

The Regents of the University of California

HEALTH SERVICES COMMITTEE

December 10, 2019

The Health Services Committee met on the above date at the following locations: Luskin Conference Center, Los Angeles campus; Lote H-4, Carretera Federal 200 Km. 19.5, Punta Mita, Mexico.

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

In attendance: Regents Leib, Reilly, Sures, Um, and Weddle, Faculty Representatives Bhavnani and Gauvain, Secretary and Chief of Staff Shaw, Deputy General Counsel Nosowsky, Interim Executive Vice President and Chief Financial Officer Jenny, Vice President Nation, Interim Vice President Gullatt, and Acting Vice President Lloyd

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

1. PUBLIC COMMENT

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

- A. Sharon Kramer spoke of the health effects of mold in poorly maintained military housing. She stated that these effects have been denied by expert defense witnesses, including a UCLA faculty member, and decried fraud perpetrated by landlords and the medical profession. She expressed concern about misuse of the University of California's name in this matter.
- B. Aidan Arasasingham, UC Student Association (UCSA) representative and UCLA student, spoke in opposition to any further expansion of UC partnerships with Dignity Health (Dignity). He thanked the Committee and Chancellor Hawgood for not pursuing the partnership that had been contemplated earlier in the year between Dignity and UCSF. UCSA was concerned about care restrictions in the current contracts with Dignity and opposed to any expansion of these contracts under such terms.

2. APPROVAL OF MINUTES OF PREVIOUS MEETING

Upon motion duly made and seconded, the minutes of the meeting of October 10, 2019 were approved.

Committee Chair Lansing welcomed Carrie Byington, the new Executive Vice President – UC Health. President Napolitano stated that UC was delighted that Dr. Byington had joined the University. Dr. Byington had already begun addressing challenges and opportunities in UC Health.

3. **INTRODUCTORY COMMENTS OF THE EXECUTIVE VICE PRESIDENT – UC HEALTH: BACKGROUND, PERSPECTIVES, AND NEXT STEPS**

[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 introduced herself. She was raised in rural South Texas, near the Mexican border, in a multi-generational household speaking both English and Spanish. This land has a long history and experience of government by Spain, Mexico, the Republic of Texas, and the United States. This geography had instilled in her an understanding that borders are fluid and sometimes transient and that lives are connected in spite of borders. Growing up, she had experienced disparities in healthcare, seeing family members who lost their lives due to lack of access to health care. These experiences motivated her to pursue a career in medicine. She became a physician and the first health professional in her extended family. Dr. Byington was drawn to pediatrics because of the potential of children and the ability to influence long-term health outcomes at an early stage in life. She also specialized in infectious diseases, completing a fellowship in pediatric infectious diseases at UCSF. Her work as an infectious disease specialist has taken her around the world and has enabled her to participate in guideline development and policy decisions concerning pandemics and emerging infections such as H1N1 influenza, Ebola, and the Zika virus.

Throughout her career, Dr. Byington has been a clinician, caring primarily for children with Medicaid or who are uninsured, an educator of residents and fellows, and a National Institutes of Health investigator. She embraces the missions of academic medicine and has been successful in these areas. Dr. Byington began to take on administrative roles when she understood that only in this way could systematic change be realized. Health care in the U.S. is now at an important inflection point. Healthcare delivery, education, and research are undergoing dynamic transformations. She wants to be active in this transformation, demonstrating her commitment to affordable health care, to eliminating health disparities, and to preserving and sustaining academic healthcare in the U.S., and this was her reason for coming to work at the University of California. The UC system has the scale to transform health care in California and the credibility to inform discussions at the national level.

Dr. Byington had completed her first month at UC Health and was engaged in a listening tour including campus visits and visits with external stakeholders. She was looking for ways in which systemwide collaborations can add value to the work of the UC medical centers and had identified four areas that she believed would be important over the coming year. First, UC Health should lead with clearly articulated values. Employees should be proud of this organization because of the values it supports. Dr. Byington would seek to

reframe the expression of UC Health's values to more clearly recognize its commitment to public service. Second, UC Health can and should play a role in the strategic planning for clinical enterprises and create an integrated system linking all the campuses. Academic health centers are unique in being both academic enterprises and businesses. For the academic enterprise to be sustained, the business of healthcare delivery must be successful. Dr. Byington stated her goal of making these interdependencies more transparent in the interest of better planning. The healthcare landscape in California is complex and competitive. One role of UC Health is to support the work of individual campuses by developing infrastructure and identifying strategic opportunities that will benefit the entire system. This approach was being implemented in the Leveraging Scale for Value initiative and could be extended to employee health, student health, UC benefits, and to the State in finding new ways to deliver value-based care. Third, Dr. Byington would seek to leverage scale for value in the research and teaching missions of UC Health, developing more opportunities for cross-campus, inter-professional education and, potentially, new degree programs. The UC Health system should address the workforce needs of the State of California. There were opportunities for new, creative programs to deliver more healthcare providers to underserved areas of the state, to lower student debt, and to improve patient outcomes. Fourth, Dr. Byington believed that UC Health could become more active on the legislative front at the State and national levels. UC Health must play an active role in discussions and development of policies that will allow it to continue to fulfill its mission. Development of a policy portfolio was a priority. Dr. Byington would begin legislative visits in Sacramento in January 2020.

These four areas of focus would result in new data, reports, and recommendations. Her office was working with Committee Chair Lansing on creating a standing agenda for 2020. Dr. Byington expressed her gratitude for the opportunity to work for the University of California and its health enterprise.

4. **APPROVAL OF EXTENSION OF APPOINTMENT OF AND COMPENSATION FOR BRADLEY SIMMONS AS INTERIM CHIEF EXECUTIVE OFFICER, UC DAVIS MEDICAL CENTER, DAVIS CAMPUS, IN ADDITION TO HIS EXISTING APPOINTMENT AS CHIEF OPERATING OFFICER, UC DAVIS MEDICAL CENTER, DAVIS CAMPUS AS DISCUSSED IN CLOSED SESSION**

The President of the University recommended that the Health Services Committee approve the following items in connection with the extension of the appointment of and compensation for Bradley Simmons as Interim Chief Executive Officer, UC Davis Medical Center, Davis campus, in addition to his existing appointment as Chief Operating Officer, UC Davis Medical Center, Davis campus:

- A. As an exception to policy, extension of the appointment of Bradley Simmons as Interim Chief Executive Officer, UC Davis Medical Center, Davis campus, effective retroactively from October 1, 2019 through June 30, 2020 or until the appointment of a new Chief Executive Officer, UC Davis Medical Center, Davis campus, whichever occurs first.

