

The Regents of the University of California

HEALTH SERVICES COMMITTEE

October 20, 2020

The Health Services Committee met on the above date by teleconference meeting conducted in accordance with Paragraph 3 of Governor Newsom's Executive Order N-29-20.

Members present: Regents Lansing, Makarechian, Park, Sherman, and Zettel; Ex officio members Drake and Pérez; Executive Vice President Byington; Chancellors Block, Hawgood, and Khosla; Advisory members Bindman, Hernandez, and Spahlinger

In attendance: Regents Leib, Muwwakkil, Reilly, Stegura, and Sures, Regent-designate Torres, Secretary and Chief of Staff Shaw, Deputy General Counsel Nosowsky, Executive Vice President and Chief Financial Officer Brostrom, Vice President Nation, Interim Vice President Lloyd, and Recording Secretary Johns

The meeting convened at 10:50 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 concerning the items noted.

- A. Syreeta Nolan, UC San Diego student, noted that many disabled students choose their undergraduate or graduate institution based on the quality of the health services offered there. She expressed concern that, in a discussion of the UC Health Division's strategic plan at the September Regents meeting, there had been no consideration of disabled students, faculty, or staff. She asked that UC Health enhance its support for disabled students, faculty, and staff and consider their needs as a population.
- B. Theresa Lovelace, postdoctoral scholar at UC Irvine, drew attention to the fact that the University's share of healthcare costs for postdoctoral scholars was paid directly by the laboratory in which the postdoctoral scholar was employed rather than from a central fund. Professors hiring postdoctoral scholars knew that healthcare costs would be higher if the scholar had a family included in the UC health plan. This situation created uncertainty for professors and could be an incentive for discrimination against postdoctoral fellowship applicants with families.
- C. Diana Garcia, UC Santa Barbara student, urged the University to divest from the Thirty Meter Telescope project on Mauna Kea, which involved the desecration of sacred land and restricted freedom of religion for Native Hawaiians. Destroying

this land in the name of Western science was a form of intellectual discrimination and harassment against students with ancestral ties to this land.

- D. Livia Solari, UC Berkeley student, urged the University to divest from the Thirty Meter Telescope project on Mauna Kea. The University's responsibility to uphold its values of diversity, equity, and inclusion extended far beyond its campuses. This racist and colonialist project would desecrate a site sacred to Native Hawaiians and this disregard was a form of systemic racism, as defined by UC itself.
- E. Anna Fernandez, UCSF emergency department nurse and member of the California Nurses Association (CNA) warned of unacceptably low staffing levels at UCSF. Patients were waiting longer to come to the hospital and were coming in sicker. Nurses' workload had increased. UCSF management was asking nurses to do more with less. There were not enough security guards. Nurse practitioners at UCSF Benioff Children's Hospital Oakland were still without a contract. The University's nurses were tired and burnt out from short staffing and repeated exposure to COVID-19, and morale was low. UC was ill-prepared for a coronavirus surge; Ms. Fernandez demanded better staffing levels for the safety of patients.
- F. Tamara Totten reported that she had been laid off from UC San Diego. This had been a traumatic experience and she hoped that other Black women would not have this experience. Ms. Totten had filed a report of discrimination regarding her supervisor. She stated that she then endured harassment, threats, ridicule, and isolation and that racial discrimination was a factor in her layoff. She asked the University to investigate her case.
- G. Marcia Santini, UCLA emergency department nurse and member of CNA, stated that there was a crisis of short staffing at UC medical centers which was causing burnout, fatigue, and low morale. Management was relying on nurses to work extra shifts and overtime. This was unsafe and unsustainable. For the first time in ten years, UCSD and UCSF had resorted to the Nursing Staffing Review Panel (NSRP) process in the contract to address staffing needs. Ms. Santini demanded safe staffing levels.
- H. Jeannette Bell asked the University to allow exemptions to the influenza vaccine mandate. The decision about being vaccinated should be up to each individual. People might not wish to receive a vaccine for medical, religious, or other reasons. Ms. Bell questioned the efficacy of the vaccine.
- I. Michael Cahn reported that the UCLA Bicycle Academy, UC Bikes!, and a small contingent of Nobel laureates were advocating for an active transportation policy at UC Health, one which would promote healthy modes of transportation rather than perpetuating the myth that everyone drives a car. The car culture leads to a culture of obesity, diabetes, and cancer. In adopting such a policy, UC would be a leader in community health, sustainability, and financial savings that come from people driving fewer cars.

- J. Lisa Hale, pediatric nurse practitioner at UCSF Benioff Children’s Hospital Oakland, spoke of unfair treatment of nurses at this hospital. Actions by UCSF were detrimental to nurses and patients alike, such as misguided cuts to specialty programs, leaving nurse vacancies unfilled, layoffs of highly skilled nurse practitioners who have served at this hospital for decades, increasing already full workloads, unequal pay for the same work, pay that was lower than standard for the San Francisco Bay Area, and denying job security and workplace protections enjoyed by nurses at other UC Health sites. These actions compromised patient safety and negatively affected the hospital’s ability to recruit and retain highly skilled nurses. The Regents should hold UCSF accountable for healthcare equality for East Bay nurses and patients.
- K. Charles Doran, UCLA employee and member of the UC Administrative Professionals Network, expressed concern about the possibility of curtailment or furloughs. He recalled that this action had been taken by the University in 2009, and that, in his then department, faculty were able to excuse themselves through a furlough exchange program. Only the lowest-salaried administrative employees ended up absorbing a loss in pay. There was talk that employees might earn accruals during curtailment, but Mr. Doran reminded the Regents that accruals do not pay the rent.

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

Upon motion duly made and seconded, the minutes of the meetings of July 29 and August 24, 2020 were approved, Regents Lansing, Makarechian, Pérez, Sherman, and Zettel voting “aye.”¹

3. **UPDATE OF THE COVID-19 IMPACT ON THE UNIVERSITY OF CALIFORNIA: UC HEALTH ISSUES AND FINANCIAL 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 Byington remarked that, while there had been scientific breakthroughs in the fight against COVID-19, there had been a 20 percent increase in U.S. deaths from coronavirus from March to July 2020, with more than 17,000 of those deaths in California. Health and economic disparities had widened. Intentional misinformation and politics had overshadowed and undermined public health messages, giving rise to public confusion and polarization. The unfortunate consequence had been preventable illness. COVID-19 cases now exceeded eight million in the U.S., and these illnesses had led to more than 220,000 deaths, with tens or even hundreds of thousands more predicted by the end of winter. The United States was now entering what Dr. Byington believed would be the most difficult phase of the pandemic, the first winter season with the SARS-CoV-2 virus among an unvaccinated and mostly non-immune population. Clear

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

communication about COVID-19 was more important than ever, including clear communication about what was and was not known. It was known that wearing masks was effective against COVID-19, as were social distancing and hand washing. It was known that the flu shots would protect people from influenza, which might require hospitalization. If widely adopted, this measure could help protect hospital capacity. These measures would prevent infections and deaths while the nation waited for point-of-care testing, new therapeutics, and a safe and effective vaccine. The public and private sectors must work together to engage communities, especially those which have been marginalized, and to develop a better understanding of the many alternatives for mitigating the harm of the pandemic. Trust was required for effective public health solutions. Dr. Byington expressed pride in the University of California's role in being a trusted voice during the pandemic and being a partner with the State in developing testing capacity, training contact tracing workers, conducting clinical trials of therapeutics and vaccines, piloting exposure notification technologies, and reaching underserved communities. The previous day, Governor Newsom had announced a new COVID-19 Scientific Safety Review Workgroup to advise the State on any SARS-CoV-2 vaccines that receive approval from the U.S. Food and Drug Administration (FDA). This group was chaired by Arthur Reingold, M.D., Professor of Epidemiology at the UC Berkeley School of Public Health, and included representatives from UCLA Health, UC San Diego Health, and UCSF Health.

