

The Regents of the University of California

**HEALTH SERVICES COMMITTEE**

July 29, 2020

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

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

In attendance: Regents Anguiano, Butler, Cohen, Elliott, Estolano, Kieffer, Kounalakis, Leib, Mart, Muwwakkil, Ortiz Oakley, Reilly, Stegura, and Sures, Regents-designate Lott, Torres, and Zaragoza, Faculty Representatives Bhavnani and Gauvain, Secretary and Chief of Staff Shaw, General Counsel Robinson, Provost Brown, Executive Vice President and Chief Financial Officer Brostrom, Executive Vice President and Chief Operating Officer Nava, Interim Vice President Lloyd, Chancellor May, and Recording Secretary Johns

The meeting convened at 9:50 a.m. with Committee Chair Lansing presiding.

**1. APPROVAL OF MINUTES OF PREVIOUS MEETING**

Upon motion duly made and seconded, the minutes of the meeting of May 20, 2020 were approved, Regents Lansing, Makarechian, Napolitano, Park, Pérez, Sherman, and Zettel voting "aye."<sup>1</sup>

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

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

- A. Per policy, extension of the appointment of Bradley Simmons as Interim Chief Executive Officer, UC Davis Medical Center, Davis campus, effective July 1,

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

2020 through December 31, 2020 or until the appointment of a new Chief Executive Officer, UC Davis Medical Center, Davis campus, whichever occurs first.

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

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

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

Interim Vice President Lloyd briefly introduced the item. This action required approval by the Health Services Committee because this Chief Executive Officer position was a Level One position in the Senior Management Group. As the position served UC Health and was paid for solely from sources other than State General Funds, the Health Services Committee had the authority to review and approve the appointment and compensation without further Regents' action. No change was being requested for the interim base salary of \$753,984. Bradley Simmons would also maintain his position as Chief Operating Officer at the UC Davis Medical Center.

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

3. **UPDATE OF COVID-19 IMPACT ON THE UNIVERSITY OF CALIFORNIA: UC HEALTH ISSUES**

[Background material was provided to Regents 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 noting that, at the time of the May meeting, California was on a stubborn plateau in the trajectory of COVID-19. Unfortunately, since then, the United States had left the plateau and there had been a significant expansion of the pandemic across the country, essentially a doubling of the number of cases compared to March, April, and early May. The reopening of society had occurred at the local level, without a national plan. The United States now had the highest number of cases in the world, at 66,440 cases per day on average for the past week. The size of the U.S. population was approximately 382 million. The countries of the European Union together had a population of approximately 446 million, and were reporting 6,425 cases per day. China, where the coronavirus was believed to have originated, was reporting 128 cases per day. New Zealand, a small island nation that had done remarkable work in containing the pandemic, was reporting less than one case per day. On average, the U.S. was reporting 896 deaths per day, and there had been days with 1,000 deaths. The European Union was reporting 81 deaths per day. China was reporting less than one death per day.

Unfortunately, California was no longer leading the nation in combating the virus and bending the curve. California was one of the three states—the other two were Florida and Texas—approaching 10,000 cases per day. California was now experiencing higher rates of COVID-19 than New York had experienced in the spring. California was one of the states with the largest number of COVID-19 hospitalizations, over 8,000 in the past week. California was fortunate in having 74,000 staffed hospital beds. The COVID-19 hospitalizations were taking about 12 percent of the available hospital beds.

Dr. Byington reflected that there were a number of reasons for the current status of the pandemic in California, but the most significant factor was the way in which the reopening was handled: state by state, county by county, city by city. There was guidance as early as

March from various entities, including State and federal bodies, private organizations, and professional societies. People were to slow the spread of the coronavirus by physical distancing. State by state, reopening was to be triggered by declines in the number of cases and having testing widely available. It was necessary to ensure that hospitals could treat all cases, states could test all those who had symptoms, and that one could perform active monitoring of all cases and contacts. There was also a need for accurate statistics.

