The Regents of the University of California

HEALTH SERVICES COMMITTEE
February 12, 2020

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

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

In attendance: Regents Um and Weddle, Regents-designate Muwwakkil and Stegura, Secretary and Chief of Staff Shaw, Deputy General Counsel Nosowsky, and Vice President Nation

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.   Aneri Suthar, UCLA student, referred to UC policies on non-discrimination and noted that Dignity Health hospitals in California have faced lawsuits due to discriminatory practices. There was dangerous denial of treatment at Catholic healthcare facilities. UC recognizes that reproductive and sexual health care is simply health care. Affiliations with Catholic hospitals were a compromise of good health care and the University should not pursue affiliations with entities that ban services for women and LGBT patients. Reproductive justice was under national attack. The University should take a firm stance to protect abortion, contraception, gender-affirming services, and the End of Life Option Act.

B.   Hannah Oltman, UCLA student, recounted that she had required multiple surgeries due to polycystic ovary syndrome. On one occasion, she was taken to the emergency room at a Catholic hospital which was now a partner of Dignity Health, and was denied a necessary treatment. Dignity Health's denial of reproductive health care and health care for LGBT patients created dangerous situations and was discriminatory. The University should not discriminate and should take a stance in favor of all students and patients.

C.   Clare Glavin, UCLA student, noted that she was Catholic but believed that patients have the right to make their own healthcare decisions. The University should not affiliate with Dignity Health and bring religion into a secular university. Dignity

Health did not provide abortion services, even for survivors of sexual assault. The University's own Working Group on Comprehensive Access had found that Dignity Health's policies were discriminatory toward women and LGBT patients. Not performing in vitro fertilization was discriminatory toward same-sex couples and men and women who are infertile. Denial of service to patients can result in dangerous delays in care. While an affiliation with Dignity Health might expand the number of patients who can access UC care, this should not happen at the expense of women and LGBT patients. The fact that Regent Reilly served on the Board of Directors of the Dignity Health Foundation created a conflict of interest.

D.   Jane Ni, UCLA student, expressed opposition to a proposed partnership of UC and Dignity Health, an organization rooted in Catholic religious values. Dignity Health denied care to women and LGBT patients. As a public institution, UC is not permitted to discriminate or support religion. Nonreligious patients should not be subjected to religious mandates.

E.   Sophia Su, UCLA student, stated that to remove access to abortion, birth control, reproductive technology, and gender-affirming surgery would be an attack on women and LGBT patients. Access to reproductive health care is a fundamental human right, and agreements with Catholic hospitals which do not even recognize the existence of transgender people would be an attack on human bodily autonomy. Law forbids the imposition of religious doctrine on UC students, faculty, and staff.

F.   Martin Diaz, UCLA student, told of how his gay identity conflicted with his Latino community's traditional beliefs. As a student at UCLA, he had been able to receive access to HIV testing. A few days earlier, a religious group had come to UCLA, the University of Southern California, and local high schools to express disapproval of LGBT rights and existence. He was opposed to a UC partnership with Dignity Health because it would mean removing human rights.

G.   Navya Nagubadi, UCLA student, expressed dismay that UC, a secular institution that should be a safe space for people from all walks of life, would affiliate with Dignity Health. Dignity Health claimed that its practices were not discriminatory, but its policies denied patients contraception and abortions and erased the existence of LGBT individuals.

H.   Audrey Faulks, UCLA student, stated that she was familiar with restrictions on reproductive health in Texas. While she was a Christian, she felt that religion should not be imposed at a secular, public university. Dignity Health had a history of discrimination toward women and LGBT patients. These patients were harmed by not receiving comprehensive care. In considering whether to partner with Dignity Health, the University should consider the needs of all UC students.

I.   Emily Gibson, UCLA student, stressed that UC, as a public institution, should provide secular, timely, and accessible healthcare options for students and community members. She asked that the University make a courageous and

honorable decision to ensure high-quality health care without sacrificing the health and safety of women and LGBT patients. An affiliation with Dignity would be a setback for modern medicine and women's and LGBT rights.

J.   Maddison Murphy, UCLA student, expressed concern that the religious restrictions imposed in an affiliation between UC and Dignity Health would fail a multitude of minority groups, having lasting effects on the quality of reproductive and LGBT-inclusive care received across California. Such an affiliation would endanger the diverse community of UC. The University should consider whether an affiliation with Dignity Health was more important than upholding the values of its non-discrimination policies.

K.   Michael Cahn, of the UCLA Bicycle Academy, observed that, while many doctors think that their work takes place in the hospital consulting room, the true consulting room is in fact the entire community. Healthy mobility is a community health need. Hospitals can support more active, healthier, and more sustainable lives in their communities by offering safe cycling education. He asked that UCLA Health become an active member of its community and involved in the regional planning process so that mobility solutions are both healthy and sustainable.

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

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

Committee Chair Lansing recalled that the current structure of the Health Services Committee had been instituted four years earlier. This restructuring, with inclusion of outside advisors, had proven successful. Discussions over the past four years had been productive and meaningful.

3.   **INTRODUCTORY COMMENTS OF THE EXECUTIVE VICE PRESIDENT – UC HEALTH: REFLECTIONS ON THE FIRST 90 DAYS AND PLANS FOR 2020**

[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 reflected on her first 90 days in office. She had made five campus visits, attended four Regents meetings, made two trips to Sacramento, and one pandemic had broken out. In her visits, she had met with extraordinary UC faculty, staff, students, and stakeholders. Health care was now in a period of transformation, which presented challenges and opportunities. Dr. Byington expressed confidence in UC Health faculty, administrators, students, and staff to lead the University through these challenges and to create opportunities for UC patients, trainees, and the system as a whole.

Dr. Byington presented a list of the largest healthcare systems in the U.S., ranked by 2018 total operating revenue. UC Health ranked number 14 and was the only academic

medical system in the top 20. This unique size and scale meant that the University has a responsibility to work in areas that influence the state and the nation. With regard to the quality of the UC Health operation, she noted that UC hospitals are consistently ranked the best in California, and the UCLA and UCSF medical centers are ranked among the best in the nation. The same is true for the University's health professional schools. UC Health's contributions to the national research enterprise are highlighted by the fact that UC has five National Institutes of Health (NIH)-designated comprehensive cancer centers as well as five Clinical and Translational Science Award sites for the largest and most competitive NIH awards. This was unmatched anywhere in the U.S. Of all NIH funding to academic health centers in the U.S., UC receives 14 percent or about $2 billion annually.

While these were impressive statistics, Dr. Byington remarked that UC Health also works in areas which are of vital importance although not often reported. One example was UC San Diego's response to the state's need for human milk banking. Annually, 3,500 low birthweight infants are born in California, and what they are fed is very important. UCSD had stepped up to coordinate a statewide effort to feed these infants and create a non-profit milk bank. This effort is vital to the future of these infants. Only a public institution like the University of California could do this for the state.

In the realm of research, Dr. Byington drew attention to the use of real-world data, including electronic health, billing, patient satisfaction, and other records. Under the direction of Chief Data Scientist Atul Butte, UC was becoming a national expert in real-world data, creating databases that could be used to improve health. Working with organizations such as the U.S. Food and Drug Administration, UC would be able to better identify side effects from new drugs and better prepare clinical trials across the pharmaceutical industry. Dr. Byington anticipated that UC would be the leader in this area of healthcare research in the future.

Based on her experience with infectious diseases, Dr. Byington believed that the coronavirus was on the path to becoming an international pandemic. UC was on the cutting edge of helping the state and the world to resist this pandemic. At this point, several airports in the U.S. had been designated for screening activities by the Centers for Disease Control and Prevention. UC medical centers were actively involved in the screening and care of coronavirus patients, in the development of new diagnostic testing, in epidemiology, and in working with State and federal health departments. The University had an extensive infrastructure that would be able to respond to this international need.

At this time of transition in the healthcare arena, UC Health's values needed to be articulated in a very clear way. These values would be discussed in further detail later in this meeting and they should serve as the "North Star" for UC Health decision-making. Dr. Byington expressed her wish to engage the Regents as partners with UC Health in developing and implementing UC Health's strategic plan, in developing policies, and in UC Health's engagement across the state. In order to improve this collaborative work, Dr. Byington wished to regularize the agenda for the Health Services Committee with an annual agenda and timelines for action. This would allow the Committee to focus more on strategic issues, policy development, and to hear more about the impact of UC Health. She

presented and outlined a draft annual agenda and areas of focus. She noted that many UC Health stakeholders had expressed an interest in greater integration of the academic and clinical missions. There would be an annual community benefit report, for which there were national benchmarks.

