The Regents of the University of California

HEALTH SERVICES COMMITTEE
August 13, 2019

The Health Services Committee met on the above date at the Luskin Conference Center, Los Angeles campus.

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

In attendance: Regents Kieffer, Leib, Um, and Weddle, Faculty Representatives Bhavnani and May, Secretary and Chief of Staff Shaw, General Counsel Robinson, 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 10:05 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.   Beverly Weiss spoke about the debilitating effects of myalgic encephalomyelitis (ME), or chronic fatigue syndrome (CFS), a neuroimmune disease which affects at least as many people as HIV/AIDS. Many cases remain undiagnosed or have been misdiagnosed and there are few specialist doctors who can treat this disease. She asked the University to treat and diagnose people with ME.

B.   Mary Callender described cases of ME, which renders people unable to work or engage in ordinary activities. She acknowledged that it would take many years to solve the problem of ME and urged the University to help people with ME to regain their lives by diagnosing and treating them.

C.   Katy Coyle noted that, due to the complexity of symptoms in ME patients, the disease can go unrecognized for years. The National Institutes of Health recognized ME as a severely debilitating disease in 2015. She asked that the University partner with ME activists to formulate a plan for the UC system in order to teach medical students about this disease and to support a new generation of specialists.

D.   Martin Weiss commented on how difficult it is for ME/CFS patients to find treatment. Twenty-five percent of ME/CFS patients are bedbound, unable to

tolerate sound or light. Many, perhaps most, are homebound and cannot work. He asked that doctors and nurses be trained to recognize this disease and that UC include ME/CFS in its continuing medical education curriculum and in its mandatory curriculum.

E.   Gregory Gabrellas, a resident physician in psychiatry in his third year of postgraduate training and representative of the Committee of Interns and Residents (CIR), which was in negotiations for its first contract at UCLA, described the financial and work pressures experienced by medical residents. Residents were asking that they be able to access their union in the workplace.

F.   Daniel Okobi, a second-year resident in neurology at UCLA and member of CIR, noted that, under AB 119, unions are entitled to meaningful access to members at the workplace, contact information for members, and the right to meet with new employees during orientation activities. UCLA had failed to provide this access and information for CIR.

G.   Kathryn Weaver, a fellow in child psychiatry at UCLA and CIR member, commented that residents are often reluctant to see a doctor when they need care themselves. UCLA residents spent about 60 percent of their monthly income on rent. CIR wished to ensure that residents receive their health benefits at UCLA and without co-pays.

H.   Caleb Wilson, a third-year resident at UCLA, emphasized the importance of maintaining the healthcare benefits offered to UCLA medical residents. Residents experience significant physical, mental, and financial strains. He asked that UCLA recognize this and that this be reflected in UCLA's negotiations with CIR.

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

Upon motion duly made and seconded, the minutes of the meeting of June 11, 2019 were approved.

3.   **REMARKS OF THE EXECUTIVE VICE PRESIDENT – UC HEALTH, AND FOLLOW-UP TO DISCUSSION ON A CLINICAL QUALITY AND SAFETY WORKING GROUP**

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

Executive Vice President Stobo welcomed two recently appointed UC Health administrators, UC Davis School of Medicine Dean Allison Brashear and UC Riverside Health Chief Executive Officer Donald Larsen.

Dr. Stobo presented a financial summary chart for the UC medical centers. He noted that the days' cash on hand for UC San Diego was slightly below the required level of 60 days.

He had discussed this with UCSD Health Chief Executive Officer Patricia Maysent. UCSD was aware of the target level and had a plan to achieve 60 days' cash on hand over the next several months. All other figures showed that the UC medical centers were performing well financially.

Regent Makarechian asked why both modified operating income and modified earnings before interest and depreciation had declined from 2018 to 2019 for UC Davis, while there had been increases at all the other medical centers. UC Davis Human Health Sciences Vice Chancellor David Lubarsky recalled that, a year earlier, there had been a $90 million settlement with Sacramento County, and this had significantly inflated UC Davis' earnings for that one year. Dr. Stobo added that this money owed to UC Davis had to be recorded as one lump sum even though it would be paid out over a period of years. Dr. Lubarsky noted that this period might last 20 to 30 years.

Regent Sherman asked about the reason for the large income and earnings increases at UCLA from 2018 to 2019. UCLA Health President Johnese Spisso attributed these increases to some out-of-period funds as well as to a risk performance improvement program that produced $80 million through work on revenue cycle, supply chain, and other efficiencies.

Regent Sherman asked if these income and earnings levels would continue or if there would be a decrease because one-time funds received this year would not be received the following year. Ms. Spisso anticipated that there would be a decrease and that UCLA would return to an expected level in its five-year financial plan.

Dr. Stobo recalled data presented at past meetings several years prior indicating that, if no changes were made in the management of the medical centers, the medical centers' expenses would begin to exceed their revenues around 2017-18. Outstanding management of each UC medical center was the reason for the positive performance. In the face of diminishing reimbursement and rising expenses, each medical center has a robust expense reduction plan and financial improvement plan to stave off the expected financial challenge.

Regent Sherman asked about the amount of the medical centers' contribution to the medical schools in this fiscal year. In past years this amount had ranged from $400 million to $500 million. Dr. Stobo anticipated that the contributions would remain the same or be greater in some cases.

Dr. Stobo then reported on recently released hospital rankings by *U.S. News and World Report*. All five UC medical centers ranked in the top ten California hospitals. In national rankings, UCLA Medical Center was ranked sixth in the U.S. and UCSF was ranked seventh. This was an indication of the outstanding management and leadership at all the UC medical centers.

Dr. Stobo recalled that, at the last meeting, he had suggested the formation of a working group, a subgroup of the Committee, to help exercise the fiduciary responsibility of the

Committee with regard to quality and safety at the medical centers and in faculty practice groups. Regents Park, Zettel, and Makarechian and Advisory member Spahlinger had agreed to serve in this working group to examine the Clinical Quality Dashboard and other quality benchmarks, goals for the coming year, and other issues related to quality. He had asked Dr. Spahlinger to report on the working group's deliberations to the Committee. He also noted that President Napolitano had formed a working group on affiliations.

President Napolitano explained that this Working Group on Comprehensive Access arose as a consequence of the decision to withdraw from UCSF's negotiations to expand its relationship with another health system in the San Francisco Bay Area. One outcome of those discussions was a commitment to review all of UC Health's existing affiliations and address concerns that had been raised. The University must ensure that it is fulfilling its core values and that these values are integrated into its health services agreements. The Working Group would develop recommendations to ensure that UC personnel remain free to advise patients on all treatment options and that patients have access to comprehensive services. The Working Group's goal would be to provide written recommendations to President Napolitano within 90 days of the Working Group's first meeting. Chancellor Gillman, Regents Lansing and Elliott, and Advisory members Hernandez and Hetts had agreed to serve on the Working Group, and there would also be representatives of the Academic Senate and UC Health campuses.

4.   **APPROVAL OF 2019 BENCHMARKING FRAMEWORK/MARKET REFERENCE ZONES FOR NON-STATE-FUNDED UC HEALTH POSITIONS IN THE SENIOR MANAGEMENT GROUP**

Contingent upon approval by the Governance Committee, the President of the University recommended that the Health Services Committee approve the 2019 Benchmarking Framework/Market Reference Zones for non-State-funded UC Health positions in the Senior Management Group, as shown in Attachment 1.

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

Executive Vice President Stobo explained that the Committee and the Board were charged with examining the Market Reference Zones (MRZs) for UC Health executives, about 30 individuals. Parameters set by the Committee and the Board guide the development of the MRZs.