- B. Per policy, continued appointment of Bradley Simmons as Chief Operating Officer, UC Davis Medical Center, Davis campus.
- C. Per policy, an annual base salary of \$753,984 during the extended appointment as Interim Chief Executive Officer, UC Davis Medical Center, Davis campus. At the conclusion of the extended interim appointment, Mr. Simmons's annual base salary will revert to his base salary in effect as of September 30, 2018 (\$592,250) plus any adjustments made under the UC Davis salary program during the initial and extended interim appointment periods.
- D. Per policy, continued eligibility to participate in the Short Term Incentive (STI) component of the Clinical Enterprise Management Recognition Plan (CEMRP), at the Chief Operating Officer position level with a target award of 15 percent of base salary (\$113,097) during the extended interim appointment and a maximum potential award of 25 percent of base salary (\$188,496) during the extended interim appointment, subject to all applicable plan requirements and Administrative Oversight Committee approval. Mr. Simmons will not be eligible to participate in the Long Term Incentive (LTI) component of CEMRP. Actual STI award will be determined based on performance against pre-established objectives.
- E. Per policy, continuation of standard pension and health and welfare benefits and standard senior management benefits (including senior management life insurance and executive salary continuation for disability after five consecutive years of Senior Management Group service).
- F. Per policy, continued eligibility to participate in the UC Employee Housing Assistance Program, subject to all applicable program requirements.
- G. Per policy, continuation of monthly contribution to the Senior Management Supplemental Benefit Program, based on Mr. Simmons's Chief Operating Officer position.
- H. Mr. Simmons will continue to comply with the Senior Management Group Outside Professional Activities (OPA) policy and reporting requirements.

The compensation described above shall constitute the University's total commitment until modified by the Regents, the President, or the Chancellor, as applicable under Regents policy, and shall supersede all previous oral and written commitments. Compensation recommendations and final actions will be released to the public as required in accordance with the standard procedures of the Board of Regents.

[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.]

Acting Vice President Lloyd introduced the item. The chief executive officer (CEO) role was a Level One Senior Management Group position; therefore, this action required

Regents' approval. Mr. Simmons' initial interim appointment had begun in 2018 after the departure of the former CEO, Ann Madden Rice. UC Davis Health was in the process of completing a leadership structure review. Mr. Simmons' appointment as interim CEO was needed to ensure continuity in leadership while a decision was made regarding the CEO role and other key leadership positions at UC Davis Health.

Upon motion duly made and seconded, the Committee approved the President's recommendation, Regents Guber, Lansing, Makarechian, Napolitano, Park, Sherman, and Zettel voting "aye."¹

5. **PROPOSED REQUEST FOR THE NEW HOSPITAL AT UCSF HELEN DILLER MEDICAL CENTER AT PARNASSUS HEIGHTS PROGRAM, SAN FRANCISCO CAMPUS**

The President of the University recommended that the Health Services Committee authorize the San Francisco campus to request approval from the Finance and Capital Strategies Committee at a future date for (1) preliminary plans funding, budget, external financing, and design pursuant to the California Environmental Quality Act (CEQA) for the New Hospital at UCSF Helen Diller Medical Center at Parnassus Heights Program and (2) any amendment or modification to the foregoing.

No irrevocable commitment is being made through this authorization.

[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 introduced the item, explaining that UCSF was proposing a new hospital at the Helen Diller Medical Center at Parnassus Heights to address seismic deficiencies for its acute inpatient care facility and to replace outdated clinical facilities that are undersized, obsolete, and expensive to maintain and repair, and that cannot accommodate the growing and complex patient population. This program was part of an active planning effort to revitalize the Parnassus Heights campus.

UCSF Health Chief Executive Officer Mark Laret described how this complex project reflected UCSF's need to address seismic and functional obsolescence issues at the Parnassus Heights site. The Moffitt and Long Hospitals together form the Helen Diller Medical Center at Parnassus Heights. The Long Hospital was seismically sound, but the Moffitt Hospital, which housed the emergency department, intensive care units, and most operating rooms, was functionally obsolete and did not meet 2030 State seismic standards. Many units did not have air conditioning.

This project was intended to replace Moffitt Hospital on the current site of the Langley Porter Psychiatric Hospital and Clinics. One complex aspect of the project was that UCSF needed to relocate Langley Porter, and plans were under way to relocate the inpatient and

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

outpatient facilities. UCSF would then tear down that facility and begin construction of a new hospital with the goal of completion by 2030. Based on initial programming, with an increase to 675 patient beds, the campus projected a cost of \$3.8 billion. The project would be funded by \$2 billion in debt, \$1.2 billion in philanthropic support, and \$600 million in reserves. UCSF had secured a \$500 million commitment from the Helen Diller Family Foundation toward construction of this project. Other complications included the size of this facility and limits established in 1976 on the number of square feet that may be constructed at Parnassus Heights. There would be numerous presentations to the Regents at future meetings and opportunities for the Regents to provide advice and guidance. This project was contemplated in the UCSF 2014 Long Range Development Plan with the goal of certifying a new Environmental Impact Report (EIR) by the end of 2020. The campus aimed to present a detailed budget, financing, design plans, and construction timetable by 2022.

In response to a question by Regent Makarechian, Chancellor Hawgood confirmed that UCSF was proceeding with the Integrated Form of Agreement approach that had been approved by the Regents at the November meeting.

Advisory member Lipstein distinguished construction costs and future operating costs. He suggested that the financial projections include operating statements and balance sheets showing UCSF costs before and after the opening of the new hospital. Even with significant philanthropic support, the asset would depreciate in value and UCSF would have to operate the hospital based on the Medicare reimbursement policy in 2030, which was a matter of great uncertainty. He asked how UCSF was carrying out this financial modeling and how it could ensure that future administrators would be able to afford to operate this hospital. Mr. Laret recalled that planning for the Mission Bay Hospital had begun in 2005. The hospital then opened in 2015. UCSF had the same questions at that time, and its financial projections proved true. UCSF experienced an operating loss when it opened the hospital due to depreciation and the increase in support space requiring more cleaning and other services. UCSF had not anticipated all these costs but it had also not anticipated how quickly volume would grow. Nevertheless, Mr. Lipstein had identified a significant risk for big and lengthy projects like this one. At a time of great uncertainty, UCSF was making assumptions about Medicare, Medicaid, and the commercial insurance market in the future. Obviously, UCSF would have to adapt to significant changes in Medicare and Medicaid policy, if such changes were to occur.