At this point there were more than 40 million cases of COVID-19 across the world, and more than eight million in the U.S. There had been more than one million deaths worldwide. The number of cases was increasing as the Northern Hemisphere entered winter. Dr. Byington presented a chart illustrating the seven-day average in number of COVID-19 cases in the U.S. from early March to mid-October. The last two months showed a troubling increase. She pointed out that, when the U.S. experienced the first surge, it was able to bring down the number of cases to a baseline of about 20,000 cases per day. The second surge began at that baseline and reached a peak of almost 70,000 cases per day. This surge then diminished to a baseline of between 30,000 and 40,000 cases per day. Dr. Byington stressed that this was a much higher baseline than the 20,000-case baseline in spring. This was a serious concern.

Dr. Byington then presented a chart showing new cases per day in the United States, with three surges in April, July, and mid-October. The chart also included maps showing the density of infection rates in the U.S. for the peak of each surge period. Infection rates were now lower in California than they had been in the summer, while rates were higher in much of the rest of the U.S. Numbers of cases and deaths were now declining in California. In the U.S. overall, cases had increased by 68 percent and hospitalizations had increased by 22 percent since September 7. California was experiencing the opposite trend; cases had decreased by nine percent and hospitalizations had decreased by 26 percent since September 7. California had experienced as many as 9,000 hospitalizations for COVID-19; at this point there were about 3,000 hospitalizations. A map with hospitalization numbers for each state showed that this was a smaller number than in Texas and proportionately smaller than in many other states which were now experiencing surges. There were about 70,000 licensed hospital beds in California.

Dr. Byington then presented a chart with numbers of COVID-19 inpatients seen at UC medical centers from February to October. The previous week, UC Health recorded the lowest number of these patients in over six months, with 78 COVID-19 inpatients across the UC system. This was good news, and this circumstance helped UC Health to prepare for the winter surge.

Dr. Byington showed UC Health data on test positivity rates broken down by age group. Most recently, the highest rates of positivity were in younger age groups. The ten- to 19-year-old age group had a positivity rate of 6.4 percent. Children aged zero to nine years and young adults ages 20 to 29 had positivity rates of 4.5 percent.

A study published the previous week had examined transmission dynamics by age group in COVID-19 hotspot counties. The researchers had found that, in hotspot counties, particularly those in the South and West, percent positivity increased earliest in younger persons (zero-17 and 18-24 years), followed by several weeks of increasing percent positivity in older age groups. Dr. Byington stressed that it was these older age groups who would end up in the hospital with complications and mortality.

A chart with UC Health COVID-19 inpatient mortality rates by age group showed that mortality increased steadily for older patients. The mortality rates were low for younger age groups, about one percent. The mortality rates for the three oldest groups were 9.5, 13, and 22 percent. Another chart indicating inpatient mortality by age and month showed that, in the month of April, there had been 38 deaths in the oldest age group, over 80 years of age; in September, there were only 18 deaths in this group, about a 40 percent reduction in the highest-risk group. This was in part due to the fact that UC had learned to better care for patients with COVID-19. Dr. Byington displayed another chart with data on medications given to patients. UC Health tracked the medication given to every patient for COVID-19. UC was able to assemble and analyze these data, looking at the classes of medications that patients were receiving and patient trajectories. UC Health could use this information to make better decisions about which medications might be effective for patients. UC was one of the only institutions in the U.S. able to collect data at this level and to share these data with the U.S. Food and Drug Administration.

A chart with COVID-19 positivity and mortality rates in California, broken down by ethnicity, showed the significant impact of COVID-19 on the Latino(a) community in California. This community represented a disproportionately large segment of coronavirus cases and deaths. There was also a disproportionately large number of deaths from COVID-19 in the African American community. There continued to be racial and ethnic disparities in the risk for infection and in outcomes.

The California Department of Public Health had created a new health equity metric as part of the reopening plan for California counties. This plan took account of daily case numbers and test positivity rates, and had now added a health equity metric, supported by Dr. Byington, which measured the test positivity rate and case numbers in the lowest quartile in each Healthy Places Index census tract. This would ensure that, as counties move toward reopening, they recognize where transmission was occurring and if there were

portions of a county requiring additional attention or resources in order to bring the virus under control. Test positivity rates in most counties with UC locations had been declining, and these counties were meeting the State's health equity metric. This metric was pragmatic and recognized those communities most devastated by the pandemic. Counties would not be able to reopen safely if there were pockets of high transmission. The current goal for the counties was to move to positivity rates below two percent, but as one was entering the winter season, this would require great effort.

The Commonwealth Fund had issued three scenarios earlier this year on the possible course and outcome of the pandemic, an optimistic scenario, a catastrophic scenario, and a "patchwork middle" scenario. Under the optimistic scenario, by September 1, 2020, non-pharmaceutical interventions would be shown to be effective and these interventions would be in use everywhere. By November 1, there would be treatment that would reduce mortality for the elderly from 20 percent to one percent. By January 1, 2021, there would be an effective vaccine, and by July 1 the population would be immunized and the pandemic would essentially be over. The U.S. health system would return to normal by September 1. Dr. Byington did not believe that these goals would be achieved by these target dates, but that the actual course of events would be more like the outline of the patchwork middle scenario. By September 1, 2020, non-pharmaceutical interventions would be shown to be effective but were used in only 50 percent of U.S. states; this was the case, and there was ongoing transmission. By January 1, 2021, there would be some treatment for severe illness. One was still waiting for this. It seemed likely that there would be a vaccine, but not everyone would be vaccinated immediately, and the vaccine was unlikely to be 100 percent effective. Under the patchwork middle scenario, the population would be vaccinated by July 1 and there would be some herd immunity. In order to build trust, it would be necessary to communicate with people to assure them that the vaccine was safe and effective. By September 1, Dr. Byington believed that one would still see a mixed recovery of the nation's health system from the pandemic.

With regard to the financial impact of COVID-19 on UC Health, Dr. Byington presented a chart showing that the greatest losses had been experienced in April; since then there had been steady improvement. Charts with systemwide operating statistics compared April levels to average levels, and showed that emergency department visits had declined by 43 percent; average daily census had declined by 25 percent; ambulatory visits declined by 32 percent; and surgical cases declined by 57 percent. The month of April was the period of greatest loss of patient numbers, but UC Health kept its number of paid, full-time equivalent employees flat throughout the year. The cost per adjusted discharge had increased. In April, because the numbers of discharges were lower and personnel costs were the same, the cost per adjusted discharge increased by 64 percent. This cost was now declining.

Dr. Byington then presented a chart showing the impact on operating revenue and expenses. Operating revenue declined in April, while expenses remained flat or increased. From March to August, UC Health lost revenue and experienced additional COVID-19-related expenses amounting to about \$1.1 billion compared to the predicted fiscal year 2020 budget. The University had received Coronavirus Aid, Relief, and Economic Security

(CARES) Act funding of approximately \$500 million which could be directed to address this loss.

UC Health was now seeing increases in ambulatory visits, with numbers higher than before the pandemic. This was due to virtual, telehealth visits. From March to September, there had been more than one million virtual visits. Labor-related costs as a percentage of net revenue were increasing, currently at 61.5 percent. Compared to major teaching hospitals in the U.S., this percentage placed UC Health between the 20th and 35th percentiles nationwide. Pre-audit 11-month financial margins had declined, but the system still had positive margins. There were additional pressures on these margins: capital reinvestment needs, seismic replacement required by law that would not generate additional revenue, support for UC Health's academic and research mission, above-market rates for represented labor, changing requirements for the CARES Act relief funds, and possible worsening of the payer mix due to COVID-19-related unemployment. This would mean increasing numbers of Medi-Cal patients, and UC medical centers lose money on all governmental payers. There was downward pressure on reimbursement rates from commercial payers, and retirement plan costs continued to rise. Dr. Byington pointed out two pre-audit statistics which remained strong—days' cash on hand, 145 days, and days in accounts receivable, 47.3 days. She believed that these ratios remained strong due to the exceptional work done by the Leveraging Scale for Value and Revenue Cycle teams and by the medical center chief executive officers. The cash position was strengthened by a \$900 million Medicare advance payment which must be repaid over 29 months. Without this advance payment, UC Health's days' cash on hand would be 121.6 days, pre-audit; this compared favorably to 2019, when this number was 122 days. This liquidity was due to the advance payment, but also to the work with all payers to decrease time in accounts receivable. In this COVID-19 year, UC Health was able to decrease the days in accounts receivable from 52.8 to 47.3. Dr. Byington felt that UC Health's financial position was much better than that of many peer academic medical centers in the U.S.