Regent Park suggested that there be more frequent discussions about workforce planning and more attention paid to workforce issues. Dr. Byington responded that the California Future Health Workforce Commission would be meeting in April and that a follow-up report to the Committee could be made in June.

4.   **UC HEALTH CAPITAL FINANCIAL PLAN**

The President of the University recommended that the Health Services Committee waive its authority to review the UC Health-related projects included in the 2019-25 Capital Financial Plan approved by the Regents in November 2019, subject to the following conditions:

A.   The Health Services Committee's waiver shall not apply to the following projects:

UC Davis	– Hospital Bed Replacement Tower – Inpatient Regional Strategy – Outpatient Regional Strategy II
UC Merced	– Health and Behavioral Sciences Building
UC San Diego	– Hillcrest Replacement Hospital – Hillcrest West Wing Replacement
UC San Francisco	– Benioff Children's Hospitals Oakland Phase 2

B.   The Health Services Committee's waiver shall apply only to the extent of UC Health-related projects at the medical centers and campuses occurring during fiscal years 2019-20 to 2024-25 (Waived Projects).

C.   Any Waived Project requiring review, approval, concurrence or other action by the Finance and Capital Strategies Committee shall require consultation with the Executive Vice President – UC Health.

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

Executive Vice President Byington explained that this proposed waiver by the Health Services Committee to review projects would not apply to certain projects due to their size, scope, or strategic importance. The Committee had approved a similar waiver in February 2019. This action would supersede the previous year's waiver.

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

5.   **UC HEALTH REPORTS OF FINANCIAL AND QUALITY METRICS**

[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 presenting a financial summary chart for the UC medical centers. In her view, this chart, with figures for operating income, earnings, days' cash on hand, and debt service coverage, was just a snapshot, and it could be expanded with more information to help the Committee understand the environment in which UC Health was operating and UC healthcare quality.

Dr. Byington presented a chart indicating days' cash on hand and debt service, followed by a chart with operating statistics. One benchmark was available beds, important for daily operations and especially important for emergency situations like a pandemic or surge. Other benchmarks were patient days, admissions, and discharges. For UC Health, these figures were large: there had been approximately 172,000 hospital discharges in the past fiscal year. The University also gathers statistics for its outpatient visits. UCLA had 2.8 million outpatient visits in fiscal year 2019. The next statistic presented, average length of stay, also had to do with the quality of care. It could be compared to national benchmarks, reflected the efficiency of UC Health, and could serve to motivate discussions about how UC Health could work better as a system.

The case mix benchmark describes how complicated patient conditions are and how many conditions patients might have. This UC Health case mix benchmark was higher and indicated greater complexity of patient conditions than in general hospitals across California. Dr. Byington then presented a chart with quality metrics, which are captured by UC chief nursing and chief medical officers in areas such as diabetes care, colorectal cancer screening, tobacco assessment, blood pressure, and immunizations.

Payer mix is an important factor to consider when evaluating the financial sustainability of UC Health. Dr. Byington stressed the fact that UC Health's primary payer mix, about 70 percent, was non-commercial, government-sponsored payers such as Medi-Cal and Medicare. She presented a chart showing a $968 million Medi-Cal cost increase for UC Health from fiscal year 2013 to fiscal year 2016. Dr. Byington underscored that this figure represented how quickly the nature of payments to UC Health can change when State or federal policy changes. The UC system has little time to react to such changes, and for this reason it is important for UC to work with State and federal policymakers to influence policy. When the State decided to expand Medi-Cal, UC Health saw a rapid increase in the number of its Medi-Cal patients. Medi-Cal reimbursements do not necessarily meet UC costs. Medi-Cal costs affected UC's ambulatory care as well as its hospital system.

Committee Chair Lansing referred to the figure of 2.8 million outpatient visits for UCLA and observed that much care for patients was now moving from hospitals to urgent care

and outpatient facilities. She recalled that UC medical centers are judged on patient readmission rates, but noted that this was not a fair benchmark unless one considered the underlying causes for readmission in greater detail. She requested more information on this point. Committee Chair Lansing referenced the fact that the U.S. population is aging and that many individuals, including patients leaving UC hospitals, need the services of caregivers but cannot afford the cost of these services. The Committee should also have a discussion at a future meeting about how UC Health can become involved in seeing how these costs can be reimbursed. This was a significant problem for the nation.

Regent Sherman referred to the chart showing the increase in Medi-Cal costs and asked if this was net of all reimbursement for Medi-Cal. Dr. Byington responded in the negative. This was the figure for hospital costs attributed to Medi-Cal patients. Regent Sherman asked about the percentage of this cost for which the University is reimbursed. Dr. Byington responded that this percentage varied by facility; the reimbursement rate ranged from 70 to 77 percent. Regent Sherman estimated that, for the time period indicated in the chart, the University had expended $300 million for the public benefit, costs which were not reimbursed. Dr. Byington believed that, in fact, UC expends a higher amount for the public benefit. She would defer to the campuses for a precise figure. Regent Sherman stressed that it was important for the California public to know this number, as a measure of the benefit the University provides for the State of California. Dr. Byington responded that UC Health was calculating this number as part of its reporting on community benefit.

Regent Sherman then referred to the figures for outpatient visits and asked what percentage of UC outpatients become hospital patients. Dr. Byington responded that this information could be provided. UCLA Health President Johnese Spisso commented that UCLA has about 80 physical sites in its region and about 180 practices at these sites, providing primary and some secondary specialty care, such as oncology. UCLA Health wishes to be within 30 minutes of its patients, so that patients are not required to travel to the Westwood or Santa Monica hospitals. About 26 percent of the patients who have had episodic visits later require an acute care stay in a UCLA hospital. This figure was likely due to the fact that UCLA's oncology services have a significant presence in the community, with about 200 infusion chairs. This was not a typical primary care network.

Regent Sherman asked what other specialty services are offered in UCLA Health's network of sites. Ms. Spisso responded that UCLA has six ambulatory surgery and procedure sites in the community. These clinics also provide special care cardiology, gastrointestinal, urology, and neurology services. UCLA Health was experiencing most of its growth in the outpatient setting.

Regent Zettel asked if UC Health was tracking the overall health of its patients by age group. Dr. Byington responded in the affirmative. This was part of case mix and risk adjustment calculations for individual patients. Regent Zettel asked if age affects average length of stay. Dr. Byington responded in the affirmative. In response to another question by Regent Zettel, Dr. Byington remarked that average length of stay reflects quality of care but also the patient case mix. A number of causes can contribute to length of stay: case mix, difficulty in releasing a patient back into the community and ensuring long-term care,

mental health issues, or inefficiencies that UC Health can identify and work to reduce. Regent Zettel asked why no figures for patient mortality had been shown. Dr. Byington explained that this presentation had included only a small sample of examples. Mortality and readmission rates are important statistics and would be included in future presentations. She would like to present metrics that UC Health and the Regents agree are important and to look at these over time.

Advisory member Lipstein suggested that the information on financial and operating statistics could include explanation of context, indicating whether a specific figure represents a good or bad trend. This could take the form of a narrative on each chart. Information could also be provided on how UC Health benchmarks such as days' cash on hand or debt service coverage compare to peer health systems. With regard to statistics on volume, Committee members would like to compare these figures to figures for the preceding year in order to understand the direction of trends. If patient volume growth were entirely in Medi-Cal patients, this would support the University's mission but exacerbate financial shortfall.

Regent Park requested that there be a more detailed discussion at a future meeting on outpatient services. This raised questions of strategy and variations among local markets. It would be beneficial to have an understanding of the factors influencing outpatient volumes. She referred to a chart included in the background materials, but not discussed, concerning healthcare quality. There was a list of aspects of quality: safety, effectiveness, patient-centeredness, efficiency, equity, and timeliness. These were comprehensive and expansive criteria. She asked how UC Health was measuring itself on these expansive criteria compared to granular benchmarks, such as the number of patients who have received a particular vaccination. She also asked if UC Health needed to focus on any one of these expansive criteria in particular. Dr. Byington responded that one should be able to map all the granular statistics being presented onto the quality indicators. Delivering higher quality has an impact on financial statistics; higher quality is usually associated with lower cost. With regard to the question of whether any quality indicators merited special attention, Dr. Byington stated that she was still listening to and gathering opinions and concerns of the UC Health community. Two areas had drawn her attention. UC hospitals were always full, and timeliness for patients was a concern—timely entry and consultation. Equity was another concern. Not all UC campuses had access to UC-Health branded providers. UC Health would learn more through patient experience surveys and studies.