Mr. Lipstein suggested that the financial summary report for the UC medical centers include a volume/performance index. The Committee did not have a sense of how much activity was taking place at the medical centers and how this was changing from quarter to quarter. Population growth projections for the San Francisco Bay Area were staggering, and this was part of UCSF's planning for the new hospital. UCSF currently had to turn away transfer patients. It would be desirable for the Committee to be able to track volume performance in the same way as it tracks financial performance. Dr. Byington agreed, noting that financial and volume projections were important for developing strategy and should be carried out at the systemwide level. New reports would be forthcoming.

Committee Chair Lansing emphasized that UCSF could not stand still, given the seismic concerns of the existing hospital. This project was a work in progress, and changes could be made as the healthcare environment changes and new information is received.

Regent Reilly asked about community engagement on this project and about communication with neighbors and community groups. Chancellor Hawgood responded that efforts in this area had been under way for about nine months. UCSF had organized a community advisory committee with 20 to 25 members, including people who are likely to have questions and concerns or even to express outright opposition to the project. There had been numerous town hall meetings open to the public, and UCSF had met in person with every elected official who might be interested in this project—City supervisors, the Mayor, the Governor, and State Assembly and Senate members. The next step would be to communicate about the size and scope of the project; this information was in the public domain.

Regent Sherman asked if UCSF was considering housing as part of this project, given the significant shortage of housing in San Francisco, and supposed that it would be an important element in the EIR process. Chancellor Hawgood responded that UCSF had undertaken comprehensive planning for the Parnassus Heights campus over the past 15 months, seeking to reimagine the form of the entire campus over two to three decades. UCSF planned to add 1,000 housing units on this campus for students, faculty, and possibly staff. UCSF had a comprehensive housing program across all its sites, and intended to use the west end of the Parnassus campus for housing.

Mr. Lipstein emphasized the difference between this project and others the Committee had considered. Between the present time and 2030, the Medicare trust fund would begin deficit spending. At some point between 2025 and 2028, less money would come into the Medicare trust fund than was going out of the fund to pay for claims. All UC campuses would be operating at a deficit without the special, add-on money received from the federal government through the Medicare program. There would be a significant change in Medicare policy midway through the development of this hospital. The Regents should be aware of this during the planning process and not taken by surprise.

Committee Chair Lansing asked that UCSF include consideration of this matter in its updates on the project. She asked that the Committee receive updates on Medicare policy and its implications for all the UC hospitals. Dr. Byington responded that this was a systemwide issue; UC Health needed to incorporate this in its financial planning and to work at the State and federal levels.

Upon motion duly made and seconded, the Committee approved the President's recommendation, Regents Guber, Lansing, Makarechian, Napolitano, Park, Pérez, Sherman, and Zettel voting "aye."

6. **PROPOSED REQUEST FOR THE UCSF MISSION BAY BLOCK 34 CLINICAL BUILDING, SAN FRANCISCO CAMPUS**

The President of the University recommended that the Health Services Committee authorize the San Francisco campus to request approval from the Finance and Capital Strategies Committee at a future date for (1) preliminary plans funding, budget, external financing, and design pursuant to the California Environmental Quality Act (CEQA) for the UCSF Mission Bay Block 34 Clinical Building project and (2) any amendment or modification to the foregoing.

No irrevocable commitment is being made through this authorization.

[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 introduced this item. UCSF proposed to construct a new 190,000-square-foot clinical building at the Mission Bay campus for an ambulatory surgery center and adult primary and secondary multi-specialty clinics. UCSF was also considering including state-of-the-art radiation oncology treatment with proton therapy at this location.

UCSF Health Chief Executive Officer Mark Laret described the location of the proposed building in relation to other UCSF facilities. The concept for Block 34 was a parking structure and clinical building with ambulatory surgery space, outpatient clinics, and urgent care. UCSF estimated the cost of this project at \$366 million with a 12-year payback period; the ambulatory surgery center would have a seven-year payback period. The target date for opening the facility would be 2024.

Regent Sherman asked if a 190,000-square-foot building would make use of the whole site. Chancellor Hawgood responded that this planned size represented the maximum entitlement for this block. Seeking increased entitlement would take years and delay the project.

Regent Sherman asked if this would be a low-rise building with subterranean parking. Chancellor Hawgood responded that the water table in this location was high; the parking structure would be above ground.

Regent Zettel asked if additional floors might be constructed if permission was received in the future to do so. Chancellor Hawgood responded that UCSF was considering potential future entitlement on this block.

Upon motion duly made and seconded, the Committee approved the President's recommendation, Regents Guber, Lansing, Makarechian, Napolitano, Park, Pérez, Sherman, and Zettel voting "aye."

7. **UPDATE ON THE UC HEALTH WORKING GROUP ON CLINICAL QUALITY, POPULATION HEALTH, AND RISK MANAGEMENT AND BRIEF REMARKS REGARDING REDUCTIONS IN UNPLANNED ADMISSIONS AT UC MEDICAL CENTERS**

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

Advisory member Spahlinger reported that the UC Health Working Group on Clinical Quality, Population Health, and Risk Management had met that morning to discuss its charge, to study how the Health Services Committee can exercise its responsibility to ensure the quality and safety of care across the UC system. Over the next year, Deputy General Counsel Rachel Nosowsky would provide a review of governance best practices, and the chief nursing and chief medical officers would create an inventory of quality and safety plans in the UC system. The Working Group would develop systemwide goals and priorities with Executive Vice President Byington. The Working Group would have recommendations by December 2020. Dr. Byington underscored that the Working Group would identify significant goals that all of UC Health can strive for.

