The Regents of the University of California

HEALTH SERVICES COMMITTEE
February 14, 2024

The Health Services Committee met on the above date at the Luskin Conference Center, Los Angeles campus and by teleconference at 455 Golden Gate Avenue, San Francisco, 1130 K Street, Sacramento, and 2777 South Kihei Road, Kihei, Hawaii.

Members present: Regents Guber, Makarechian, Park, Pérez, Reilly, Sherman, and Sures; Ex officio members Drake and Leib; Executive Vice President Rubin; Chancellors Gillman, Hawgood, and Khosla; Advisory member Ramamoorthy

In attendance: Regents Batchlor, Ellis, Kounalakis, and Tesfai, Regent-designate Beharry, Faculty Representatives Cheung and Steintrager, Staff Advisor Emiru, Secretary and Chief of Staff Lyall, General Counsel Robinson, and Recording Secretary Johns

The meeting convened at 10:00 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 13, 2023 were approved, Regents Guber, Leib, Makarechian, Park, Pérez, Reilly, 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. Omar Al expressed dismay at the destruction of institutions and hospitals in Gaza. He stated that U.S. weapons, funded in part by the University, had enabled the genocide of 30,000 Palestinians, including 340 healthcare workers. He urged the University to end its complicity in illegal occupation and genocide directed against Palestinians rather than pursuing criminal charges against 13 students who had engaged in a peaceful sit-in the past month. He called on the University to drop the charges, divest from war, and invest in students. He hoped to see an agenda item for divestment from Israeli apartheid at the March Regents meeting.

    B. Julianne Lempert, a member of IGNITE at UCLA, a reproductive advocacy group, expressed concerns about Campus Assault Resources and Education (CARE).

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

CARE employees had reported that their offices are located together with case management services, so that assault survivors do not want to come to the office because perpetrators are often in the same room. Ms. Lempert requested that UC provide funding for separate offices and more space and resources to ensure privacy and confidentiality for students seeking services and for CARE employees.

C. Jing S., a member of UC Alumni for Palestine, urged the Regents to divest from war and the genocide currently occurring in Palestine. She asked the Regents to drop charges against 13 peaceful student protesters. These were unprecedented times, and UC Alumni for Palestine were asking UC to divest from hurting people's lives. The number of lives lost in Gaza was at 30,000 and growing. Students and alumni were following events closely and actions by the Regents, such as whether they would listen to the call for peace, were very much being watched.

D. Delia Falliers, a member of IGNITE at UCLA, requested increased funding for CARE offices. A 2020 needs assessment revealed that CARE offices were underfunded and understaffed, and that 50 percent of CARE staff had a tenure of 2.5 years or less. While UC has expressed the wish to be a national leader in preventing and combating sexual violence and sexual assault, this would not be accomplished if offices working with survivors every day were not being fairly resourced; this put students in danger.

E. Vincent Rasso, speaking on behalf of the California Undocumented Higher Education Coalition, voiced concern about recent challenges with the Free Application for Federal Student Aid (FAFSA), which were disproportionately affecting undocumented and mixed-status households and students. UC campuses were communicating various deadlines, and this was causing confusion and inconsistency for those students considering different UC campuses. He asked the Regents to direct the campuses to set April 2 as the priority financial aid application deadline for both FAFSA and the California DREAM Act application (CADAA).

F. Angelica Interiano, UCLA student, spoke on behalf of the UC Divest Coalition and in solidarity with unions and workers. Workers at the Fairfield and Aloft Los Angeles Airport hotels have been exploited. The hotels were owned by Blackstone, a company that had been identified as one of the leading causes of the global housing crisis by United Nations officials, and in which UC invested approximately $7 billion. Ms. Interiano recalled that it had taken the Regents more than a decade to divest from companies perpetuating the South African apartheid regime. She excoriated the Regents' investments for perpetuating ongoing genocide and colonization in Palestine, the military occupation of the Philippines, and for harming working class people, especially Black and Brown people, here on Turtle Island and abroad.

G. Michael Cole, UC San Diego professor emeritus in the fields of communication, psychology, and developmental sciences, referred to plans for the expansion of online courses to encompass students' entire educational careers at UC. In the early

1980s he successfully instituted online discussion sections of an introductory course to fulfill campus writing requirements as a means of inducing students to develop their writing skills as part and parcel of their ability to master the content of the course. Professor Cole conducted campus-to-campus courses, using the capacity of the internet to create multimodal hybrid classes to enrich the offerings of his UC colleagues.

H. Annette Becerra, employee at the UCLA Health patient access call center and member of Teamsters Local 2010, stated that she was happy to be able to help patients every day through her work. Unfortunately, numbers have become more important to management of the call center, and they were imposing impossible targets for employees, which takes away from patient care. This included penalizing employees who go to breaks and lunch late due to helping a patient. Employees were being threatened with write-ups and potential termination if they did not meet these impossible metrics, were suffering from stress, and were being put on leave for voicing their concerns about how these metrics were affecting patient care negatively.

I. Aditi Hariharan, UC Davis student and member of the UC Student Association, urged the Regents to mandate a systemwide baseline standard for collegiate recovery programs, to be professionally staffed by at least one full-time coordinator. Not all the campuses had collegiate recovery programs, and there were wide variations in the resources provided at campuses with programs. Many students can benefit from these programs as they navigate recovery from substance abuse, eating disorders, and other addictions or conditions.

J. Kyle Johnson, a fourth-year transfer student at UC Davis, advocated for establishment of a systemwide baseline standard for collegiate recovery programs at UC with professional staffing. Collegiate recovery programs serve as a support network or a continuum of care for students struggling with substance abuse. Recovery is different for each individual, and, for this reason, collegiate recovery programs with full-time staff are critical. Mr. Johnson thanked the UC Davis administration for moving toward hiring a full-time collegiate recovery program coordinator and urged the Regents to make this reality across the UC campuses.

K. Elena Salazar identified herself as a concerned UC Berkeley parent. She related that, on February 9 at 8:40 p.m., a man began opening fire with a semiautomatic handgun on the UC Berkeley campus. Nine shots were fired in the middle of Sproul Plaza. Many students were in or near this in part of campus, all unaware that an active shooting was in progress. The warning emergency notification system failed. UC police courageously did their job, ran into the line of fire, and apprehended the individual. Students began hearing about the shooting from other students via social and other media, but there was no warning from the University for 30 minutes. Terrified students barricaded themselves in campus buildings and dormitories, while others were still walking in the area of the shooting. Ms. Salazar stressed that

this demonstrated an egregious flaw in UC Berkeley's warning system and called on the Regents to oversee the restructuring of the warning system.

L.   Jocabed Torres, representative of Survivors of the Abortion Holocaust and a former UC Berkeley student, expressed opposition to fetal tissue research at UCSF. While UCSF has stated its commitment to address discrimination, biases, and hate, it was engaging in discrimination against a whole class of people, the pre-born. Ms. Torres alleged that UCSF was involved in human organ harvesting and trafficking and entreated the Regents to stop this practice.