What needed to be done was clear, but it was not done. In California, this led to multiple outbreaks which would need to be addressed by a multiplicity of methods. There were outbreaks among essential workers, most of whom belonged to minority groups. Fifty-five percent of COVID-19 infections in California were occurring in the Latino(a) population, many of whom were service workers, earning a low income and living in dense, multigenerational housing. In California, as in Dr. Byington's home state of Texas, workers were coming home and infecting multiple members of their families. Multiple members of families were dying, and this was creating immense trauma. Outbreaks were occurring in congregate settings such as prisons and skilled nursing facilities. Some outbreaks were linked to gatherings of young people, and outbreaks were also occurring among the homeless population. Different methods would be needed to contain the outbreaks among these various groups, different forms of communication and intervention.

Dr. Byington presented a projection of how the number of COVID-19 cases might rise and fall repeatedly in 2020 and 2021 during periods of physical distancing and reopening. The model extended to July 2022, the estimated amount of time that would be required for the U.S. population to develop sufficient immunity to reduce transmission. Immunity could be developed in two ways: either through natural infection, in which case it was not known how long that immunity would last, or through immunization. Under the first scenario, this would be achieved when 50 percent of the population had been infected, projected to occur by the target date of July 2022. Immunity could be achieved sooner if a vaccine was ready and able to be distributed. Dr. Byington emphasized her advice to the University to be prepared for a pandemic that would last for at least the next two years. The effects of the pandemic on UC would be felt for longer.

Dr. Byington presented charts showing rates of COVID-19 since April 1, in the nation as a whole and in California. Because California had done a good job of suppressing COVID-19 in the spring, it was now experiencing its first dramatic surge, and death rates were higher than in spring. COVID-19 hospitalizations in California had nearly doubled since spring.

These models and projections had implications for the resumption of operations on UC campuses. Dr. Byington presented a chart with test positivity rates on July 9 and July 22 for those counties with UC campuses. Positivity rates were an important indicator of how well one was controlling the pandemic. A desirable goal was to keep the test positivity rate below five percent. The State of California had identified a test positivity rate of eight percent as a significant risk factor, and this was one criterion for placing a county on the COVID-19 "watch list." Currently, 37 of California's 58 counties were on the watch list. The watch list criteria included number of cases, test positivity, and hospital capacity.

Ninety-three percent of Californians lived in counties on the watch list, and all UC campuses were located in counties on the watch list.

UC Health had lost \$1.15 billion in revenue from March through June. The maximum losses were experienced in April, followed by progressively smaller losses in May and June, and UC Health believed that losses in July would be smaller still. The greatest part of the lost revenue, \$963 million, was attributed to deferred medical procedures, with losses of \$802 million at the medical centers and \$161 million at clinical programs in the schools of medicine and other academic health science programs. An additional \$140 million was incurred in costs for emergency medical services, \$14 million for facilities maintenance and cleaning, and \$19 million for online costs, expanding telemedicine capabilities. To date, UC Health had received \$494 million in Coronavirus Aid, Relief, and Economic Security (CARES) Act funding, covering approximately 43 percent of its losses. There was potentially additional CARES funding, either directly for COVID-19 hot spots and provider relief, or indirectly through the State of California for purposes such as testing. UC Health was seeking reimbursement from the Federal Emergency Management Agency (FEMA) for \$165 million across all UC medical centers.

The UC Health system was performing outstanding work in treating COVID-19 patients from around California and from out of state. To date, UC had tested more than 170,000 patients, and this number might soon rise to 200,000. UC Health had tested hundreds of thousands of other individuals who were not UC patients through public health departments. UC had tested almost 16,000 of its healthcare workers, and less than one percent of the UC Health workforce has tested positive for COVID-19. UC had cared for more than 6,000 COVID-19 patients. There were currently 232 such patients in UC hospitals, and there had been 132 deaths. This last number was remarkably low compared to many healthcare facilities in the U.S.