UCLA Health Chief Medical and Quality Officer Robert Cherry referred to Clinical Quality Dashboard data provided in the background materials. The medical centers were performing well with regard to mortality, readmission rates, central line infections, and patient satisfaction. Over the last four quarters, in readmission work, the number of beds that have been saved as a result of preventing patient readmissions totaled 888 bed days. This translates to 143 new admissions of patients requiring tertiary and quaternary care. This success was due in part to the increased use of predictive analytics at UC Health and integrating these data into case management workflows. UC Health has also been using new transitional care management codes developed by the Centers for Medicare and Medicaid Services (CMS). These codes allow primary care physicians, nurse practitioners, and others to evaluate patients much more quickly after discharge. UC hospitals were also developing “medication to beds” programs where a patient’s prescription is pre-filled and brought to the patient before discharge. It was also important to reconcile any medications that might conflict with each other and cause readmissions. There were additional efforts at some UC medical centers in which clinical pharmacists assist clinical teams with these reconciliations and ensure that discharges are safe. There has been robust outreach activity to patients’ homes to ensure that patients have a clear understanding of their plan of care. There has been increased engagement in post-acute care and establishing networks of preferred facilities that meet UC expectations. UC Health has been improving its documentation, allowing it to focus on unplanned admissions.

Regent Park referred to a chart showing readmission rate averages from the first quarter of 2018 to the second quarter of 2019. For a number of medical centers, the averages were still higher than desired, even though trend lines were going in a good direction. She asked about when the various measures described by Dr. Cherry had been implemented. Dr. Cherry responded that the time frames of these activities varied. About four years prior, UC Health had begun working collaboratively to reduce readmissions. One challenge is to

optimize these activities, such as bringing skilled nursing facilities together on clinical objectives. Sometimes these facilities have a financial incentive to hold patients for longer than necessary. The University can exercise leverage over these facilities by selecting those who are willing to accommodate UC requests for enhancements to the pathway of care.

Regent Makarechian referred to a chart showing rates of central line-associated bloodstream infections over time and asked why the rate at the UCLA Medical Center had increased in the most recent quarter for which there were data. Dr. Cherry responded that UCLA attributed this to an increased workload for nursing staff. Over the next several months, UCLA would implement a plan to ensure dedicated, protected time for unit directors to engage nurse managers and bedside nurses to work on improvements in day-to-day performance.

Regent Sures asked about the causes for increases in readmission rates. Dr. Cherry responded that this varied among institutions, but that one common cause across the UC system was a diagnosis of sepsis. UC Health was also making efforts for the early recognition, diagnosis, and treatment of sepsis. These early interventions reduce mortality and longer-term morbidity. Different types of infections can give rise to sepsis.

In response to another question by Regent Sures, Dr. Cherry explained that UCLA had found that there could be better scheduling of unit directors' meetings to allow unit directors more time to interact with nurses and clinical teams during peak rounding times.

Regent Park requested comments from the medical center chief executive officers about their efforts to address readmission rates.

UCSF Health Chief Executive Officer Mark Laret stated that this was a regular topic of discussion with all clinical unit leaders. All readmission cases are reviewed. Sometimes the cause of readmission has nothing to do with the initial hospitalization or discharge. This requires constant vigilance. Socioeconomic variables must be taken into consideration, and hospitals that care for more indigent patients have higher readmission rates.

UCLA Health President Johnese Spisso remarked that this was a matter that is reviewed daily at UCLA. UCLA has also implemented post-discharge telephone calls with patients who are at risk of readmission. UCLA Health also works to ensure that the patient and family understand the discharge care plan and when they might have to return to a clinic to address an issue, rather than returning to the emergency department.

UC Davis Human Health Sciences Vice Chancellor David Lubarsky stated that UC Davis reviews all readmissions. UC Davis has a high percentage of Medicaid inpatient admissions, close to 40 percent. The lack of home support services influences the rate of readmissions, especially in light of the fact that UC Davis Health serves a large homeless population through its emergency department. Dr. Lubarsky described this as a source of academic examination and frustration, because there was not sufficient risk adjustment for socioeconomic factors that lead to readmission and to readmission penalties from the

federal government in its payment rates. He suggested that UC Health, as one system, might have a stronger voice on the question of how CMS evaluates readmissions.

UC San Diego Health Chief Executive Officer Patricia Maysent reported that UCSD physicians perform in-home visits. UCSD Health had recently opened an observation unit attached to its emergency department. This unit can place some patients on observation status, address their situation and discharge them, rather than admitting them to the hospital. UC San Diego had also opened a geriatric emergency department and had experienced a 12 percent improvement in readmission rates for this patient population, because it is able to address and organize the situation of some patients when they arrive at the hospital, allowing them to go home rather than being admitted to the hospital.

Advisory member Lipstein observed that the federal government uses the data it has, not the data that it needs, to measure clinical quality. The federal government does not have these necessary data, but UC Health does. He suggested that UC Health, working together, could develop a composite measure of clinical quality, which he defined as adherence to contemporary standards of medical care. There should also be a composite metric of patient satisfaction. Two other categories requiring improvements in measuring and reporting were preventable harm and serious patient safety events. For an institution the size of UC Health, preventable harm events would be measured in the thousands, while serious patient safety events would be measured in the tens. Mr. Lipstein would thus recommend four composite scores on clinical quality, patient satisfaction, preventable harm, and serious patient safety events. He advised against using government figures, instead urging UC Health to draw on its extensive talent base to develop a methodology and to educate the Regents about this methodology.

Committee Chair Lansing expressed concern about the continuity of care for patients who see different doctors, sometimes UC doctors and non-UC doctors, and receive different medicines, drugs that can act against each other. This problem needs to be addressed for the aging population. If UC Health can demonstrate that its measurements are effective, it could lobby the government to recognize and accept them.

Mr. Laret observed that the concern that patients are well cared for when they go into the community highlighted the need for UC Health to have partnerships with other physician groups and hospitals in its region. UC medical centers were developing relationships in which outside physician groups' records are included in UC electronic medical records, including alerts for drug interactions that should be avoided. Committee Chair Lansing emphasized that this requires vigilance.

Dr. Cherry reflected that readmission rates are a local problem. All UC medical centers must take into account community needs. Social determinants are an important factor. The vulnerable populations in UC communities are different and require local solutions.

Advisory member Hetts noted that UC Health has excellent pharmacists who work with physicians to ensure proper drug stewardship. He underscored that electronic medical

records are helping the work of care coordination. These concerns are very much on the minds of UC physicians and other health professionals who help manage patient care.

8. **BEHAVIORAL HEALTH COLLABORATION, SAN DIEGO 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.]