M.   Eliza Aiken, UCLA student, thanked the Regents for their work so far in tackling antisemitism at UC. She expressed support for a policy regulating statements that are posted on UC department websites and asked that UC make it possible for deans to hold students accountable for antisemitism. Campus groups which violate time, place, and manner restrictions on expression should not be able to access University funding. Ms. Aiken requested that training and education about antisemitism be added to UC diversity, equity, and inclusion training programs.

N.   Brad Paden, UC Santa Barbara professor emeritus of engineering, alleged that criminal acts had been committed within the UCSB administration. Professor Susannah Scott, Chair of the UCSB Division of the Academic Senate, collected over a hundred faculty signatures in an effort to deter three administrators from falling into an ethical abyss into which they arrogantly jumped anyway. This abyss was an alleged felony extortion or attempted extortion of a $100,000 personal consulting contract from a staff member who was acting within policy. Five UCSB administrators might have criminal liability, and Professor Paden asked that the Regents investigate this matter.

O.   Jason Vazquez, representative of the Southern California College Attainment Network, shared that his organization was leading an effort by over 50 organizations to request that UC and the California State University implement solutions to mitigate barriers that have resulted from the transition to a new FAFSA, especially for students from mixed-status families. There was no immediate solution in sight and limited guidance. The situation called for cooperation and compromise to maintain the state's progress on college access. Mr. Vazquez and his coalition recommended that UC temporarily accept the CADAA in lieu of the FAFSA for students excluded from submitting a FAFSA, extend the student intent to register deadline to June 15, ensure consistent communication about the April 2 deadline, and accept the streamlined California DREAM Act Assembly Bill 540 affidavit.

P.   Ananya Visweswaran, UCLA student, expressed dismay about the arrest of 13 UC students at the January Regents meeting. She adjured the Regents to listen to student voices and to provide funding to support survivors of sexual assault on campus and to pay campus workers appropriately. The Regents should not invest in weapons manufacturing but in the community that they were supposed to

represent. Ms. Visweswaran raised the question of whether UC was an educational institution or a business.

Q.   Tai-Ge Min, UCLA student, explained that it had become challenging as a resident assistant to direct first-year students toward campus resources and student support and criticized the University for not allowing undocumented students to work on campus, for not paying student and unionized workers enough, and for not ensuring a safe environment on campus for Muslim, Arab, and Palestinian students. The University should bargain in good faith with the American Federation of State, County and Municipal Employees (AFSCME), drop charges against the students arrested at the January meeting, and divest from BlackRock and Blackstone and reinvest this money in students and workers.

R.   Ashley Emmert, UCLA student, stated that demand for UC divestment from what she described as the genocidal Zionist project would only increase. Students, workers, and all oppressed people would be ever more consistent in their fight to prevent tuition money and campus labor from being exploited and funneled into genocide and to instead ensure that they are reinvested into care of the community. In her view, the Regents did not care about the challenges and struggles of students and workers. The oppressed masses would arise and compel the University to stop funding genocide.

S.   Rebeca Duran, recent undergraduate and current graduate student at UC Irvine, addressed item B1, *Consideration of Senate Regulation 630.E*, concerning a systemwide "campus experience" requirement to earn an undergraduate degree, to be discussed later that day by the full Board. She noted that she understood the importance of in-person instruction but urged the Regents instead to create a requirement for internships or networking, as this would do more to further students' careers. Ms. Duran reflected that, while her undergraduate classes in person were an excellent experience, she would not have achieved her current goals without networking and internships.

T.   Ashley Avantes, employee at the UCLA Health patient access call center and member of Teamsters Local 2010, reported that new rules and excessive work performance targets were causing stress and anxiety for employees. Workers in this unit were afraid of taking breaks or walking away from their desks. There were no data showing that these performance metrics were achievable, and employees were being treated like robots. UCLA should provide better resources for this unit, such as noise cancelling headphones and standing desks, and more support from supervisors.

U.   Stephany Cartney, UCLA student, drew attention to the situation of approximately 100,000 undocumented students trying to complete the FAFSA and CADAA, as reported by the Campaign for College Opportunity. She called on the Regents to accept the CADAA for U.S. citizens with mixed household status in place of the FAFSA and to work diligently to ensure that students receive all financial aid for

which they are eligible. While UC had extended its FAFSA deadline to April 2, some campuses continued to publicize the date as March 2, causing confusion and inconsistency. Ms. Cartney asked the Regents to remember the faces behind these stories. As a student and as an immigrant, she understood the importance of swift and decisive action. She asked the University to work together with students to remove these barriers.

3.   **REVIEWING DRAFT OF THE UC HEALTH STRATEGIC FRAMEWORK, OFFICE OF THE PRESIDENT**

[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 Rubin began the discussion by remarking that this revised strategic framework for UC Health was the result of many interviews at the campuses, with Regents, and with leaders both within and outside the University of California. He presented a slide which listed forces which were reshaping the UC Health strategy and drew attention to three forces in particular that were reshaping the University's role in a fragmented market: UC Health understood its growing role as a safety net provider; UC Health recognized increasing access challenges; and UC Health was experiencing unique challenges to its training programs as students from many programs, some from outside the state or online, were competing for training opportunities, particularly in the Central Valley and in the Riverside area.

In his discussions with stakeholders, Dr. Rubin tried to arrive at a vision for UC Health that would join everyone together, and this vision was in alignment with strategic plan priorities that had been enunciated in May 2023. UC Health would play a guiding role in protecting and improving the health of all people in California and serve as a model for the nation and the world. UC Health should elevate its tripartite mission in these discussions. First, UC would continue to provide high-quality care that is affordable, convenient, and navigable for employees, students, and residents of California who were increasingly being left behind in the healthcare market. Second, UC had vibrant educational programs that would train a diverse, interdisciplinary workforce to address workforce shortages and improve health outcomes. Third, UC should recognize the particular value of its translational and comparative research programs that were developing the interventions, technologies, and solutions that would transform care and benefit all communities.

The unique advantage of the UC Health division at the Office of the President (UCOP), compared to the UC Health campuses, was its influence, due to its ability to work with and bring together many different stakeholders from UC, the State, and California communities, and its work was often in the intersection between all the stakeholder groups.

The revised draft strategic framework would be based on five pillars. The first was to drive investments to improve access, quality, clinical integration, and patient experience. The second was to expand the interdisciplinary workforce. The third was to advance healthy communities through key partnerships, and UC Health's focus on its public health role had

only grown since the COVID-19 pandemic. The fourth was to accelerate translational and comparative research programs and innovation. The fifth pillar was to facilitate systemwide initiatives that would help UC Health to achieve fiscal resilience.