Dr. Byington presented a chart showing the total number of COVID-19 inpatients in UC hospitals from February 15 to July 22. UC Health had learned a great deal, starting at the very beginning of the pandemic, when UC was caring for most of the COVID-19 patients in California. She described this experience as a steep learning curve, even when UC was caring for only a handful of patients. It took significant effort to understand this disease and how UC needed to protect its healthcare workers. Through the spring, UC Health became stronger in these efforts as it was caring for 100 to 150 patients daily, and sharing information and best practices. UC was now caring for twice the number of patients as in spring, and because of the strengths it developed early in the pandemic, it was able to care for COVID-19 patients as well as patients with other conditions and needs.

UC Health was beginning to see improvement in its inpatient census. A chart showing the systemwide census from January to June indicated a dramatic decrease in spring, when UC Health was at less than 60 percent of capacity. Inpatient census was now slowly increasing. Another chart showed ambulatory visit volume. There had been well over 500,000 ambulatory visits in January 2019, and ambulatory volume remained at roughly this level until the pandemic. During the pandemic, the number of telehealth visits had increased to 176,000 in June 2020. By increasing telehealth visits and bringing ambulatory

capacity closer to usual levels, UC Health had experienced the highest level of ambulatory visits ever in June 2020, higher than in 2019. UC Health would continue to rely on telehealth to increase capacity for virtual visits.

In the midst of the pandemic, UC hospitals were still able to maintain their high rankings. UCLA Health was recently rated the number one hospital in California and fourth best in the U.S. by *U.S. News and World Report*. UCSF Health was ranked number eight in the nation. All UC hospitals were recognized as being among the best hospitals in California. Dr. Byington expressed pride in these rankings, which were good news during the pandemic.

UC Health had been able to further consolidate its electronic health records, to build its enterprise data warehouse, and to receive data daily from every campus in order to better respond to the pandemic. UC Health shared these data with the State, the National Institutes of Health, the U.S. Food and Drug Administration (FDA), the Centers for Disease Control and Prevention, and published the data daily on social media. So far, these UC Health data had been viewed 1.8 million times.

Vaccine trials were ongoing at UC. Moderna had entered Phase Three vaccine trials on July 27. UC San Diego and UCLA had been chosen as sites for these trials due to the number of cases in Southern California. A viral vector vaccine developed by Oxford University and AstraZeneca would begin trials later in summer at UCSF and UCLA. The following day, UC Health would be having discussions with Pfizer about its messenger RNA (mRNA) vaccine and would be having discussions with Johnson and Johnson in the fall. UC Health was working to qualify all its sites, or as many sites as possible, to offer vaccine trials for the State of California. UC Health had also been working on more testing options. UCLA had optimized the SwabSeq technology, which would allow for rapid, high-volume testing. Emergency use authorization from the FDA for this technology was expected soon. Approaching what would be a difficult fall season, UC Health was working on developing medical assistance teams which would allow critical care providers to be deployed across the system if the need should arise, and telehealth for occupational health, as people return to the working environment.

Dr. Byington enumerated some positive outcomes for UC Health during the pandemic. UC Health was working much more closely as a system. Through the UC Health Coordinating Committee, it was making systemwide decisions and policies to develop laboratory capacity and share supplies, equipment, and best practices. There had been gains in data and research, such as the creation of daily dashboards to manage bed capacity, personal protective equipment, personnel, and testing. UC Health had developed a systemwide COVID Research Data Set. Any UC faculty member could use these data for research without seeking additional approval. UC Health had coordinated COVID-19 clinical trials, including the trial of Remdesivir, which was the first drug to receive emergency use authorization, convalescent plasma trials, and now vaccine trials. UC Health had increased its use of telehealth capabilities so that there were now almost 60,000 telehealth visits a week. All of this was taking place in the context of a national and local imperative to deliver health equity and address health disparities.