UC San Diego Health Chief Executive Officer Patricia Maysent referred to the information on growing Medi-Cal costs. On the aggregate, the University was underwriting the Medicaid/ Medi-Cal system by almost $1 billion annually. About 41 percent of UC San Diego's patients were Medi-Cal patients. UCSD had made a commitment to its physicians that they would not bear the brunt of Medicaid patients and has subsidized their salaries to the 50th percentile of the Medical Group Management Association (MGMA) standard, which is the market standard. UCSD wishes its physicians to be paid at market rates, and this represented a $90 million annual subsidy, due to UCSD's payer mix. For UCSD, the total annual subsidy for taking care of Medi-Cal patients was $300 million.

Regent Zettel asked if these subsidy amounts were being brought to the attention of State legislators. Ms. Maysent responded that UCSD was worried about possible changes to Medicaid payments and supplemental payments to public hospitals. The current proposed rule would be disastrous for UC medical centers. At this point, Democratic State governors could not take a strong position with the federal administration, while Republican governors were in support of this rule. This was a risky time for Medicaid reimbursement.

UCSF Health Chief Executive Officer Mark Laret commented on a dramatic change over the past ten years. UCSF used to earn a great deal through commercial insurance, lose a little on Medicare, and lose a great deal on Medi-Cal. Over this time, Medi-Cal reimbursement had improved to about 70 percent. UCSF was still losing money on every Medi-Cal patient. The major change had been the tremendous growth of Medicare. UCSF was now losing almost $400 million annually on Medicare fee-for-service business. At the same time, the commercial insurance business, which had been subsidizing Medicare and Medi-Cal patient care, was shrinking as companies found ways to avoid providing coverage for employees. A generic financial issue that the Regents should consider is this change and the outcomes it would produce over time as well as the question of how the UC health systems, one of whose jobs is to be financially self-sufficient, can manage through this situation, fulfill their public service and academic support missions, and achieve a balance between revenues and expenses. The leaders of the UC medical centers were worried about their ability to manage this. The challenges included labor costs, drug costs, and new regulatory requirements. Unfavorable budget decisions in Washington, D.C. could have very bad consequences for the UC medical centers.

Committee Chair Lansing stated that the current situation was disquieting; the financial state of UC Health was fragile.

UC Davis Human Health Sciences Vice Chancellor David Lubarsky observed that UC Health experiences a 30 percent loss on every Medi-Cal patient even after supplemental funding. The status of supplemental funding was currently at risk in Washington, D.C. The University had natural allies in other academic health systems and was working closely with them on shared concerns, such as billing legislation that would set emergency room rates, the possible end of the 340B Drug Pricing Program, which was being considered, and the denial of intergovernmental transfers (IGTs), which draw down Medicaid funding for a variety of services provided by UC Health. Dr. Lubarsky emphasized that UC Health was exceptional, performing well on all benchmarks, and the sharing these data would be impressive. At UC Davis, 39 percent of hospital inpatient admissions were Medicaid patients. The UC Davis Medical Center is located in an economically disadvantaged area. He gave a hypothetical example of a patient who might be treated for congestive heart failure, released in South Sacramento, which is a food desert, and then readmitted due to a high salt load. In hospital rating systems, UC Davis would receive no credit for this case and would look worse in terms of readmission data. In his view, *U.S. News and World Report* had one of the best rankings of hospital quality because it did take into account observed-to-expected data, morbidity and mortality, volumes of complex procedures, and comprehensiveness of services offered. Dr. Lubarsky noted that UC was taking a leadership role on the issue of caregivers. The UC Davis School of Nursing Family

Caregiving Institute was developing a "train the trainers" program in concert with the California Alzheimer's Disease Centers. Seven of these ten Centers are operated by UC. This effort would leverage this infrastructure in order to reach one million caregivers over the next year.

Committee Chair Lansing remarked that her principal concern was not the training of caregivers, which UC Health was engaging in, but that people would not be able to afford caregiving services because these were not covered by insurance. The U.S. population was aging and caregiving presented an opportunity for job growth, but because the cost of these services was at least $25 an hour, many people could not afford them. Insurance companies should cover these services, and Committee Chair Lansing asked that the Committee delve into these questions.

Regent Blum expressed concern about the status of healthcare reimbursement from the federal government. He anticipated that not all Americans would have health insurance if Donald Trump were to be reelected in November. The University should consider its range of options and the best- and worst-case scenarios. Dr. Byington agreed with the need for scenario planning and considering the most likely policy changes. There were many people in the UC system with expertise in healthcare economics, and UC Health could use this expertise to develop scenarios that would help chart a path.

Regent Sherman suggested including benchmarks along with the financial and quality metrics, which would allow one to focus on significant misses and gains and to learn from errors.

UCLA Health Sciences Vice Chancellor John Mazziotta stated that the outlook was ominous and troubling, but UC Health had managed its way through difficult situations. UC Health faced external market forces but was now also challenged by internal obstacles, self-imposed by the UC system, which limited the degree of freedom UC Health had to respond to those external forces. UC medical centers were in a free market and a tough business environment, and their competition did not have the same constraints. If constraints were extreme, UC Health might not continue to be able to manage. A balance needed to be achieved.

Committee Chair Lansing remarked that an important goal of the Committee was to lessen those constraints. The Committee very much wanted to hear from Dr. Byington and the medical centers about these constraints. She concurred about the need for a fine balance. Dr. Mazziotta responded that the medical centers saw the Committee as an advocate in addressing a long list of concerns.

Chancellor Block stated that he was startled by data on length of patient stay in hospitals at UC Irvine compared to UCLA. The data indicated an 18 percent shorter stay in Irvine, and he asked if this was due to patient case mix or other factors. Ms. Spisso responded that one measure that UCLA reviews is excess bed days, using the Vizient database in order to compare itself to leading academic medical centers. This allows UCLA to consider specific patient populations, such as liver transplant patients, and determine what constitutes excess

bed days for this diagnosis-related group (DRG). She recalled that the Ronald Reagan UCLA Medical Center license includes the Mattel Children's Hospital, which provides purely quaternary care. The case mix index in the Children's Hospital was over 3.0, the highest in the Vizient database. These numbers can be explained if one considers these factors.

Committee Chair Lansing observed that these data were both helpful and dangerous. Looking only at raw numbers, one could come to a mistaken conclusion; understanding the patient case mix was important.

UC Irvine Health Interim Chief Executive Officer Larry Anstine confirmed that case mix accounted for the data on length of stay at UC Irvine. The case mix at Irvine was typically 2.0 or less, the lowest among the UC hospitals. UC Irvine did not perform liver or heart transplants, procedures with a high case mix.

Committee Chair Lansing emphasized the importance of having a correct understanding of these data and of conveying this understanding to the public at a time when there are national debates about health care.

6. **STRATEGIC PLAN AND FISCAL YEAR 2020-21 BUDGET FOR UC HEALTH DIVISION, OFFICE OF THE PRESIDENT**

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

    Executive Vice President Byington recalled that the current strategic plan for the UC Health Division at the Office of the President (UCOP) had been developed in 2017 and was in place through 2022. UC Health had refreshed this plan in collaboration with UCOP.

    Dr. Byington commented on some of the strategic planning decision drivers. In this plan update, the UC Health Division worked to align itself with UCOP. Its framework had differed slightly from that of UCOP, and the framework was adjusted for greater consistency across UCOP divisions. At a UC Health leadership retreat meeting in December 2019, participants discussed systemwide goals that all medical centers and schools would embrace and that no one institution could accomplish on its own. The first is to improve the health of all people living in California; the second is to promote health equity and eliminate health disparities; and the third is to reduce barriers to access to UC's clinical, education, and research programs by creating more inclusive opportunities for employees, students, and trainees. Dr. Byington saw the Division's strategic plan as a way of providing tools to achieve these goals.

