Chair Pérez asked about the interaction of COVID-19 and myalgic encephalomyelitis/chronic fatigue syndrome (ME/CFS) and suggested that this be discussed at a future meeting. Dr. Byington responded that UC Health had a systemwide group that was focused on long COVID and working on standardization of intake and evaluation. The mechanisms of long COVID might be related to ME/CFS. The causes of ME/CFS were heterogeneous. Research on long COVID might be applicable to ME/CFS. This could be reported on at a future meeting. The future healthcare costs of long COVID would be significant.

Committee Chair Pérez referred to the figure cited by Dr. Byington of children and youth who have lost a parent or caregiver during the pandemic. One must consider the disproportionate impact of these losses on certain communities, and their implications for public health and for educational institutions. Dr. Byington responded that the impacts on education had not yet been fully analyzed. A young person's ambitions and the ability to contemplate college attendance are affected when a wage earner in his or her family has died. There had been declines in community college enrollment, and there might be impacts felt at UC and the California State University as well.

Regent Park asked if the projected shift to an annual vaccination schedule would help one get closer to the 70 percent vaccination goal, or if one might lose ground. Dr. Byington responded that, without a concerted effort to address vaccine hesitancy and to vaccinate large parts of the world, one would lose ground and be in a worse situation the following winter with respect to worldwide immunity. The winter surge this year was greater than the winter surge last year. She raised the question of how many more such surges healthcare workers could endure. The loss of healthcare workers was an issue of great concern. Dr. Byington stated that she felt less certain about the general will to undertake the national and global effort that was required to address these problems than she had felt two years prior.

Regent Park asked how one would address vaccine hesitancy and increase public health literacy. Dr. Byington responded that public health communications had improved. The social and behavioral sciences would help one understand what people would and would not do. She would like to frame the issue as one of empowering the population with knowledge so that people can recognize misinformation and make informed decisions. Public health measures, such as wearing a mask, had been politicized. People should see these public health measures not in political terms, but as neutral and empowering, allowing them to protect themselves and their communities. Science literacy, communication, and data interpretation, the ability to distinguish accurate from false data, were all important.

Regent Park referred to the fatigue experienced by healthcare workers as they entered the third year of the pandemic and the fact that there were not enough healthcare workers. She asked about strategies for building up this workforce, both in numbers and resiliency. Dr. Byington responded that engagement with healthcare workers themselves was needed. Their needs at the beginning of the pandemic were different from their needs now. One needed to take a strategic look to the future and consider what new models of care could

be implemented and how one can use teams and technology. One could not return to the American health system of 2019 but must develop a workforce that would differ from the earlier workforce, with new populations in health professional careers and new types of health professions, with professionals working more often as teams. There would never be enough doctors, nurses, and subspecialists to meet U.S. healthcare needs and new models would have to be developed.

UC San Diego Health Chief Executive Officer Patricia Maysent commented that the UCSD Health workforce was extraordinarily tired. The tone of interactions with patients had changed substantially over the last year. In particular, there was a level of crisis and depression among employees in the critical care teams, the emergency department, and infectious disease units that was of great concern. The medical centers were making targeted investments in these faculty and staff. There was a massive need for mental health support and there were not enough providers. UC Health would have to find creative ways to build up the mental health workforce to address this growing demand for services.

Committee Chair Pérez underscored the need for a values-based discussion and, in working toward new models of health care, striving to find the best of the older model and the best of the new model. He noted that UCLA had good models for mental health services for its providers.

UCLA Health President Johnese Spisso mentioned UCLA's efforts and tools to provide mental health services for healthcare providers and medical students. Compared to the early part of the pandemic, when patients were generally grateful to healthcare workers, in recent months, patients had become frustrated with rules, such as restrictions on visits. There was now an effort underway to remind patients to show kindness to healthcare workers. There had been an increase in conflicts with patients. Even small gestures, such as giving thank you cards to staff, can build resilience in the workforce.

Regent-designate Blas Pedral asked about UC measures as mask mandates were lifted in California and students go out into communities with much lower vaccination rates than the UC campuses. Dr. Byington responded that the campuses had developed satisfactory infrastructure for testing, tracing, quarantine, and isolation. There might be implications of students going from the campuses into less protected community settings, and this highlighted the important role of public health literacy. Students should have awareness of these issues, check the vaccination rates in a certain community, and be able to make a plan for themselves and take appropriate precautions. She hoped that all UC students would be conversant with the public health measures for COVID-19 and would be able to convey them to others.

Committee Chair Pérez remarked that there were not great differences among the UC campuses in terms of vaccination rates, but there were differences among California communities where the campuses are located.

Faculty Representative Horwitz reported that the Health Care Task Force of the Academic Senate had found a high number of "ghost providers" for mental health services—providers

who claim to be offering mental health services but do not because they do not receive sufficient reimbursement. This was a problem in the University's own insurance policies and benefits packages. Dr. Byington responded that the University was aware of this and that this was an area in which UC had not fully leveraged its strength to demand networks that are fully staffed. This was an area that needed work, and she hoped that the University could also grow its own resources to help address these needs.