Acting Vice President – Human Resources Lloyd explained that the MRZs presented in this item were for UC Health clinical enterprise positions which were non-State-funded and which required approval by the Health Services Committee and the Governance Committee. If approved today by the Health Services Committee, these MRZs would be presented to the Governance Committee for approval at the September Regents meeting. All other MRZs, requiring approval by the full Board, would also be presented at the September meeting. The benchmarking framework used for the 2019 update of UC Health MRZs was unchanged from the 2018 benchmarking framework. The updated MRZs

reflected updates to the underlying market data. No individual increases were being recommended in relation to these updated MRZs. In January 2019, a Working Group review of the Sjoberg Evashenk "University of California 10 Campus Study" provided recommendations regarding salary decisions. The Working Group recommended that the University continue to support salary-setting at market-based rates, evaluate the MRZs annually rather than every two years, and provide an opportunity for chancellors to provide input into the MRZ benchmarking process. Ms. Lloyd reported that, in light of these recommendations, a working group would be formed in this year to review current Senior Management Group (SMG) MRZ benchmarking practices. Chancellors and Regents would be involved in the discussions and outcome. The working group would be established and would have sufficient time to consider any updates to the underlying methodology for approval by the Regents in June-July 2020. For 2019, only the underlying market data had been updated. There was no change to the benchmarking framework or process. Compared to the 2018 MRZs, in the aggregate, the 50th percentile for the proposed 2019 MRZs had increased by 9.8 percent across UC Health non-State-funded positions.

Advisory member Lipstein recalled that a working group several years prior had identified peer groups for each MRZ. While the methodology had not changed, it might be helpful for both the Health Services Committee and the Governance Committee to receive information identifying the peer groups. There were different peer groups for different positions. It would provide comfort to both Committees to know that these peer groups were extensive and representative. Dr. Stobo recalled that there were more than 100 comparators and about 45 percent of the comparators were public institutions. This was a robust comparison with public and private institutions across the country. Ms. Lloyd added that this information could be provided. Dr. Stobo stressed that the MRZs were guidelines for determining compensation. Approval by the Governance Committee in September would not result in any salary increases.

Regent Park raised a number of concerns. There were disparities in salaries among the medical centers. The Regents must be mindful of the growing income inequality between staff and executives at the medical centers. Referring to the working group to be formed in 2019, she asked what factors should be considered. The University might consider increasing bonus compensation rather than salary and examine trends in executive compensation other than simply increasing that compensation.

Committee Chair Lansing stated that the Regents must be aware of comparative salaries, and not only for executives. The income disparity referred to by Regent Park was that within the Regents' purview. The Regents should also focus on other positions, positions that were not in their purview, and ensure that these positions were paid fairly. She underscored the realities of the job marketplace.

Regent Kieffer observed that the Regents were often torn between different fiduciary duties to meet the University's needs, to maintain the quality of the University, and to spend State money wisely. He suggested that, in the future, the Regents could consider a policy of how they examine compensation for employees other than SMG members. Historically, for UC, this has been the market rate; UC wishes its salaries to be at market levels at a minimum.

The University might take a leadership role nationally in how it considers this compensation. This would have to be balanced against the Regents' fiduciary duty to spend the University's money properly and wisely. If the Regents had an overall policy on compensation for these employees, they might be more comfortable about decisions made for executive-level employees and in collective bargaining.

President Napolitano explained that when UC negotiates its union contracts, it uses the market as the benchmark for wage proposals. Market compensation levels in California were rising.

Regent Um stated his view that a situation in which UC loses an employee and tries to hire for the position would serve as an indicator of UC's position relative to the market. He suggested that the Regents receive accounts or anecdotal information about such cases, real-life situations that would provide comfort about the compensation decisions the Regents make. Dr. Stobo responded that this kind of anecdotal information about compensation had been presented at past meetings. These were cases of individuals who had left UC or had decided not to come to work at UC simply based on compensation. He stated that, based on the MRZ information, UC Health did not overpay its executives. It was equally important to discuss the salary differences between executives and other employees. In his view, UC was close to being in danger of losing certain employees because it was paying far below market.

Committee Chair Lansing observed that some of the concerns being expressed pertained to other employees who were not within the purview of the Health Services Committee. Chair Pérez and President Napolitano might consider how to address this issue.

Chair Pérez expressed agreement with Committee Chair Lansing. In the case of the proposed MRZs, there was a clear, logical argument for the University to move in the direction of the market to secure the talent that it needs. He noted that the market might not always be in alignment with the values of the Regents and the University. If the market is unreasonably low, the Regents should consider whether they are comfortable with compensation at that level or if they wish to set an example of where the marketplace should be. For example, the Regents might consider whether they wish to change the marketplace compensation situation for medical interns and residents.

Committee Chair Lansing recalled an earlier time when UC hospitals were not performing well financially and the University considered separating them off as separate entities. UC Health must secure the best people for patient care and medical research, and the Regents do not wish to jeopardize this effort.

Upon motion duly made and seconded, the Committee approved the President's recommendation, Chair Pérez abstaining.

5.   **UNIVERSITY OF CALIFORNIA EFFORTS TO IMPROVE DIVERSITY IN THE HEALTH PROFESSIONS**

[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.]

Vice President Nation began the discussion by noting that much of the University's motivation to improve diversity in UC Health, besides the goal of institutional excellence, stemmed from the demographics in the State of California. California's population was among the most diverse in the nation. Cultural and linguistic limitations create barriers to health care and access, particularly in the most underserved communities, which in California includes rural communities, inner cities, the San Joaquin Valley, and the Inland Empire. Patient-provider concordance of race and language strengthens the bond between them and improves patient satisfaction. Ninety-two languages are spoken in K-12 public schools in Los Angeles County. Diversity in the health workforce helps expand access for the underserved, serves as an impetus for research on areas of need, and improves cultural and linguistic competence among providers. The University of California has an important role to play. UC is among the largest training systems of its type in the U.S. Improving diversity in the health professions depends on the success of educational institutions like UC in recruiting, training, and preparing increasingly diverse populations of students. UC Health professional schools are top ranked in the nation. The University operates six schools of medicine, four nursing schools, two schools of public health, two schools of pharmacy, and an internationally recognized school of veterinary medicine. UC is training the next generation of healthcare providers. California leads the nation in the success and retention of medical students and residents. UC Health's professional schools enjoy graduation rates of 98 to 99 percent, and students go on to be successful in their careers. Dr. Nation recalled that, at the April meeting, there had been a discussion on the report of the California Future Health Workforce Commission. Among the top ten of the Commission's recommendations, half focused on the need to improve access to health care for underserved communities and identified the need for improvements in diversity of students and residents. The UC Health strategic plan was finalized in 2018 and refreshed and updated in February 2019. One of the plan's goals is to support each UC health professional school in its efforts to improve diversity and campus climate for all UC health professional students, faculty, residents/fellows, staff, and administrative leaders by sharing strategies that have proven effective in the health sciences by June 2020. The UC Health Diversity and Inclusion Task Force, which had representatives from all 18 UC health sciences schools, had the charge of identifying effective policies, practices, and/or assessments that aim to improve diversity and campus climate, increase accountability, and create opportunities to share best practices across the UC health professional schools.

UCSF Vice Chancellor Renee Navarro remarked that the pipeline of students to UC health sciences schools varies by field. The Task Force had identified challenges to achieving diversity and was moving the schools toward a comprehensive and focused action plan. This would start with a clearly articulated goal, foundation, and commitment from leadership in each of the schools. The Task Force had formed subgroups, which were examining the unique challenges for students, residents, fellows and faculty. The Task

Force and subgroups would continue to meet and work on a report to be presented in 2020. The report would include recommendations for continuing work on improving diversity.

Dr. Navarro presented a chart indicating the race/ethnicity of UC health sciences students by profession. By program, the highest percentage of underrepresented minority (URM) students, 32 percent, was in the nursing programs. Thirty-one percent of students in Doctor of Public Health programs were URM students as well. Several programs faced significant challenges, with less than ten percent URM students. The schools of medicine combined represented the largest program, with 3,081 students. About 24 percent of medical students were URM students: 16.7 percent Hispanic, or 514 students; 7.4 percent African American, or 228 students; and only 0.3 percent, nine individuals who were American Indians or Alaska Natives. Asian American students were the largest group of medical students, at 31.5 percent, while white students made up 30.8 percent of medical students. In the UC health professional schools overall, the largest represented group was Asian American, at 34.6 percent; white students were 31.7 percent of the total. URM students made up a combined 20.2 percent of the total.

Dr. Navarro then presented a chart with data on health sciences faculty that indicated challenges with racial and ethnic diversity. The health sciences schools also had relatively few ladder-rank or equivalent faculty positions available. Across all 18 health sciences schools, there were seven American Indian or Alaskan Native, 51 African American, and 92 Hispanic ladder-rank faculty members. They represented 8.2 percent of ladder-rank or equivalent faculty. With regard to faculty in non-tenure-track positions, only 8.2 were from URM groups as well. While URM students accounted for about 20 percent of the student body, only about eight percent of faculty were from URM groups.