Executive Vice President Byington explained that this item concerned a potential collaboration between UC San Diego Health and two other entities, the County of San Diego (County) and Scripps Health, a private, nonprofit health system, to provide health services primarily for underserved populations in central San Diego. All three entities were committed to improving care for this complex population. The current plan would place two facilities under UC San Diego Health's general acute care license. The arrangement would present additional considerations and potential risks for UCSD as the license holder, and the campus was seeking guidance from the Committee on the "guardrails" for this agreement to address financial, operational, and reputational risks.

UCSD Health Chief Executive Officer Patricia Maysent began the discussion by noting that UCSD was currently involved in public negotiations with the County to develop a regional behavioral health solution. The negotiations were moving quickly and there were time constraints. UCSD was working to secure a binding letter of intent early in the next calendar year. She recalled that UCSD Health was in the process of redeveloping its Hillcrest campus, for which the Long Range Development Plan had recently been approved by the Regents. The Plan anticipates six phases of redevelopment. The first phase would include the dismantling of the locked behavioral health unit, the West Wing. UCSD had been seeking ways to ensure care for this patient population and had begun discussions with the County on collaboration to address mental health needs, particularly those of the behavioral health inpatients in San Diego. The County had deed restrictions on the Hillcrest property, and, in negotiating the removal of these restrictions, UCSD had committed to working with the County on developing a regional solution for mental health. The transaction that UCSD had been working on would potentially require placing the UCSD Health license on the existing County psychiatric inpatient facility. The reason for doing so was that the County was not able to collect Medicaid payments for this standalone psychiatric facility, where 85 percent of the patients were covered by Medicaid. One goal of the transaction would be to create a vehicle for payment for the care of these patients. She estimated that this might draw from \$11 million to \$20 million in incremental income into the region annually. The agreement also anticipated the development of a new facility, to be located between the Hillcrest campus and the Scripps Health campus. The facility would provide 48 to 60 inpatient beds and outpatient services for the long-range care of patients. UCSD Health viewed this as a special project, an opportunity to solve a larger regional problem by providing inpatient services as well as outpatient and continuum-of-care services, working with the County and other partners. UCSD Health was aware that there was a great deal of risk associated with such a project but believed that it was the right action to take.

UCSD Health Chief Strategy Officer Douglas Cates recounted that UCSD Health had been in discussions with the County for several months, and more recently with Scripps Health, about what would be required to make this a successful collaboration. The first principle for a successful collaboration would be to identify the scope, with clarity about the range of activities to be included in the collaboration. These activities would include the two sites and care coordination across the sites, the question of how patients get from an emergency department to an inpatient unit, stepdown unit, or outpatient care as needed. Having an “air traffic control” function for these patients, being able to get patients to the right place at the right time, is critical. A second principle was that UCSD must have reserve powers as the general acute care license holder; UCSD was working to define what these powers must be. The third principle was that the financial contribution would be a prerequisite for participation in this collaboration. Each partner must have a significant stake in the undertaking and feel ownership. The fourth principle was the need for a financially sustainable model, which is challenging in the case of care for underserved populations. The County had committed to changing reimbursement rates to better align with the cost of care, and had begun to do so in other regional collaborations. The fifth principle was utilization management, guidelines for how care will be delivered. The reputation and financial risks of the collaboration had been mentioned. There would be a financial impact on Disproportionate Share Hospital payments and on UCSD Health’s balance sheet. Another consideration was how one would blend UCSD and County staff, nurses and physicians, represented and non-represented. Governance was an important question; how to have three entities build a collaboration in the best interest of patients with a sustainable pathway. Mr. Cates believed that this could be accomplished with the right spirit and that UCSD and its partners were making good progress.

UCSD Health Department of Psychiatry Vice Chair David Folsom noted that this partnership began as an effort to address inpatient psychiatric hospital needs for UCSD and the County, but had grown beyond that initial goal. In discussions with the County, both parties have realized that one of the most significant challenges is that of successfully transitioning patients from hospital care to outpatient mental health treatment. These two treatment systems were completely separate. Discussions had focused on how to improve this situation, and the “hub and spoke” model being developed would bring critical outpatient services to these psychiatric hubs. There would be a focus on ensuring that patients who come to the hospital are stabilized and can successfully transition and receive the outpatient care they need, avoiding the need for re-hospitalization. UCSD would seek greater access to certain County programs for its patients, programs that can shorten the length of time that a patient needs to stay in the hospital. The County psychiatric hospital also has to wait in line to get its patients into these programs. There had been a commitment across the board to improve this process and to ensure that intensive case management services and other wrap-around services, largely provided through Mental Health Services Act funding, are available to patients in the hospital, so that this kind of treatment can begin there, and to ensure that this kind of treatment successfully follows the patient after discharge. This collaboration would provide many opportunities for improving the system of care in San Diego, which had been fractured for a long time. This was a nationwide problem and this collaboration could be a model for the country.

Ms. Maysent added that the collaboration would also include a focus on workforce development, with UCSD Department of Psychiatry leadership in a position to coordinate with the County and others in the region on workforce development; expansion of UCSD medical training in these different environments; and opportunities for clinical research.

Committee Chair Lansing disclosed that she served on the Board of Directors of the Scripps Research Institute and recused herself from the discussion.

President Napolitano stated that this collaboration represented an interesting opportunity. She advised the campus to keep certain points in mind in the next round of negotiations. The first was the sharing of reputational and legal risks, since these facilities would be on the University's license. It was not clear how this would be reflected in the agreement documents, but this point should be discussed by the negotiators. The second point concerned financial risks. The County would be the largest payer in this partnership. These payment obligations needed to be firmly established, and the financial health of UCSD Health and the Hillcrest redevelopment should not be put at risk by entering into the partnership. The third point was that there would be both represented and non-represented staff. This was a complex issue and should be dealt with at the outset. The final point concerned governance. If this was to be a genuine partnership, there must be clarity regarding what each partner is contributing and what each partner reserves to itself. The issues of risk sharing, financial obligations, and workforce planning can be embodied in the governance documents. While a collaboration between only UCSD and the County would be simpler, participation by Scripps Health made this more complicated.

Regent Sherman asked about the timing of the negotiation process. Ms. Maysent anticipated that a high-level letter of intent would be finalized in the next few months, with execution of definitive documents by summer 2020. If UCSD proceeded with putting its license on the existing County psychiatric hospital, located on Rosecrans Street in San Diego, the transition to this facility would occur sometime in 2020. The building of a new facility would take at least five years.