4. **UC IRVINE HEALTH SCIENCES STRATEGY, IRVINE 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.]

Chancellor Gillman began the discussion by noting that a central feature of UC Irvine's overall 2016 strategic plan was a commitment to dramatically expand its health sciences programs and clinical enterprise. A year later, the campus announced a historic \$200 million gift from Susan and Henry Samueli to support the innovative College of Health Sciences. This allowed UCI to expand in a truly integrated manner. Over the course of the last three years, UCI had seen rapid growth in its research endeavors, the launch of a new School of Pharmacy and Pharmaceutical Sciences, and the expansion of clinical services throughout Orange County. The College's programs in medicine, pharmacy, public health, and nursing were growing rapidly as an interprofessional collaborative across the schools and the healthcare system. New buildings opening this fall for the College and for the School of Nursing would bring them together to help realize the integrated, tripartite mission of discovery, teaching, and healing. UCI was continuing to expand its footprint with new clinical sites across Orange County and the construction of the UC Medical Center Irvine would bring world-class academic healthcare services to southern and coastal Orange County.

UCI Vice Chancellor Steve Goldstein observed that UCI Health Affairs was proud to say that it did not practice medicine but created it. Never had this been more apparent than during the last two years, when UCI providers, clinician scientists, full-time researchers, and students developed life-saving therapeutics, diagnostics, and community-supporting programs. UCI Health Affairs was using the cycle of discovery, teaching, and healing to create a diverse future healthcare workforce, to redress health inequities, and to improve wellness and the treatment of disease for individuals and communities.

UCI Health Affairs was building something novel—an alliance across health disciplines without traditional divisions. The discover-teach-heal mission yielded continuous quality improvement and placed the patient at the center of whole-person, team-based precision care. UCI Health Affairs included the Susan and Henry Samueli College of Health Sciences, the health delivery system or UCI Health, and the UCI centers and institutes of health. The deans and the Chief Executive Officer on Dr. Goldstein's cabinet had shared goals. UCI was using a unique opportunity to forge and build an alliance that was a model for the 21st century. Within its unusually collaborative milieu, UCI had brought to fruition the promise of the College by surrounding the School of Medicine with the School of Nursing, the School of Pharmacy and Pharmaceutical Sciences, and the Susan Samueli

Integrative Health Institute. UCI hoped that its program in public health would soon be transitioned into a school. This was an optimal structure for interprofessional education programs and to produce a future of team-based care. The College was also committed to fostering great careers for its diverse undergraduate student population in allied health disciplines. This interdisciplinary model was fully manifested in UCI's centers and institutes of health. The Chao Family Comprehensive Cancer Center and the Institute for Clinical and Translational Science both recently received maximal years of renewed funding from the National Institutes of Health (NIH), despite robust competition. California voters have allowed the California Institute for Regenerative Medicine to continue its support for the Sue and Bill Gross Stem Cell Research Center. The new Center for Clinical Research and the Digestive Health Institute were growing rapidly. The prior day, Chancellor Gillman had announced the launch of the Institute for Precision Health, bringing together existing UCI strengths so that patient-controlled data can optimize care for individuals and communities while lowering the cost of care and reducing health inequities. This collaborative approach was a competitive advantage in the marketplace of ideas and care.

UCI Health Affairs was succeeding because it was ensconced in the foundational excellence of UCI. The collaborative culture of UCI allowed full engagement of Health Affairs with the Schools of Information and Computer Sciences, Engineering, Law, Humanities, Social Ecology, Biological Sciences, Physical Sciences, Arts, Business, and UCI's commercial incubator, Beall Applied Innovation. Dr. Goldstein credited this drive for success to Chancellor Gillman, who urged the campus to innovate rather than imitate, and to extraordinary faculty, visionary donors, and the Southern California entrepreneurial spirit. An example of this dynamism in action was UCI's response to the COVID-19 pandemic. Whereas the classical response to an emerging disease was to have individual practitioners compare notes over time, with COVID-19, UCI computer scientists and clinicians came together with a machine-learning artificial intelligence approach to yield a COVID-19 vulnerability and navigation tool. Each patient taught UCI how to perform better for the next patient. The results were dramatic. UCI Health patients with COVID-19 were treated without hospital stays or were quickly discharged, making space for transfers from surrounding communities at times when other medical centers were completely overwhelmed. UCI was elaborating this approach, which it called "care for the 101st patient," enterprise-wide, and this was part of the new Institute for Precision Health, which would measure its success in better patient outcomes, reduction in health inequities, and lower costs.

UCI formulated its strategic priorities for Health Affairs by bringing together and consulting with the leaders of the schools, the health system, and the institutes and centers. These priorities were innovations in education and research, health equity, and precision health. These priorities or pillars did not supplant the strategic plans of the individual units; rather, they allowed units to work together, serving as a compass for focus and investments over the next five years. Working groups of faculty and leadership were now engaged in goal-setting and implementation. This focus could not have succeeded if faculty and administrators were isolated by academic discipline or separate from the healthcare system,

which served as a safety net and provider of advanced care for 3.5 million people in the Orange County community.