To address the first pillar of improving access, quality, clinical integration, and patient experience, UC Health would support network expansion across UC campus regions not only in current health center locations, but in Riverside, Merced/Fresno, and Santa Cruz. UC Health would strengthen networks to improve access for Medicaid-enrolled patients, behavioral health networks, and the capability of student health services. UC Health would position itself to improve the health of UC students, employees, and retirees. The University had recently completed negotiations with Anthem Blue Cross and was developing a request for proposals for its preferred provider organization (PPO) health plans. UCOP was reviewing UC health plans, and UC Health would be involved in this process and would work to provide more convenient, affordable care that would attract UC students and employees. UC Health would optimize quality, clinical integration, and patient experience by driving systemwide improvements through quality goals that focus on safety, access, and patient experience. UC would leverage data from the Center for Data-driven Insights and Innovation in primary and specialty care settings. Dr. Rubin noted that, because he was not a participant in the Clinical Enterprise Management Recognition Plan (CEMRP), this allowed him to join the CEMRP administrative oversight committee and to help define transformative, longer-term goals. UC Health's systemwide goals were in the areas of network access, patient experience, clinician experience, safety and quality, and operational efficiency. UC Health was in the process of organizing an Executive Advisory Council to work on the development of systemwide goals, and this effort would also leverage UCOP teams focused on public health, clinical quality, population health, health equity, and finance and operations. UC Health would identify those populations it needed to prioritize and improve processes for facilitating access to care.

Regarding the second pillar, expanding the workforce, Dr. Rubin remarked that this had been a traditional strength of UC Health. UC Health would continue to develop and promote its Programs in Medical Education (PRIME) and other health sciences programs. There would be a particular focus on the emerging educational programs at Riverside and Merced/Fresno. UC Health would facilitate the growth of its clinical affiliations and integrated networks to support regional care, ensure consistent training across the health professions, and partner with the systemwide employee relations group to address employee needs as the medical centers and health systems grow.

In pursuit of the third pillar, advancing healthy communities, UC Health would develop its public health partnerships. Dr. Rubin anticipated that the University's capabilities in this area would begin to change over the next few years as UC Health developed in-house experience and leadership in public health engagement. UC Health would partner with the State on initiatives to improve maternal and child health outcomes, continue to work on public health preparedness, and would position the health systems to implement community-based solutions to emerging health challenges, leveraging relationships with UC schools and programs in social welfare and public health. A community benefits

strategy would result in more direct community investment by UC programs. UC Health would steward and promote the Global Health Institute.

Regarding the fourth pillar, accelerating research, UC Health had the opportunity to accelerate the clinical trials process. For example, when a clinical trial opens at one campus, UC Health would work to expedite and open enrollment for this trial at other campuses as well. These efforts would endeavor to make UC one of the leading sites for clinical trials in the nation and perhaps the world. Through the Center for Data-driven Insights and Innovation, UC Health had a unique advantage to focus on artificial intelligence, digital applications, virtual care, and reducing the employee burden at the site of care. For the final, fifth pillar, UC Health would facilitate fiscal initiatives that achieve economy by optimizing payer strategy and streamlining and supporting systemwide operations through procurement, among other strategies.

Dr. Rubin concluded that UC Health would differentiate itself in the current healthcare market, which was volatile but also dynamic, through exceptional quality, cutting-edge innovation, and improvements in equitable access to care. By systematically investing, UC Health would position its network to improve and strengthen its relationship with students, employees, community members, and State partners. Capitalizing on the achievements of the University's nationally acclaimed academic institutions would fortify UC Health's reputation for scientific innovation and workforce development, ensuring that patients have prompt access to the latest medical breakthroughs and treatment innovations, including those related to digital technology and artificial intelligence. This revised strategic framework would strengthen the University's tripartite mission and reinforce its leadership in health care in California and the nation.

Regent Park asked Dr. Rubin to name three tangible outcomes that would result from the revised strategic framework. Dr. Rubin responded that UC Health would ensure that it develops its programs in the Central Valley and in Riverside to achieve healthcare access and stabilize training and education in these regions for years to come. He described this as a collective strategy of increasing the UC Health footprint to provide care and access in the geographic regions in which campuses are located. The second outcome would be how UC Health positions its growing network to provide affordable access and care. UC Health would need to pursue this in partnership with UCOP and leverage direct investment by the medical centers and health systems to provide affordability and access for students and employees through UC health plans. The health systems would make direct contributions, whether through rates that create affordability or direct investment to buy down premiums, to help support access by UC students and employees with a competitive plan that would be desirable for students and employees compared to other offerings through UCOP.

In response to another question by Regent Park, Dr. Rubin confirmed that the goal was that more employees and students would seek and be able to receive affordable care at UC medical centers. The third outcome was that UC Health would expand its relationship with Medicaid and work with the State to provide greater access to Medicaid-enrolled individuals in California. Regent Park expressed appreciation for the concrete nature of the

goals Dr. Rubin had outlined and hoped to hear reports on the attainment of these goals in the future.

Regent Sures referred to overcrowding in emergency departments at UC medical centers and increasing patient wait times. He asked if the strategic framework would address this. Dr. Rubin responded in the affirmative. This was being addressed through hospital acquisitions and affiliations with community physicians. This issue would be at the forefront because UC Health could not tolerate these continued challenges for inpatient access. UC Health would make further investments in a "digital front door" or virtual primary care, virtual urgent care, and other ways to relieve the pressure being experienced in emergency departments.

Regent Batchlor expressed appreciation for the priorities outlined in the strategic framework. She asked to hear more about details and a timeline for actions that UC Health intended to take, particularly for priorities such as expanding a diverse and interdisciplinary workforce and expanding access to care for Medicaid patients. These were laudable goals, but Regent Batchlor hoped in the near future to see an actual timeline, plans, and implementation that will bring the UC Health system closer to achieving these priorities. Dr. Rubin responded that UC Health was now in the process of organizing and coordinating all the work being done at the locations for Medicaid-enrolled patients in order to develop a collective approach for providing access for Medicaid patients in the future, especially as UC Health develops its programs in the Central Valley and in Riverside. Not everyone was aware of the UC Health footprint, including its relationships with Federally Qualified Health Centers and Medicaid partners. Unlike many existing health systems, UC Health did not have the ability to cap patient access. Dr. Rubin looked forward to discussing this at future meetings. UC Health would be working with the State, particularly with the Department of Health Care Services, in determining how to position UC Health to be a partner in expanding access for this population.

Regent Batchlor emphasized that this concerned one of the most under-resourced communities in the state and caring for patients who had great difficulty accessing services at UC Health, services which they needed regularly. She was very interested in what was being done to address this problem.