Regent Sherman asked when the Committee would receive progress reports. Ms. Maysent responded that, if the parties achieved a binding letter of intent in next few months, she anticipated that the campus would report back in February or March 2020. She noted that the County Supervisor of UCSD's district would like to see documents by January. Given the additional participation of Scripps Health, the last year of legal work done by UCSD would need to be completely reconsidered.

Regent Pérez praised this endeavor. He stated that UCSD, in discussing this collaboration, should highlight the very positive opportunities for workforce development, academic and clinical training, and research. The complicated nature of this patient population would provide a unique opportunity for UCSD Health, and this should be discussed apart from the reputational risks of the collaboration. Any important agreement with two outside entities would present reputational risks, and the risks in this case were not necessarily due to this particular patient population. He complimented UCSD Health on the thoughtful approach it had taken.

Regent Zettel asked if UCSD was reaching out to community advocacy groups. Ms. Maysent responded that UCSD has been working with a number of advocacy groups who have input on how UCSD is shaping this plan. Dr. Folsom remarked that many of the patients cared for by UCSD are homeless. The hub model would provide opportunities for improving the care for homeless people. UCSD Health has discussed this with groups working on these issues throughout San Diego.

Faculty Representative Gauvain requested clarification of the term “behavioral health.” Dr. Folsom responded that this is a broad term for psychiatric treatment; it can refer to inpatient psychiatric treatment as well as a broader range of mental health care. The term “behavioral health” is used interchangeably with “mental health.” Ms. Maysent added that, in the short term, UCSD and its partners would focus on development of inpatient beds, for which there is a great need in the San Diego region. Nevertheless, the participants realized that the real secret or magic of this collaboration would be in care coordination, ensuring a continuum of care and bridging gaps for patients.

Regent Park asked if this agreement would require approval by the Committee. Ms. Maysent responded in the affirmative.

Regent Park asked if placing the Rosecrans facility on the UCSD license would require Centers for Medicare and Medicaid Services (CMS) approval. Mr. Cates responded that the facility would need to meet CMS requirements within the University’s license.

Regent Park asked if Medicaid reimbursement would be automatic or contingent on other approvals. Mr. Cates responded that this would be contingent upon approval as a licensed facility. Ms. Maysent added that, once the facility was under UCSD’s tax identification number, it should fall within UCSD contracts.

Regent Park asked how critical this anticipated revenue was for execution of the proposed transaction. Ms. Maysent responded that this was a complicated question that UCSD was currently studying. The transaction could stand on its own, without UCSD necessarily placing its license on the Rosecrans facility. The building of a new facility in central San Diego County and the development of a “hub and spoke” system across the region could happen without this revenue. Having the UCSD license on the Rosecrans facility was important because it would unlock \$30 million to \$40 million that could fund employees, research, education, and facilities. UCSD and the County had hired a financial management company to help validate the exact reimbursement that would be released.

Regent Park asked about the Rosecrans facility’s record with regard to licensing and corrective action plans over the past five years. Ms. Maysent responded that the facility had recently gone through the accreditation process with the Joint Commission. Behavioral health facilities are concerned about reducing suicide risk. Many locked behavioral health units were located in old facilities. While the Rosecrans facility had successfully passed the Joint Commission process, it was an old facility, and UCSD and the County viewed it as a short-term solution while a new facility was being built.

Regent Park asked whether, if UCSD put the Rosecrans facility under its license, it would still be staffed by County employees, with supervision by UC employees. Ms. Maysent responded in the affirmative. There would be a time limitation on UCSD's license for the Rosecrans facility. UCSD might lease the employees from the County. The Rosecrans management team must be UCSD employees, but with regard to staff, UCSD might use a staff lease agreement for the short term. UCSD was still working through this issue.

Regent Park asked which aspects of this collaboration were most complicated. Ms. Maysent responded that, in the history of partnerships with counties across the U.S., counties have sought ways to exit transactions or contracts. This could not be the case with this transaction. UCSD and the County would be partners for 15 to 20 years. This could not be a vendor-vendee relationship, such that the County could jettison the relationship; too much would be at risk. The County had shown itself to be creative and flexible in this matter. The financial risks of the collaboration were significant. UCSD Health faced challenges in its days' cash on hand and in the Hillcrest facility project. UCSD could not enter into a transaction that would jeopardize the Hillcrest project in any way.

Regent Park praised the work done by UCSD Health on this collaboration to address a major challenge in the U.S. healthcare system and society.

Regent Leib commended UCSD Health and Ms. Maysent for the work on this project. The County was acting in more innovative ways, and he anticipated further changes in the next year or two. It would be important to ensure that Scripps Health was a genuine partner in the collaboration.

Advisory member Lipstein asked about the wait time for an inpatient psychiatric bed at UCSD. Dr. Folsom responded that this varied. Most patients could be admitted on the same day if they had some kind of insurance. The situation of uninsured patients was difficult. If there was room in the UCSD unit, these patients could be placed in about two days, but admission anywhere else was impossible.

Mr. Lipstein observed that there was a shortage of inpatient psychiatric beds across the country. It would be safe to assume that, once the County beds were transferred to the UCSD license, UCSD would not be able to close the facility. As municipalities across the U.S. close their inpatient psychiatric facilities, they are seeking private sector partners. A plausible scenario was that the County, in spite of its good intentions now, would walk away from this collaboration in three to five years. While this was an important and necessary project, he cautioned that UCSD might find itself left alone in this endeavor. There was a shortage of inpatient psychiatric beds because no one was paying for them. The demand was acute and there needed to be community-wide solutions. It would be advisable to find a way to hold the County and Scripps Health to the agreement so that they cannot walk away. Ms. Maysent responded that the scenario described by Mr. Lipstein was UCSD Health's worst nightmare and the reason why UCSD was working with the Office of the General Counsel on legal structures and the shape of this joint powers authority or joint venture. She believed that acute psychiatric needs would only increase in the future and agreed with Mr. Lipstein's assessment that, once UCSD entered into this collaboration,

it would never close the facility and the patient beds. UCSD was aware of this warning and advice and would work hard to ensure that all partners had a stake in this project.

Regent Park requested information on the legal basis for State and County obligations in this collaboration, in order to understand what the University can do to forge an enduring partnership.