The College of Health Sciences had 2,800 students. Fifty-three percent of undergraduates were first-generation college students. Thirty percent of undergraduates, 24 percent of the graduate students, and 26 percent of professional students identified as underrepresented minorities. These statistics indicated progress in diversity. Twenty-three percent of the College's students were Hispanic, an 18 percent increase since 2017, but 11 percent below Orange County demographics and 16 percent below state demographics. The College's success in this trajectory was due to creative programs that engaged students, communities, and community leaders. UCI Health Affairs was a \$2.3 billion enterprise and rapidly growing. External research awards had increased by 63 percent over the last three years, nearing almost \$250 million.

Over the last year, philanthropic support had increased by almost 90 percent to \$87 million. Over the next five years, UCI Health Affairs would expand its facilities by over two million square feet in nine capital projects that had been approved by the Regents, including the new UCI Medical Center in Irvine. Dr. Goldstein briefly described some of the major new capital projects. The Falling Leaves Foundation Medical Innovation Building would be the first new basic and translational health research space on campus since 2003. This space was desperately needed, given the increase in federal funding. The proximity of the Health Sciences district to the new UCI Medical Center Irvine, only one mile away, would foster UCI's integrative approach to discovery, teaching, and healing.

UCI Health Chief Executive Officer Chad Lefteris reported that the UCI Medical Center Irvine project was proceeding on schedule and on budget. The first outpatient building, the Center for Advanced Care, was scheduled to open in 2023 as planned. He recalled that UC Irvine took over the county hospital in the City of Orange in 1976. With no county hospital, UCI was the safety net provider for nearly 3.5 million people. UCI was the only academic health system in Orange County. UCI Health had a long history of expanding access for the underserved, and, while it was investing in the new Irvine Medical Center, it was continuing to invest in the main Medical Center in Orange.

During the worst of the COVID-19 pandemic, UCI Health took time to reconsider its focus and take a long view. The UCI Health framework, which connected the entire organization, focused on three essential elements of improving health, increasing value, and transformation to advance healthcare delivery. In addition, UCI Health had over 40 strategic operating plans.

Despite the pandemic, UCI Health continued with key growth priorities over the last two years, bringing advanced care to Orange County and opening complex clinical programs not offered by any other provider in the community in areas such as cardiovascular and cancer care. In 2021, UCI opened a new inpatient unit, permanently expanding its acute care capacity in Orange by nearly 15 percent.

UCI Health has expanded outside the City of Orange. Last year, UCI added multi-specialty sites of care in Laguna Hills. UCI had two Federally Qualified Health Centers, which it wholly owned, operated, and staffed. Orange County was a competitive environment for healthcare delivery. While UCI had come late to growing its ambulatory care due to lack of capital, UCI had made significant strides in bringing its expertise closer to where Orange County residents live and work.

Mr. Lefteris presented a chart showing increases in outpatient visits, inpatient discharges, and operating revenue from fiscal year 2009 to fiscal year 2021. The challenge that UCI Health chose to embrace was caring for a high percentage of Medi-Cal patients while balancing the tertiary and quaternary care needs of the entire community. A concomitant challenge would be to generate sufficient capital.

The future of UCI Health was bright. In Orange County, UCI Health would continue to meet the demand of the growing community. Where appropriate, UCI was working with partners and choosing these partners carefully. One partner was DispatchHealth; through this partnership, since mid-November 2021, more than 600 UCI patients had been seen in their own homes. UCI's partnership with the Children's Health of Orange County (CHOC) had never been stronger. Together with its partners, UCI Health would transform health care for Orange County and improve the health of its communities.

Dr. Goldstein concluded the presentation by commenting that the kind of innovation in education and research that will produce a diverse future healthcare workforce has its demands. UC must find ways to support and promote faculty as a priority. Interdisciplinary education and team-based research that spans disciplines or creates pathways into allied health fields were less readily recognized in UC appointment and promotion criteria. UCI, as a safety net provider and the only academic health system in Orange County, faced financial challenges that its local competitors did not face. Capital projects to be presented at future meetings would address crucial space needs for UCI Health Affairs.

Regent Park referred to the percentages of underrepresented minority undergraduates, graduate students, and professional students in the College of Health Sciences and asked about this enrollment across the five entities in the College. Dr. Goldstein responded that the overall trajectory for these students was like that of Hispanic students. The School of Nursing was making sustained progress, and the enrollment percentage of underrepresented minority students there was in the high 20s and low 30s. He offered to provide more detailed information, and Regent Park requested this.