UC Health's margin was important for the achievement of systemwide goals and the mission of the University. At the UC Health leadership retreat in December 2019, UC Health set three goals. First, to improve the health of all people living in California; second, to promote health equity through the elimination of health disparities; and third, to reduce barriers to access to UC's clinical, education, and research programs. Inclusion was part of all of these goals.

The COVID-19 pandemic had demonstrated the existence of health disparities. Dr. Byington presented a chart with data on age-adjusted COVID-19-associated hospitalization rates by race and ethnicity from March 1 to October 10. The rate of hospitalization for non-Hispanic whites was 85.9 per 100,000 people. By contrast, the rates for Hispanic, Native American, and African American populations were all above 375 per 100,000. There were huge disparities not only with regard to COVID-19, but throughout the U.S. health system with regard to health outcomes for these populations.

A study of age-adjusted mortality rates for Black and White Americans for a period of more than 100 years, showed that African Americans have had significantly higher

mortality rates than Whites every year since 1900, and lower life expectancy. The highest life expectancy for Black Americans was recorded in 2014, but it was below life expectancy levels for Whites since 1989. Black Americans had not been able to see the same gains and benefits in health that the White population had seen. For Whites to experience the same death rate in the best year recorded for Blacks, 2014, there would have to be about 468,000 additional deaths in the White population. Dr. Byington stressed the urgent need to close this gap. The purpose of UC Health's margin was to reinvest in communities, educational programs, and trainees in order to end these health disparities.

Dr. Byington had recently co-authored an article in the journal *Academic Medicine* titled "Learning from the Past and Working in the Present to Create an Antiracist Future for Academic Medicine." This article discussed what individuals, organizations, and professional societies can do to dismantle structural racism that has existed for generations in academic medicine. Part of this effort was for UC Health to look at its own statistics and its own diversity. She presented charts showing the gender and ethnicity of senior managers at UC Health. There was room for improvement, and this should begin with good leadership, and one goal was to ensure that UC Health leaders reflect the diversity of UC Health trainees and students, and California communities. UC Health senior managers were primarily male and White. There were opportunities to diversify this leadership.

Dr. Byington enumerated several grants received by UC Health medical schools to address health disparities. These represented only a small part of the work being done with students, trainees, and researchers. On the clinical side, UC Health was also working to better understand health disparities in its own operations. The Area Deprivation Index (ADI) had been developed at the University of Wisconsin School of Medicine and Public Health. The ADI uses census block groups to score neighborhoods and estimate their socioeconomic status based on income, education, employment, and housing quality and to identify health disparities in a population. UC was able to link the UC Health primary care population to ADI data, and calculated ADI status for more than 600,000 attributable primary care patients. UC Health now had a much better understanding of its patients, from the least to the most disadvantaged, and what they might be facing in their home environment. UC patients populated all ten of the ADI deciles.

UC Health was using the ADI deciles to measure and try to address disparities. The first such project examined ADI deciles in a cohort of 33,000 patients with Type II diabetes. Eleven percent of these patients were in the lowest, most advantaged quintile and 29 percent were in the highest. UC found that hemoglobin A1c, a measure of diabetes control, is independently associated with the ADI. Higher and worse A1c is associated with higher and more disadvantaged ADI deciles.

UC Health can use this information when it sees patients to tailor treatments and recommendations, and was working on the incorporation of ADI into the systemwide risk score. This had been completed at one campus and was being extended to all campuses. UC Health could use this information to inform local and systemwide interventions and to direct resources in order to help the greatest number of people possible. Targeted screening for patients with high ADI scores would allow for referral to more intensive case

management and community services. Dr. Byington believed that this tool would transform UC's approach to population health. There were ongoing discussions about whether this could become a national tool to address health disparities. Dr. Byington concluded by noting the many activities UC Health was engaged in for the benefit of California communities, such as COVID-19 vaccine trials, testing, and community education. She presented a poem, "For the Children," by UC Professor Emeritus Gary Snyder and remarked how the beauty of nature, even flowers in one's own backyard, can provide solace during these difficult times.

Regent Makarechian asked about the efficacy of ultraviolet light and humidity against the coronavirus. Dr. Byington responded that more was being learned about the survival of the virus when it was outside the human body. The virus was able to survive longer at colder temperatures and in dryer environments. This was a reason for concern about a surge in winter, as people in colder climates began to spend more time indoors. It was better to spend time with other people outdoors, with sunlight and air circulation, and to avoid crowded locations indoors. This might be easier in the southern and western states, which had more sunny days. The virus was not yet in a seasonal pattern. One could not rely only on temperature, humidity, and light as protections against the coronavirus.

Regent Makarechian referred to information on a slide shown earlier with hospitalization numbers by state. He asked why Texas and Florida had relatively high numbers. Dr. Byington responded that this illustrated the need not to rely only on temperature, humidity, and light as protections but to use non-pharmaceutical interventions such as wearing masks, social distancing, and hand washing. Some of the southern states had reopened without a mask mandate. People were gathering without wearing masks, and this facilitated transmission.

Regent Makarechian referred to information on a chart shown earlier which indicated that medical center financial losses were decreasing while losses at the general campuses appeared to be remaining constant or increasing. He asked if this was due to losses in campus auxiliary revenues from student housing and dining. Dr. Byington responded that UC medical centers had done everything possible to return to regular patient services and increase patient volume. Executive Vice President and Chief Financial Officer Brostrom confirmed that the primary losses on the campuses had been in auxiliaries. Dormitories were currently occupied at five to 50 percent. There were significant losses from cancelled housing and dining contracts. A recent milestone date had passed, and UC had not received federal stimulus funds that would have reversed cuts by the State; all the campuses were experiencing a \$300 million cut to their State appropriation this year.

Regent Makarechian asked about the medical centers' gross profits, recalling differences between UCLA and UCSF. Dr. Byington responded that the medical centers all had positive margins. There were differences in accounting among the medical centers. UCSF Health Chief Executive Officer Mark Laret explained that UCSF included all expenses above the line. The other campuses with medical centers show medical center performance; there is a transfer to support the faculty practice below the line. This was the primary

accounting difference between UCSF and the other campuses, but there were other differences as well.

President Drake raised the question of why UC Health would use different accounting practices. He also asked what the difference would be if one were to move the medical center transfers above the line. Mr. Laret responded that there were historical reasons for these different practices. At the time of an attempted merger of UCSF and Stanford health services, the faculty practice and medical center revenues were all pledged against outstanding debt. UCSF accounted for these two revenue sources together. In 2014, Mr. Laret worked with Chancellor Hawgood, who was then Dean, to change the funds flow model so that there would not be a separation between the faculty practice and the hospital. UCSF Health would be one clinical enterprise, taking all professional and technical revenue, paying for professional services, to support the academic enterprise, and to run the hospital; margins would be determined thereafter. Mr. Laret believed that this approach presented a total picture of the clinical enterprise and represented a trend in academic medicine. President Drake commented that he had introduced this approach at Ohio State University when he served there as President. In the future, it might be appropriate to have all medical centers using the same accounting approach, allowing for comparison among them.

Regent Makarechian concurred that this ability to compare the medical centers, based on all using the same accounting approach, would be desirable.

UC San Diego Health Chief Executive Officer Patricia Maysent noted that another important financial factor to consider was variations in payer mix. Payer mix variations affected the medical centers' margins.

Regent Pérez suggested that there be an in-depth discussion at a future meeting about diversity among UC Health senior managers. He referred to information on a slide about UC Health's calculation of the ADI status for its primary care patients, including the fact that UC patients populated all ten of the ADI deciles. He asked for information on rates within each decile within each geographic location. He was interested in how many patients UC served within each decile, and how these patients compared to other UC patients and patients in other health systems. This was an area where UC Health could add tremendous value and this would be worth exploring further. He pointed out that there were pockets within geographic areas. There might be significant differences based on race even within one census tract. One can lose sight of these factors. This could also be the subject of a future discussion. Dr. Byington responded that there would be upcoming discussions of these questions.