Regent Leib asked Dr. Rubin to identify the two or three most urgent issues for UC Health. Dr. Rubin responded that the first issue of concern was the "front door," or the ability of patients to access care for basic services. UC Health was growing quickly to try to respond to this need, but there was much difficult work to be done in order to achieve some modicum of access for outpatient primary and specialty care services. The University of California, because of its mission, found itself isolated in a state with fragmented health systems and health insurance companies masquerading as providers for individual service lines. Dr. Rubin noted that it had been refreshing to find that UC medical center leaders were all focused on the mission of UC Health and the larger collective responsibility, in spite of very challenging issues.

Regent Makarechian asked why student health services were being discussed in a separate agenda item at this meeting, since one would expect that the goals for these services would be the same as for other patient care. Committee Chair Pérez asked about the reporting mechanisms for student health, whether through UC Health or otherwise, and how student health issues are reported to the Board. Dr. Rubin responded that student health was a separate program. UC Health was reconsidering this, and he anticipated that this structure would change over time. Student health was overseen by Academic Affairs at UCOP. The Student Health Insurance Plan was provided through the Office of Risk Services in the UCOP Finance Division. Currently, UC Health's role in student health services was to provide the chief medical advising through Medical Director Brad Buchman and his team and some command and control coordination to try to organize services, but UC Health did not have the authority to build and deploy services. This situation might change due to challenges in student health that would be discussed in the following item. Some campuses were experiencing significant access concerns and challenges, were more actively deploying services, or taking over the management of their student health services, particularly if there is a medical center at the campus. UC San Diego had already developed that relationship. UCSD Health Chief Executive Officer Patricia Maysent confirmed that these services had been integrated at UCSD for about a decade. UCSD had implemented the Epic electronic records system in student health. Dr. Rubin noted that UCSF had announced plans to integrate its student health program. UC Berkeley had its own unique program and was using a different and more limited data system. The Epic system provides real time data and allows for better care and follow-up, and most of the UC student health centers did not currently have this capability.

Committee Chair Pérez observed that there was a lack of structural alignment in how UC manages student health. The question raised by Regent Makarechian was precisely one that needed to be discussed.

Regent Makarechian encouraged the University to determine what authority UC Health would need to become more engaged in student health. This seemed desirable, given the capabilities and expertise of UC Health.

Regent Park asked how the University might use CEMRP to ensure accountability for systemwide strategic framework goals and to ensure that there is a direct link between the attainment of goals and UC Health executives' CEMRP awards. Many CEMRP benchmarks were based on local statistics and achievements. CEMRP should also consider contributions to the collective success of UC Health. Dr. Rubin responded that a preliminary first discussion had taken place. One relevant question for CEMRP was how many goals could be managed at one time. Currently, CEMRP was focused on short-term, one-year goals, but this was not how health systems think about their work, and Dr. Rubin preferred that CEMRP move toward long-term, five-year, and transformative goals in alignment with work going on at the locations. For example, reducing the waiting times for patients seeking appointments was not a one-year goal. Other goals might pertain to experience of care and care coordination. Dr. Rubin would prefer fewer but longer-term goals that would be measured consistently year to year and with which all the medical centers agree.

Regent Park asked that the results of UC Health discussions about CEMRP be shared with the Committee at a future meeting in order to understand how this program is leveraged for local and systemwide goals, which ideally should be in harmony.

Chancellor Khosla explained that, under the current CEMRP arrangement, a percentage of compensation, 50 percent to 60 percent, was tied to local goals and the remaining percentage to systemwide goals. Oversight of CEMRP had changed over time, and Committee Chair Pérez had wished to see greater involvement by the Regents. UCSD Health accounted for at least 50 percent of the profit and loss for UC San Diego. Campus revenues were the responsibility of the campus, and it did not make sense to Chancellor Khosla that UCOP would set goals that would not help a campus achieve revenue. The CEMRP goals were both local and systemwide, not one or the other. It would not be advisable to find that only the strategic goals should be of importance because an error of one or two percent in the margin of a $4 billion enterprise can lead to a significant shift in the financial viability of a campus.

Committee Chair Pérez recalled that, in the past, CEMRP goals were adopted and at best ratified by the Regents. The Board was not actively engaged in establishing or signing off on the goals. Over time, there was a desire for the Committee and the Board to approve CEMRP distributions. The Regents should not approve distributions if they were not engaged in approval of the established goals. Over multiple years, the Regents became more engaged in the development of the systemwide goals. Importantly, the current Executive Vice President was not a participant in CEMRP and could ensure, at arm's length and in an impartial way, that systemwide goals were appropriate.

Regent Park referred to Chancellor Khosla's comments and observed that, while profit and loss considerations were important, the Regents would approach this enterprise very differently if profit were the exclusive goal. CEMRP goals should be developed in a collaborative process, and if campuses did not agree with a goal, they should say so. The UC Health strategic framework reflected general agreement and was designed to improve all the campuses. An appropriate percentage of CEMRP would be related to revenues, while another appropriate percentage would be related to harmony with systemwide goals. Certain past CEMRP goals had seemed far too granular. All stakeholders should be in support of a careful calibration of CEMRP goals.

Committee Chair Pérez believed the CEMRP process was on a path that had resulted in refinement and a more collaborative nature. In his view, current discussions about CEMRP were focused in the same areas of efficiency and cost savings as in the past but were much more significant in terms of operations. The concept of CEMRP was to place a certain amount of compensation at risk, and this risk existed at the locations. The current discussion was a healthy one and productive in moving CEMRP to a better state.

Regent Reilly referred to the important issues of affordability and access. UC Health was increasing its footprint, and this would help increase patient access. She asked how UC Health would lower costs for patients. Dr. Rubin responded that this was one of the greatest challenges for UC Health. The cost structure was increasing. Rates are payment for services

delivered in a certain setting. To achieve value, one must deliver care in lower-cost settings and provide more proactive care. In his work on clinical optimization, Dr. Rubin focused on the question of how to position the work of integrated care teams to more proactively reach out to and follow up with patients not in office settings, and to manage care away from the office. Modes of virtual urgent care were also being created. This was not an easy process and would take significant work as UC Health shifted to a focus on patient access. The leaders of all the medical centers understood the urgency of this work. The UC Health division at UCOP added value by facilitating collaboration and acceleration of work and solutions between the campuses. Important considerations were where patients receive care and how much risk the medical centers are willing to take to provide a competitive product in subsidizing the cost of the health insurance premium for employees and students. UC Health did this because it cared about the UC workforce, and this was a unique advantage for employees who work for the University.

Regent Reilly asked Dr. Rubin for his thoughts on the current governance structure of the entire UC Health enterprise. Dr. Rubin responded that he found the UC Health locations to be a very collaborative group. While not an exact analogy, he compared this to his past work with school systems and school districts during the COVID-19 pandemic. The medical centers were all unique, and his job and the role of UCOP was to find the right balance; to add value to the system while allowing UC Health locations to innovate. There were limits to what the central office could accomplish versus what was occurring on the campuses. UC Health must understand the advantage of cross-campus work and perform this work in a way that makes sense and is not a distraction for the campuses.