President Napolitano remarked that partnership agreements can include the process and associated penalties for withdrawal from the partnership. Elected officeholders would be replaced during the period of this partnership, and the next group of County supervisors might not be as committed to this project. UCSD could consider building this factor into the negotiations.

9. **SPEAKER SERIES – HOW UC SAN DIEGO SAVED A FACULTY MEMBER AND LAUNCHED THE FIRST DEDICATED PHAGE THERAPY CENTER IN NORTH AMERICA**

[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 prefaced this discussion by underscoring the current threat of antibiotic resistance. The Centers for Disease Control and Prevention had recently released a report with an estimate that approximately 50,000 deaths occur in the U.S. annually due to antibiotic resistance. At this time it was important to develop new and innovative strategies to address antibiotic resistance.

UC San Diego Associate Dean of Global Health Sciences Steffanie Strathdee recounted how, while she and her husband, Thomas Patterson, a faculty member in the UCSD School of Medicine Department of Psychiatry, were on vacation in Egypt in 2015, he became very ill. He was medically evacuated to Germany, where doctors discovered a giant abscess in his abdomen and an infection by acinetobacter baumannii. Mr. Patterson was returned to San Diego and it was found that this bacterium was resistant to all available antibiotics. His condition worsened, he was on full life support, and it seemed that his death would be imminent.

Ms. Strathdee combed through the medical literature and came upon an article on bacteriophage therapy or phage therapy. Phages are viruses that have naturally evolved to attack bacteria. Bacteriophages were identified in 1917 by a French-Canadian microbiologist, Félix d'Hérelle, and used successfully to treat patients in the 1920s and '30s. With the development of penicillin, phage therapy was generally forgotten in the West, and it was considered experimental because clinical trials had not been carried out. Ms. Strathdee believed she might find phages to match her husband's bacteria. She received assistance from Professor Ry Young of Texas A&M University. Within a week, one of his graduate students found four matching phages. UC San Diego Health infectious disease specialist Dr. Robert Schooley contacted the U.S. Food and Drug Administration (FDA), who advised him that the U.S. military was also researching phages. The U.S. Navy

was able to find four matching phages. FDA and other permissions were received to undertake phage therapy. This was a historic moment. Mr. Patterson was the first person to receive intravenous phage therapy to treat a systemic, multidrug-resistant bacterial infection. No one knew what might happen because it was not certain that enough endotoxins had been removed. Three days later, Mr. Patterson woke up from a coma and he was removed from all life support within two weeks.

On the 100th anniversary of the discovery of bacteriophages, in April 2017, a year after Mr. Patterson's treatment, his case was presented at the Pasteur Institute in Paris. Since then, it has been reported by the news media and commented upon in academic medical journals. Intravenous phage therapy has been used for a number of patients at UC San Diego. Each case requires careful phage matching and FDA permission. Ms. Strathdee and her colleagues have also been consulted on dozens of cases in the U.S. and abroad. Chancellor Khosla awarded \$1.2 million to launch the Center for Innovative Phage Applications and Therapeutics (IPATH) at UCSD.

In the past year, the first patient in the world to receive a genetically modified phage cocktail was treated in the United Kingdom. Her therapeutic regimen was intravenous, a billion viruses per dose. She was in hospice care at the time. This was a mycobacterium abscessus infection, a systemic infection with skin nodules and an open chest wound. This patient left the hospital within a week. Dr. Schooley was one of the physicians on this case, and all the phages were crowdsourced by students as part of a Howard Hughes Medical Institute-funded program. This was the first mycobacterium infection to be treated with phage therapy, and mycobacterium abscessus is a cousin to mycobacterium tuberculosis, which kills at least 1.5 million people annually. The possibility that phages could be used to treat tuberculosis is being investigated.

With regard to next steps for research, Ms. Strathdee stated that, in her view, it would be an error to jump to efficacy trials without carrying out translational studies to determine pharmacokinetics, pharmacodynamics, valency, dose, and the best routes of administration. In some cases there is synergy with antibiotics, where phages and antibiotics put selective pressure on bacteria; it would be important to optimize and capitalize on this. The National Institutes of Health (NIH) had just funded their first clinical trial of phage therapy, with Dr. Schooley as the principal investigator. The case of the U.K. patient mentioned earlier had spawned an interest in genetic engineering for phage therapy and synthetic phages.

Ms. Strathdee concluded by outlining some opportunities. IPATH could be expanded across UC Health, because the NIH-funded clinical trial, which was about to begin, was funded through the Antibacterial Resistance Leadership Group (ARLG), a network of investigators of antibacterial resistance. Phage therapy is on the ARLG agenda, with some leading work being done at UCSF. UCSD and UCSF were already involved in phage therapy, and other UC Health partners could also be engaged. There is also a need for phage libraries, matched to the ever-expanding number of multidrug-resistant pathogens, so that phages do not have to be procured from environmental sources. The phages that healed Mr. Patterson were sourced from sewage. Another barrier is the availability of a facility to

produce clinical-grade phage; this would be needed for clinical trials and for patients who are less seriously ill. There was also an opportunity to engage UC students, such as the students who crowdsourced phages for the U.K. patient.

Ms. Strathdee expressed her gratitude to UC San Diego for engaging in an untested, unproven treatment which had saved her husband's life. Mr. Patterson stated that he felt privileged to work at UC San Diego, an environment and people who went to great lengths to save his life. He recalled that he had spent nine months in the hospital and emphasized the potential of phage therapy to reduce hospitalization times.

Committee Chair Lansing concluded that this story was extraordinarily moving and an excellent reminder of the motivation for the work done by UC Health.

Regent Zettel asked about the source of Mr. Patterson's infection. Mr. Patterson responded that he might have been infected in a clinic. Infection by a superbug is as likely to occur in the U.S. as any other place in the world.

Committee Chair Lansing anticipated that this therapy would save many more lives.

10. **COLLABORATING WITH CALIFORNIA COUNTIES TO ENHANCE STUDENT AND COMMUNITY MENTAL 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.]

Medical Director Brad Buchman provided an update on the University's efforts to secure Proposition 63 funding for student mental health services and to seek opportunities for working with counties and the State. At present there were unfortunately no existing grants or proposals awarding money to UC student health and counseling centers. The last time UC had received Proposition 63 funding was about seven years prior, for suicide prevention, early intervention, and suicide awareness.