Regent Zettel referred to earlier statements in the presentation about how COVID-19 positivity rates increased earliest in younger persons, followed by several weeks of increasing positivity in older age groups. She asked if this was because young people were bringing the coronavirus home with them. Dr. Byington confirmed that this was the case. About one-third of the U.S. population was vulnerable to more severe disease. Younger people were spreading COVID-19 to older adults.

Regent Zettel asked about the use of Vitamin K antagonists as a medication against COVID-19, listed on a slide shown earlier. She referred to information on a slide shown earlier about the racial and ethnic demographics of senior managers at UC Health. Asian Americans represented only 2.4 percent of this group. This was surprising, as was the fact that the UC system did not consider Asian Americans an underrepresented group. She asked for answers to these questions at a later point.

Regent Sherman asked what process the State of California would apply to a vaccine after it had been approved by the FDA. He asked if a situation might arise in which the vaccine was available in other states but not in California. Dr. Byington responded that, because the pandemic had been handled so differently state by state, she could imagine such a situation occurring. UC Health was waiting to hear from Governor Newsom about what this process would be. Following the FDA approval process, data should be presented to the Advisory Committee on Immunization Practices at the Centers for Disease Control and Prevention, which would decide on allocation of the vaccine. Governor Newsom was assembling the COVID-19 Scientific Safety Review Workgroup to ensure that these processes have been followed and that data can be reviewed.

Regent Reilly referred to information provided in charts which indicated increasing numbers of COVID-19 cases compared to two months prior. She asked if this took increased testing into account. Dr. Byington responded that more testing was occurring now than at the beginning of the pandemic, but not much more than two months prior. In some states, there might be less testing than two months prior. The increasing numbers were an indicator of more coronavirus cases, not more testing.

Regent Reilly asked about the causes of death in COVID-19 cases. Dr. Byington responded that COVID-19 patients were dying of respiratory, kidney, and heart complications. There had also been an analysis of “excess deaths” in the U.S. Healthcare providers were seeing a 20 percent increase in deaths. Not all of these were due to COVID-19, and some might be due to undiagnosed COVID-19. Some deaths were due to chronic conditions in patients who had not received the health care they needed, because patients were afraid to go to the hospital, or because hospitals were overwhelmed with COVID-19 cases. President Drake underscored that there was no specific treatment for this virus.

Regent Muwwakkil highlighted the fact that, behind the mortality statistics presented by Dr. Byington, there were individual lives and destinies. The African American community was suffering disproportionately, but the entire nation was suffering. While there was no specific treatment for COVID-19, the numbers of deaths in UC medical centers were declining as UC Health became better at treating patients with COVID-19. Regent Muwwakkil asked about the financial factor, insurance factor, or cost basis for better outcomes, when patients receive access to some kind of effective intervention. Dr. Byington responded that patients with government or private insurance had access to ventilation, dialysis, anticoagulant therapies, and drugs that have been approved under emergency use authorization. The distinction now concerned experimental drugs, which were not available outside a clinical trial. There was a difference between clinical trials and standard treatment.

UC Davis Human Health Sciences Vice Chancellor David Lubarsky drew attention to how well all the UC medical centers were performing; they were among the best in the world.

Committee Chair Lansing noted that people would be spending more time indoors in winter and would be gathering during the winter holiday season. She asked about appropriate social distancing indoors and use of air filtering. Dr. Byington responded that indoor gatherings should be kept as small as reasonably possible, maintaining as much distance as possible, washing hands, keeping the gathering as short as possible, opening windows for ventilation. If individuals from outside the “family bubble” would be visiting, she advised everyone to wear masks, even indoors.

Committee Chair Lansing asked about taking visitors’ temperatures and ideal distancing. Dr. Byington responded that an individual with a normal temperature might be an asymptomatic carrier of COVID-19. The ideal distance was six feet, but a greater distance was better.

4. **APPROVAL OF APPOINTMENT OF AND COMPENSATION USING NON-STATE FUNDS FOR MATTHEW COOK AS SENIOR VICE PRESIDENT – CHILDREN’S SERVICES AND PRESIDENT OF BENIOFF CHILDREN’S HOSPITAL, UCSF HEALTH SYSTEM, SAN FRANCISCO 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 appointment of and compensation using non-State funds for Matthew Cook as Senior Vice President – Children’s Services and President of Benioff Children’s Hospital, UCSF Health System, San Francisco campus:

- A. Per policy, appointment of Matthew Cook as Senior Vice President – Children’s Services and President of Benioff Children’s Hospital, UCSF Health, San Francisco campus, at 100 percent time.
- B. Per policy, an annual base salary of \$995,000.
- C. Per policy, eligibility to participate in the Clinical Enterprise Management Recognition Plan’s (CEMRP) Short Term Incentive (STI) component, with a target award of 15 percent of base salary (\$149,250), and a maximum potential award of 25 percent of base salary (\$248,750), subject to all applicable plan requirements and Administrative Oversight Committee approval. Mr. Cook’s actual award will be determined based on performance against pre-established objectives.

If Mr. Cook’s hire date is on or before January 1, 2021, his eligibility to participate in the STI component of CEMRP would start in the 2020-21 plan year, and his award would be prorated in his first year of participation. If his hire date is on or after January 2, 2021, his eligibility to participate would start in the 2021-22 plan year.

- D. Per policy, a hiring bonus of 17.6 percent of base salary (\$175,000), which is intended to make the hiring offer market-competitive and assist in securing Mr. Cook's acceptance of the offer. The hiring bonus will be paid in a lump sum subject to the following repayment schedule if Mr. Cook separates from the University within two years of his appointment: 100 percent if this occurs within the first year of employment and 50 percent if this occurs within the second year of employment, subject to the limitations under policy.
- E. Per policy, eligibility for standard pension and health and welfare benefits and standard senior management benefits including eligibility for Senior Management Life insurance and Executive Salary Continuation for Disability (eligible after five consecutive years of Senior Management Group service).
- F. Per policy, eligibility to participate in the UC Employee Housing Assistance Program, subject to all applicable program requirements.
- G. Per policy, reimbursement of actual and reasonable moving and relocation expenses associated with relocating Mr. Cook's primary residence, subject to the limitations under Regents Policy 7710, Senior Management Group Moving Reimbursement.
- H. Mr. Cook will comply with the Senior Management Group Outside Professional Activities (OPA) policy and reporting requirements.
- I. This action will be effective as of Mr. Cook's start date, estimated to be on or about December 31, 2020.

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.]

Interim Vice President Lloyd briefly introduced this item for the appointment of and compensation for Matthew Cook as Senior Vice President – Children's Services and President of Benioff Children's Hospital, UCSF Health System.

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

[At this point Executive Vice President Byington left the meeting.]

5. **APPROVAL OF INCENTIVE COMPENSATION USING HEALTH SYSTEM OPERATING REVENUES FOR FISCAL YEAR 2019-20 FOR CARRIE BYINGTON, M.D. AS EXECUTIVE VICE PRESIDENT – UC HEALTH, OFFICE OF THE PRESIDENT AS DISCUSSED IN CLOSED SESSION**

The President of the University recommended that the Health Services Committee approve the Clinical Enterprise Management Recognition Plan (CEMRP) incentive award for Carrie Byington, M.D., as Executive Vice President – UC Health, Office of the President, in the amount of \$136,061, which is comprised of a Short Term Incentive award for the 2019-20 CEMRP plan year. The total recommended incentive award is 23.4 percent of Dr. Byington's prorated base salary (\$581,455) as of June 1, 2020 (\$869,800 x 66.8493 percent).

The incentive compensation described shall constitute the University's total commitment regarding incentive compensation until modified by the Regents or the President, 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.]

Interim Vice President Lloyd introduced this item, which proposed a Clinical Enterprise Management Recognition Plan (CEMRP) incentive award of \$136,061 for Carrie Byington, M.D., as Executive Vice President – UC Health for the 2019-20 CEMRP plan year.

Regent Pérez expressed strong support for this incentive compensation.