Committee Chair Pérez elaborated on the last question by Regent Reilly. Some governance structures were location-specific. How did UC Health deal with the tensions between different governance structures? Should the Regents concern themselves with this question, especially in an era when UC Health might have acquisitions and more locations? Dr. Rubin responded that UC Health had many governance structures, and the ultimate governance structure was the Board of Regents. He saw the governance structure as a partnership and a collaborative endeavor. He did not see the UC Health division at UCOP as separate from the medical centers or health systems; this was a federated network. Developing systemwide goals was not Dr. Rubin's responsibility in and of itself; it was his responsibility to identify clinical leaders at the campuses in order to harmonize governance. UC Health should focus on goals that all agree are priorities for patients. Correct governance would be an appropriate blend, drawing from the expertise of the campuses and not a top-down model according to which UCOP institutes policies. UC Health governance was a collaboration that also involved stakeholders from outside UC Health—the Regents, State partners, and community partners. UC's role in these discussions was to serve as a mediator and to establish stronger governance structures, accountability, and checks and balances.

Regent Batchlor asked how and when the Regents would have an opportunity to hear more about details and planned actions related to the strategic framework and how they would monitor progress on an ongoing basis. Dr. Rubin responded that this was a framework, not a timeline. It would be worthwhile to return to the Regents with a timeline and a review of

activities and progress toward the "pillars" and goals. These topics would be discussed at Committee meetings, like student health at this meeting. UC Health would develop these agendas to ensure that the Regents receive periodic progress reports.

Ms. Maysent praised the strategic framework as an excellent plan. UCSD Health was currently struggling with the amount of work it faced. UCSD was assimilating new organizations, and in December 2023, it hired another 750 employees, another 100 members of medical staff, and undertook a turnaround plan for a new facility. With respect to accountability, one should ask about the three or four most important goals, goals toward which the health systems could realistically work and demonstrate progress. UC Health teams across the system would not be able to deliver results on ten or 20 accountability goals, given all the other work they had to do.

UCLA Health Sciences Vice Chancellor John Mazziotta observed that the UC Health campuses were responsible for breaking even and making a profit to support the medical schools and other activities. But the campuses could not do certain things on their own, and the Anthem contract negotiation was an example. The UC Health campuses need to work together. With respect to determining systemwide initiatives, these should be satisfactory for the locations, so that a location feels that it will benefit from an initiative and will participate. There might not be results in two months, a year, or even three years, but in the long term there would be a benefit for the location, and this would increase solidarity and cohesiveness within UC Health. The medical centers were being given more missions and goals to achieve, a seemingly endless process. The medical centers did not have the opportunity to reduce or end other activities. UC Health's competitors had two goals: making money and good patient care. The list of UC Health goals kept growing, and it would be necessary to be able to reduce some activities in order to increase or begin others.

Committee Chair Pérez stated his view that the goal of some of UC Health's competitors was to make money and provide good enough patient care to avoid visits from regulators or being shut down. If the competitors had goals for patient outcomes and quality of care similar to UC Health's goals, the healthcare marketplace would be very different. He expressed agreement with Dr. Mazziotta about the growing list of UC Health goals and the need to determine which goals reinforce the core mission of the institution and which goals, while valuable, do not.

Regent Batchlor requested clarification of the situation of medical centers having an overwhelming amount of work and not being able to meet all goals. In creating a strategic plan, one should match goals to resources. It did not make sense to develop a strategic plan that one did not have the means to implement. Committee Chair Pérez responded that this was not a case of rejecting elements of the strategic plan but of additional expectations, not necessarily within the strategic plan, which were placed upon the campuses. He believed that the strategic framework was a good document, but, as reflected in Regent Batchlor's comments, there was a desire for accountability, next steps, and understanding deliverables. He asked that, at the next meeting, the Committee receive a timeline, which might not be complete, but which would indicate when some goals would be implemented. He also requested a discussion about establishing fair measures of accountability, so that

the strategic framework would move from being a document about a vision to being a guiding document.

Regent Park stressed the need for honesty in the strategic framework. If UC Health was not serious about pursuing a particular goal, then that goal should not be included in the framework. UC Health was pursuing acquisitions and making more work for itself in the service of a mission, for strategic advantage and to create greater patient access to care. The strategic framework should be treated with as much seriousness as the goals for specific UC Health locations. Dr. Rubin recalled that, in addition to its relationships with the medical centers, UC Health at UCOP had a relationship with the Regents and a relationship with the State. The Regents and the State played an important role in contributing to the strategic framework. One should not discount how much work the campuses had to do, but one should try to create strategic alignment in matters such as acquisitions. This was already occurring, and the strategic framework was not a completely new vision. One needed to understand finances and the resources and limitations of the campuses and medical centers. In this process, one could distill the overall work of UC Health into a few goals and a few deliverables on which UC Health could work in conjunction with the State and community partners. The value of a systemwide office was in its ability to connect these activities in a way that the individual campuses might not be able to.

Committee Chair Pérez asked if there were elements of this strategic framework to which UC Health was not committed. Dr. Rubin responded in the negative. Committee Chair Pérez reiterated his request for a timeline and more details about accountability and implementation.

Ms. Maysent commented that the medical center leaders were in agreement with all elements of the strategic framework. Some elements of the plan would be addressed outside the individual health systems and medical centers. With respect to goals for the health systems, a timeline would be developed and goals to be accomplished in the shorter term would be identified.

Committee Chair Pérez noted that timelines and plans must also recognize that opportunities and challenges, such as acquisitions, can present themselves in real time. In the case of opportunities, it might require much work and effort to evaluate whether an opportunity is worth pursuing, and it was important to reserve sufficient time and resources for the health systems to address real-time challenges and opportunities.

UC Riverside School of Medicine Dean Deborah Deas referred to Regent Park's comments on priorities. Dr. Rubin had identified clinical expansion at UC Riverside, UC Merced, and access to care at UC Santa Cruz as a priority. Focus on this priority, not eliminating any other goals, would be appropriate and would lead to accomplishment of the framework in the future.

Chancellor Khosla reflected that past strategic plans had been limited in their resources. It was important to ensure that the current strategic framework was not a conceptual

document in need of resources that no medical center chief executive officer would be willing to provide. The discussion of sufficient resources needed to happen at the same time.

Committee Chair Pérez believed that, compared to past plans, there had been more collaboration in this strategic framework, not only in discussions but in execution. For example, there had been more meaningful engagement from other UC Health locations about plans for UC Riverside and UC Merced than in the past.

Dr. Rubin remarked that UC Health operated in a complex environment. There were many different entities and actors in California, and much competition for resources. He recognized the need for timelines and emphasized UC Health's commitment to the identified priorities. At future meetings, UC Health would report on how it would prioritize goals for this year. Not all goals could be accomplished in the short term, and this was Dr. Rubin's reason for thinking of this in a period of three to five years. UC Health was already at work on many initiatives.