Regent Park noted that different entities within an institution can become isolated and separate. She asked how UCI was achieving better integration among its schools and programs. Dr. Goldstein responded that this was a work in progress and that changing the culture of an institution takes time. This work went both from the bottom up and the top down. A working group on interprofessional education was evaluating best practices. UCI was seeking to build new programs for interdisciplinary education. The new research building would be populated with interdisciplinary research and education programs. Chancellor Gillman observed that the College of Health Sciences was not in a situation of

being built out and then having to figure out how to remove divisions between different entities. When UCI undertook this process, it had some health sciences programs in a developmental stage, not fully built out. UCI took advantage of the College of Health Sciences structure to build within an interdisciplinary and integrated culture and recruited leadership who wanted to work in this culture.

Regent Park asked about the interactions between the schools of engineering and medicine, and what this might yield. Dr. Goldstein explained that surgeons might work with engineers on better devices, such as valves, for insertion in patients. Nurses might work with engineers on better ways to move patients, while pharmacists would be interested in new ways to deliver medication and primary care providers would be interested in ways to monitor patients at a distance in real time.

Regent Park commented that UCI should also strive for diversity in its engineering and computer science programs. She then referred to information included in the background materials about UCI research on schizophrenia which found that too much of a certain amino acid in utero can cause schizophrenia in mice and might do so in humans. She suggested that there be a report on this at a future meeting. Dr. Goldstein briefly underscored UCI's commitment to research and treatment in the field of mental health.

President Drake congratulated the campus on the impressive developments of UCI Health Affairs, including the increasing diversity in the College of Health Sciences. He hoped that the trajectory of diversity would continue. Dr. Goldstein responded that, until three years ago, when the School of Medicine launched the Leadership Education to Advance Diversity – African, Black and Caribbean (LEAD-ABC) program, there were one to two African American students in each class. In the three years since this program began, there have been 12, 12, and 13 African American students in the classes of 114 students. This was following a history of having from zero to one or two African American students in any one year.

Regent Leib asked about UCI Health's competitors in Orange County and about UCI's competitive advantage. Mr. Lefteris responded that UCI was surrounded by outstanding healthcare providers but was the only academic medical center. With that status comes the opportunity to offer services that no other institution can.

Committee Chair Pérez asked if UCI Health was top rated in Orange County. Mr. Lefteris responded that this was the case in some rankings. UCI differentiated itself by offering programs and depth of clinical services that other outstanding health systems could not provide. This was accomplished through strategic recruitments in the faculty practice.

Committee Chair Pérez observed that UCI's positive outcomes were based on a much more heterogeneous patient population than that of other top providers in Orange County. UCI patients reflected the economic diversity of the county and a broader cross-section of the population. UCI was achieving positive outcomes regardless of a patient's economic circumstances and complicating health factors. Dr. Goldstein added that UCI Health was designated as the lead provider in the region for certain services—the only National Cancer

Institute–designated comprehensive cancer center in Orange County and the regional Burn Center.

Regent Leib referred to a map that had been shown with UCI Health locations. There appeared to be some gaps in Orange County, and he asked about expansion to those areas. Mr. Lefteris responded that UCI had been regularly opening new sites, and this would continue. UCI had plans to move elsewhere in the county and was being strategic about locations.

Regent-designate Blas Pedral asked if any philanthropic funds would be used for student scholarships, paid internships, or other similar opportunities. Dr. Goldstein responded in the affirmative. Many gifts would be endowments that could be applied to scholarships, while others would be directly focused on scholarships.

Regent-designate Blas Pedral asked if there were discussions about use of the Medical College Admission Test (MCAT) in admissions, given the Regents' action to cease using the SAT for undergraduate admissions. Dr. Goldstein responded that the MCAT was being evaluated. Executive Vice President Byington added that there was discussion about whether UC would continue to use the MCAT. Some other standardized tests used by the medical schools had moved to a pass-fail basis. This was still under discussion.

Regent-designate Blas Pedral asked about the enrollment of underrepresented minorities in graduate programs in the College of Health Sciences, broken down by school or study area. Dr. Goldstein responded that he would provide this information. Committee Chair Pérez asked that these figures be provided to the Secretary and Chief of Staff for other Committee members as well.

Advisory member Ramamoorthy stated that, among the many exciting strategic priorities of UCI Health Affairs, one should be to ensure that UCI is a great place to work. Ideas about improving the situation and environment for healthcare workers should be built into the plan. Dr. Goldstein expressed pride in how Mr. Lefteris had managed and supported the UCI healthcare workforce. Mr. Lefteris added that UCI had a set of strategies for recruitment and retention of healthcare workers. This was an ongoing effort.

5. ANNUAL REPORT ON STUDENT HEALTH AND COUNSELING CENTERS AND THE UC STUDENT HEALTH INSURANCE PLAN

[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.]

Chief Medical Officer Brad Buchman began the presentation with COVID-19 vaccination data for UC students in UC's electronic health records. The high vaccination rates in fall 2021 as the campuses reopened were a remarkable achievement and resulted from the work of the administration in drafting a policy and the work of the student health centers in ensuring that students were vaccinated.