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

[At this point Executive Vice President Byington joined the meeting.]

6. **SPEAKER SERIES – PREPARING FOR TOMORROW: UC DAVIS' PREDICT AND ONE HEALTH WORKFORCE PROJECTS**

[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.]

Jonna Mazet, Professor of Epidemiology and Disease Ecology at the UC Davis School of Veterinary Medicine and founding director of the UC Davis One Health Institute, remarked that the University had been preparing for the current pandemic for the past decade. One knew that a pandemic such as COVID-19 was coming. The PREDICT – Pandemic Preparedness for Global Health Security program had been working with partners around

the world to identify emerging global health challenges. This work had been mostly in developing nations, not in the U.S. Dr. Mazet observed that, in general, three new infectious diseases emerged in the world every year. She noted that this number included only those diseases that affect humans, not diseases that might affect animals or cause disruptions in the food system. The effect of COVID-19 had been terrible, but efforts now should focus not just on addressing this pandemic, but considering what new diseases might appear in the future.

About 240 zoonotic viruses, transmissible from animals to human beings, were known, but there might be 500,000 viruses still to be discovered. PREDICT had been working in more than 30 countries around the world and knew how to identify viral threats. Dr. Mazet hoped that this work would lay the groundwork to ensure that a situation like the COVID-19 pandemic would not happen again. PREDICT knew how to identify viruses and the cost of doing so, and knew how to identify and characterize risk at the high-risk transmission interfaces between humans and animals.

Over ten years, PREDICT had used about \$200 million in federal funding from the U.S. Agency for International Development to detect viruses, characterize risk, and mitigate risk as well as to identify and develop materials and operating procedures, costing, and forecasting needed to plan for future pandemics. PREDICT worked with more than 60 laboratories around the world. When this work began, some of these laboratories did not have polymerase chain reaction (PCR) technology; these laboratories were now engaged in virus discovery and characterization and were among the first to detect and diagnose SARS-CoV-2. PREDICT had trained more than 6,000 individuals to identify viruses and work across disciplinary lines. In Dr. Mazet's view, this approach had contributed to a better response to COVID-19 in these countries than in the U.S. During this work, PREDICT discovered about 1,000 novel viruses with pandemic potential. In these same virus families, PREDICT was able to detect zoonotic potential in more than 200 known viruses. The same diagnostic platform could detect and diagnose new and known viruses, and allowed for expanded knowledge of the host, risk interfaces, and geography.

Long before the emergence of SARS-CoV-2 and the COVID-19 pandemic, PREDICT responded to more than 50 outbreaks, at the request of governments around the world. These outbreaks were mostly of Ebola, hemorrhagic fevers, and influenza. PREDICT had a major impact in a number of countries during the current pandemic. PREDICT worked with the team in China that was the first to identify the full sequence of SARS-CoV-2 and put it out into domains to develop the first diagnostic protocols. Laboratories in South and Southeast Asia jumped into action with diagnostics, even before there was a specific diagnostic test, and began the public health response in their countries. PREDICT partners in Africa were the first to publish coronavirus studies and were the best-trained people in their countries with regard to personal protective equipment and diagnostics.

It was known that, if one tested every mammalian and bird species in the world at a certain level identified by PREDICT, with a certain number of sample sizes in all key ecosystems, one would discover all existing animal viruses and begin to characterize the risk in order

to inform strategy. Dr. Mazet noted that these viruses do not leave their hosts and actively infect people; people, by their own behavior, were putting themselves at risk. If one understands where the viruses are and how one might interact with them, one can reduce this risk. One also needs to rank the viruses. Countries cannot carry out surveillance for 500,000 viruses. PREDICT had developed risk scores and a risk ranking tool that could be used by anyone discovering viruses anywhere in the world. Governments can use this tool to survey the viruses in their countries and to determine which viruses should be at the top of their “watch list.”

Dr. Mazet stressed the need to continue with this collaboration, with scientists coming together across national and disciplinary boundaries. These efforts would inform the development of drugs, vaccines, and diagnostics. Even before the advent of COVID-19, viruses identified by PREDICT were being used for novel vaccine pipeline development. Remdesivir, currently the only licensed treatment for humans with COVID-19, was tested with PREDICT viruses. Earlier, it had been developed by the UC Davis School of Veterinary Medicine and Gilead for feline coronaviruses.

Woutrina Smith, Professor of Infectious Disease Epidemiology at the UC Davis School of Veterinary Medicine and director of the UC Global Health Institute Planetary Health Center of Expertise, discussed a sister project, the One Health Workforce – Next Generation project, which she described as the “training arm.” This project had begun one year prior and brought together UC faculty and partners from universities in 17 countries in Asia and Africa to build a multidisciplinary workforce that could collaborate and enable early responses to disease outbreaks.

As people and food move around the world, pathogens move with them. This had been manifested to a greater extent than ever during the COVID-19 pandemic. The One Health approach examines the connections between people and animals in their shared environments, areas with high interface and high risk. One Health works to build preparedness, skills, and competencies that enable participants to detect outbreaks as they occur and take collaborative approaches to health challenges around the world. The debut of this project had been amazing, and it had four years to go.

Dr. Smith related that it was a special pleasure to work with health professional colleagues around the world. These included nurses, physicians, veterinarians, social scientists, and economists. More than 100 universities across Asia and Africa were networking and were committed to the collaborative One Health approach. The project now had a strong starting point, a foundation that could be leveraged for new ideas. The timing of the project turned out to be perfect, just as a global pandemic unfurled.

Dr. Smith presented examples of the work One Health was doing. One of the most important innovations being used was the online forum to communicate with colleagues around the world and share real-time information. As COVID-19 was breaking out in different places, One Health deployed online engagement sessions, a virtual community of practice, with professionals from universities in Asia and Africa, and open to anyone in the world. Sessions were offered at appropriate hours for time zones in Africa and Asia.

Participants tuned in from all over the world to discuss the status of COVID-19 and best practices to address the pandemic.

One Health has also been using a format of regional engagement, with webinars and interactive training sessions online. This was a way of bringing together experts from across a country or region. One Health was interested in fostering collaborations and decolonizing global health. One Health was a living experiment in fostering relationships in the Global South that would help shift power dynamics in this field.

One Health had adapted to a new normal during the pandemic. In Vietnam, physicians, nurses, veterinarians, and student One Health clubs were working together across the country on outbreak response and control for COVID-19 and other diseases. They developed innovative methods and shared ideas with colleagues from around the world in real time. In Africa, the One Health university network had piloted a number of innovations. Some innovations concerned the safe performance of training sessions in a pandemic situation. Robots were being tried out in the healthcare setting to reduce contact between patient and provider. Interesting ideas were coming forward from students and faculty around the world, and this was facilitated by the One Health structure. Dr. Smith emphasized the ability of students to produce innovative ideas. Students involved in the One Health project created communications, such as posters, flyers, and videos to promote best practices and how to live safely during the pandemic in a local, community context.

Dr. Smith recognized the power of the UC system, which had allowed this project to take place. The PREDICT project, described by Dr. Mazet, was a successful international consortium of wildlife experts which grew into a powerful viral surveillance and discovery platform. It was continuing to evolve and innovate. When the opportunity arose for the One Health Workforce – Next Generation project, the training arm, rapid action was required to engage faculty from across the UC system based on their areas of expertise. The UC Global Health Institute, located at the Office of the President, was important in creating a successful network of gifted and dedicated individuals. Dr. Smith credited the UC system's power as one reason this project received a five-year, \$85 million award, as well as partnership with others in the U.S., including Columbia University and EcoHealth Alliance. She hoped that One Health would have further opportunities to draw on the expertise of UC faculty, and that she would be able to report to the Regents in the future about developments in this area.

Regent Zettel asked about the fact that the PREDICT and One Health projects had had such a positive impact in other countries, but not in the U.S. Dr. Mazet explained that these projects were funded by the U.S. Agency for International Development, which only funded projects in other countries. As UC faculty and scientists, Dr. Mazet and her colleagues were advocating for the same kind of work to be done in the U.S.; she remarked that the need for this kind of work in the U.S. was not recognized immediately. COVID-19 had become politicized during the U.S. presidential campaign season. Dr. Mazet stressed that this should not be a political issue.