    Based on speaking with and listening to the concerns of UC Health stakeholders across the system, Dr. Byington had developed ten priorities for calendar year 2020. These are: (1) to define UC Health and articulate UC Health values; (2) to develop a UC-branded healthcare strategy for all campuses, including campuses without medical centers, which has been emphasized as an urgent need by campus stakeholders; (3) to create a strategy team to

address care collaboration, population health management, and government and commercial payment issues. With regard to payment issues, it would be important to develop national-level strategy and have a national-level policy focus at UC Health to help guide the institution. Goal (4) is to support the health professional workforce needs of the state. Dr. Byington noted that, since taking up her office at UC, UC Health had committed to train mental health nurse practitioners. Three UC nursing schools were working together to train 300 mental health nurse practitioners over the next five years. This would represent a doubling of this vital specialty in the State of California. Goal (5) is to develop systemwide programs for diversity, inclusion, and leadership development in UC Health. Dr. Byington enumerated some leadership development programs in which UC Health participates. In June, she would receive a report from a systemwide task force led by Vice President Nation with recommendations for making further improvements in diversity, inclusion, and leadership. Goal (6) is to optimize UC Health benefit plans to better meet the needs of UC employees and offer more employees the opportunity to receive care from UC Health. UC Health delivers the best cancer care in the state, and Dr. Byington stated that this care should be available to all UC employees. Goal (7) is to develop the capacities of the UC Cancer Consortium and complete hire of a director; (8) is to complete critical hires for the UC Health Division; (9) is to finalize UC Health policies and processes on affiliations, conflict of interest, labor relations, and sexual violence and sexual harassment in the clinical workplace; and (10) is to articulate and make transparent the economic impact of UC Health for the UC system and the State of California. UC Health was working to provide a clearer picture of funds flow and its contribution to the overall financial portfolio of the University. UC Health had engaged consultants to better present this perspective to the State government.

Dr. Byington then outlined UC Health Division core values: accountability, collaboration, diversity and inclusion, excellence, innovation, integrity, and being mission-driven, particularly with regard to public service. The excellence of UC Health's education and research activities were widely recognized but there was less awareness among the public and even within UC Health about the degree to which UC Health provides services for the state.

In the UC Health Division framework for strategic objectives, Dr. Byington noted that the number of objectives had been reduced from seven to five. The two objectives of "systemness" and innovation had been moved to UC Health's statement of core values. The five current objectives concerned people, financial stability, operational excellence, policy and advocacy, and executing the mission. Dr. Byington then outlined UC Health Division goals contained within each strategic objective. Several goals were new or represented enhanced versions of earlier goals. Goal no. 3, to develop the health benefits portfolio strategy, and goal no. 13, improving access to health services for all campuses, were new goals. The goals led by Dr. Nation, which concerned integration of the academic and clinical missions of UC Health, had been substantially enhanced. Dr. Byington pointed out the goals that would be self-funded by UC Health. Goal no. 4 is to improve systemwide financial analysis. Goal no. 5 is to pursue savings and efficiencies through the Leveraging Scale for Value initiative. Goal no. 6 is to create a quality/population health management function. This function was becoming more important over time, and Dr. Byington anticipated that this would become a regular item on the Committee's agenda. Goal no. 7 is

to establish a center to leverage systemwide data. Goal no. 10 is to more effectively influence public policy as a system. Goal no. 11 is to develop the capability of launching systemwide strategic initiatives. These might be activities that UC Health had not engaged in before and activities that would need the support of the UC Health Division central office. One example would be seeking ways of applying the idea of leveraging scale for value to the academic enterprise, such as unified curricular elements for UC medical schools or having UC Health operate its own internal match process for graduate medical education.

Referring to a chart showing the proposed funding for these self-funded goals, Advisory member Lipstein recalled that the UC Health Division had four budgets. Three of these were for the Division at UCOP, for collaborative activities among the medical centers, and for the self-funded health plans. Dr. Byington explained that the fourth budget was for State funds which come to UC Health and for which UC Health acts as steward and distributor.

Chancellor Khosla observed that the UC Health liabilities weigh upon the campuses. The financial status of UC Health was not separate from that of the campuses. When UC Health experiences a financial loss, the campuses must deal with this. At the same time, investment in the schools of medicine and in research is squarely the responsibility of the UC Health system. He recognized that the UC Health Division experienced pressures from UCOP to invest in systemwide initiatives and from faculty to invest in research. Chancellors find themselves caught in the middle of these pressures. He asked how chancellors can be informed about funding issues, liabilities, and how UC Health decisions are made. Dr. Byington responded that understanding funds flow and the transparency regarding funds flow was of vital importance. The operating margins of the medical centers were subject to capital calls to support research, education, and the functioning of the campuses. As UC Health seeks to balance the use of these funds, which are under tremendous pressure, it must constantly evaluate the return on investment. Dr. Byington stated that she wished to monitor this and to be able to show to chancellors the return on investments made in UC Health. It is the chancellors' duty to determine the best investment for the funds their campuses have. Chancellor Khosla stated that the chancellors would rely on Dr. Byington to provide this comprehensive vision of how the chancellors of campuses with medical centers can work together. It would be useful to have regular conversations about these issues. He emphasized that the economic pressures related to other campus operations such as enrollment, tuition, and faculty compensation were no different.

Regent Park commented on the need for strategic systemwide investments in general and on the difficult balances and tradeoffs that must be made at the campus level. She asked about the funding for goals related to achieving greater diversity. Dr. Byington responded that one could not advance inclusion and diversity without funding. She had allocated $150,000 for goal no. 1, which was to advance progress in promoting diversity and inclusion. This funding would come from UC Health's core budget. She acknowledged that this amount was only a tiny fraction of the real need. There needed to be further, more detailed discussions about how various goals would be funded. She anticipated that the core budget would be in the range of $3.7 million to $4 million.

Advisory member Hetts presented an example of UC Health's positive impact. Years ago, stroke treatments were futile. New techniques were developed which proved much more effective, but which were also expensive. The first hospital that was persuaded to implement these treatments was San Francisco General Hospital, because it was the only payer that saw the full spectrum of cost and benefit. San Francisco General had to pay up front for expensive treatments but, in case of bad outcomes, San Francisco General was also the payer for Laguna Honda Hospital in San Francisco, which provides long-term care. The cost of caring for these patients might be as much as $100,000 a year for many years. Dr. Hetts encouraged UC Health, as data on specific diseases and outcomes become available, to incorporate this in reports to Regents and to the State, to show the benefit of UC Health to improving the lives of people in California.

Dr. Byington then presented a chart with the proposed UC Health Division annual funded full-time equivalent employees (FTE). Some would be located at UCOP and some at the campuses. A final chart showed the savings generated by the Leveraging Scale for Value initiative through improvements in the areas of revenue cycle and procurement. Dr. Byington hoped to be able to provide a line item for each campus showing savings or revenue return. In difficult times, when campuses are trying to prioritize projects, administrators could see the return on investment and predict what future returns might be.

Committee Chair Lansing stated that the Committee's task was now to find the funding to achieve and execute these goals. Dr. Byington added that these goals had been vetted with the chief executive officers, chancellors, and President Napolitano.

Regent Park remarked that the $4 million core budget seemed small relative to the task at hand. The case for return on investment seemed clear. Dr. Byington responded that the questions of the appropriate size of the UC Health Division budget deserved a detailed discussion as one considered a new model in the future. The core budget should be consistent year over year. She stated that it would be desirable to have the core budget represent one percent of the overall UC Health system budget. When one considered the size of UC Health and what UC Health was investing in policy development, clinical strategic planning, or planning for health plans, it was clear that UC Health was not investing to the same extent as other organizations in the list of the 20 largest healthcare systems in the U.S. that had been presented earlier in the meeting that day. UC Health was managing to maintain its presence in the top 20, but this was not guaranteed for the future. UC Health would have to be creative in managing this situation.

Chancellor Hawgood noted that the total budget for the UC Health Division, the core budget and the three other budgets mentioned earlier, approached $30 million.

UC Davis Human Health Sciences Vice Chancellor David Lubarsky stated that UC Health was underfunded and needed a stronger central function. He reported that healthcare colleagues in other parts of the country felt that UC Health was not leveraging its scale in the way it could. He noted that it sometimes takes time, two to three years, before one sees return on an investment, and UC Health should develop such a longer-term view. UC Health should be a statewide force in every category of care that it provides. The UC

medical centers were in fourth place in their respective urban markets, not in the prominent position they could occupy. Funding would be forthcoming because UC Health was indispensable and could not be left out of networks. The State must consult with UC Health when there are important policy decisions regarding medical care. In his view, UC Health should invest more in its central function; this was an investment rather than an expense.

Dr. Byington concluded the discussion by emphasizing that there should be transparency about UC Health's numbers, since the University is a public institution. She looked forward to working with the Regents to ensure that there would be sufficient resources to support UC Health, which is a vital operation for the State of California and the UC system.