UCSF School of Medicine Dean Talmadge King reminded the Committee that UC Health was an academic health system and different from other health systems. UC Health must support the tripartite mission of the University, and this created pressure and had impacts that UC Health's competitors did not experience.

4.   **IMPROVING ACCESS TO CARE ACROSS STUDENT HEALTH SERVICES**

[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 Rubin began the discussion by noting that, when he came to UC Health in fall of the past year, he was struck that, at every meeting, students spoke during the public comment period about their concerns regarding access to care. UC Health had a very dedicated team working on student health, but under tremendous strain from a rising mental health crisis, personnel losses during and after the COVID-19 pandemic, and the subsequent need for rehiring. As UC Health focused on the mental health crisis, there were perhaps unintended consequences in effects on access to care and financial management of the student health centers. The UC Student Health Insurance Plan (UC SHIP), which served 142,000 students, was under strain due to a large deficit this year caused by rising costs for services and increasingly unaffordable specialty care medications. There had been a fundamental shift in the way students were using services. Students were using emergency departments much more now than several years prior and making less use of student health services. This raised questions and concerns about access to services and was creating an additional $25 million cost for UC SHIP services.

Dr. Rubin believed that the University had reached an inflection point when it was necessary to think about the future of student health services—the nature of the services, how to triage and manage care for students, and how to ensure that student health centers are well staffed and operated. Many decisions were now being made on individual

campuses. The University's student health program had been run on a tight budget for many years with an electronic health system that did not permit the timely management of care. In the absence of necessary care management capabilities, the risk was that a student can be lost in the shuffle and an illness that requires prompt attention would not receive prompt attention.

Medical Director Brad Buchman confirmed that there had been significant escalations in the use of emergency room services by UC students over the past several years. UC Health had been engaged in a study of primary care visits within student health compared to emergency room visits by students over a five-year period. During that period there had been an approximately 20 percent decline in student health primary care visits and a 32 percent increase in emergency room visits.

Dr. Buchman presented a chart showing student health primary care visits over the past five years by campus, per 1,000 based on enrollment. The middle three years in this period—2019–20, 2020–21, and 2021–22—were affected by the pandemic, the emergence of COVID variants, and campus closures. In its analysis, UC Health was focusing on the pre-COVID year 2018–19 and the most recent year, 2022–23. During that interval, there had been a decrease on average by about 20 percent in student health primary care visits, with some campuses having higher percentages.

The next chart showed UC SHIP emergency department utilization over the same period. The average for all the campuses was an increase of about 32 percent, while five campuses had increases of 40 percent or more. There was a decline in the COVID year of 2020–21 followed by sharp increases. Dr. Buchman noted that data for UC Berkeley were not included in this study. UC Berkeley worked with a different carrier. UC Health had requested this information, had not yet been able to obtain it, and hoped to include it in future reports.

The third chart displayed ratios of emergency department visits to student health primary care visits by campus over the same five years. Most campuses showed a slow but steady increase in the ratio. The ratio growth at UCSF was exceptionally high, and Dr. Buchman attributed this to the departure of a medical director.

The following chart illustrated the financial impact that the increase in emergency department utilization had on UC SHIP. Over the past five years on average, the systemwide per member per month costs for emergency room services had increased by 84 percent, with some campuses experiencing increases of over 100 percent. The total dollars paid for emergency room services increased from $20 million in 2018–19 to $44 million in the most recent year 2022–23, more than 100 percent. Emergency department services claims currently made up about one-sixth of the total medical claims cost for UC SHIP.

Dr. Buchman outlined steps being taken by student health and UC SHIP administrators to improve access to care. The student health centers were expanding communications to students to ensure that they are aware of care options available after hours. The student

health centers were updating their recruitment plans to address vacancies in physician and nurse practitioner positions. Dr. Buchman believed that this factor had been ignored over the last few years and had contributed to the decrease in student health primary care visits. UC SHIP was in the process of developing a tool to survey emergency department use by students who went to the emergency room for relatively minor conditions such as a sore throat or a urinary tract infection, conditions which could have been addressed in an urgent care visit or by UC providers the following day. UC Health would interview students about the factors that led to the decision to go to the emergency room. Lastly, a work group of UC SHIP administrators and student health leadership had been convened to survey after-hours capacity and infrastructure.

Dr. Buchman concluded by outlining key issues and questions. These concerned communication and student awareness of services on campus; all campuses had telephone triage capacity, but students were not able to make an appointment for the next day; UC did not currently have the ability to retain information from telephone triage and assessment and enter it into a clinical record that student health providers would see the next day and therefore relied on vendors for this service; appointment facilitation, which would reduce costs due to after-hours care; and provider access, provider mix, and insufficient support staff levels. If a doctor shares one medical assistant with two or three other doctors, this impedes the amount of work that can be done. Finally, while there had been great improvement in electronic health records, there were gaps to be closed, such as portability of student health information, which affected the ability to coordinate care among UC healthcare entities. UC San Diego had an advantage in this area in that both student health and counseling and the medical center were using the Epic medical records system. The Point and Click system used by UC did not lend itself well to extracting information for health outcomes research and healthcare analytics. UC student health services would like an improvement in its ability to access data and ensure that the services it provides are enhancing healthcare outcomes.

Regent Makarechian referred to the 32 percent increase in emergency room visits and the 84 percent increase in costs for emergency room services. He asked if this reflected more complicated issues being treated in the emergency room, or if this was simply a matter of costing. He asked for an example of an emergency room visit. Dr. Buchman explained that the number of visits increased by 32 percent, but the dollar amount cited was the amount per member per month paid by UC SHIP. Using the per member per month cost was a way of normalizing and taking account of growth in the insurance pool. UC SHIP membership had grown from about 130,000 members to 142,000. The amount paid was due to acuity of the illness or injury, the number of students going to emergency departments, and pricing. The cost of emergency room services can increase year over year. These three factors were at work and accounted for the increase in per member per month costs.

Regent Makarechian observed that UC SHIP was collecting more money in premium payments. Dr. Buchman confirmed that this was the case. The premium had gradually increased, but emergency room costs had also increased. On a per student per month basis, emergency room costs had increased by 84 percent, almost doubling in five years. UC SHIP premiums had certainly not doubled in five years, and this could lead to trouble.

Regent Makarechian requested further elucidation of the reasons for student emergency room visits on weekends. Dr. Buchman responded that, in the course of the last year, when the volatility of COVID-19 had passed, the peak days of the week for emergency room use were Saturday, Sunday, and Monday. UC Health did not yet know why this was the case. When one examines weeks of the year, emergency room use was much higher during academic terms than during winter or summer breaks.

Regent Makarechian asked if there were statistics on the reasons for emergency room visits, such as excessive alcohol consumption. Dr. Buchman responded that UC had diagnostic data on emergency room claims.