Regent Zettel referred to information provided online by Johns Hopkins University and Medicine showing small numbers of cases in Uganda, Kenya, and Tanzania. She asked if this was due to the work of PREDICT and One Health in helping prepare these nations to deal with the pandemic. Dr. Mazet responded that she hoped this was the case. The projects had worked to prepare laboratories in these countries and advocated for One Health platforms in their governments, so that there would be emergency operations centers. In the past, Uganda had taken months to respond to Ebola outbreaks, but had responded to COVID-19 within 24 hours and had teams working on both animal and human investigations. There had also been good outcomes in Vietnam, where there were few cases.

Regent Zettel asked if warm and humid climates had an impact on COVID-19. Dr. Mazet responded that there had been a great deal of discussion of the question of how long a virus in such a climate can remain viable outside a host. There were questions about whether some viruses lived better in warmer or cooler climates. This factor was not yet established for this coronavirus. The weather seemed to have little impact on COVID-19, which had spread globally, but it might have an impact on individuals' health and resilience to infection.

Committee Chair Lansing expressed the University's pride in the work of Drs. Mazet and Smith and their colleagues.

7. **UC HEALTH CLINICAL OBJECTIVES: ALIGNING WITH THE VIZIENT UNIVERSITY HEALTHCARE CONSORTIUM AND THE INSTITUTE OF MEDICINE/NATIONAL ACADEMY OF MEDICINE**

[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.]

UCLA Chief Medical and Quality Officer Robert Cherry recalled that UC chief medical and chief nursing officers discuss and establish annual clinical objectives. In determining these objectives, UC Health made use of Vizient, a healthcare performance improvement organization which was founded as a combination of VHA Inc., a network of community hospitals, and University HealthSystem Consortium, an alliance of leading academic medical centers. Eighty-five percent of academic medical centers and about 30 percent of all hospitals in the U.S. used Vizient in their performance improvement activities. These included academic health systems, large integrated healthcare delivery systems, and community hospitals, both teaching and non-teaching. Vizient allowed for the sharing of very valuable data and the use of a rich analytic platform and consultative services.

Vizient provided annual Quality and Accountability Scorecards and ranked UC Health among other academic medical centers. This gave UC a more accurate understanding of where there were opportunities for improvement than would benchmarking UC against the larger community of hospitals. Solutions for UC medical centers might be different because of UC's greater complexity. Vizient measured performance across the Institute of Medicine/National Academy of Medicine-defined domains that define high quality in

medical care: care that is safe, effective, patient-centered, timely, efficient, and equitable. Recent events and debates in the U.S. had enhanced awareness of healthcare disparities and issues of equity. The equity domain used by Vizient analyzed measurement sets related to sepsis, heart attacks, congestive heart failure, and maternal care and looks for statistical differences in race, socioeconomic status, and gender. This was an appropriate moment for UC to reaffirm its commitment to healthcare equity.

Dr. Cherry outlined key principles for UC Health in these efforts to improve clinical quality. UC Health is committed to Vizient as a collaborative for benchmarking and performance improvement activities. UC Health wants to ensure that its clinical objectives represent the six quality domains mentioned earlier. Five or six years earlier, UC Health tended to focus on a single goals as objectives, such as goals for readmission rates or length of stay; it now took a broader approach. UC Health realized that it had measures that came close to addressing the six domains, but wished to ensure that it also addressed equity in its clinical objectives. Healthcare disparities were recognized as a major public health concern.

Dr. Cherry presented an example of a Vizient scorecard, the 2020 Quality and Accountability Scorecard for UCLA Health. In this year, Vizient had ranked three UC medical centers—UC San Diego, UC Irvine, and UCLA—among the top hospitals, with a five-star rating. It was unusual to have three UC medical centers achieve this rating, and it was a positive inspiration for the future. He then presented a template, a chart with inpatient quality benchmarks for all UC medical centers for the second quarter of 2020, including Vizient rank. This had been a dynamic quarter, with the height of the pandemic, and Vizient also had to reconsider its risk models. Dr. Cherry drew attention to improvements in scores for individual medical centers but stressed UC Health’s broader outlook on clinical quality, with a variety of factors and criteria. He commented on the complexity of the equity benchmark and the questions it raised for UC Health, such as how UC can provide customized care. UC Health wished to track its own progress, and had developed a scoring system to define improvement over time. The medical centers would continue to seek improvements in clinical quality and share best practices.

8. STATE GOVERNMENTAL RELATIONS 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 Byington began the discussion by remarking that the COVID-19 pandemic had brought healthcare issues to the forefront during this U.S. presidential election season. UC Health was a substantial portion of the UC system, and for this reason, Dr. Byington wished to bring regular updates on State and federal issues to the Health Services Committee.

Associate Vice President Kieran Flaherty explained that he oversaw the Office of State Governmental Relations (SGR), which was focused on State legislation in areas relevant to the University—academic, business, and health. This office also advocated for the

University in the State budget and worked to advance UC goals in Sacramento. The Legislature had now completed its 2019-20 legislative biennium. This had been a challenging session due to COVID-19. During this year alone, SGR reviewed 2,700 new bill introductions, about 3,000 subsequent amendments to these bills, and worked to assess their potential impact on the University. For UC Health, 365 measures in 2020 were deemed to have a significant impact. SGR announced positions on 23 measures, and 14 of these were in the health portfolio.

There had been some good outcomes for UC Health in the 2020 State budget. The combined efforts of UC stakeholders at the Office of the President and UC Riverside were able to secure ongoing funding of \$25 million for the UCR School of Medicine. This was particularly notable. Governor Newsom strongly supported the full allocation in his January budget proposal. Then the pandemic hit, and the May Revision proposed only \$11.3 million. The University was grateful to the Legislature and the Governor for funding the full \$25 million amount. An additional \$15 million in ongoing funding was allotted to the UCSF Fresno branch campus and the UC Merced medical education partnership. Governor Newsom supported, and the Legislature approved, funding to compensate for the declining tobacco tax revenue, which was used to support graduate medical education programs.

On behalf of UC Health, SGR supported successful health workforce bills and helped to defeat Senate Bill 977, which would have had significant negative ramifications for hospital acquisitions and consolidation. Three health workforce bills that UC supported and that were passed were either based directly on recommendations of the California Future Health Workforce Commission or aligned with the broader principles outlined by the Commission.

In the COVID-19 situation, the Governor and Legislature wished to change the law in the area of workers' compensation. SGR monitored and communicated with the Legislature on about a half-dozen measures that sought to expand or recast eligibility for workers' compensation protections in light of the pandemic. By early summer, the three bills of highest priority for the University were Assembly Bill 196, introduced by Assembly member Lorena Gonzalez; AB 664, introduced by Assembly member Jim Cooper; and SB 1159, introduced by State Senator Jerry Hill. SGR assessed the potential impact of these bills on the University. The Assembly measures failed on the Assembly floor, but SB 1159 was signed into law on September 17. UC regarded this bill as the least problematic. SGR looked forward to working with individual campuses on advocacy for legislation in this and other areas in the coming year.

Mr. Flaherty drew attention to a bill that SGR was able to resolve before a floor vote in the second house, something SGR typically tries to achieve in order not to have to request a veto. AB 3096 targeted the University with unique penalties, potentially several million dollars per year, for employer communications determined by the California Public Employment Relations Board to discourage or deter unionization. This bill was held in the Senate policy committee, and this example underscored the difficulty the University faced on labor issues in Sacramento. The political balance in the Legislature, which made it

possible for UC to achieve a positive outcome on this bill, made for uncertainty regarding other types of bills. The University would have to focus on these issues in the months and years ahead to achieve successful outcomes. In the case of SB 493, the University first opposed the bill, although it shared the same goal, which was protection and fairness for victims of sexual assault. UC worked hard to have this bill amended to the point where UC could support it, and Governor Newsom signed the bill into law.