The COVID-19 pandemic had been a disruption, but it was also an opportunity for a transformation of UC Health, to recover and reposition today's enterprise for maximum resilience, and to "remake," creating new enterprises for the COVID and post-COVID world. UC Health would leverage all its existing strengths and the strengths in collaboration, communication, and service developed during the pandemic. As part of its recovery, UC Health would be focusing on the development of a pharmacy benefits manager program for UC. This was an area of growth in the industry, and the development of such a program could bring savings and increased value to patients. UC Health would also be focusing on virtual care and the ability to deliver UC care anywhere, beginning with the UC campuses without medical centers, and then beyond. UC Health was working with systemwide Human Resources to optimize UC's health benefits plan and provide more UC plan options for UC employees. Dr. Byington concluded her remarks by emphasizing UC Health's commitment to continue to give its best effort through this pandemic.

Committee Chair Lansing referred to the decreasing financial losses for UC Health in May and June, with a further decrease projected for July, and asked whether this was due to the fact that the coronavirus appeared to be affecting the younger population, who did not need hospitalization. Dr. Byington responded that there were a number of causes for the decrease in losses. The primary reason was that UC Health was now able to serve more patients and offer essential healthcare services, not just COVID-19 care.

Committee Chair Lansing asked why UC Health was able to do this now. More people were being diagnosed with COVID-19, and she asked if they were requiring less hospitalization. Dr. Byington responded that, early in the pandemic, UC trained its workforce how to care for COVID-19 patients and built up its supply of personal protective equipment and its testing capacity. All of this enabled UC to better care for COVID-19 patients and to bring non-COVID-19 patients into a safer environment.

Committee Chair Lansing asked if there had been any progress on developing a quick, point-of-care test for COVID-19. Dr. Byington responded that there had been progress on point-of-care testing, which must be a priority for California. There were technologies which had received emergency use authorization or were close to receiving it, and which would allow point-of-care testing. Point-of-care testing can produce results in 15 or 30 minutes and would be needed to reopen the U.S. Committee Chair Lansing asked about tests that could be self-administered, without the need to go to a testing site. Dr. Byington responded that there were reports of testing that could be done in the home. This would need to be validated and would require FDA approval. Over the next several months, one of the most important efforts must be to develop point-of-care testing. The U.S. must invest in these efforts to make frequent, rapid, and low-cost testing available.

Regent Makarechian expressed skepticism about statistics cited earlier for the numbers of COVID-19 deaths in China and the European Union. He noted that some European Union nations did not have adequate methods for gathering data and questioned the reliability of the numbers provided. Dr. Byington responded that UC Health had to use the numbers that were available. All infectious disease scientists and public health officers believed that the

numbers of deaths were undercounted everywhere in the world. Dr. Byington believed that the trends that were being reported were accurate, and that the numbers of deaths were lower in the European Union and China. Other countries were taking measures that the U.S. was not taking. There was not a clear mandate in the U.S. to wear a face covering. There were data indicating that wearing a face covering slows the transmission of COVID-19, yet Americans were arguing about public health measures and about whether face coverings were necessary. Americans were arguing about whether tests were important or not. The countries that had been more successful in controlling the pandemic were more willing to carry out national public health interventions. The lack of clear messaging in the U.S. was confusing and there was an acceleration of cases and deaths.

Regent Makarechian asked about the immunoglobulin G (IgG) test for COVID-19. Dr. Byington explained that this was an antibody test. UC performs antibody tests in its hospitals. Many tests used in the home have been inaccurate. UC Health did not recommend these tests for routine use due to the inconsistent results. Dr. Byington believed that there would be ways to test effectively for COVID-19 in the home setting, but robust technology would be required.

Regent Zettel referred to information provided earlier on a slide, according to which UC Health had treated 6,273 COVID-19 patients and that 1,665 of these were inpatients. She asked if the remainder were treated in an outpatient setting. Dr. Byington confirmed that this was the case. Regent Zettel asked how many of these hospitalized patients were referred to UC by other health systems. Dr. Byington responded that many of these patients were referred; she would try to find out this number.