Dr. Buchman then commented on the volume of COVID-19 cases treated by student health services centers from March 2020 to December 2021. The centers diagnosed a high number of cases and managed an exceedingly high number of quarantine and isolation cases; these latter were not simple to manage and often required work in the evening and on weekends. UC student health centers administered more than 56,000 vaccine doses. At six campuses, the student health centers were also responsible for employee testing, and at five campuses, the student health centers were responsible for campus employee vaccination records. Four of the UC campus student health center directors provided oversight of the campus COVID-19 laboratory.

A survey of student satisfaction with telehealth indicated high levels of satisfaction for student health services in terms of ease of use, overall experience, and likelihood of repeat use and recommending this service to other students. Counseling and psychological services via telehealth also reported high levels of satisfaction with regard to effectiveness and overall experience, and even higher levels with regard to individual therapist, cultural sensitivity, and likelihood of recommending this service to other students. All the student health and counseling centers were continuing to provide telehealth services, and this would continue into the foreseeable future.

Senate Bill (SB) 24 makes it an obligation to offer medication abortion at student health centers; the implementation deadline for UC was the end of this year. Implementation of this service was delayed due to COVID-19. UC Berkeley, UCSF, and UC Irvine have already started offering this service, and 16 medication abortion services have been provided to date. UC Santa Cruz and UC Santa Barbara were about to launch this service. UC has received \$2.2 million in grant funding for readiness expenses, and the campuses had so far requested reimbursement of about \$434,000. UC was working with the California Commission on the Status of Women and Girls and with Essential Access Health on this implementation.

The UC Student Health Insurance Plan (UC SHIP) lost some enrollment in fall 2020 but recovered in fall 2021. The anticipated initial pooled renewal for Plan Year 2022–23 was 1.9 percent. Each campus' specific renewal was subject to the pooled renewal being adjusted, based on that campus' performance relative to the pool and changes in plan design. UC SHIP reserve funds included about \$20 million in the UC Total Return Investment Pool, which had earned slightly over \$1 million in interest over the past several years. Reserve fund expenditures included a non-medical transportation pilot program to help students get to routine appointments and startup funding for the Virtual Care Collaborative. A campus medical care assistance fund had been distributed to the campuses based on UC SHIP enrollment. Campuses can use this fund when students need some assistance in meeting their co-pays or deductibles. The prior year, there was a plan year buy-down of the renewal of \$6.4 million. The pooled renewal was 3.6 percent, but UC was able to buy this down to about 1.6 percent. Students on the UC SHIP executive oversight board decided on this action.

The University had fared well due to high vaccination rates in the fall, the campuses' case management work, and non-pharmaceutical interventions. Burnout was a major issue for

employees in student health and counseling. Much work had been done at the student health and counseling centers to keep the campuses open, and employees were often working on nights and weekends without a relief shift. There had been a large COVID-19 surge when campuses opened shortly after New Year's Day. All the campuses deferred in-person instruction for a few weeks. Booster shot compliance was a critical priority. As of the prior week, at five or six campuses, the average compliance rate for booster shot-eligible students was 84 percent. Dr. Buchman expressed appreciation for the high level of cooperation received from the medical centers on those campuses with medical centers but stressed that, without the student health and counseling centers, it would be difficult for UC campuses to open, remain open, and to keep students safe.

Director of Student Mental Health and Well-Being Genie Kim reviewed spring 2021 data from UC's administration of the American College Health Association national health assessment. Students reported moderate to high well-being, moderate resilience, that their overall health was good, and that their sense of belonging was moderately high. When surveyed about psychological, academic, and career distress, students reported moderate to severe distress in all these areas. In particular, 55 percent of respondents reported academic distress affecting their mental health. These preliminary data suggested that the COVID-19 pandemic has had some impact on UC students' mental health and well-being, but students' resilience remained high, which was promising.

The spring 2021 survey also considered five major impediments to academic success: stress, anxiety, depression, sleep difficulties, and headache/migraines. The survey had an approximately ten percent response rate, or about 10,000 students across all campuses. Trans/gender-nonconforming students reported higher rates for these complaints. It was important to understand that many students in underrepresented or marginalized groups experienced mental health challenges differently than the general student population.

Ms. Kim briefly outlined systemwide strategies for equity in mental health and expanded campus services. The State Budget Act of 2021 provided UC with \$15 million in ongoing student mental health funding. This represented an opportunity for UC to enhance and develop behavioral health services, support, and programs across the continuum of care: prevention, early intervention, holistic treatment, and recovery support. The campuses were tasked with developing equity-focused spending plans and strategic plans to address equity gaps for the most marginalized students, such as liaisons and support for LGBTQ+, Black, Indigenous and People of Color (BIPOC), and students with disabilities. These efforts would align with recent national and state reports and analyses on mental health. UC was advancing student mental health in a holistic manner. Ms. Kim noted that there was no single, "one size fits all" approach to support student mental health. The University must ensure that it is providing choice and options for students to engage in self-care and management of mental health conditions and challenges.