SGR anticipated a busy year in 2021, with measures that had failed the previous year or had not been resolved. Two pieces of high-profile legislation were likely to be reintroduced: AB 1611, which concerned surprise billing and proposed to limit the cost-sharing required of a patient receiving covered emergency services at a hospital that did not have a contract with the patient's health plan, insurer, or third-party payer; SB 758 intended to extend the 2030 deadline for completion of seismic safety work for general and acute-care inpatient hospitals. Seismic safety was an important issue for UC, and the University was involved in discussions about the form this bill would take. SGR also anticipated an effort related to hospital consolidation. SB 977 would have required the Attorney General to agree to hospital transactions, with some limited exceptions; another version of this bill was expected. AB 2164 was passed but not signed into law. This bill would have extended telehealth flexibility, including telehealth in Medi-Cal reimbursement. Governor Newsom vetoed this bill due to cost concerns, but SGR expected to be engaged with this bill again in the coming year. There were also two bills having to do with contact tracing about which the University officially expressed concern and for which UC sought amendments; both bills were held in committees.

Mr. Flaherty then outlined some administrative and budgetary matters that SGR would be working on in the coming year. UC would work with the State to identify federal and State resources to support hospitals in addressing COVID-19 expenses. This year's State budget maintained a plan to transition all Medi-Cal services provided under the pharmacy benefit from managed care to fee for service by January 2021. There was some funding to provide supplemental payments to hospitals and clinics which participated in the federal 340B drug pricing program. The California Association of Public Hospitals and Health Systems estimated, however, that this support was insufficient to cover losses, only about one-fifth of the amount. UC would seek adjustments. UC was also seeking licensing law flexibility for mental health treatment across state lines, to allow UC students to maintain mental health treatment while studying remotely. It was clear the Governor and the Legislature wished to see changes in law regarding personal protective equipment. Two bills had passed, and UC would participate in the California Hospital Association's personal protective equipment implementation task force, working on issues related to these two bills, AB 2537 and SB 275.

Committee Chair Lansing suggested that SGR identify people in the Legislature with whom the Regents should have stronger relationships. SGR could schedule video conference meetings with or without an agenda, focused on healthcare legislation. Regent Leib expressed support for this idea.

Vice President Nation thanked SGR and expressed UC Health's appreciation for the successes in securing funding for the UCR School of Medicine and UC Health's efforts in the San Joaquin Valley.

Regent Stegura stressed the large number of healthcare-related bills and issues that SGR dealt with, and that SGR reports like this one to the Health Services Committee were very worthwhile.

9. **CENTER FOR DATA-DRIVEN INSIGHTS AND INNOVATION AND OTHER STRATEGIC PLAN-RELATED UPDATES FOR AREAS FUNDED BY MEDICAL CENTERS AT UC HEALTH**

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

This item was deferred.

10. **ADVANCING PROGRESS TO PROMOTE DIVERSITY, EQUITY, AND INCLUSION ACROSS UC HEALTH SCIENCES PROFESSIONAL SCHOOLS**

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

Executive Vice President Byington began the discussion by stating that the convening of a systemwide UC Health Sciences Task Force on Diversity, Equity, and Inclusion (DEI) was a high strategic priority, and UC Health had been working on this throughout the past year.

Vice President Nation recalled that UC operated the largest health sciences program in the nation, annually enrolling nearly 15,000 students and trainees, with 20 health professional schools on seven health sciences campuses. UC Health led the nation in the retention of its graduates, who remain to practice in the state. The UC Health Strategic Plan outlined 13 goals to help set the direction and priorities of the UC Health Division through 2022. One important goal was to “advance progress in promoting diversity, equity, and inclusion”—to support each UC health professional school in its efforts to improve diversity, equity, inclusion and campus climate for all health sciences students, residents, faculty, and administrative leaders by developing recommendations and sharing strategies that have proven effective in the health professions.

The work toward this goal had been a systemwide partnership. The UC Health Sciences DEI Task Force had 18 members representing all UC health sciences schools. The core elements of the Task Force's charge were to identify effective and inclusive policies, practices, strategies and/or assessments that aim to improve diversity, equity, and inclusion and campus climate; to provide recommendations for students, residents, and faculty; and to compile and disseminate information identifying model programs and best practices across all UC health professional schools. Dr. Nation presented a list of the Task Force members. The Task Force was chaired by UCSF Vice Chancellor Renee Navarro.

The Task Force focused on the elimination of barriers to the full inclusion of racially and ethnically diverse people. The Task Force recognized the need for additional focus on other underrepresented and marginalized groups, including LGBTQ+, individuals with disabilities, and others. The Task Force had three subcommittees addressing students, residents, and faculty. The Task Force Report included recommendations for improving DEI as well as an inventory of promising practices and programs.

Dr. Navarro commented on systemic racism as a persistent driver of health inequities, inadequate access to health care, and poor health outcomes for underserved groups and communities. Racial disparities in health were substantial and continued to result in adverse outcomes for underrepresented groups. Therefore, the underrepresented groups (URG)—African American/Black, American Indian, Alaska Native, Latino(a) and other people of color—experienced poorer outcomes in life expectancy, morbidity, health status, disease prevalence, use of services, and diagnosis. Racism was truly a public health crisis.

The work of the Task Force was guided by a number of considerations. Social determinants of health have long been recognized. Money, power, and resources are not distributed equitably in the health sciences, the state, or the nation. There was also recognition of the need for increased diversity in the healthcare workforce as one of the strategies for eliminating gaps in health outcomes. URG health care providers were more likely than non-URG peers to serve and practice in underserved communities. The Task Force was further guided by the demographics of the State of California, where Latino(a) individuals formed the largest ethnic group, but were underrepresented in the health sciences and health workforce. Black, indigenous, and other people of color bore a disproportionate burden of disease. The state health workforce was not sufficiently inclusive of these groups.

Dr. Navarro presented a chart showing the diversity of UC Health professional students, residents, and faculty in 2018-19. URGs constituted 20 percent of students, or 1,625 students; only 10.3 percent of residents, or 536 individuals; and 8.1 percent of faculty, or 985 faculty members. White and Asian Americans represented the majority of UC health professional students, residents, and faculty. UC Health faculty were nearly 60 percent white.

Dr. Navarro stressed the need to measure outcomes for equity, examine the implementation of policies, practices, and procedures, have the courage to challenge standards, and allocate sufficient resources to effect the structural changes that were necessary. The Task Force also identified the need to look to faculty and to examine the impact of institutional climate.

The Task Force produced 18 recommendations to advance DEI among students, residents, and faculty and to improve campus climate and leadership accountability. Many of these strategies make connections across populations and multiple points of coordination would be needed. The recommendations recognized that current practices and programs varied among UC Health schools and professions. The Task Force also included a list of proposed actions that offer specific and actionable ways to implement each recommendation.

Dr. Navarro presented a chart showing UC Health student diversity by profession. The nursing student cohort had the highest percentage of URGs. There were large opportunities for student diversification in optometry, pharmacy, and veterinary medicine. With regard to students, the Task Force recommended that UC Health expand outreach programs, partner with other higher education institutions, increase need-based scholarships for lower-income UC health science students from underrepresented groups, develop and sustain a “holistic student affairs office” at each health sciences school, providing support for student success, and sustain and optimize the scale of UC Programs in Medical Education (PRIME) and replicate the PRIME model for other UC health professions.

Dr. Navarro presented a chart showing UC Health resident diversity by profession and emphasized the important role of residents, who provide a significant amount of care at UC Health as well as education to students. National data indicate that there is a high probability for residents to remain to practice in the state where they have completed their residency. The state of UC Health residents was a window into the future California health workforce. URGs made up only 11 percent of residents in medicine, six percent of residents in optometry, and four percent of residents in pharmacy. The Task Force recommendations for residents included transparency in reporting demographic data for each stage of the resident selection process to facilitate an accountability structure, greater support for resident diversity efforts, opportunities for URG health science students to participate in visiting elective scholars programs, and career development programs dedicated to supporting diverse UC residents interested in pursuing a career in academia.