Regent Zettel noted that there had been concerns about a vaccine that used a live virus. She asked which trials were using a live virus. Dr. Byington responded that the Moderna mRNA vaccine did not involve a live virus; neither did the other trials that were planned to be carried out at UC.

Regent Ortiz Oakley noted recent concerns about attempts by the Chinese government to steal intellectual property. He asked about UC's relationship with the research community in China and about precautions UC was taking to protect its research. Dr. Byington stressed the importance of the security of UC research. UC had cyber security initiatives, and UC representatives had had meetings with the Federal Bureau of Investigation to understand risks.

Regent Ortiz Oakley asked about information sharing in communications UC had with Chinese researchers and medical professionals. Dr. Byington responded that the University tried to be collaborative. The pandemic had been a time of remarkable collaboration. UC Health had shared clinical information with and received clinical information from colleagues in China. This was important early in the pandemic, because they had taken care of many more patients than UC Health had, and UC Health appreciated receiving this information. UC Health worked with scientists in the U.S. who were from many countries and who believed in sharing scientific knowledge freely as all were trying to combat the pandemic.

Regent Reilly referred to the loss of revenue due to postponing or canceling elective surgeries. She asked how far along UC Health was in getting back on track with these procedures. Dr. Byington noted that she considered these procedures essential rather than elective; these were surgeries for conditions such as cancer or major accidents and trauma. UC Health as a system was at 85 to 87 percent volume. The UCLA, UCSF, and Davis Medical Centers were close to 100 percent full each day. UC Health was carefully tracking staffing, personal protective equipment, the number of COVID-19 patients, and activities necessary due to COVID-19, and balancing this with the number of other procedures UC hospitals could offer. The presence of COVID-19 meant that UC hospitals could not move patients in and out of the operating room at the same speed as usual; additional precautions were necessary. It might be difficult to return to the usual level of these procedures as long as COVID-19 was present.

Regent Reilly recalled that the Latino(a) community was disproportionately affected by COVID-19. UCSF had been working to increase testing for this population in San Francisco. She asked about other efforts UC Health was making statewide to narrow this gap and serve the underserved. Dr. Byington responded that this was an enormous concern. UC was making public health efforts systemwide. UC had translated study protocols, consent forms, and other information into a number of languages. It was clear that UC Health needed to communicate in Spanish and find messages that would resonate with communities. Communication about COVID-19 risks with the Latino(a) community and agricultural communities in the San Joaquin Valley would be an important effort during the coming months.

Regent Leib noted that Sweden had reopened its society to some degree, but the daily number of COVID-19 cases and the number of deaths in that country had decreased. He asked if this outcome was due to following scientific guidance, which was not always the case in the U.S. Dr. Byington responded that Sweden had taken a different course. Over the course of the entire pandemic, it would become possible to analyze which actions had been effective and which not. In her view, an important factor was that people in Sweden had a sense of personal and community responsibility; there needed to be more effort on this in the United States. She stressed the gravity of this public health crisis and that it was everyone's civic duty to protect others by wearing a mask and following the recommendations of public health experts, whose advice should be listened to, not politicized.

Regent Park recalled that the California Nurses Association (CNA) had expressed concerns about staffing levels and the safety of frontline workers. She asked about the status of these discussions with the union. Dr. Byington responded that she met with CNA representatives the prior week and had also met with the medical center chief executive officers to discuss CNA concerns. UC Health had assembled all leaders in occupational health, infection prevention, and telehealth in order to coordinate a systemwide response and ensure that similar protocols were being followed at each site. This work was beginning. She reiterated that UC had tested almost 16,000 of its healthcare workers. Positivity rates varied by location. Dr. Byington anticipated that, by bringing a systemwide group together to address

these matters, there would be changes that frontline workers would appreciate. Regent Park and Committee Chair Lansing thanked Dr. Byington for addressing these concerns.