7.   **SPEAKER SERIES – SERVING THE MISSION: HEALTH DISPARITIES AND COMMUNITY ENGAGED RESEARCH**

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

Executive Vice President Byington introduced David Lo, M.D., Distinguished Professor of Biomedical Sciences at the UCR School of Medicine and Juliet McMullin, Professor and Chair of the UCR Department of Anthropology, the co-directors of the Center for Health Disparities Research at UC Riverside. The Center was funded by the National Institutes of Health (NIH) National Institute on Minority Health and Health Disparities in August 2019 with a grant of $16 million over the next five years. The Center at UCR is one of 13 such centers in the U.S.

Dr. Lo stated that the overall mission of the Center for Health Disparities Research was to develop programs in health disparities research and to train a new generation of researchers in health disparities and community engagement. The Center's activities cut across all three UC missions of education, research, and public service.

William Osler (1849-1919), considered a founding father of modern medicine, is quoted as saying: "The good physician treats the disease; the great physician treats the patient who has the disease." The University's medical centers and schools do an outstanding job of diagnosis, identifying treatment options, and establishing a standard of care, Dr. Lo raised the question of how well UC addresses the other needs of the patient and treats the patient who has the disease. In order to do this, one should consider factors in an individual's life that can lead to poor outcomes, such as social determinants of health, disparities in access to care, unhealthy behaviors, environmental exposures to toxins and other detrimental living conditions, and social policies that may not serve the needs of a patient population.

The UCR School of Medicine was founded with an explicit mission to improve the health of the people of California and, especially, to serve the people of Inland Southern California. The Center for Health Disparities Research would contribute to this mission.

Dr. Lo defined health disparity as health differences, susceptibility or outcomes, which are closely associated with economic, social, or environmental disadvantage. Health disparities

affect groups of people based on factors such as racial or ethnic group, socioeconomic status, mental health, cognitive, sensory, or physical disabilities, geographic location, or other characteristics historically linked to discrimination or exclusion. Health professionals hope to treat all patients equally, but these patients do not come from equal circumstances.

As mentioned earlier, the Center had been funded by the National Institute on Minority Health and Health Disparities, one of the newer institutes within the NIH. This is a topic of emerging importance recognized by the NIH. The leadership of the Center is cross-disciplinary and the Center engages in interdisciplinary collaborative research. One of the benefits of interdisciplinary collaboration is that each leader of the collaboration not only provides input from his or her field but also serves as a translator who can explain the work of the collaboration to colleagues in that field.

Among other efforts, the Center provides mentoring and pilot grant awards. For investigator development, the Center has two types of pilot projects. One is the Fostering Interdisciplinary Research Early Stage (FIRST) awards, for emerging investigators, such as senior postdoctoral scholars and junior faculty, to support research and help them to become competitive for extramural grant funding. An important part of the FIRST awards is the development of interdisciplinary mentorship teams. The second type of project is the Pilot Interdisciplinary Collaborative (PIC) research grants, awarded to investigators at any level, with the condition that there be two or more collaborators across disciplines and schools. The Center also provides Continuity Collaboratory fellowships, which fill in gaps in research, supporting researchers who provide continuity for a project that would otherwise end due to the departure of a graduate researcher.

Ms. McMullin then discussed the Center's efforts focused on community engagement and dissemination. The Center wished to bring the community into the conversation about research. She briefly outlined the membership of the Center's external advisory board and its community advisory board, which includes public health professionals, grass roots activists, and representatives of community organizations.

Ms. McMullin presented a chart illustrating the National Institute on Minority Health and Health Disparities' research framework, which is used to define types of research and to determine if research addresses different levels of influence and domains of influence. The framework is also a tool for the Center to orient its own research projects and to determine if there are gaps where the Center might conduct research, and to find ways to bring in community partners to shape research. Community-engaged research can mean having community members helping to develop questions and methodology as well as being involved in dissemination. Bringing community into the research process was a way of beginning to achieve health equity.

Three areas have a significant impact in the effort to address health disparities: (1) building a shared vision around health equity; (2) increasing community capacity to help shape health outcomes through training and community engagement; and (3) fostering multi-sector collaboration. With regard to the last point, Ms. McMullin stated that, by working

with its advisory boards and network, the Center would move from research findings to policy changes.

Dr. Lo described one of the Center's research projects, which was focused on childhood asthma and environmental exposures. In the Salton Sea region in Riverside and Imperial Counties, childhood asthma rates are at least three times as high as in the rest of California. The effects are felt disproportionately by the Latino population, mainly agricultural workers living near the Salton Sea. The population in nearby Palm Springs and Palm Desert is much less affected. There are clear differences in race and ethnicity between these two populations. The population of Palm Springs and Palm Desert is largely white, with a higher socioeconomic status. One could look at this factor and conclude that this was the reason for the health disparities. However, the working hypothesis of this research project is that the aerosol dust generated at the Salton Sea is contributing to childhood asthma more than socioeconomic status or ethnicity. This project has involved a community advisory board, community-based survey studies with families, engagement with the community, and dissemination of information. Some of the researchers involved in the project are environmental scientists, studying aerosol particle transport in the Coachella Valley. In the laboratory, mice are exposed to these aerosols in order to study the impact. Based on information gained from community and laboratory studies, the project's working hypothesis is that the lung inflammation in this case is not an allergic inflammation as in conventional asthma. The aerosols generated by the Salton Sea are contributing to a novel type of inflammation that produces asthma-like symptoms. Dr. Lo noted that the project participants were eager to follow how well the laboratory animal studies might predict clinical patterns observed in the human community. This project illustrated interdisciplinary collaboration among the fields of environmental science, engineering, anthropology, and biomedical science.

Another one of the Center's research projects concerned childhood obesity in low-income families in the Coachella Valley. A randomized control trial was in preparation, and intervention would focus on education and nutrition. The region served by the Center has many other health disparities. Mental health is a high-priority issue. Dr. Lo concluded the presentation by underscoring how the mission of the Center for Health Disparities Research, with its focus on health disparities in Inland Southern California, complemented the mission of the UCR School of Medicine.

President Napolitano asked which factors—race, ethnicity, socioeconomic status—were particularly significant in contributing to health disparities. Dr. Lo responded that the Center's research was not limited to any set of categories. Some disparities are based on factors such as sexual orientation and HIV status. The circumstances of an individual can determine access to care and outcomes.

Regent Zettel asked about the Center's timeline for growth and full staffing. Dr. Lo responded that the award made to the Center was for five years, but the mission clearly extends well beyond that timeline. An important goal is to train a new cohort of investigators who will be competitive for NIH and other funding. It was his hope that this

would be a self-sustaining activity, both for training and providing necessary infrastructure to support research.

Regent Park stressed that policymakers in Sacramento should be informed about the work the Center was engaged in. The timelines of research and policymaking do not always align well. Elected officials at the State and local levels should learn about this tremendously valuable work; it should be part of the University's messaging in Sacramento. Dr. Lo affirmed that this was one of reasons for the Center's activities; to generate facts and data, present these to officials and lawmakers, and bring awareness of the most pressing health disparity issues to State government.

UCR School of Medicine Dean Deborah Deas expressed agreement with Regent Park. The work of the Center needed to become a policy issue. As Dean, she had made a commitment to support the Center after NIH funding was gone, and this would require participation by the community, the Legislature, and others. The Center for Health Disparities Research could be a model for the state because other regions of California have health disparities as well.

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

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

Chief Medical Officer Brad Buchman began the discussion by noting that, since her arrival, Executive Vice President Byington had brought expertise, energy, and new ideas to UC Health. Dr. Byington was committed to a continued focus on accessibility, high quality, and cost-effective care for UC students; she was eager for UC Health to work as one system and interested in how UC can integrate care provided by student health and counseling centers with its clinical, teaching, and research capacities. At a UC Health leadership retreat meeting in December 2019, the chief executive officers of the medical centers discussed and committed to working with the student health and counseling centers. Another impending change was the recruitment for a new position, the Director of Student Mental Health and Well-Being, by Student Affairs at the Office of the President. A number of administrators who had overseen aspects of student mental health and wellness had departed over the past year, and Dr. Buchman looked forward to having this position filled.

Turning to an update on access to student mental health services, Dr. Buchman commented that this year, as in previous years, the campus counseling centers had focused on ensuring that urgent access remains excellent. Most students with urgent needs are seen the same day; 95 percent to 96 percent of these students are seen within seven days. Dr. Buchman explained that some students choose to have an appointment later in the week, and the data reflected this. In the access reports for past fall, UC Health took a more stringent look at access during the active academic terms. Earlier, access statistics were considered for the fiscal year or first half of the fiscal year. This included many months of summer break in the data, as well as winter break and other holidays. The latest survey carefully examined

an eight-week period, an active period when campuses on the semester and quarter systems are in full session. The data were similar or slightly better than the past fiscal year. For routine intake counseling appointments, the average wait was about 11 days, and 75 percent of these students were seen within two weeks. The benchmark goal for the University was to see 80 percent of these students within two weeks. For routine intake psychiatry appointments, the average wait was 11 days, with about two-thirds of these students seen within two weeks. The average wait for follow-up psychiatry appointments was 22 days, a slight improvement over the prior fiscal year.