Regent Makarechian asked if UC was educating students about when it was appropriate to seek emergency department service. Dr. Buchman responded that UC SHIP provided information on its website on appropriate levels of care. All the campuses had websites with information on after-hours care. UC Irvine referred students to the UCI Health on-call system and was unique in this regard. Each campus presented this information somewhat differently, and UC SHIP replicated this information. There needed to be more effort in this area.

Regent Makarechian asked how the premiums were set. Dr. Buchman responded that UC SHIP used consulting firms and actuaries. UC SHIP tried to target premiums to correspond to exact expenses for the next year. In some years the program had surpluses, while this year had seen a deficit. Nevertheless, UC SHIP still had sufficient reserves to cover its expenses. In the renewal process this year, the UC SHIP executive oversight board, which included students, was reviewing the plan very carefully.

Regent Makarechian suggested that charging an additional fee might discourage excessive use of emergency room services. Dr. Buchman responded that UC SHIP was encouraging all campuses to raise their emergency room deductibles, which were around $125. UC SHIP would like these to be raised to about $200 or $250, like most health plans at UC. It was also crucial to communicate with students about urgent care clinics near campus and telehealth options.

Committee Chair Pérez asked about peak emergency room utilization at the medical centers. Ms. Maysent responded that UCSD emergency room utilization was enormously high. UCLA Health President Johnese Spisso stated that this was also the case at UCLA. This year, UCLA had opened an on-site urgent care clinic located adjacent to the emergency department and directed students to this walk-in site. Ms. Maysent added that UCSD had an urgent care clinic next to campus. She noted that UCSD students were going to the emergency department at Scripps Health. UCSD was trying to change this. One should not assume that UC students were going to UC Health emergency departments. UC Davis Human Health Sciences Vice Chancellor David Lubarsky recalled that the main Davis campus was located 13 miles from the medical center. Students go to Sutter Health in Davis for emergency care.

Committee Chair Pérez commented that it was illogical for students to go to emergency rooms when there were better options. No one expected an excellent experience while waiting for treatment in an emergency room. The fundamental problem appeared to be a problem of communication and informing students about other options. Information on websites might not reach students, who use digital applications (apps). UC Health must consider using apps as a means of communicating this information. There was also a question of whether student health centers' hours of operation were in alignment with the patterns of utilization. UC Health should be strategic in the recruitment of providers, keeping in mind changes to operations that should take place. The ability to locate urgent care clinics in proximity to hospitals was significant. One must think about students' extracurricular activities over weekends and how to redirect students to more effective engagement with healthcare resources. The problem of not being able to capture and share information was significant. He asked why the student health centers were not using Epic, with the exception of UC San Diego. Dr. Buchman responded that UC Health had been discussing this for more than a decade. The implementation costs were exorbitant, about $6 million to $7 million per campus and annual maintenance costs of $1 million to $1.5 million. The high cost was the major factor in not implementing Epic. A number of campuses wished to move in this direction, and this might occur in the next year or two. Ms. Maysent confirmed that Epic was an expensive system. UCSD Health subsidized Epic for student health services. The cyber risk inherent in the current health records system was very high. While an implementation cost of $6 million appeared exorbitant, the cost and impact of a cyber security breach involving student health records would be worse. This was an important factor to consider, as well as the better functioning of the Epic system.

Committee Chair Pérez asked if the average student knew how to access advice nurses or nurses on call, at any time. Dr. Buchman responded that the student health centers and counseling centers both emphasized same-day and urgent issue access. Campuses might hold and keep available 20 percent to 40 percent of their appointments each day.

Committee Chair Pérez asked how confident Dr. Buchman was that students know that they can access an advice nurse in order to figure out where to go for care. Dr. Buchman responded that he was less confident about this than about same-day access during regular operating hours.

Committee Chair Pérez voiced his concern about whether students know that they can receive care at student health centers in real time. Dr. Buchman responded that students are informed about student health services upon arrival, during orientation, but the orientation includes a large amount of material. There was much work to be done in this area.

Committee Chair Pérez asked if UC also used low-technology approaches to informing students about student health and advice nurses, such as on bulletin boards in dormitories and dining commons. Director of Student Mental Health and Well-Being Genie Kim responded that peer health educators go out and educate students about the various resources available on the campuses and provide orientation programming. During the COVID-19 pandemic period, many students went home and did not have access to their student health centers. This circumstance might be a factor in increased emergency room

utilization. Ms. Kim expressed agreement that there needed to be improvement in communication to students about resources available, at what hours, and what the services can be accessed for.

Committee Chair Pérez remarked that, while the pandemic had brought about changes, there was a 20 percent to 25 percent annual turnover of the undergraduate student body in any case. The students represented in statistics from before and after the pandemic were different cohorts and populations. Both low- and high-technology interventions might be effective, and cyber exposure was a significant concern. He asked how UC SHIP payers should be considering this. Associate Vice President and Chief Risk Officer Kevin Confetti responded that the task of communicating with students was in large part left to the individual campuses. Nevertheless, UC SHIP needed to be more creative in how it communicated with students. UC had recently finished a request for proposals for enabling UC to text student health participants, and this capability should be in place soon. The University was moving in this direction but needed to do a better job of communicating with students in this area.

Committee Chair Pérez expressed concern about increasing out-of-pocket costs for emergency room visits. Some students would never see these bills; instead, their parents would receive the bills and the change in cost would not bring about change in emergency room utilization. Other students, who were more independent, would pay these bills. There were more cost pressures for these students and the increased cost might result in under-utilization. It was reasonable to consider increasing this cost, but the increase should not be too high, and this type of intervention would be less meaningful than effective communication about services available to students that might be cheaper and less frustrating than waiting in an emergency department for many hours.

Regent Ellis commented that UC SHIP allowed UC Merced students to receive care off campus. Other issues outlined in this discussion did not seem to have changed since 2007, when he was a student at UC Merced. Students might prefer to receive text messages rather than telephone calls, and the University must be nimble over time and responsive to the student body. The same discussion about expanding use of the Epic system had been going on 15 years ago. UC needed to make sensible structural changes that also met student needs. With respect to co-pays for an emergency room visit, he observed that $200 would be a significant cost for an undergraduate. UC should try other means to change utilization before increasing co-pays. Students wished to have a health maintenance organization (HMO) culture in student health services, with follow-up, outreach, and a continuum of care. Regent Ellis expressed frustration at the fact that student health services at UC were not better than they were at present.

Regent Park asked how these issues had come to Dr. Buchman's and his colleagues' attention. Dr. Buchman responded that for a number of years, student health services had focused on mental health staffing and access. Finally, following the pandemic, student health staff began to complain about burnout, loss of physicians, and retention issues. UC Health then examined staffing levels, and it was not until fall 2023 that it assembled and

examined data on five-year trends in student health visits. This work had occurred in the last few months.