Regent Stegura remarked that the pandemic had led to a decrease in blood donations. She praised efforts by UCLA Health to make blood donation easy. UCLA was also offering a free antibody test for people who donate blood, and this was a smart move.

Regent Kieffer asked about the impact the coronavirus would have on the University if it persisted, as projected, for two years. Dr. Byington responded that pandemics do not come and go in a period of a few weeks. The effects of the 1918 pandemic lasted through 1920 to 1921. The coronavirus had swept the world, and making it disappear was not a possibility. People would have to develop significant immunity before there would be a change in the current situation. Until there was greater immunity in society, either through natural infection, a vaccine, or a combination of both, one would be dealing with COVID-19. The changes to procedures in UC hospitals necessitated by COVID-19 would continue even after a vaccine was available. The impact would last for years.

Regent Kieffer asked about campus operations after January 2021. Dr. Byington responded that this fall was a time of concern, given the rate of transmission. She did not wish to make projections for January and February, but believed that UC would still be dealing with the pandemic. Coronaviruses usually appear in fall and winter. A seasonal pattern had not yet been observed for COVID-19, and it can take time for viruses to get into a seasonal pattern. Other respiratory viruses would appear in winter, including influenza. This year would be stressful for the UC campuses, with outbreaks of respiratory illnesses. She hoped that, like UC hospitals, the campuses would get better at managing COVID-19 with each semester, allowing for the resumption of an increasing number of normal operations.

Advisory member Bindman referred to Dr. Byington's mention of healthcare options for UC employees. He asked if this meant benefits related to current health plan offerings or different kinds of plan offerings. Dr. Byington responded that UC medical centers were interested in supporting employee health. UC Health was considering a number of options, such as benefit offerings for mental health and telehealth which could be more widespread across the UC system. UC Health would work with systemwide Human Resources, the Academic Senate, and other groups on ways of supporting employee and student health during this stressful time and beyond.

Regent Butler asked about testing of students on UC campuses and overall progress. Dr. Byington responded that each campus was taking actions to protect students. UC was trying to ensure rapid turnaround for testing students and employees, with results within 24 hours. This was a priority. Each campus was considering how to carry out contact tracing. UC San Diego had done outstanding work in a pilot program with students living on campus including regular testing and contact tracing. Chancellor Khosla added that UCSD was also testing the sewage coming out of buildings, because the virus can be detected in sewage. As the campus reopened, UCSD would test not only individuals, but also the sewage from every campus building. UCSD would test surfaces in classrooms, and wearing a mask would be mandatory on campus. While there was concern about COVID-

19 transmission among students living on campus, he noted that some off-campus living situations were worse in terms of hygiene or crowded conditions.

Regent Pérez asked about the proportion of COVID-19 patients in California being cared for by UC as opposed to other healthcare systems and how UC could maximize its impact for the benefit of other providers. Patients in counties with disproportionately high numbers, such as Imperial County, were being transferred to hospitals as far away as Irvine and Davis. He asked how UC could maximize its positive impact beyond those patients being treated at UC hospitals. Dr. Byington responded that UC Health was working with the State on such an effort. UC Health had developed telehealth critical care networks in order to advise physicians and providers in other hospitals. This had benefited hospitals in Southern and rural California. UC Health knew that the state would need more support in fall and winter. UC Health facilities were among the best in California in expertise and experience. UC Health knew that it must be an important resource for the state.