Dr. Navarro discussed initiatives undertaken at UCSF that showed progress and promise. In 2010, a relevant Chancellor's Cabinet position was created, and a campus and medical center strategic plan was completed in 2013, the Roadmap to Inclusive Excellence. Under the Roadmap, UCSF defined the need for comprehensive interventions to create and sustain diversity and inclusion for students, faculty, and staff. She described this work as "continuous equity improvement," introducing interventions, measuring impact, and making course corrections. The UCSF Office of Diversity and Outreach facilitates partnerships across schools, the medical center, departments, and leadership on issues of recruitment, inclusive curriculum development, culturally competent care, mitigation of bias, and establishment of a climate and culture that are welcoming for all groups. Much education and training is focused on climate. An unconscious bias initiative has trained over 5,000 members of the campus community. UCSF had created a diversity, equity, and inclusion certificate program for staff. The intention is that staff who receive the certificate return to their departments and act as agents for change. Over 1,000 faculty had received training at day-long diversity, equity, and inclusion Champion Training sessions. UCSF has also focused on institutional barriers in order to strategically disrupt the status quo and raise questions about the physical environment, the admissions process, the hiring process, and accountability over time for decision-makers. From 2010 to 2017, URM faculty had grown from 136 to 270, an increase from 5.4 percent to nine percent of all faculty. The percentage of URM students, residents, and fellows had increased from 12.9 percent to

16.1 percent. UCSF was making progress but it was still slow. Incentives for hiring had contributed to faculty progress. The Advancing Faculty Diversity grant from the Office of the President had facilitated the hiring of four ladder-rank faculty. UCSF had hired only one Presidential Postdoctoral Scholar due to the small number of ladder-rank faculty positions. Dr. Navarro credited the Program in Medical Education (PRIME) at UCSF for increasing the number of URM applicants to the UCSF School of Medicine.

Dr. Nation discussed the PRIME program, which provides an annual set of successful outcomes and aims to align the University's medical education program with its mission in society by focusing on the needs of medically underserved communities, in alignment with the state's changing demographics. PRIME is a systemwide initiative that had been launched 17 years earlier as a strategy for expanding medical student enrollment, because UC had experienced very little growth in its total number of available spaces for medical students in decades, in spite of the number of college graduates interested in attending medical school and the large number of applicants who do not gain admission to a UC medical school. The application pools for UC medical schools range from about 5,700 applicants at the newest school, the UC Riverside School of Medicine, for an entering class of 70, to more than 14,000 at the UCLA School of Medicine. In the PRIME program, each school has an identified area of focus: rural communities at UC Davis, the Latino community at UC Irvine, and the urban underserved at UCSF; and there is a regionally designated PRIME program focused on the San Joaquin Valley. There are core elements of the PRIME program, but the details are entrusted to the faculty and leadership for each program. Each program has a recruitment strategy for students who will return to practice in these areas. Each program has a step in the admissions process to assess the candidate's "fit" for the program, assessing this student's interest and likelihood that, for example, a UCSF student will return to work on behalf of the urban underserved. In each program, students must meet all basic requirements for graduation and take core courses with all other students, but there is an additional increment to sustain their interest in these goals, some of which focuses on disparities in health status. When students enter clinical training, there is preferential consideration for these students to be placed in sites serving these populations. The newest of these programs is the San Joaquin Valley PRIME program, with UCSF as the designated degree-granting school. This program preferentially recruits students from the San Joaquin Valley or with close family ties to the region and who articulate hopes and interest in returning to these communities in the future. In 2018-19, there were 354 medical students enrolled in PRIME programs. Many PRIME students also seek to complete a master's degree in business or public health, seeking additional skills in order to be able to serve as advocates for underserved communities. Sixty-two percent to 67 percent of PRIME students were URM students, and this had been the case for more than a decade. Dr. Nation concluded her remarks by outlining the next steps for the UC Health Diversity and Inclusion Task Force, whose findings and recommendations were expected to be presented in fall 2020. While other fields and professions face different challenges, they could learn from these findings and recommendations. She asked two UC Health deans to present remarks and noted that the University of California manages and operates about 40 percent of all graduate medical education in California.

UCLA School of Medicine Dean Kelsey Martin stated that there is decreasing diversity along the trajectory from medical students to residents, faculty, chairs, and leadership, and this decrease needs to be addressed. In biosciences at UCLA, about 25 percent of Ph.D. students were currently from URM backgrounds; this declined to about 15 percent among postdoctoral fellows, and the percentage was significantly lower at the faculty level. One of UCLA's efforts, in addition to addressing each level from medical student to leadership, has been to focus efforts on graduate medical education and residency selection. UCLA has established a Resident Diversity Committee, which has been active in developing mentoring for current students and establishing programs for open houses. An event scheduled for early September would provide information on applying for residency at UCLA for all interested Southern California medical students. This was an effort to ensure that UCLA recruits the highest-quality diverse class of residents, recognizing that some residents stay on as faculty after completing their residency.

UCSF School of Medicine Dean Talmadge King discussed UCSF efforts to increase URM faculty. While UCSF had successfully recruited URM medical students, it had earlier neglected to communicate that it hoped that these students would stay on as faculty. When UCSF plants this seed, it changes how students feel about UCSF, and students have a different mindset about their path forward through medical school and residency. There are many discussions about diversity at UCSF, and Dr. King reflected on different aspects of this complex issue. Efforts on diversity are part of the annual review of UCSF departments and most departments have a diversity leader. UCSF's Watson Faculty Scholars program provides grants to faculty who believe in the mission of diversity. Dr. King noted that the first three to five years in faculty members' careers at UCSF are critical for the retention of faculty.

Chair Pérez praised the presentation but wondered whether it reflected the intensity and urgency needed in addressing this question. He was shocked that there was no explicit discussion of sexual orientation and gender identity. It had been noted in other discussions that many people who are openly gay or lesbian in the rest of their life do not disclose their sexual orientation to their physicians. As a result of this, doctors write inaccurate medical histories and bad decisions are made with regard to managing patient care. Many UC medical schools were training doctors to be culturally competent in this area; this should have been highlighted in this discussion. With regard to language competency needs in health care, data indicated great need for medical practitioners who speak Spanish, Vietnamese, and Filipino languages, most significantly Tagalog, given the high concentrations of patients speaking these languages in California. This should be addressed with more specificity. Chair Pérez asked why UC Riverside was not included in a chart showing PRIME enrollment numbers. Dr. Nation recalled that the PRIME program was launched in 2004, before the decision was made for establishing an independent School of Medicine at UCR. When plans moved forward for the UCR School of Medicine, it was clear from the beginning that the mission of this sixth school of medicine would be to focus on the needs of the rapidly growing Inland Empire region, based on factors such as health disparities and access to care. Earlier, UCR had had a PRIME program, a joint program with UCLA. The UCR leadership reviewed this program and felt that the entire mission of the new UCR School of Medicine was oriented toward PRIME goals. Because the entering

class size for the PRIME program was small, only four students, and no State General Fund monies were linked to the enrollment, UCR discontinued this PRIME program. Most PRIME programs have 12 to 15 students per year, with 80 to 85 PRIME students graduating annually systemwide. The UCR School of Medicine was getting close to graduating 70 students annually, most of whom have ties to the Inland Empire. The UCR School of Medicine student body is diverse, with opportunities for merit scholarships that enable the cost of attendance to be repaid if, following training, they return to the region. There have been discussions about a possible PRIME program at UCR focusing on mental health. UCR would develop a PRIME program in the context of the School of Medicine and one that would not compromise the overall mission of the School.

Chair Pérez observed that success in this area was uneven across the UC system, as one might expect in a large, highly variegated organization. He suggested that UC Health consider targets set by campus chief diversity officers. He emphasized that this was an urgent matter and remarked on how it was related to accountability and criteria such as how UC performs compared to other institutions and how long it would take UC to achieve targets. He identified diversity among faculty in public health as a particular concern. He expressed appreciation for the efforts outlined by Drs. Nation and Navarro but concluded that there was more that UC Health could and needed to do.