The International Accreditation of Counseling Services recommended a ratio between 1:1,000 and 1:1,500 for counselors. The University's target has been in the middle of that range, about 1:1,250. UC's average ratio is about 1:1,100, and nine of the ten campuses were close to or at the target of 1:1,250. Guidelines of the U.S. Department of Health and Human Services recommend one full-time psychiatry provider per 6,500 students; seven of the ten campuses were at or near this ratio, and the psychiatry ratio at the campuses had been stable over the past several years.

The University had requested $5.3 million in new funding for student mental health from the State and that $4.8 million in one-time funding be made permanent. These requests were denied and not included in the Governor's January budget proposal. The prior year, a bill was put forward to provide student mental health funding for UC, the California State University (CSU), and the California Community Colleges; this bill might be introduced in the current legislative cycle.

The University was continuing its collaborative work on mental health services with Yolo, Merced, and Fresno Counties and examining existing collaborations between UCSF Fresno and Fresno County and between UC Davis and Yolo County. There were also discussions with CSU San Bernardino, which had secured County funds for its student health and counseling center. At UC Davis, the director of the student health program had one full-time equivalent (FTE) position on the campus, funded by the County, to assist Medi-Cal students with accessing care and having their Medi-Cal coverage adjusted. UC Davis was negotiating for a second such FTE. The prior week, representatives of Kaiser Permanente came to UC San Diego to discuss how they could assist students who are enrolled with Kaiser. Dr. Buchman stated that this might be the beginning of potential assistance from Kaiser.

The Board of Regents might consider an increase in the Student Services Fee. Dr. Buchman noted that some campuses already had resources for mental health services from earlier student referenda, and some were considering future referendum proposals. He also drew attention to collaboration at UC San Diego between the Medical Center and student health and counseling; this might be a model for the future.

Dr. Buchman discussed some innovative care delivery models. At most UC student health and counseling centers, students can make appointments online and schedule and appointment in the following 24 hours. Most student care is episodic. When students decide they want to be seen, they want to be seen immediately. Many centers are able to provide

care through a secure online patient portal for services such as assessing a urinary tract infection or having students carry out testing for a sexually transmitted disease.

UC Berkeley had developed a collaborative care model. For every primary care group, there were five providers and two psychologists. Every patient who comes in for a medical visit is screened for depression and anxiety. Alcohol and drug screening would soon be added. UC Santa Cruz and UC Davis were using similar integrated care models.

The University had a number of functioning telehealth platforms. UC Merced psychiatry services on campus were delivered exclusively by telemedicine. There were no psychiatrists in Merced County. Through the UC Student Health Insurance Plan (UC SHIP), Anthem has provided Live Health Online, its commercial telemedicine service. UC San Diego was launching tele-psychiatry pilot program. There were a number of telemedicine and tele-behavioral health options available to students. Mental health screening was ongoing on all campuses. All campuses were using a crisis text line, which is preferred by some students. Therapy Assistance Online is a digital platform where students can find self-help modules and receive directed cognitive behavioral therapy from their therapist.

With regard to quality improvement and compliance, Dr. Buchman noted that all student health and counseling centers other than UCSF were accredited by the Accreditation Association for Ambulatory Health Care and were required to carry out ongoing quality assurance projects. There are also systemwide quality projects, and in the past year the student health centers undertook a safe injection practices benchmark project. The results of patient satisfaction surveys for the student health centers have been very positive.

The health centers have been engaged in efforts for many years to minimize the risk of incidents of sexual violence and sexual harassment and were complying with systemwide guidance. All providers have had boundaries training in the past two years. Chaperone policies were in place, and the presence and identity of chaperones was documented by the electronic records system.

Dr. Buchman briefly remarked that a Peer Review and Corrective Action Investigation policy was in the final stages of development. The student health centers had more recently worked on privacy policy guidelines to ensure that students' privacy is guarded to the extent allowed by law.

Dr. Buchman concluded his presentation with information on UC SHIP, the self-funded student health insurance program. All campuses except UC Berkeley had joined UC SHIP, and the current membership was approximately 130,000. The pooled premium base plan renewal for the following plan year was 1.4 percent, which reflected a low inflation rate. For three out of the past four years, the increase had been between one and two percent. The prior year there had been a nine percent increase due to sporadic volatility in claims. These claims were not related to chronic illnesses, but injuries and accidents. UC SHIP had sponsored a number of innovations in mental health. Live Health Online, Anthem's telehealth platform, was implemented at all campus counseling centers. UC SHIP had co-

funded the Therapy Assistance Online pilot program. UC SHIP was currently engaged in a Request for Proposals for non-emergency transportation, so that, if students need a ride to a psychiatry or specialty consultation, this would be funded by UC SHIP. UC SHIP was also working on a proposal for a mental health referral database. UC SHIP continued its outreach efforts with the California Department of Health Care Services to find ways to assist Medi-Cal students. UC SHIP was unique in that it was funded by students and run by students, who serve on the Executive Oversight Board. The plan was functioning well.

Regent Park asked about disparities among the campuses in counseling and psychiatry provider-to-student ratios and if some campuses had more resources to spend. Dr. Buchman responded that not all campuses had the same stable funding platform of providers when the mental health care initiative was funded in 2015. Some providers might have been funded by income funds; as long as there was sufficient income, these providers could be retained. In some cases, these funds might have been exhausted, and providers were supported by newly available funds or were let go. Another factor is enrollment growth. The mental health funding initiative anticipated an enrollment growth rate of one percent to 1.25 percent over five years. Enrollment at UC Riverside grew by 6.7 percent. The funding initiative had been suspended and new funds were not forthcoming. Enrollment growth rates varied among the campuses. Dr. Buchman emphasized that, before the funding initiative, the funding used to support providers on the campuses came from various sources. Some providers were supported by temporary funds and some by income funds. UC San Diego Health Chief Executive Officer Patricia Maysent added that another factor was turnover and the need to refill vacancies; this sometimes accounted for lower rates of access to services. She expressed concern about the University's ability to offer competitive salaries in comparison to the open market. Another factor was a significant increase in the demand for services. UC San Diego enrollment had increased by 30 percent but the demand for mental health services had increased by 90 percent.

Regent Park asked if UC had a goal of meeting a ratio on every campus. Dr. Buchman recalled that the University's target has been in the middle of the range recommended by the International Accreditation of Counseling Services, at 1:1,250. Counseling directors would prefer to see the ratio closer to the bottom of the range, or 1:1,000. Some universities have hired more counselors in order to achieve ratios in the range of 1:700 to 1:750. UC enrollment continued to rise and demand for services had been increasing at a rate of eight percent annually over the past ten years. Prevention work was ongoing on all campuses, although with insufficient funding. Dr. Buchman anticipated that this problem would be solved by adequately funding prevention, wellness, and early intervention programs and by working with the medical centers to respond to clinical demand.

Regent Park again asked if there were specific ratio goals for each campus. Dr. Buchman responded that his office recommended that campuses get as close to the bottom of the range as possible. There was not a specific numerical goal. Many campuses were close to the bottom of the range or below it.

Regent Park referred to the collaboration at UCSD between the medical center and student health and counseling and asked if ratios mattered less in this situation. Ms. Maysent

responded that UCSD did not take this view. It might be desirable for the UC system to make a commitment to achieve certain benchmarks for response to telephone calls, triage, and wait times for in-person visits, and then to seek the resources to achieve these benchmarks. The implementation of the Epic medical records system was providing a better overview of patient conditions.

Regent Park asked how the ratios would be affected if the University did not receive the approximately $10 million in State funding it had requested. Dr. Buchman responded that the ratios would worsen over time, depending on enrollment growth, and there would be variation among the campuses. The University would pursue every other avenue of finding funds. With regard to the question about ratios at UCSD, he stated his view that collaboration with an academic medical center did not mean one could let ratios rise. The campuses needed the additional capacity that medical centers can provide for services that cannot be provided on campus, such as care for students who need ongoing, regular care, with visits once or twice a week, and care for acute illnesses. The campuses need to maintain appropriate ratios.