Regent Pérez cited COVID-19 statistics for the Latino(a) community and for people who work outside the home and stated that UC must maximize testing opportunities for UC employees who were working in the UC healthcare system and on the campuses who believe they might have been exposed to the coronavirus. In the implementation of new and innovative therapeutics, he asked how those therapeutics could be maximized in areas where there were disproportionate rates of positivity. Dr. Byington responded that academic medical centers such as UC Health and Stanford University would carry out clinical trials because they had the required infrastructure. UC needed to be able to enroll widely across the state, not just at UC, and this was being discussed with Governor Newsom. New therapeutics must go through clinical trials. At times there was competition, because any one COVID-19 patient could only be enrolled in one trial. All patients in the State of California needed to be enrolled in trials. Trials must be prioritized so that therapeutics which were most likely to be effective would be tested first.

Regent Pérez thanked Dr. Byington and UC Health for these efforts to leverage its work for a broader impact beyond UC hospitals. UC San Diego Health Chief Executive Officer Patricia Maysent commented on the situation in Imperial County. UCSD Health had a management service agreement with El Centro Regional Medical Center, where UCSD was providing telehealth critical care as well as critical care personnel. Telehealth critical care had been established in early March. The UCSD emergency department was assisting the emergency department in El Centro and navigating patient transfers. COVID-19 rates appeared to have leveled off in Imperial County. The fall season would be challenging. UCSD had been very involved in El Centro and was doing its best to assist this community.

UCSF Health Chief Executive Officer Mark Laret reported that UCSF's affiliate hospitals and physician groups were very eager for information on accessing Remdesivir and supplies of personal protective equipment. He anticipated that, over the course of the next few years, UC Health must increase affiliations and relationships that serve the underserved. This was a critical issue in order to address the tremendous health inequities in California.

Regent Muwwakkil agreed with Regent Pérez that UC Health must engage with those communities most affected by COVID-19, regardless of whether they live in the proximity of UC campuses or not. He noted that UC Santa Barbara Student Health was not testing asymptomatic patients at this point. He asked if asymptomatic patients would receive COVID-19 tests in the future. Dr. Byington emphasized the importance of testing asymptomatic patients. There was currently a shortage of testing materials, so that testing was prioritized for patients with symptoms and for individuals with close contact or exposure to COVID-19. The testing supply needed to be increased. The supply chain must be strengthened to allow UC Health to provide on-demand, low-cost point-of-care testing. UC Health was working toward this, and Dr. Byington would continue to advocate for this goal.

Chancellor Khosla reported that, the prior week, UCSD announced that any employee on campus who believed he or she had been exposed could receive a test for free. UCSD did not yet have the testing capacity it needed, but did have 200 tests per day that it was not using; these would be allocated for asymptomatic testing on demand.

Committee Chair Lansing expressed the Regents' gratitude to Dr. Byington for her leadership.

Student observer Noah Danesh commented that loneliness and anxiety among UC students, already an issue before the pandemic, had become more pronounced. In addition to providing adequate mental health care, the UC system should do anything it can to reduce stresses on students. A significant cause of stress was uncertainty. The University should make decisions about the fall term sooner rather than later and communicate these to students. Each campus would have unique needs, but systemwide guidelines would help reduce uncertainty. A major focus should be point-of-care testing with quick test results. The current multi-day waiting period was stressful for students. There should be robust contact tracing teams and ongoing blanket testing to detect asymptomatic cases and prevent outbreaks. This would require significant resources. There needed to be a strong mask mandate on the campuses. Mr. Danesh suggested that UC form a public-facing, systemwide work group to update students and provide basic guidelines. Housing was another area of uncertainty for students, many of whom relied on UC housing and had few other options. As UC was adjusting housing arrangements and providing quarantine rooms, it should make sure that it was not turning away students who needed housing. There should be a comprehensive appeal process for students denied housing, so that they can find a place on campus. The University was able to control the environment in on-campus housing, but not off campus, so it should focus efforts on providing as many safe options for students as possible. Mr. Danesh expressed optimism about UC's research and work on developing COVID-19 therapeutics and vaccines. UC should ensure that its innovations are openly and rapidly available to the greater health community when they are ready.

The meeting adjourned at 11:20 a.m.

Attest:

Secretary and Chief of Staff