Dr. Navarro presented a chart showing UC Health faculty diversity by profession. UC Health faculty were less diverse than residents, who in turn were less diverse than students. This should not be accepted as a given. UC Health should ask itself why it tends to lose URG individuals along this path. Of the 10,814 medical school faculty, only 568 were Latino(a), 262 were African American, and 29 were American Indian or Alaska Native. Isolation might affect these faculty members. The Task Force recommendations for faculty concerned providing necessary resources. The health sciences schools should be included in all Office of the President-sponsored funding opportunities for targeted recruitment and hiring incentives to increase diversity and improve the retention of faculty. There was a lack of full-time equivalent positions in the health sciences schools. This presented a challenge to providing some level of guaranteed funding for salaries. UC Health must ensure that there were mentoring programs that recognized the unique challenges faced by URG in the academy. The Task Force also recommended that the Academic Senate address the lack of representation for health sciences clinical and adjunct faculty, who were a diverse group of faculty. This situation perpetuated a feeling of disenfranchisement among these non-Academic Senate faculty.

With regard to campus climate, the Task Force found that there needed to be vocal and visible leadership by chancellors, deans, chief executive officers, and department chairs that articulates and includes action plans and accountability for assessing and addressing climate. UC Health could transform the care of individuals and communities if all its health sciences graduates had competency in the elimination of race-based inequities. Faculty and staff should have this competency as well.

The Task Force recommended that at each UC health professional school share its plan to address DEI within the next 12 months, that each medical center work with its campus' chief diversity officer to determine the roles and responsibilities for a senior diversity officer within the medical center, and that UC Health work to determine roles and responsibilities for a senior diversity leader within the UC Health Division at the Office of the President.

Given the complexity and deeply entrenched nature of challenges to full equity and inclusion, Dr. Navarro felt that this report offered a starting point. The recommendations would be beneficial to all, but the intersectional identities and challenges of other marginalized and/or underrepresented groups should be further explored. Racial justice must be inclusive of economic justice. Dr. Navarro hoped that UC Health would also examine the inequities and opportunities for staff and leadership positions within UC. With a sustained investment of time and energy, leadership, and financial resources, one could disrupt the status quo and put UC Health programs on a different, more diverse, equitable, and inclusive course.

Dr. Byington commented that this report had focused on the academic side of the UC Health enterprise, on the medical schools, students, trainees, and faculty. UC Health would embark on the same process for its hospitals and clinics. The 18 recommendations of the Task Force were fundamental for achieving transformation and excellence in the UC Health enterprise. Financial resources would be required to support these recommendations. UC Health would work with the Office of the President to identify resources that might be available on the campuses and systemwide, to seek opportunities to go to the State Legislature to expand resources that would allow UC Health to better train individuals from diverse communities and to support health equity. There was an opportunity for philanthropy at the UC Health system level. Dr. Byington had taken four of the 18 recommendations and instituted them as long-term goals for the Clinical Enterprise Management Recognition Plan program. These four goals were broad, system-level goals: appointing a leader for diversity at UC Health to oversee systemwide initiatives, to review statistics and present them to the Regents and to legislators, and to hold UC Health accountable; establishing a systemwide anti-racism competency; addressing structural barriers that prevented non-ladder rank health sciences faculty from participating in the Academic Senate; and partnering with the California State University and the California Community Colleges to help prepare students who could then be recruited into UC's health professional schools. Dr. Byington had experience in this regard with Native American and other URG students. There was an opportunity to link such preparatory programs to the Program in Medical Education (PRIME) or expansions of PRIME. Dr. Byington hoped that UC Health could work on these goals over the next three years and find ways to achieve all the Task Force recommendations.

Student observer Medha Vallurupalli emphasized the importance of diversity in her undergraduate educational experience at UCLA: diversity of experience, race, and culture. This diversity created vibrancy and motivated meaningful conversations in class. Meeting people from all walks of life gave new meaning to education. This vibrancy was lacking in the UC health sciences schools, where only about eight percent of faculty, ten percent of

residents, and 20 percent of students came from underrepresented racial groups. UC had a responsibility to uplift minority students and set an example for the future of health care through scholarships, pathway programs, as well as additional health career counselors and career development resources. The vibrancy that Ms. Vallurupalli and her peers had experienced as undergraduates in the UC system should not decline as they progressed in their medical careers. Although the Task Force report focused primarily on racial minorities, attention should also be paid to disparities due to gender, immigrant status, LGBTQ+ identification, and more. Women made up only 35 percent of practicing physicians and were often vastly outnumbered in high-paying specialties and leadership roles. Women made up only a quarter of all surgical specialists, only 12 percent of neurosurgeons, and only five percent of orthopedic surgeons, not to mention the wage disparities when they enter the workforce. Women and URGs faced obstacles as they entered health professions, and it was UC's responsibility to address these discrepancies and provide pathways that support and encourage these groups to enter healthcare careers in order to address the growing need for healthcare providers in the U.S. and California. Having a diverse workforce would allow patients to identify with their providers, form meaningful connections, and feel supported by their healthcare team. This would lead to better health outcomes and emphasis on primary care, and, as a result, a reduction in future healthcare expenditures.

With regard to enrollment at health sciences schools, Ms. Vallurupalli noted that, as the population continued to grow in California, the state lacked the necessary health professionals to sustain this growth. As the largest health education system in California, UC must act to increase the number of available seats in its health sciences programs. Studies showed that primary care physicians were much more likely to practice where they train or have a personal connection. Yet California was sending many of its own students out of state to complete their medical education due to a lack of available seats in California schools and programs. UC currently had about 850 medical students per class enrolled in its six medical schools. This number was insufficient and must rise to meet the growing need for California doctors. UC must make it a priority to increase enrollment in a sustainable manner in its medical schools. The recently allocated funds of \$25 million and \$15 million, respectively, to the UC Riverside and UCSF-Fresno medical schools should be used to develop innovative strategies for increasing enrollment while making it a priority to recruit diverse classes of students from California. She urged UC to consider these points as it continued to plan for the future of health care in California.

Regent Muwwakkil referred to the Task Force's second recommendation: "Partner with higher education institutions that enroll more diverse student bodies, including California Community Colleges and California State Universities, as well as Historically Black Colleges and Universities, Hispanic-Serving Institutions and Tribal Colleges and Universities to diversify the applicant pool for UC health sciences education and training programs." He asked how UC would go about this, whether through establishment of pipeline programs, shifting of resources, or marketing and branding.

Dr. Byington responded that there were opportunities for outreach pipeline programs. She referred to her experience and engagement with Native American and Latino(a)

communities, visiting high schools and colleges, hearing about individuals' needs in contemplating attending medical school, and answering questions. This involved students' families as well, helping families to understand what would be needed to support student success in medical school. Pipeline programs would bring additional resources to help prepare future medical students for the Medical College Admission Test, for interviews, including having appropriate clothing for interviews, and for writing personal statements. These hands-on efforts could be connected to participation in PRIME, which might be of interest to these students, and to State financial aid. These programs would break down barriers so that students could see that this career path was possible. Dr. Byington stressed her wish to work with the California Community Colleges and California State University to bring about such programs. Vice President Nation added that there was more information on proposed next steps in the Task Force report. There were many examples of programs like this across UC, and there were programs in the U.S. that served as models. One of the aims of the Task Force was to put together an inventory of these programs as a resource for deans and campus leaders. This topic had been one of those considered by the California Future Health Workforce Commission. UC Health was communicating with the California Community Colleges and California State University about the development and expansion of pipeline programs.

Regent Muwwakkil asked about the retention of doctors in different geographic regions of California. Dr. Nation remarked that California enjoyed a significant return on the public investment in medical education. California exported more medical students than it could accommodate in its own schools. UC health sciences schools focused overwhelmingly on the admission of California students. The facts of where students lived and had family ties had predictive value, and high percentages of UC health sciences graduates remained to practice in California. The UC Davis PRIME program focused on rural communities and the intentional recruitment of students from rural communities. There was one explicitly geographic PRIME program, the San Joaquin Valley PRIME program, which aimed to recruit and train medical students and retain them as practicing physicians in the San Joaquin Valley. The UC Riverside School of Medicine was similarly focused on medical students in the Inland Empire region.

The meeting adjourned at 2:40 p.m.

Attest:

Secretary and Chief of Staff