Regent Park referred to the range of different telehealth platforms and asked why there was not a consolidated platform. Dr. Buchman explained that this situation had developed over time. UC Merced developed a platform first due to the lack of psychiatrists in Merced County. So far, UC had not identified another provider to replace the services at UC Merced, if it wished to consolidate all platforms. There had been some resistance in the counseling centers to implementing Anthem's product, Live Health Online, and implementation took about a year-and-a-half. The student health centers were pleased to have a backup telemedicine option for break periods and times when the health centers are closed. The counseling centers needed more persuasion to agree to this platform and to promote it to students. Some campuses had accepted the responsibility for co-payments so that students can access these services free of charge. UCSD's tele-psychiatry platform was still in an early stage; it would be launched in summer.

Executive Vice President Byington stated that she would like to see UC Health develop a UC Health tele-counseling, tele-psychiatry platform which could be beneficial to students, UC employees, and the general public. There were opportunities to seek funding mechanisms within UC SHIP and UC's employee insurance products in order to increase mental health services.

UCLA School of Medicine Dean Kelsey Martin asked if UC Health was looking at all the additional activities being undertaken at the campuses to address student mental health needs. These were valuable experiments and campuses could learn from one another. Dr. Buchman responded that the UC Student Mental Health Oversight Committee was currently carrying out a systemwide survey of prevention, early intervention, and wellness activities. This information would allow campus Student Affairs departments to share best practices and to determine if there were funding differences among the campuses.

Ms. Maysent observed that college mental health and counseling centers can be provincial in nature, but were progressing and maturing. She affirmed that there was a desire across

UC Health to address student mental health needs, and there should be a systemwide forum and discussion among the student health and counseling leadership to identify and share best practices. The Epic medical records system was a powerful tool for predictive analytics. Dr. Martin added that social workers should be included in these efforts.

UC Davis School of Medicine Dean Allison Brashear observed that the schools of nursing and veterinary medicine could also make contributions to student mental health. UC could differentiate itself by being able to offer clear, easy access to telemedicine and mental health services 24 hours a day and seven days a week. Parents of students would appreciate this.

Dr. Byington stated that telehealth, or health care online, was preferred by the student age population. She suggested that many of the UC Health schools and programs could benefit student mental health. For example, the clinical training sites for the mental health nurse practitioner program that was going to be launched could include student counseling centers. Animal therapy, using dogs and horses, has been successful. Much could be accomplished in this area through thinking strategically and working as a system rather than as individual campuses.

Advisory member Spahlinger anticipated that there would be increasing use of telehealth and online health tools on campuses. His own institution, the University of Michigan, could simply not hire enough counselors, and was making use of these other tools in addition to face-to-face interactions.

UC Davis Human Health Sciences Vice Chancellor David Lubarsky commented that discussions are taking place about restructuring the delivery of psychiatric support services. One conception is a structure of concentric circles with different levels of expertise from physicians to student peer counseling. Most students suffering from anxiety or problems in personal relationships can be helped by people who are not psychologists. The University needed to consider these alternative models because there were simply not enough people to do the work that needs to be done.

Committee Chair Lansing recalled that student mental health services had been identified as a priority by the Health Services Committee and the Regents a few years prior. She expressed agreement with Dr. Spahlinger and others about the need to implement new methods, but stressed that the Regents still wish to improve the provider-to-student ratios and to secure the necessary funding.

Regent Park asked about the UC SHIP and Medi-Cal student populations and if there were dual enrollees. Dr. Buchman responded that about 130,000 students systemwide were enrolled in UC SHIP and 20,000 in Medi-Cal. Students who have Medi-Cal or who are Medi-Cal-eligible can waive UC SHIP. The Regents have mandated that all students have health insurance. Students are enrolled in UC SHIP as they register, and they can opt out of UC SHIP with comparable insurance.

Student observer Noah Danesh introduced himself as a UCLA student majoring in psychology and pursuing a path in medicine. He commended the University for recruiting a Director of Student Mental Health and Well-Being, a position which would help meet the unique needs of 285,000 UC students. With regard to telehealth, Mr. Danesh noted that there was high usage of Live Health Online by students, with high satisfaction. It would be desirable to develop one strong and unified UC telehealth solution for mental health. Students had reported to Mr. Danesh that there were too many barriers for students seeking mental health services and that this made them apprehensive. One barrier was the timing of office visits. Telemedicine would provide flexibility and would allow students to receive services without missing classes. A second barrier was the wait time between initial screening and being seen by a specialist. The University had the potential to improve these wait times through use of telemedicine and by addressing unmet needs: there were 30 vacancies for counselors on UC campuses, and 27 more positions would be needed to meet the 1:1,000 counselor-to-student ratio. With regard to funding for mental health, UC's requests for funding should be at levels adequate to address these needs. Mr. Danesh praised UC Davis' new vision for collaboration with its community. Emphasis in new partnerships with cities and communities should be on proactive care, to identify and treat at-risk populations. This model should be implemented at each UC medical center, with fine tuning to reflect the unique needs of each community.

9.   **THE VALUE OF ACADEMIC MEDICAL CENTER AND COMMUNITY HEALTHCARE PARTNERSHIPS AND COLLABORATIONS**

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

Executive Vice President Byington explained that this discussion would elucidate some of the strategies that are pursued "behind the scenes" at UC Health. UC Davis Human Health Sciences Vice Chancellor David Lubarsky had given this presentation the previous month at the J.P. Morgan Healthcare Conference, and she felt it was important for the Regents to hear this presentation as well.

Dr. Lubarsky began by underscoring the impressive reach and impact of UC Davis Health, the sole academic medical center for rural and agrarian areas of Northern California and the Central Valley. He referenced changes in the film industry in recent decades, in production and distribution, as an example of how disruptions occur in business and how players in an industry must be ready to take risks and make changes.

UC Davis Health was now in the position of not wanting to build more hospitals, even though it did not have enough beds. In fact, UCD Health did not need more beds, but the right patients in beds. It did not need more specialty care units, but it needed to use these units better. What UCD Health needed was care delivery partnerships. Only 60 percent of hospital beds were filled in California, even though all beds in UC hospitals were filled. One question for UC Health was how to make use of a stock of underused healthcare resources and bring the cost of health care down. In order to do this, UC must increase the skills and level of care of its community hospital partners through placing UC faculty or

staff in these organizations and/or having contractual relationships to train nurses and caregivers from these organizations. UC must use all existing hospital beds and specialty care facilities to full advantage. UC medical centers are built to carry out complex procedures and should maximize the use of their unique capabilities. UC Health needs a broad variety of settings to train its students, not just its own facilities. There is a wide range of types of practice to which students must be exposed. UC Health must facilitate access to cutting-edge research and the ability to enter clinical trials. This was an area in which the U.S. was failing. For example, only 1.3 percent of National Cancer Institute-designated cancer trials involved Hispanic patients. With a correct approach, UC Health could address this and strike at the heart of disparities in cancer care and outcomes.

UCD Health serves 33 counties as their Level One trauma center. The hospitals in these counties are often at a great distance from UCD Health, sometimes a five- to six-hour drive. It was not reasonable to expect patients to travel these distances. The only way to provide UCD Health care for these patients was by partnering with community hospitals. In this matter, UCD Health did not have a choice. In these communities, there is often only one hospital on which residents rely. UC Davis currently had formal relationships with about 25 such community hospitals, providing significant support for emergency department, pediatric, and other services, and training intensive care unit nurses from these community hospitals under affiliations and contractual arrangements. The primary focus for UCD Health is on the people served by these institutions. In order to address access to health care in rural communities, UCD Health had programs such as the Rural-PRIME program, for training medical professionals, and the Compadre program. Compadre is an education and training partnership with Oregon Health and Science University and 31 regional hospitals, many of which are faith-based, to expand access to health care in rural areas.

Dr. Lubarsky shared a story that had appeared that day on the UCD Health news webpage, about a Stockton resident whose infants were able to receive urgently needed care from UC Davis hospitalists in the Neonatal Intensive Care Unit at the Adventist Health Lodi Memorial Hospital. The mother expressed her gratitude for being able to find this care close to home and not having to travel to Sacramento, with the challenges of traffic, the additional cost of gas, time spent driving, and care for children left at home. Dr. Lubarsky acknowledged that individuals who spoke earlier that day during the public comment period had criticized affiliations with faith-based health organizations, but stressed that this was a nuanced question and that UCD Health was able to do good work in its affiliations.