In response to a question by Regent Makarechian, Dr. Navarro explained that the majority of Latino students at UC Health are in the fields of medicine and nursing, while only a few are enrolled in veterinary medicine, optometry, and pharmacy programs.

Regent Makarechian asked about financial aid. Dr. Navarro responded that financial aid is a significant issue for URM students and students from low-income families because the costs of medical education are substantial. There are some scholarship programs, such as the Geffen scholarship at the UCLA School of Medicine. The State of California had introduced a payoff of student loan debt up to $30,000 per year for medical and dentistry students who would, as practitioners, accept Medi-Cal patients and work in areas with high concentrations of Medi-Cal patients. The federal government also offers loan forgiveness programs for students who pursue biomedical research; students can apply for these programs. Dr. Nation added that California has some longstanding loan forgiveness programs administered by the Office of Statewide Health Planning and Development, largely available for physicians. The California program mentioned by Dr. Navarro came about through Proposition 56, the Tobacco Tax Act, which provided a new pool of approximately $200 million for loan forgiveness for physicians and dentists who would provide service to Medi-Cal patients. This is administered by Physicians for a Healthy California, a private foundation linked to the California Medical Association. There are also local resources derived from philanthropy. She referred to scholarship resources that would pay the full cost of attendance for graduating UCR School of Medicine students who return to practice in the region for five years. The cost of attendance for UC medical schools had grown substantially. Annual mandatory charges were at $30,000 and above, and the cost of living in cities where the medical schools are located was high, with the exception of Riverside.

Regent Makarechian stated that it is important to advertise whatever financial aid the University can provide. The cost of a medical school education is a primary concern for any potential student.

Regent Park asked how the applicant pool for UC Health programs compared to enrollment numbers. Dr. Martin recalled that one element of UCLA Health's efforts for diversity is a partnership with Charles R. Drew University of Medicine and Science in South Central Los Angeles. The UCLA medical student applicant pool was currently at 16 percent URM. She recognized UCLA's challenge as encouraging students early on to apply to the UCLA program.

UC San Diego School of Medicine Interim Dean Steven Garfin reported that UCSD begins with a pool of 17 percent URM applicants; the acceptance rate for these students is about 25 percent. Discussions with URM medical students indicated that UCSD's outreach was not effective, and UCSD has added staff for recruitment efforts. This was a pipeline issue. UCSD Health provides some summer jobs for high school and college students, who receive mentoring and exposure to the health sciences.

UC Davis Human Health Sciences Vice Chancellor David Lubarsky stated that UC Davis views the situation as a crisis and takes seriously its responsibility to the Central Valley and to urban areas. UC Davis invested its own funds in the creation of eight new full-tuition scholarships for individuals dedicated to practicing in the urban core. In doing this, it changed the mindset of many of its own applicants and, this year, matriculated the most diverse class in the history of UC Davis Health. UC Davis was working with the California Medical Association to ensure that there are scholarships and pathways for medical students who will be dedicated to serving the underserved. With regard to Chair Pérez's concern about gender identity, Dr. Lubarsky noted that UC Davis Health supports the only free transgender clinic in a three-county area. Dr. Lubarsky has asked family practice and internal medicine to develop an education program for all primary care physicians regarding patient sexual orientation and to ensure that the HIV prevention medication PrEP is available to all patients, without stigma. Chair Pérez recognized that UC Davis was among the first institutions to focus on cultural competence in healthcare delivery for all its medical students. Dr. Lubarsky commented that, when one trains a diverse workforce, people who communicate, empathize, and belong to a community, this results in more effective medical practice and patients listen to what their provider says.

UC Irvine School of Medicine Dean Michael Stamos noted that UCI's diversity efforts included the recent hiring of Douglas Haynes, the campus' first vice chancellor for equity, diversity and inclusion, whose activities would extend to the health enterprise as well. The School of Medicine's Diversity Council works to ensure that students feel welcome. An alumni philanthropic gift has allowed UCI to create an LGBTQ scholarship program for medical students. Dr. Stamos emphasized that UC medical schools are in a competitive environment and they are not the only medical schools interested in recruiting URM students. Students at this level have many choices, and UC medical schools needed to develop a pipeline from junior high and high schools. One of UC Irvine's advantages is

that UCI owns two Federally Qualified Health Centers, which are of interest to many URM medical students.

Regent Park asked how UC Health values what a student brings in terms of community asset. UC Health had clearly identified all the benefits that result from a more diverse workforce. She wished to ensure that the commitment to this value is consistent across all stages of the pipeline including admissions and recruitment. She asked about the cost of the PRIME program and if PRIME could be expanded. Dr. Nation responded that there had been little growth in health professional school enrollments over decades. There were currently challenges for the UCR School of Medicine to reach a desired scale, working with launch funding for the School. The University launched the PRIME initiative with the idea that UC would have the equivalent of marginal cost support for adding medical students, believing that this approach would be more cost-efficient than building a new medical school. There was some room for growth within the existing medical schools. With the PRIME program, the University wished to increase its medical school class sizes from 150 to about 162 to 165. UC wished to have a critical mass of PRIME students, but this increased number of students needed to fit within existing space and resources. The University conceptualized the initiative and medical schools identified their areas of focus. The University's intention was that there be General Fund support for the additional medical students, but the beginnings of the program coincided with the Great Recession experienced by the State of California. There was some initial General Fund support as the PRIME program at UC Irvine was launched, and then some support for the UCSF and UC San Diego programs, which were launched next. UCLA received no support because it was the last campus to admit PRIME students. In the prior year UC budget there was no incremental request for PRIME, but a request for the marginal cost of instruction of $35,000 per student. This cost was acknowledged by the State in funding for the San Joaquin Valley PRIME program. The additional costs were managed locally, but UC Health was seeking core support to sustain the PRIME initiative.

Regent Park remarked that UC might miss opportunities due to an inability to diversify its workforce more quickly. She reiterated that UC Health must value diversity at all points in the trajectory of health sciences education and careers. She looked forward to seeing UC Health's long-term plan for achieving its diversity goals.

Regent Zettel expressed hope that effective programs at one campus would be shared among all the campuses. Dr. Navarro responded that the purpose of the UC Health Diversity and Inclusion Task Force was to leverage the power of the UC system; this would include the sharing of best practices and programs. Dr. Nation added that, in addition to loss of URM individuals in the trajectory of student to resident to faculty member, there is substantial variation across the health professions. There were opportunities for learning not only among campuses but also among professions.

Regent Zettel asked if the PRIME program tracks its students to see if they in fact remain and practice in underserved communities. Dr. Nation responded that, at its inception, the PRIME program did not have the necessary infrastructure for such tracking. Based on review of school-specific and program-specific data, a higher-than-average number of

PRIME graduates remain in California and practice primary care medicine; an increasing number of PRIME graduates are selecting psychiatry in light of mental healthcare needs in the state. There was not a systemwide summary. Regent Zettel stated that it would be desirable to know where, in which communities, PRIME graduates are practicing.

Dr. Martin observed that policies for admissions are set by the Academic Senate. For this reason, discussions about diversity at UC Health must include the Academic Senate and medical school deans.

Advisory member Hetts stated that UC Health had an opportunity to work on how it can set an example for young people and encourage them, during the earliest stages of their education, to consider careers in medicine. He observed that many medical professionals make the decision to pursue medicine early, during middle school or high school. UC Health outreach should be pursued by faculty, but also at the systemwide level and regionally. Dr. Navarro noted that the UC system has an extensive amount of early academic outreach programming. UCSF has a Mathematics, Engineering, Science Achievement (MESA) program for middle and high school students. UCSF's Science and Health Education Partnership supports science and health education in the San Francisco Unified School District.