UCLA Director of Counseling and Psychological Services Nicole Green recalled that one should expect an "echo pandemic" of mental health as a result of the COVID-19 pandemic. She described services provided by UC's counseling centers. In addition to the individual care model, the centers offer walk-in, triage, and urgent care. The centers have developed

strategies to see and assess the most urgent cases as quickly as possible. Most centers offer group therapy as well, and there are self-help platforms on all center websites. All the counseling centers provide education and outreach training, working with faculty, staff, and students on suicide prevention other issues. The centers strive to bring students in when there might be stigma or barriers to access. A 24-hour crisis telephone line is available to all students. The continuum of care model at the counseling centers spans prevention to short-term care; the centers also try to help students with recovery in other campus spaces, because the centers do not have the capacity for all students during the entire course of their illness. As mentioned earlier, the counseling centers have consistently high satisfaction ratings. They also have consistent treatment success in reducing symptomatology. All the centers use the Counseling Center Assessment of Psychological Symptoms, a national assessment tool for distress.

The University's counseling centers are much used by students. On average, the centers see about 12.6 percent of UC students, while centers at other U.S. colleges and universities see about eight percent of their student populations.

In considering the staffing for its counseling centers, the University has referred to a 1:1,000 ratio recommendation by the International Accreditation of Counseling Services (IACS). The standard of having one clinician for every 1,000 students was based on the idea that about ten percent of students would come to the counseling center. UC counseling centers exceed this estimate of demand. Even if the counseling centers were fully staffed, UC would still have a problem with demand, because the centers see more than ten percent of students. UC had hired 70 full time equivalent counseling staff systemwide as of 2018. Staffing levels had remained the same since that time due to funding issues and hiring challenges. There were challenges with available space, providing competitive salaries, the unionization process, and attracting diverse applicants. There were retention challenges due to COVID-19, which made it difficult to manage burnout and retain staff.

The University was still trying to achieve the 1:1,000 ratio, which was meant to increase access to services. However, there was also the challenge of acuity, with needs other than just short-term care. An alternative standard for counseling centers, the Capacity and Clinical Load Index (CLI), might provide a better understanding of how many clients a clinician can see and the extent of services that can be provided, given a more sensitive understanding of demand. In 2018–19, there were about 183 clients per one clinician at UC. Staffing at this level would allow for the CLI maximum efficiency or red category with assessing and referrals, but little treatment. In 2019–20, the number of clients per clinicians was slightly lower. Staffing at this level, within the CLI yellow category, would allow for a focus on triage, demand management, and short-term care. Even with the 1:1,000 ratio, the University would not achieve the CLI green category, allowing for full-length assessments and weekly treatment, because demand was so high. To reach this green category, there would have to be only 73 students on each clinician's case load. The challenge for the counseling centers was how to operate in a way that provides as much care as possible to the most people but also provides sufficiently good clinical care and appropriate treatment.

The counseling centers have also been considering issues of equity. There were clear data about mental health disparities among certain communities. The centers have been working to serve underrepresented and minority students and international students, trying to increase and tailor services by increasing the diversity of counseling center staff, but also engaging in prevention, outreach, education, and drop-in services, all ways to get people more accustomed to addressing their mental health care and to allow for earlier treatment and prevention of worse outcomes.

There was great demand for counseling center services. Stigma was falling. Students were ready for a continuum of care model, and the availability of both telehealth and in-person visits was effective. The counseling centers were working with campus partners, including identity centers, to promote student well-being and were advocating for investment in a robust model and infrastructure. The centers were considering how to improve the electronic medical records system, find creative funding opportunities, and advocating for a systemwide recruitment strategy for diverse talent.

Committee Chair Pérez referred to information shown on a slide including the numbers of COVID-19-positive cases on each campus. When one accounted for the different size of the student population at UC San Diego and UC Riverside, these figures suggested a much higher infection rate at UCSD than at UCR. He asked what might account for this, such as the percentage of students living on campus or different testing protocols, and assumed that the infection rate at UCSD was not in fact very much higher than at UCR. Dr. Buchman responded that he agreed with this assumption. The transmission rate varied in different counties and varied over time. The information on the chart reflected a two-year period. From his own experience on the San Diego campus, he affirmed that UCSD had made aggressive efforts in public health messaging and testing. There were probably multiple factors that accounted for the difference between UCSD and UCR, but Dr. Buchman did not have the underlying data to explain the difference.

Committee Chair Pérez referred to SB 24 and the campuses' request for reimbursement of \$434,000 from a \$2.2 million fund. He asked if the \$2.2 million would be sufficient and if this expenditure would be logical if UC did not receive outside funding. There had been only 16 instances of distribution of medications. Dr. Buchman responded that this amount would not be enough for all the campuses. UC Health had done work to develop necessary infrastructure. Campuses were evaluating their needs; some had purchased equipment and supplies, and some had made investments in training. The COVID-19 pandemic had delayed a uniform implementation. He anticipated that UC would need more funds and was surprised that the reimbursement requests from the campuses for readiness expenses had not in fact been greater.

Committee Chair Pérez requested more detailed information on the \$434,000 expenditure and the cost of complete deployment. He raised the question of whether these expenditures would be commensurate with utilization in future years, and if there was a higher and better use of these funds to serve this population. The proposed use might be optimal, but he wished to ensure this.