When UCD Health entered into this partnership with Adventist Health Lodi Memorial Hospital in 2018, it did so at cost. UC Davis hired neonatologists and pediatric hospitalists. The partnership turned out to be a great boon to the community. Pediatric admissions to the hospital increased by 50 percent, while the average length of stay for children decreased by 15 percent, due to the extra care, support, and expertise UC Davis was providing. The hospital did not transfer more patients to UCD Health. UC Davis did not lose business. Creating a better hospital in the local community led to local residents having greater confidence in their hospital, and more patients being seen close to home. UCD Health had a parallel program for adult care in the same hospital. Most needs can be addressed with support via telehealth, and only the highest-acuity cases need to be transferred to

Sacramento. This makes maximum use of the beds available. Dr. Lubarsky hoped that these successful outcomes would be replicated in every regional partnership.

Previously, UCD Health had had a contentious relationship with the County of Sacramento, but it had now become a strategic ally for the County on homelessness, mental health, and for a new Federally Qualified Health Center (FQHC). UCD Health would be the sole sourcing agency for all physicians for Sacramento County's FQHCs. These efforts included the opening of one of the first full-time, dedicated adverse childhood experience clinics for foster children. Patients were benefiting from better care, but also, because UCD Health was partnering with the County, patients could receive support to address legal needs, food and housing insecurity, eviction, transportation arrangements, and a variety of other social services in one location. This effort was part of UCD Health's societal mission and had taken pressure away from the emergency department. Many people use the UC Davis emergency department to access subspecialty care. Through this partnership with the County, patients were being moved to the right environment, with the right care, and at lower cost. UCD Health could pursue its acute care mission more effectively.

Dr. Lubarsky then discussed partnerships within UC. He observed that, when UC Health partners together, it has the best cancer center in the world, and this was an area with great potential for the coming years. He presented a chart showing that, in 2018, UC collectively received 50 percent more National Cancer Institute (NCI) funding than any national peer. UC currently had 1,000 clinical trials under way. Working through its medical centers and partners, UC Health could eliminate disparities in cancer outcomes and trial research recruitment and bring cutting-edge chemotherapy infusions across California. UC Health can provide a virtual second service opinion for all complex cancers. Dr. Lubarsky reported that Chief Data Scientist Atul Butte was currently developing an engine that could review all the University's electronic medical record data and match patients to clinical trials for which they qualify. When this tool for matching patients to clinical trials was implemented for all types of studies, the NIH would be eager for UC participation in studies, because UC represents such a large part of the research efforts. UC Health can use efficiencies of scale to lower the cost of care significantly. With regard to market share, he noted that UC at present had 16 percent of the market share for cancer care in California; when UC medical centers market themselves together, the percentage of patients who would consider seeking treatment at UC increases by 60 percent. There was tremendous potential for partnership among the UC medical centers.

Dr. Lubarsky concluded with comments on the impact of academic medical center partnerships on health. There is genuine improvement in operations and care for a region. Partnerships create financial sustainability for all partners. Economies of scale are achieved through having all complex procedures carried out in one location. There is reduced duplication of services and reduced need to build more hospital beds; instead, one can make better and wiser use of the beds one already has. Patients receive better care and can stay in their own communities, closer to their families.

In response to a question by Committee Chair Lansing, Dr. Byington confirmed that one of her top ten goals for the current year was to hire a director for the UC Cancer Consortium.

Advisory member Lipstein suggested that the UC Cancer Consortium might best begin its activities by developing a UC-wide playbook on prevention, detection, screening, and surveillance. There is a great deal of scientific evidence in these areas. Disseminating UC's knowledge in these four areas across the state would represent a tremendous step forward, and the University would not encounter the same resistance it might with regard to its research agenda. Dr. Lubarsky responded that faculty members felt strongly that UC should lead with a research agenda. He agreed with Mr. Lipstein that UC should partner with organizations which already have a patient base to deploy the playbook Mr. Lipstein had outlined. Only 25 percent of patients receive appropriate genetic screening and tissue typing to start optimal cancer therapy. An improvement in this area would lead to a significant difference in outcomes.

Committee Chair Lansing expressed agreement with Mr. Lipstein about the need to focus on cancer prevention but disagreed about resistance to collaborating on cancer research. There was a great desire among institutions and entities to collaborate, and intellectual property issues can be worked out. Working in isolation is detrimental to this kind of research, as it can lead to duplication of effort. She emphasized the importance of clinical trials in addition to prevention. There was a shortage of participants in clinical trials. She hoped that the UC Cancer Consortium and collaboration in all areas would move forward quickly.

Advisory member Hetts remarked that extensive collaborations would help clinical trials find enrollees more easily and lead to breakthroughs in translational research. Dr. Lubarsky added that the University had a working pancreatic cancer consortium involving all five medical centers. UC Health had decided to begin this effort with a single type of cancer to show that this can be done, a proof of concept. If UC Health became the comprehensive pancreatic cancer center for the State of California, all patients would come to UC and UC clinical trials would be completed more quickly.

Regent Park reflected on the benefits of UC Health working as a system in order to deploy limited resources for the maximum benefit at the lowest cost. She cautioned that the chances of success were lower if UC did not get all its partners in the state engaged in this discussion and expressed concern about a possible downward trajectory if UC Health did not succeed in system thinking. She asked how UC can engage its partners at the system level. Dr. Lubarsky responded that the University should be a statewide cancer resource. The downward trajectory could be reversed by investing in this. Providing superior cancer care would underwrite the costs of other care. It would be a self-funded initiative but would require initial investment, and this was the difficult point.

Dr. Byington stated that she would like UC Health to find a way to engage all stakeholders in California. Four of the largest healthcare providers in the U.S. were headquartered in California. She would like to break down isolated silos across the state as well as within

UC Health. One should not be satisfied with the idea that it was only UC's responsibility to care for Medi-Cal patients or underserved patients in rural areas. It was a question of all stakeholders working together with the patient and the healthcare goals of the state at the center. Dr. Byington reported that she had been engaged in discussions with the chief executive officers of large healthcare organizations in California about how collaboration can take place. It was also important that State leaders have an understanding of UC Health as a resource for the state.

UCSF School of Medicine Dean Talmadge King commented that UC must remind the public that a great deal of money is required for seismic upgrades merely to keep UC Health facilities in place, not for expansion. He recalled that enrolling one patient in a clinical trial often requires working with seven to ten others. For clinical research to be effective, the four areas mentioned by Mr. Lipstein must function effectively. Academic medical systems must do a better job at taking care of primary care patients, those who are not eligible for participation in clinical trials.

President Napolitano asked what the UC Health system can do to address racial disparities among patients in clinical trials, given the difficulties of getting a patient enrolled in a trial in the first place. It seemed that, if UC continued to proceed as it always had, this issue would not be addressed. Dr. Lubarsky responded that the investment in computational health sciences would allow the development of applications that could allocate patients to studies. Screening would occur automatically, with real-time knowledge of individuals by demographic category. Most clinical studies are designed for 30 percent to 50 percent more patients than are needed in order to ensure diversity in the final patient pool. This research could be made more efficient and easier. Eliminating disparities was part of the model being proposed.

UCLA Health President Johnese Spisso observed that UCLA was leveraging referrals from its partners in clinical trials. UCLA Health runs the Venice Family Clinic, an FQHC, and patients of the Clinic are able to participate in clinical trials. When UCLA entered into an agreement with L.A. Care Health Plan, the largest Medicaid provider in Los Angeles, an important consideration was facilitating referrals of patients with tertiary cancer care needs.

President Napolitano asked if UCLA services were being accessed by providers caring for the Medicaid population. Ms. Spisso responded that most referrals came from primary care physicians. UCLA conducts outreach to these physicians so that they learn which services are provided at UCLA.

UC San Diego Health Chief Executive Officer Patricia Maysent commented that each medical center was compelled to address health disparities. UCSD Health had placed study coordinators in Chula Vista and the Imperial County as part of this effort. She observed that the UC Health systemwide collaboration on pancreatic cancer had begun organically, among the researchers themselves.

UCSF Health Chief Executive Officer Mark Laret noted that another challenge in clinical research was the high cost to an individual of participating in a clinical trial, since this

might involve setting aside work and family obligations. The Lazarex Cancer Foundation was working to provide support to patients who qualify for clinical trials and to make it feasible for low-income patients to participate in clinical trials.

Committee Chair Lansing stated that there was a general lack of knowledge about clinical trials on cancer. The UC Cancer Consortium could change this situation. She urged UC Health to move forward expeditiously with the work of the Consortium and hiring a director.

The meeting adjourned at 2:50 p.m.

Attest:

Secretary and Chief of Staff