Faculty Representative Bhavnani referred to the information that had been presented on loan forgiveness programs. She expressed concern that students from economically disadvantaged backgrounds were being directed toward certain career paths while economically privileged students would have more choices. She asked what white neurosurgeons and cardiologists are doing to encourage diversity to ensure that people of color are entering the faculty ranks. Dr. Navarro responded that UC Health sends the message that it needs underrepresented people across the spectrum of health sciences and among faculty. This work could not be done successfully without engaging white people. Marginalized groups do not have power to make the necessary changes. This work requires partnerships to ensure sustainability over time and accountability in the decision-making of all individuals. Dr. King reported that in UCSF's diversity, equity and inclusion training program, 80 percent of those who initially volunteered to take the course were women. Few white men volunteered, and Dr. King was tasked with encouraging them to take this class. This was an area where work needed to be done. He noted that UCSF has a program called Differences Matter, which engages with all the issues UCSF feels are important to diversity, equity and inclusion. UCSF staff play an important role in making UCSF's organizational culture a culture that values differences and diversity. Work groups are led jointly by staff and faculty.

With regard to the composition of the Task Force, Regent Weddle encouraged UC Health to consider students as key decision-makers and stakeholders in this work, particularly in the development of diversity programs and initiatives. UC Health has helpful statistics on enrollment and the demographics of its faculty, but she asked how UC Health measures culture and climate, and which indicators might help track change over time. Dr. Navarro responded that culture and climate often determine whether an individual chooses to join the faculty following completion of his or her residency. A systemwide climate assessment

had been carried out several years earlier, and some campuses continue to perform assessments every three to five years. Campuses examine complaints of harassment and discrimination, and some campuses have been examining early intervention for microaggressions and how to address difficult situations.

Regent Park commented that, while UC Health's existing programs were admirable, they were not sufficient. In her view, it would be naïve to think that growing programs would lead to a more diverse workforce. A deeper systemic change was needed on all levels. As mentioned by Dr. Martin, the Academic Senate must be a part of this effort. The University highly values academic excellence, but the value of community contributed by students must be manifested somewhere. UC Health must fundamentally change how it does business, and this point would no doubt arise in the Task Force's discussions.

Student observer Ashraf Beshay recalled that the annual Student Services Fee of $1,100 funds various campus services. Some of this funding has been used to supplement mental health services. While the student population continues to increase, staffing levels have remained the same and campus services have received minimal increases in funding, without the ability to increase capacity. As a former transfer student, Mr. Beshay presented as one example the need for a full-time academic counselor for the 7,000 to 8,000 transfer students at UCLA, a need which has not yet been addressed. He stated that the proposal that would be discussed in the following agenda item would take a much-needed preventative approach to mental health issues. This was fundamentally a Student Affairs issue with health consequences. The University needed better academic support services, stronger retention efforts, and faster crisis response times, among other improvements. He hoped that UC would pursue a collective strategy in addition to the funding request that would be outlined in the following discussion. Students should be included in the conversations about mental health. Student efforts had contributed to the receipt of $5.3 million in additional funding for mental health services from the State this year.

With regard to diversity in the health sciences, Mr. Beshay stressed the importance of the PRIME program. Two-thirds of the students in rural PRIME programs return to practice medicine in rural communities. It was ironic that a program that serves minorities was not receiving the support from the State that it needs; but UC cannot abandon such a good program. The University must also champion initiatives such as the UCSF School of Medicine Dean's Diversity Fund, which has supported the recruitment and retention of faculty interested in serving marginalized populations. URM students face barriers at all stages on the way to becoming a faculty member. Hispanic people represented 39 percent of the California population, but only 14 percent of UC Health students were Hispanic. Only about seven percent of physicians in California were Hispanic. UC must do better in its recruitment efforts for this population. Issues of gender, racial, and economic inequality are the causes of underrepresentation, even in the health professions. UC must ensure that its admissions criteria explicitly include social awareness and activism, just as they include high performance on examinations. This is a challenge UC can take on.

6.   **ESTIMATED FUNDING NEEDS FOR UNIVERSITY OF CALIFORNIA STUDENT MENTAL HEALTH SERVICES THROUGH FISCAL YEAR 2024-2025**

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

Executive Vice President Stobo introduced the discussion, remarking that there was no doubt that student mental health services are critically important. There was no lack of individuals who understand this but there was a lack of means to accomplish what UC wishes to accomplish in this area.

Chief Medical Officer Brad Buchman recalled that this topic had been discussed in July at the meeting of the Public Engagement and Development Committee. At that time, he and his colleagues were asked to return with an estimate of additional funding needed for student mental health services. This discussion would present funding estimates and potential fund sources.

Dr. Buchman presented a list of the core services provided by UC's counseling and psychological services staff. These include direct services provided to students in face-to-face counseling or group counseling; outreach and prevention work on campuses; and services in consultation with the campuses, such as crisis response, faculty and staff training, consulting, and serving as liaisons to various departments. Members of the Legislature had asked if the University could hire part-time counselors. While this might be possible, it might not be desirable to hire counselors who are not familiar with campus resources and the unique needs of UC students.

Dr. Buchman then reviewed a three-tiered model used by the University for prioritizing investments in student mental health. This model was created in 2006 by the UC Student Mental Health Committee. Tier Three, which should be the largest investment, is concerned with creating healthy learning environments on the campuses. These are critical services that have been underfunded for many years, such as student support services and faculty and staff mentoring. The goal of these efforts is to create a supportive learning environment so that, when students are struggling with stress, everyone on campus is part of the support network. Tier Two investments are focused on targeted interventions for vulnerable groups, such as first-generation students, undocumented students, LGBT students, international students, or any number of student cohorts known to be at higher risk. Other universities use sophisticated data analytics software to monitor student success, which is related to student support services and academic support. This kind of monitoring can lead to timely intervention. Some medical groups and systems are using predictive analytics to be aware of patients or clients demonstrating risk factors for mental health decline. UC Health was in the process of building such a system, funded by the medical centers, with participation by a number of campuses. Dr. Buchman was proposing that UC Health fund a small group to perform population health management for the student population, taking advantage of the infrastructure that had already been built. Tier One services are critical direct mental health services to students and crisis response services.

Dr. Buchman then presented a chart indicating the UC counselor-to-student ratio over time. Through the Long-Term Stability Plan for Tuition and Financial Aid, UC had been able to lower this ratio almost to its goal of one to 1,000. He cautioned that the chart presented idealized estimates, the ratios if all positions were currently full, with no vacancies. While this idealized presentation was appropriate when discussing funding, in fact, the standard vacancy rate for counseling was about ten to 11 percent, and slightly higher for psychiatry. The University had 264 full-time equivalent (FTE) counselor positions, but there might be 25 or 26 positions currently vacant, so that the counselor-to-student ratio was about one to 1,200. The next slide indicated the ratio of psychiatrist providers to students. A recommended ratio is one psychiatry FTE for about 6,500 students. The Long-Term Stability Plan for Tuition and Financial Aid had reduced this ratio to an acceptable level. The chart indicated that the ratio would increase along with student enrollment growth if UC was not able to hire additional staff.

Dr. Buchman recalled that the Student Services Fee assessment was interrupted after Year Three of the five-year Long-Term Stability Plan, and UC has observed some gradual erosion in services. The University received a year's worth of support from the State the prior year and $5.3 million for the current year, which would likely be needed to support existing counseling staff.

Dr. Buchman and his colleagues had been asked how much funding would be needed for clinical services, campus-based prevention, and targeted intervention services. To maintain the counselor-to-student ratio at one to 1,000 and the psychiatrist-to-student ratio at one to 6,500, over the next five years, the University would need approximately $35 million or $7 million annually. Another wise investment would be adding case managers at each campus to work with higher-risk patients to facilitate and avoid admissions or to facilitate stepdown care in case a student did have to move to an inpatient treatment facility. This would cost about $15 million over five years. Another desirable investment would be a population health management capacity at a cost of $5 million over five years. The cost of implementing these Tier One and Tier Two clinical recommendations would be about $55 million over five years or $11 million per year, which would amount to a $1.1 million increase in ongoing campus funds per year on each campus. Dr. Buchman drew attention to the fact that, until enough Tier Two and Tier Three services were provided, these increases would be necessary indefinitely. Demand for services was increasing at about eight percent annually. The cost of care continually increases and the number of students at UC increases. It was not feasible to think that the University could make one lump investment to address this need. These needs would increase, and the University needed to find a stable funding source, one that would not be interrupted or periodic.