In response to another question by Committee Chair Pérez, Dr. Buchman stated that about 45 percent of UC students were enrolled in UC SHIP.

Committee Chair Pérez referred to the anticipated initial pooled renewal for plan year 2022–23 of 1.9 percent, compared to 9.1 percent in plan year 2019–20, and asked what accounted for the 9.1 percent. Dr. Buchman responded that a number of factors were involved. At least one campus made a big shift, moving capitated or pre-funded services to UC SHIP and started billing UC SHIP. This had been invisible to UC SHIP previously. The other most likely contributor was the fact that even a small number of high-cost claims cases can drive alterations in renewals, primarily for the reason that, because the population is characterized as a young and healthy population, there was not much margin built into the renewals. Medical trend rates had been going down to ten percent for medical costs and 15 percent for pharmacy costs. UC Health was now reducing these to seven and nine percent, respectively.

Committee Chair Pérez stated his understanding that renewal meant change in the number of covered lives. Dr. Buchman explained that this referred to renewal in the premium for next year. Having low, single-digit renewals was excellent for an insurance plan considered in the context of commercial plans. UC SHIP has fared well. It has a young and healthy population, but because of this its margins were very narrow, and outlier cases can upset this easily. Committee Chair Pérez asked that this point be made clear in the final report. Dr. Buchman responded that this would be done.

Committee Chair Pérez referred to a chart shown in statistics for five major impediments to academic success and how these were reported by students in general and by trans/gender-nonconforming students. He drew attention to figures showing, as one example, higher rates of anxiety for trans/gender-nonconforming students; this was an indication of where UC needed to focus efforts.

Committee Chair Pérez requested clarification of the BIPOC designation and asked if he would belong in this category. When discussing students' sense of belonging and campus services, the terms one uses are important. Many people might not understand the term BIPOC and not know whether they were included. He expressed appreciation for the University's intention to be inclusive, but sometimes UC was inconsistent in its use of terms. Students must understand if they are included and UC must communicate in a way that invites students to avail themselves of services.

Committee Chair Pérez asked about UC's ability to capture certain funds and bill for mental health services and the ability to receive payment for services provided to students not enrolled in UC SHIP. Dr. Buchman responded that the student health centers were billing only UC SHIP but were examining the possibility to expand to outside payers. Students who do not have UC SHIP coverage are billed the same amount for services and have to seek reimbursement from their own insurance program. Four campuses were billing for counseling visits, one campus was billing for counseling and psychiatry, and one campus was billing just for psychiatry visits. UC had made progress in this regard. A

current challenge was trying to find a way to developing further billing capacity at the student health and counseling centers and securing resources for this.

Committee Chair Pérez expressed concern that UC was absolving external insurance payers of their responsibility to pay for services UC was providing.

President Drake referred to the approximately 50 percent higher rate of UC students' use of counseling services compared to the national average. He pondered whether UC students were 50 percent more distressed than the national average or whether they were that much happier and better off now because of this greater utilization. If UC faced the same level of challenge as other institutions but provided 50 percent more service, one would expect better outcomes, and these might be measurable. There were different ratios of counselors to students on different campuses, and President Drake asked if student satisfaction levels or student wellness, as shown in surveys, correlated with the different services provided. There was a general consensus that more services are better than fewer, and he asked if there were outcomes that show this. President Drake expressed approbation for the variety of services offered at the counseling centers, including individual and group therapy. UC did not have enough counselors or psychiatrists to allow for individual visits for every student. President Drake asked about the outcomes of the different services provided and the different methods of addressing student needs, such as telemedicine versus in-person visits, individual and group therapy, or using an application program on a mobile device rather than an in-person visit. The University must understand which of these approaches is effective in order to improve outcomes. From his own experience on UC campuses, President Drake observed that, the more the campus invested in people and services, the more students made use of them. He wanted the University to think differently and consider different perspectives in order to improve the wellness of UC students.

Regent Leib referred to the American College Health Association assessment that had been administered at UC. He asked about the baseline for this assessment and if the same questions had been asked in prior years, which would allow for comparison. Ms. Kim responded that many of the survey questions in this assessment were changed in 2021. This was a new baseline which would serve as a basis for comparison in the coming years.

Regent Leib observed that students' perception of how long it takes to get a counseling appointment might sometimes be incorrect, and that wait times were in fact shorter than students believed. He asked how the campuses could overcome this perception. Ms. Green responded that this would depend on how the campuses advertise their services, training for faculty and staff, and communication through social media. This was the reason for spending time on prevention, education, and outreach. The reality was that some students would have to wait, but students with distress or suicidal feelings should come in. Ms. Green acknowledged that there were sometimes long waits for students, but she did not believe that other systems were moving faster; mental health services in the U.S. were in crisis at this time.

Regent Leib asked how many open full time equivalent positions there were now at UC student counseling centers. Ms. Green responded that UCLA was finally staffed up and

had added positions for the first time in her eight years as Director. UCLA currently had seven open positions.