Regent Park observed that the situation of care provided on campuses and student payers, information not circulating in a timely manner, and campuses not addressing retention issues represented a kind of fragmentation. She suggested that the cost of installing and maintaining Epic on all campuses might be met with an increase in the UC SHIP fee. She did not like the idea of increasing the fee, but if it resulted in better and more timely care for students, it would be worthwhile. UC should approach this in an investment-oriented manner, considering costs and benefits. The University was paying large sums to other entities for care and had not made access to care more convenient for students. Regent Park thanked UC Health for its efforts to improve student mental health services and chancellors for paying more attention to this urgent need. Statistics, such as those showing increases in the numbers of counselors, were moving in a good direction. Dr. Buchman noted that UC SHIP received claims data from its carrier Anthem and from its pharmacy benefit manager Optum. In addition, UC SHIP had a relatively low-cost data warehouse that provided excellent information. From the standpoint of UC SHIP, data access was good. However, data access was less satisfactory from the student health centers. There were about 142,000 students enrolled in UC SHIP, while the total student population was about 290,000. The University was using different data systems to get an overview.

Regent Park commented that Epic implementation might or might not be a worthwhile investment. If not, UC must consider other ways to obtain information it needs. The doubling of the cost of emergency department care was not a good expenditure of funds.

Committee Chair Pérez raised the question of how long UC would continue to pay this excess cost before other interventions would bring this cost down.

Regent Tesfai advised against raising students' co-pay for emergency department visits. Many students would seek out the closest and quickest source of medical care. He encouraged the campuses to increase staffing levels at student health centers and improve access to same-day or next-day care. Staffing at the centers was low on the weekend. Students not living on campus would look for the closest healthcare option. It would be important to talk to students about the choices they are making, and Regent Tesfai asked if UC was gathering these data. Dr. Buchman responded that UC was designing a survey tool for precisely this purpose.

Regent Tesfai stated that this should be a first step, before raising co-pays or fees for students. He noted that some students go to emergency departments not willingly but because it is the only option. Students had expressed appreciation for the Lyra program, which provided mental health services for UC SHIP members. They had also heard that access to therapists in that program might be limited. Regent Tesfai asked if this was the case. Dr. Buchman responded that UC was now in the second year of the Lyra pilot program. It was implemented with no co-pay and no limits on visits. Mental health parity laws did not allow the University to limit visits or to treat this program any differently than other medical services. Many students had used the Lyra program, primarily via telehealth

but also with some in-person visits. The cost per visit at Lyra was about $240. Students seeing providers in the Anthem community network were being told to go back to the student health center and to be referred to Lyra because the provider would be paid more through the Lyra program than through Anthem. LiveHealth Online, Anthem's telehealth product, offered mental health services, counseling, and psychiatry at an average cost of $80 to $110 per visit. The cost in other groups in the Anthem network was about $105. The University would need to consider a combination of approaches. The Lyra pilot program was envisioned as a safety net, and when UC launched the program, it did not anticipate the volume of student visits and the cost escalation that would be associated with it. Students on the UC SHIP executive oversight board had moved to continue the program, and this would have a predictable effect on premiums. UC SHIP had spent about $9 million or $10 million a year in the last two years on Lyra, taken from reserve funds. These costs would now be moved into the premium if the University adopted this as a regular service.

In response to another question by Regent Tesfai, Dr. Buchman stated that students did not pay either for the Lyra or LiveHealth services. The campuses varied in how they promoted and marketed these services to students.

Regent Tesfai commented that he did not have a preference for one service or the other but would like to see greater student access to therapists and for UC to avoid actions such reducing the number of visits that students can have.

Committee Chair Pérez noted that LiveHealth Online did not have a co-pay or a cap on the number of visits. Dr. Buchman responded that this was the case, but this program was not as actively promoted. If the patient experience was the same and the cost for UC as the payer was less than half as much, the question was how to navigate student utilization without limitation. The University must make use of navigation to achieve cost containment but in a way that would not be rationing.

Regent-designate Beharry asked about the requirements for opting out of UC SHIP, particularly one that entailed having a specific primary care provider or even requiring a mental health provider within a certain mile radius. It was his understanding that this requirement could hinder individuals from accessing care from their preferred healthcare providers, diverse providers, and healthcare providers with specialized backgrounds. Opting out would become even more problematic if the local health infrastructure did not have the capacity to meet needs. The requirements seemed restrictive and for some students, it would force their hand to enroll in UC SHIP. Students might already have a satisfactory health plan, but one that did not meet these requirements. Regent-designate Beharry asked if the requirements for opting out could be made less restrictive. Dr. Buchman referred to the availability of sufficient diversity among providers and systems. As UC SHIP had transitioned into larger groups, with telehealth being a primary mode of interaction with patients and clients, UC had been much better able to meet patient preferences and desires with regard to diversity. Regarding the waiver eligibility status for UC SHIP and radius from the campus, he recalled that when the University began UC SHIP, all campuses had a 30-mile radius limit. The reason was to avoid a situation of a student with managed care insurance who was injured at UC Berkeley going to San Diego

to see a primary care provider. In many managed care settings, a patient must see their primary care provider in order to obtain a referral. This was the reason for radius requirements. With respect to determining maximum out-of-pocket fees and other requirements, UC student health directors gathered every year to review criteria with a focus on an adequate level of insurance for students on campus. Some of these guidelines had changed. Some campuses now had larger radiuses of 50 miles or more. This was important in some regions like the Los Angeles basin and Santa Barbara where students could travel easily back and forth between their campus and their primary care provider. Dr. Buchman suggested that he and his colleagues could further discuss the criteria for UC SHIP waiver eligibility with Regent-designate Beharry. This topic had not been discussed for a number of years and it might now be appropriate to restart this discussion.

Committee Chair Pérez commented that there was not a question of the demographic background of a provider but a question of cultural competency, of providers who have an interest and experience in serving certain populations.

Chancellor Hawgood asked if this discussion and the data provided were specific to UC SHIP. Dr. Buchman responded in the affirmative.

Chancellor Hawgood observed that this meant that the University was running a natural experiment, not randomized, but a natural experiment with about half of UC students in UC SHIP and half with other insurance products. He asked what had been learned in this experiment, and if problems were related to UC SHIP or to students in general. He asked if students not enrolled in UC SHIP were showing the same utilization of emergency department services or not. Dr. Buchman responded that UC did not have claims data for students without UC SHIP, such as students with insurance carriers from their parents. It was unlikely that UC would acquire these data in any significant amount to try and characterize the non-UC SHIP situation.

Chancellor Hawgood suggested that, while UC might be able to obtain these data from the payers, it might obtain some data from a well-crafted survey to the students about emergency department visits. Dr. Buchman responded that this could be done; this was an excellent suggestion.

The meeting adjourned at 12:50 p.m.

Attest:

Secretary and Chief of Staff