Interim Vice President Gullatt outlined Tier Two and Tier Three recommendations. Tier Three represents investments that move beyond basic prevention efforts and triage and toward mentally healthy campuses and healthier learning communities. Tier Three efforts should engage the whole UC academic community, including faculty and other academic personnel, and would include expanding academic support in campus learning centers so that students become better able to manage academic stress. The University can better promote student well-being, reduce stress, and improve the quality of student life by

enhancing recreation, civic engagement, and other programs and by working with faculty to promote and encourage inclusive campus climates characterized by civility, mutual respect, and appreciation of the value of differences within a learning community. Faculty are essential in this effort. The University should improve and expand faculty mentoring, strategic discussions about methods to improve classroom and laboratory environments for students, and focused attention on how to improve student morale and satisfaction. UC should examine its institutional policies to ensure that they do not have unintended effects, such as fostering social isolation, on international students or other vulnerable groups. Such a review would ensure that UC does not assume that all students are familiar with mental health resources. Tier Three emphasizes innovation, technology advancements, and research. UC can improve prevention by innovating in its services and programs. The results of research can also help UC better teach students how to cultivate and maintain healthy, balanced lifestyles. Bringing staffing up to benchmark levels for all campus mental health services would be the first step, but this would not be sufficient without the resources to augment and make permanent this kind of comprehensive outreach and education program for vulnerable groups.

Tier Two represents targeted prevention programs, such as training for those who work closely with students—faculty, graduate student instructors, academic advisors, tutors, and residential life staff—as well as targeted intervention programs for students who are demonstrating evidence of a possible mental health decline. Early indications might be significant drops in grade point average or multiple citations for alcohol abuse. Student-to-student mental health awareness programs are also a critical form of intervention, as are partnerships between counseling personnel and residential life professionals, to provide mental health outreach and education in residence halls, regular consultation, and coordinated crisis response. In Tier Two, UC also emphasizes its wish to restore key services to help students manage stress and to increase staffing in those areas most affected by student mental health issues. Another important component of Tier Two is raising parental awareness of the student mental health resources on UC campuses and parental awareness of the risks of certain behaviors, such as students choosing to stop taking certain medications. Additional resources would also allow UC to advance work on web-based mental health services, hotlines, and mobile applications. National organizations such as the Jed Foundation, a nonprofit organization committed to reducing young adult suicide rates and improving mental health support to college students, can help UC create campus-wide prevention and intervention models. Tier Two recommendations and investments would include "post-vention" procedures, such as interviews with students affected by suicide and return visits to student residences and outreach to students affected after a student death. The total estimated need for ongoing funds for Tier Two and Tier Three was $22 million annually or a five-year estimated cost of $110 million by 2024-25. Assuming an annual inflation rate of five percent would increase the total five-year cost to $121.6 million.

Dr. Buchman summarized the total of all the recommendations discussed: about $55 million in clinical recommendations and $121 million in campus-based recommendations, for a total of $176.9 million.

Regent Makarechian asked how estimates were developed. Dr. Buchman responded that Student Affairs developed these estimates based on the 2006 recommendations from the Student Mental Health Committee. The clinical recommendations are based on modeling carried out following implementation of the Long-Term Stability Plan for Tuition and Financial Aid and on the cost of adding counselors and psychiatrists.

Regent Makarechian asked about the University's current spending on student mental health services. Dr. Buchman responded that the figures presented were estimated additional needs. He did not have figures for current spending but this information could be provided.

Chair Pérez asked if students' health insurance could cover or pay for some mental health services. He acknowledged that this source would not cover Tier Two and Tier Three programs. Dr. Buchman responded that there was a key distinction to be made between student health services on one hand and counseling on the other. Many campus student health centers bill insurance, but most often this is limited to billing the UC Student Health Insurance Plan (SHIP). Currently, about 130,000 students were enrolled in UC SHIP, out of a total enrollment of approximately 280,000. Student health centers bill UC SHIP for selected services, such as radiology and laboratory tests. The University tries to keep the cost of student visits low, with no charge or a small co-pay, in order not to increase the cost of insurance. With regard to counseling, UC was not exceptional in how its student health centers bill for insurance. A recent survey of U.S. college student health centers found that, at 96 percent of these institutions, counseling services are funded by student services fees or registration fees; the centers do not bill insurance. The primary reason is the high standard of confidentiality at counseling centers. There is concern about bills being mailed to the home address of students' parents.

Dr. Buchman then discussed possible sources of funding. Regent Leib had been very active in the past few months, and the University had had multiple discussions with the executive director of the Mental Health Services Oversight and Accountability Commission, a State agency which oversees distribution of Proposition 63 reserve monies to the counties. Some key strategies emerged from these discussions. One is that UC needs to identify existing relationships with counties. UC San Diego and UC Davis have large programs that have been awarded or have been approved for Proposition 63 funds for community mental health. Unfortunately, the programs at these two campuses do not have to do with student health and counseling, but there might be opportunities. A second strategy is that UC must identify which resources UC student health and counseling, or other parts of UC, might have to offer the counties in return for sharing resources. A third strategy is that UC must find innovative clinical care pathways, alternatives to admissions, and methods for treating patients at lower cost or with better outcomes; UC must also focus on prevention and early intervention.

Another step in identifying funding sources was to convene a meeting with various UC constituents, including campus-based partners, to consider campus-based and systemwide strategies. The student health and counseling centers need to be involved, especially when campuses were taking a single-campus approach to the counties. Dr. Buchman stressed that

there were real opportunities for the UC system to pursue innovations that would benefit the entire student population. For these kinds of innovations, the University might obtain larger grants that could be shared systemwide. The single-campus approach was being considered for UCLA and UC Merced, based on the specific circumstances of those campuses. The single-campus approach might be taken by other campuses, but there was a need to discuss a campus' needs, the resources it could share, and how those resources might match community needs. One example of the other, systemwide approach would be a population health management program, using data analytics to identify which students are at greater risk for mental health issues. Population health management and case management were two potential proposals UC could present to the Mental Health Services Oversight and Accountability Commission. The University could work with the counties and draw on resources in the community to improve its prevention programs, such as peer counseling. While this kind of collaboration might not produce new funding, it might produce more effective peer counseling programs.

Dr. Buchman then presented a list of other funding pathways, expressing his view that the University could not rely only on Proposition 63 funds. These alternatives were the legislative process, outreach to the California Department of Health Care Services, philanthropy, and the Student Services Fee. With regard to the Student Services Fee, he noted that the Fee had not increased as the cost of counseling and the cost of other student services had increased. As campuses continue to grow and the cost of providing basic mental health and medical services increases faster than enrollment growth, the University must identify some mechanism, whether the Student Services Fee or another source, to help address this need. While the mechanism might not address the total need, it would be part of the solution. He concluded his presentation by noting planned upcoming meetings with UC constituents and with State representatives to discuss funding options.

Regent Leib recalled that Regents Zettel, Kieffer, Lansing, Leib, Weddle, and Thurmond had expressed interest in serving in a working group that would consider how the University could secure funding for student mental health services, now identified as $175 million over five years. Four avenues would be Proposition 63 funding at the county level, augmentation in State funding, philanthropy, and fees. The working group was also interested in the specific example of UCLA's work with Los Angeles County on Proposition 63 funding, and in a general discussion of how the University can achieve an exemplary mental health program for its students. Committee Chair Lansing stressed that the University needs to find a sustainable model.

Chair Pérez noted the importance of considering inflation in projecting future costs. With regard to potential payers, he suggested that insurance billing could be included to address some of these costs. He recalled one of the Tier Two elements, raising parental awareness of the risks of students choosing to stop taking certain medications. One can bill for certain interventions by pharmacy benefit managers. He asked if there were similar models for mental health interventions which might bring about cost savings over time, through increased compliance with medical instructions. The UCLA discussions with the County of Los Angeles were important. Every county has mental health funds which have not yet been programmed, and other counties might be open to conversations with the University

if UC could indicate a successful model and align that model with the needs of individual campuses. Chair Pérez encouraged the University to discuss this matter with colleagues at the California State University (CSU). CSU had convened a meeting with representatives of mental health departments of every county in which CSU campuses are located in order to discuss funding models.