Regent Leib asked if UCLA was now adequately staffed or was still lacking seven positions it wished to fill. Ms. Green referred to the recommended ratio of 1:1,000 which took into account individual clinicians but did not include triage clinicians, prevention educators, and psychiatrists. She had hired a number of employees just for triage and coordination, but UCLA had only 38 therapists for 45,000 students. Dr. Buchman added that he could provide specific data for the UC system. He would survey the campuses and compile a list of open counseling positions.

Regent Leib observed that, in the past, the problem in this area was funding; the problem now was not funding but the workforce. This year, the State had substantial interest in and funding available for mental health programs. The University should prioritize this matter in the May Revision and the State budget process in order to obtain the funding it needs for the counseling services that are needed.

Student observer Steven Gong praised the work of the UC student health and counseling centers in responding to the demands of COVID-19 and the work of all UC employees which had enabled students to come back to campus. He noted that there were disparities among the campuses in the availability of COVID-19 tests. The pandemic had been challenging for students beyond physical health, and the background material for this discussion indicated that 81 percent of students reported moderate to severe psychological distress. There was still much work to be done to improve student mental health. Mr. Gong was glad that the University recognized the “echo pandemic” of mental health, which should not be understated or ignored. Data showed that student mental health had not improved upon students’ return to campus. UC could be a national and global leader in student mental health services. He looked forward to working with the Committee to find ways to expand student health services and their quality, especially with respect to cultural competency and racial and gender equity. Data presented today had shown differences in outcomes for the general student population and transgender students. UC could always do more to achieve health equity.

Regent Reilly referred to the 50 percent higher use rate for counseling services at UC compared to other colleges and universities. She asked why the utilization rate was so high on UC campuses. Ms. Green responded that the University had invested much in mental health education on the campuses and provided robust training for faculty and staff. She did not believe that there was necessarily more distress at UC, but there was greater access to mental health services and more conversation about this. Students’ knowledge of mental health issues was greater, and this increased demand.

Regent Reilly asked how the 24-hour crisis line functions, and what services a student might receive if he or she called at 2:00 a.m. Ms. Green responded that the University contracted with ProtoCall, a company that provides counselors via telephone to a number of different colleges and universities across the U.S. ProtoCall clinicians are on the line after UC clinicians have gone home and will walk students through a crisis, like UC

clinicians. If additional support is needed, UC clinicians are on call, on rotation, and can be contacted. In a crisis, other intervention can be put into action, but, in general, crises are resolved by the crisis clinician on the telephone at that time.

Regent Reilly noted that artificial intelligence can evaluate the severity of anxiety and depression in an individual. She asked if UC was using this technology, which might help identify those in crisis. Ms. Green responded that not all campuses had this technology available at this time.

Regent Reilly asked if any campuses were using this technology. Ms. Green responded that UCLA's Depression Grand Challenge would undertake a survey this spring that would assess distress, anxiety, and depression, provide feedback about severity, and inform students about what they can do. This was a campus-specific project. Some campuses were using online self-help tools such as Therapy Assistance Online. There was not a consistent approach across the UC system.

Regent Reilly commented that the advances being made in artificial intelligence were remarkable, and that it was important to be able to identify a person in crisis in real time, since this could be a matter of life or death. Chancellor Block noted that the UCLA Grand Challenge was working with Apple to be able to use iPhones and other devices in this effort. This was still in an experimental stage, but might be helpful in screening anxiety and depression.

Regent Park suggested that the UC SHIP reserve funding might support a pilot project to developing further billing capacity at the student health and counseling centers. She encouraged the University to keep increases in the UC SHIP premium as low as possible. Buying down at a lower rate in one year might lead to an increase in the subsequent year.

Regent Park remarked that there are a number of subgroups within the BIPOC category. With respect to utilization data, it would be good to know that all subgroups are doing well, since the utilization rates might not be the same for different subgroups.

The University appeared to be moving away from using the IACS recommended ratio as a benchmark and toward using the CLI. It would be desirable to have a good understanding of this move and to track how IACS compared to CLI over time. It was Regent Park's understanding that all the campuses were striving to meet the IACS ratio. It was important for the Committee to be able to track this, whether UC was using the IACS measure or a better criterion.

With respect to workforce, the Committee should have a better understanding of how enrollment in the various schools needed to increase, and what the University can do to better provide resources for these increases. In her view, this was a joint responsibility of the Academic and Student Affairs Committee and this Committee. It would be desirable to have a clearer picture of enrollment and in which schools enrollments were static or increasing at a slow rate. The Regents and UC needed to be mindful of this, especially in the mental health field.

Regent Park referred to anxiety and depression related to academic performance and raised the question of how faculty can help with student wellness. This could be a subject of discussion at a future meeting.

Regent Park asked the administration to tell the Regents how they can be helpful in seeking County and other funding for additional hiring at student counseling centers.

The meeting adjourned at 2:35 p.m.

Attest:

Secretary and Chief of Staff