The University's current proposed strategy was to develop multi-campus, multi-county proposals bringing together three different partners: UC medical center faculty, UC student health and counseling center providers, and the counties. UC Health hoped to start with a small pilot program in Northern California and to develop strategies that can be expanded, depending on local resources, and replicated at other campuses and in other counties. The California Mental Health Services Authority and the Mental Health Services Oversight and Accountability Commission have indicated that they are very much interested in programs that can be replicated.

As a focus for these strategies, UC Health was considering students in transition, such as students coming from home and first arriving at a UC campus. Some of these students must navigate the Medi-Cal system in order to have their coverage reassigned to the county in which they are attending UC. Another transition occurs when students leave UC, and some of these students might lose insurance coverage. Other key groups of students UC was

hoping to target in its proposals were students with chronic care needs, high-acuity illnesses, or escalating care needs. The strategy would be to identify gaps in care in the student and county health systems and seek ways to provide better, more seamless care to students and all county residents, to share resources, and to develop integrated care pathways.

The previous week there had been a meeting with representatives of UC Davis Health and its Department of Psychiatry and Behavioral Sciences, Fresno County, and leadership of UC Merced and UC Davis student health and counseling. UC Merced had the highest percentage of Medi-Cal patients, almost 28 percent of its student enrollment, while UC Davis had the highest number of Medi-Cal patients in the UC system, over 7,000 students, or about 18 percent of the campus' enrollment. UC Davis and UC Merced appeared to be the campuses with the greatest need. Fresno County representatives described their successes in mobilizing Proposition 63 funds, working with UCSF Fresno faculty to provide more services in K-12 schools. Dr. Buchman recalled that there have been successes in other counties, such as Los Angeles County, in securing mental health funding for K-12 schools. Dr. Buchman hoped that these discussions would continue, including Yolo and Merced Counties. UC Davis psychiatry faculty were interested in these efforts to create integrated care models. In further meetings, the partners would develop the components of a pilot program proposal.

Interim Vice President Gullatt noted that, as this work progressed, it became clear that there was a lack of personnel at the Office of the President (UCOP) to support the work with the counties and the work toward campus mental health goals. UCOP was in the process of recruiting for a new position, Director of Student Mental Health and Well-Being. UCOP was looking for an individual conversant with public health issues who would work with the Office of Risk Services and UC Health on advocacy and fundraising.

Regent Leib praised the University for recruiting for this new position and stated that it made sense to focus the initial efforts on Proposition 63 funding with Merced and Yolo Counties.

Regent Park asked why counties have funded K-12 mental health services while there has been an absence of funding for college student populations. She asked if this was because the University had not requested such funding. She also asked how receptive counties have been to the idea of using Proposition 63 funds for the college student population. Dr. Buchman responded that UC had not requested Proposition 63 funds for a number of years. The California State University (CSU) had been trying to engage with the counties over the past year, with limited success. San Bernardino County was funding one FTE at the student counseling center at CSU San Bernardino. While there might have been a bias on the part of the counties, it was reasonable to ask whether UC had requested loudly enough or requested with a good proposal. The University was in the early stages of designing a proposal and developing a more effective request. In Fresno County, a \$112 million grant in Proposition 63 funds had been secured, with much of the clinical work being done by UCSF Fresno faculty and trainees. This would allow for expansion of training programs and additional adolescent psychiatry fellowships. UC Health was

struggling to find ways to work more closely with the counties. There had been some workforce training exercises and collaborations with the counties, but these involved small dollar amounts. The dollar amount needed by UC to meet the needs of its students was far higher.

Regent Park asked if Dr. Buchman had found, in the more recent engagement with the counties, that there had been a positive, open attitude about using county Proposition 63 funds for student mental health. Dr. Buchman responded that UC had received a strong indication from the Fresno County Director of Behavioral Health that Fresno County felt obligated to take care of UC students who are county residents. He hoped that other county mental health directors would express similar enthusiasm.

Faculty Representative Bhavnani asked about telehealth and mental wellness. Dr. Buchman responded that UC was considering telehealth as a component of its student mental health services. An advantage of telehealth is that one psychiatrist can access students at a number of locations. Multiple telehealth projects were ongoing, such as the telemedicine and telepsychiatry initiatives at UC San Diego and UC Davis. The State and counties believed that, if UC can develop a telehealth and telepsychiatry component to serve the campuses, UC might also be able to begin serving the underserved communities at some distance from these campuses, such as in the Central Valley. Telehealth would be one part of a larger strategy. All UC's partners in these discussions have expressed the need for in-person presence and capability, to whatever extent it can be provided.

Ms. Bhavnani expressed concern about some patients' language capability and their ability to express themselves in a situation of crisis. Dr. Buchman recalled that, in the student mental health funding initiative over the past four to five years, the University has emphasized diversity in its recruitment for counseling and psychiatry positions.

Faculty Representative Gauvain asked about the major mental health issues of students who seek services at UC counseling centers and if students mostly seek help for themselves, or for friends or roommates. Dr. Buchman responded that the most frequent diagnoses for students are anxiety, dysthymia, and depression. With regard to the question of self-referrals or referring others, the University was trying to make it easy for students to discuss these issues and was providing training for faculty and staff to serve as educated referral sources, so students know where to go for help. UCSD Health Chief Executive Officer Patricia Maysent illustrated the need for mental health services by noting that, at UCSD, the enrollment had grown by 30 percent over the past ten years, while the demand for mental health services had grown by 90 percent. There was an opportunity to engage UCSD Health subspecialists to address student mental health issues such as eating disorders, substance abuse, and mood disorders, chronic conditions that need higher levels of care. Dr. Buchman added that the most time-consuming and intensive care is for patients with eating disorders who are becoming suicidal, with psychoses, or with severe substance abuse problems. While there are not many such cases, they take up much of providers' time and a great deal of work is required to manage these patients.

Regent Pérez concluded the discussion by remarking that, while telehealth services for mental health should not replace in-person care, this was a promising tool. The broad-based cultural competency of providers was an important factor. There was a dearth of providers in the area around UC Merced, and there was a dearth of providers with specific cultural competencies, the most salient example being competency with respect to transgender and nonbinary students. Incorporating tele-mental health would be an important element in supplementing, not supplanting, other services. Over time, the University should track the effectiveness of tele-mental health services for different groups of students.

The meeting adjourned at 1:25 p.m.

Attest:

Secretary and Chief of Staff