Regent Weddle emphasized the importance of this topic and her appreciation for the engagement of Regents and UC administrators. She expressed approbation for the recommendation to maintain counseling and psychological services direct service provider staffing levels at nationally recommended ratios, and added that UC should consider recruitment and retention of culturally competent staff, trained to provide services for specific student populations and specialized services. Students who are survivors of sexual violence and harassment have reported a dearth of services in this area. She asked if services for these survivors were incorporated in the three-tier model or if they fell outside this plan. Dr. Buchman responded that most campuses have a separate unit that deals with responding to sexual violence and sexual harassment. There have been discussions about forensic examinations on campuses; this usually depends on a decision by the county district attorney. At this point most campuses do not provide forensic examinations, but are well prepared to provide counseling, victim support, and legal referral. While this presentation did not take up new funding for this area, there have been discussions at UC about funding for victim support outside of student health and counseling, for other campus offices that respond to sexual violence and sexual harassment.

Regent Weddle encouraged the University to consider strategies to increase staff in campus offices that are dedicated to preventing and responding to sexual violence and sexual harassment.

Regent Park suggested that it might be easier to conceptualize and understand costs on an annual basis rather than over a number of years. It was important to highlight the ongoing nature of these services. She asked if the Mental Health Services Oversight and Accountability Commission has a role in determining how county reserves are spent. Dr. Buchman responded that the Commission provides direction on how the reserves are distributed to the counties but not on how counties spend the funds after that. If UC were to pursue a systemwide effort, it might be able to work with the Commission to engage with multiple counties at one time.

Regent Park raised the question of what the University can offer counties. Counties have mandates in the area of mental health that they might not be able to fulfill themselves, especially with regard to providers. The University might be able to help counties achieve their mission by fulfilling its own workforce mission. Discussions at the county level should also include the medical center chief executive officers and medical school deans. Regent Park praised the Tier Three objectives, which went beyond mental health issues. UC should look beyond mental health funding to pursue Tier Three goals.

Faculty Representative May observed that this discussion by the Regents and the Regents' identification of student mental health services as a priority would serve as a stimulus to

obtaining funding. He noted that faculty are among the first to see students in distress, but faculty are not trained to deal with these situations. There must be training for faculty on how to respond to a situation of a distressed student and how to get students to proper care. For this reason, faculty should to be involved in the entire process and be represented in relevant committees and working groups. For students with complex issues that cannot be addressed in a course of therapy and might continue for long periods, Mr. May asked how the University helps students transition to care off campus when they graduate so that there is proper continuity of care. Ms. Gullatt responded that faculty are essential to this work and that there was a deficit of faculty understanding and capacity. Faculty training was part of the Tier Two recommendations, and Tier Three recommendations concerned the entire learning community, the core of which is faculty.

UCLA School of Medicine Dean Kelsey Martin noted that medical residents use UC's mental health services. It was critical that UC provide these services for this population as well.

Regent Sherman asked why UC was not billing insurance. All students must have either UC SHIP, private insurance, or file a waiver. While expenses might affect the financial standing of UC SHIP, this could easily be adjusted in the annual premium. The cost could be shared over a massive population through private insurance or a slight adjustment to UC SHIP. An additional ten dollars a year from the 130,000 students in UC SHIP would produce a significant amount of money. This might be an untapped funding source. The University could deal with the issue of notices being sent to students' parents. The University was treating mental health and physical health differently, but the two are linked. Dr. Buchman agreed that mental and physical health are part of a single continuum of care. He noted that there was variance among the campuses in how much is billed to UC SHIP. Some campuses bill most of their services to UC SHIP; students without UC SHIP must pay for services and seek reimbursement from their own insurance. Campuses do not bill Medi-Cal because, were they to do so, they would have to open their student health and counseling centers to all Medi-Cal patients. For this reason, UC has been engaged in discussions with the California Department of Health Care Services about an arrangement in which the Department might help pay UC SHIP premiums in lieu of Medi-Cal, enabling those students to have access to UC networks and services and be billed directly. This was a work in progress. Dr. Buchman anticipated that over time, it was likely that UC would bill insurance more. The University might need to expand its billing services to bill payers other than UC SHIP.

Committee Chair Lansing observed that other insurers might only pay for a certain number of patient visits.

UC San Diego Health Chief Executive Officer Patricia Maysent reported that her campus' Student Health Services center would soon be implementing the Epic medical records system. UCSD believed that this implementation would allow for predictive analytics, predicting students in need, and lead to more effective population health management. This would also represent a significant billing opportunity. UCSD was currently not billing private insurance for many of its medical care and mental health services. Once UCSD had

implemented Epic and was able to track billing activity, the campus would have some idea of the extent of this opportunity.

7.   **UC HEALTH TRANSITION UPDATE**

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

Executive Vice President Stobo recalled that Carrie Byington, M.D., currently serving as Vice Chancellor for Health Services for Texas A&M University System, would be taking on the Executive Vice President – UC Health role effective October 31, 2019. Dr. Stobo and UC Health have been in communication with Dr. Byington and have made it clear that they wish to work with her closely to make this transition as smooth as possible. UC Health was preparing informational materials for Dr. Byington to familiarize her with UC Health division plans and activities and Dr. Stobo had scheduled weekly calls with Dr. Byington. Dr. Byington would serve on the President's Working Group on Comprehensive Access and planned to visit all the UC Health locations in November.

Faculty Representative May expressed the wish of the Academic Senate that Dr. Byington attend a meeting of the Academic Senate's Health Care Task Force.

President Napolitano reported that she had recently met with the new Secretary of the California Health and Human Services Agency, who was interested in partnership between the State and UC Health. She suggested that, after Dr. Byington had established herself at UC, it might be desirable to have the new Secretary attend a meeting of the Health Services Committee in order to stimulate thinking about further initiatives UC Health can undertake with the State.

8.   **THREE-YEAR AGENDA PLANNING FOR THE HEALTH SERVICES COMMITTEE**

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

Executive Vice President Stobo introduced the item and asked Committee members if there were particular topics they wished to see included in the Committee's agenda in the next three years. Deputy General Counsel Rachel Nosowsky noted that, as a best practice, a healthcare board should consider certain topics on a regular basis and feedback from the board should be considered when the board's agenda is developed.

Advisory member Lipstein emphasized the complexity of UC Health, with its many stakeholders and constituents, and suggested that the Committee could evaluate the UC Health bureaucracy, determining which elements are good and which are less desirable, and considering how changes could be made. The complexity of UC was not all positive. The future of academic medicine would be exciting and challenging. It was a best practice for boards, such as the Board of Regents and the Health Services Committee, to evaluate

themselves. Committee Chair Lansing noted that the Board would carry out a self-evaluation at an upcoming Board retreat meeting.

Dr. Stobo remarked that there might be an opportunity for these issues to coalesce at the UC Health leadership retreat in the fall. One discussion topic suggested for the retreat was how UC Health can continue to be successful and grow in the future. Bureaucratic and administrative solutions were part of the answer. It was now a propitious moment for considering these issues, because the University was approaching a time when revenue from UC Health would account for more than 50 percent of UC revenues overall. This would give rise to questions about the relationship of UC Health to the rest of the University. It would be better for the University to think about this issue in advance than to react to it after the fact.

Advisory member Spahlinger suggested that the retreat meeting should consider the envisioned future of UC Health. Questions about UC Health's missions, affiliations, and investments should be considered in the larger context of what UC Health believes the future will be, rather than in a transactional context.

Regent Park asked that the Committee take a purposeful approach to workforce issues, not just the question of developing the workforce pipeline. She asked how the UC Health curriculum incorporates data analytics and how the various professional schools approach this. Workplace culture and cultural competency were important issues and should be incorporated in UC Health education and continuing education programs. With regard to labor and staff development, UC Health should create good career ladders. Research and technology transfer were also important topics. There should be more strategic discussion about what might affect patient care or UC Health finances in the next decade. The input provided by UC Health deans and chief executive officers enhanced the Committee's discussions and this should continue.

Committee Chair Lansing suggested that the Committee receive reports on the remarkable research that is being done on various diseases, in terms that a lay person can understand. An important related question is how the University can monetize this research.

Advisory member Hetts suggested that, in addition to receiving reports on UC Health research successes, the Committee should discuss the opportunities for translation of research into clinical reality, and how this work of translation can be promoted systemwide. The Committee should ensure that it hears the voices of UC Health providers who may be working far away from the main campuses, at other facilities or for affiliates. It was important to consider how this information would reach the Regents through administrators or the Academic Senate, given how extensive the UC Health network has become, and the fact that this network would grow.

Faculty Representative May expressed support for presentations to the Committee by physicians and researchers, who would share their experiences. He noted that, when UC Health evaluates and considers changes to its structure, it should remain mindful of the fact that the University, compared to other universities and in the world of academia, is based

on an extraordinary and unique structure. The University has developed this complex structure over a long time. Great care must be taken in addressing this structure, with understanding of the structure and of the nature of shared governance. If certain elements were changed, the University might irretrievably lose some aspects in which it is a leader. The University has enjoyed an excellent institutional structure for a long time which has allowed it to deal with change. Mr. May also observed that, while it is often pointed out that UC Health represents nearly 50 percent of UC revenues, most of these funds circulate within UC Health and do not represent revenue for the entire University. Half of the UC campuses do not have medical centers. There must be balance in understanding the concerns of all UC constituencies. Committee Chair Lansing responded that the Regents serving on the Health Services Committee are aware of these wider concerns.

UC Davis Human Health Sciences Vice Chancellor David Lubarsky suggested that the Committee hold a meeting in Sacramento. He had found that his own discussions with State representatives had revealed an alignment of aims in addressing healthcare disparities, improving mental health, and providing care in underserved areas. Many people in State government and elsewhere are not aware of how effective UC is in these areas. Committee Chair Lansing remarked that this might be part of a lobbying effort by a small group.

Regent Park referred to an article recently published online by UCLA Health on medical student "hotspotters." This volunteer program has led to decreases in hospitalization and emergency department visits, raised the idea of training medical students as social workers, and illustrated the power of integrating different disciplines. This kind of program appeared to be able to reduce hospital readmission rates and this was a phenomenon that UC Health should pay attention to.

Committee Chair Lansing observed that this was currently a disruption occurring in healthcare services. Certain startup companies were interested in training nurses and others to keep patients from having to go to the hospital. So far none of these companies had proved successful, but eventually one would. One company was seeking to assemble a coalition of doctors who would provide house visits for a minimal fee. In the coming years, the Health Services Committee should consider how these proposals would affect healthcare delivery and readmission rates. The University should get ahead of this situation.

UCSF Health Chief Executive Officer Mark Laret suggested that Committee meetings might start an hour early to allow time for presentations on UC Health research and care delivery.

9.   **CLINICAL QUALITY DASHBOARD FOR UNIVERSITY OF CALIFORNIA 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.]

Executive Vice President Stobo briefly introduced this item.

10.   **HEALTH SYSTEM TRANSACTIONS APPROVED BY THE HEALTH SERVICES COMMITTEE FOR FISCAL YEARS 2016-2019**

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

Executive Vice President Stobo briefly introduced this item, a report on transactions approved by the Health Services Committee or approved by the Chair or Vice Chair of the Health Services Committee, the Executive Vice President – UC Health, and the chancellor of the sponsoring medical center. The levels of approval depend on the value of the transaction. The report detailed 18 transactions.

Regent Park asked if information about details of the transactions was available. Dr. Stobo responded that the relevant campuses could provide this information.

The meeting adjourned at 2:35 p.m.

Attest:

Secretary and Chief of Staff

Attachment 1
2019 Benchmarking Framework/Market Reference Zones (MRZs)
for Non-State-Funded UC Health Positions in the Senior Management Group
For Approval by The Regents' Health Services Committee - August 2019
(Upon approval by the HSC will be presented to the Regents' Governance Committee for approval - September 2019)

MRZ Title	Location	Market Base Salary Data Proposed - 2019				
		P25	P50	P60	P75	P90
SMG Level One						
Chief Executive Officer (UCSF Health)	UCSF	$1,230.6	$1,392.9	$1,540.3	$1,761.2	$1,974.0
Chief Executive Officer (UCLA Hospital System)	UCLA	$1,230.6	$1,392.9	$1,540.3	$1,761.2	$1,974.0
Chief Executive Officer (UC Davis Medical Center)	UCD	$776.1	$1,045.4	$1,159.1	$1,329.5	$1,725.3
Chief Executive Officer (UC San Diego Health)	UCSD	$739.2	$995.4	$1,105.4	$1,270.3	$1,490.9
Chief Executive Officer (UC Irvine Health)	UCI	$698.4	$864.7	$993.5	$1,186.7	$1,305.8
SMG Level Two						
Chief Operating Officer (UCSF Health)	UCSF	$652.5	$786.5	$896.9	$1,062.4	$1,144.4
Chief Operating Officer (UCLA Health System)	UCLA	$652.5	$786.5	$896.9	$1,062.4	$1,144.4
Chief Operating Officer (UC Davis Medical Center)	UCD	$450.4	$663.3	$721.2	$808.0	$1,071.7
Chief Operating Officer (UC San Diego Health)	UCSD	$439.2	$575.8	$639.4	$734.8	$888.4
Chief Operating Officer (UC Irvine Health System)	UCI	$404.0	$487.1	$575.0	$706.8	$1,045.0
Chief Nursing Officer (UCLA Hospital System)	UCLA	$409.4	$468.4	$505.0	$559.8	$576.8
Chief Nursing Officer (UC Davis Medical Center)	UCD	$346.0	$426.3	$451.4	$489.2	$537.5
Chief Nursing Officer (UC Irvine Health)	UCI	$339.5	$358.5	$380.5	$413.5	$499.5
EVP, Physician Services and Vice Dean-Clinical Affairs	UCSF	$701.8	$813.6	$841.8	$884.1	$961.7
Chief Medical Officer (UC Davis Medical Center)	UCD	$496.5	$596.8	$632.8	$686.9	$808.9
Chief Medical Officer (UC San Diego Health)	UCSD	$470.0	$563.3	$597.3	$648.4	$766.7
Chief Medical Officer (UC Irvine Health)	UCI	$447.1	$532.8	$575.1	$638.5	$826.9

MRZ Title	Location	Market Base Salary Data Proposed - 2019				
		P25	P50	P60	P75	P90
SMG Level Two (Cont'd)						
Chief Information Officer (UC Davis Health)	UCD	$439.4	$468.9	$506.6	$563.1	$723.4
Chief Information Officer (UC Irvine Health)	UCI	$343.0	$426.3	$458.3	$506.4	$639.1
Chief Financial Officer (UCSF Health)	UCSF	$624.4	$742.7	$800.5	$887.1	$974.3
Chief Financial Officer (UCLA Health)	UCLA	$624.4	$742.7	$800.5	$887.1	$974.3
Chief Financial Officer (UC Davis Medical Center)	UCD	$471.6	$637.8	$696.2	$783.9	$928.2
Chief Financial Officer (UC San Diego Health)	UCSD	$448.3	$550.6	$599.7	$673.3	$790.3
Chief Financial Officer (UC Irvine Health)	UCI	$356.4	$484.3	$552.5	$654.9	$794.9
Associate Vice President - Chief Transformation Officer (UC Health)	UCOP	$399.1	$490.8	$523.7	$573.0	$640.4
Sr. Vice President, Adult Services/ President-UCSF Medical Center	UCSF	$472.2	$551.9	$599.1	$669.9	$818.8
Sr. Vice President, Children's Services/ President of Benioff Children's Hospital	UCSF	$621.4	$742.9	$801.0	$888.1	$1,050.9
Chief Clinical Officer (UC San Diego Health)	UCSD	$327.3	$376.8	$395.2	$422.7	$489.8
Executive Director, UC San Diego Medical Group	UCSD	$285.6	$345.0	$369.2	$405.4	$466.2
Sr. Vice President, Clinical Practice and Ambulatory Care (UC San Diego Health)	UCSD	$339.8	$398.2	$431.2	$480.8	$517.8
Approved in 2019 - Not Updated						
Chief Executive Officer (UC Riverside Health)*	UCR	$389.8	$471.4	$496.3	$533.6	$594.5
Chief Strategy Officer and Head of Health Affiliates Network (UCSF Health)**	UCSF	$557.5	$689.9	$747.9	$834.8	$925.7

*New MRZ - SMG Level One - Approved by Full Board - January 2019

**New MRZ - SMG Level Two - Approved by HSC - June 2019 / Governance - July 2019