

The Regents of the University of California

HEALTH SERVICES COMMITTEE

August 24, 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 Guber, Lansing, Makarechian, Park, Sherman, and Zettel; Ex officio members Drake and Pérez; Executive Vice President Byington; Chancellors Block, Hawgood, and Khosla; Advisory members Bindman, Hernandez, and Spahlinger

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

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

1. **PUBLIC COMMENT**

- A. Dene Schulze-Alva expressed concern about the 2020–21 UC influenza vaccine order. Students and employees should be free to make their own decisions about medical intervention, without coercion, in consultation with medical practitioners. She asked that UC rescind or revise the order by removing the requirement entirely, making the flu vaccine a recommendation only, or by expanding exemptions to include conscientious objections or religious beliefs.
- B. Roderic Moyer asked the University to consider a graduate of Tennyson High School in Hayward, currently an undergraduate at Dillard University, as a future graduate student at UC.
- C. Kiersten Clickner, UCSF birth center nurse, reported that the masks she and her colleagues were issued as personal protective equipment did not work properly. Providers were wearing masks in the operating room that did not provide adequate protection in an environment where invasive procedures are performed. Ms. Clickner and her colleagues were being asked to reuse personal protective equipment while there was an increase in COVID-19 patients. UC hospitals should not be relaxing standards, but strengthening them.
- D. Marcia Santini, a nurse at UCLA and member of the California Nurses Association (CNA), read from a letter from a group of concerned nurses who had been exposed to a COVID-19–positive co-worker. The lack of contact tracing was a problem. An

employee in the interventional radiology department at UCLA had been out sick for symptoms of cough, fever, and shortness of breath. He had a COVID-19 test on August 3 with a negative result. Despite having continued symptoms, he returned to work on August 6. He was open about his symptoms with management and co-workers. At a staff meeting on August 12, it was announced that he had now tested positive for COVID-19. Ms. Santini did not understand how he could have passed through the UCLA Health screening and tracking system to be cleared for work, and how his managers could be aware that he was symptomatic and allow him to continue to work, exposing patients and staff to COVID-19. There was no additional cleaning of work areas. Staff were not contacted to check for exposure. This was an egregious situation.

- E. Celeste Sarmiento, a nurse at UC Davis, reported short staffing in her unit and that mental health patients who should have been tested for COVID-19 had not been tested. She urged UC Davis Health to implement testing of mental health patients, especially those with acute symptoms. She reported that UC Davis was distributing non-medical grade masks to staff, which had no splash protection.
- F. Ray Sasser, a nurse at UC San Diego and CNA member who had cared for dozens of patients in the COVID-19 intensive care unit, emphasized the need to prevent the spread of COVID-19 among workers and patients and the importance of safe, high-quality masks and personal protective equipment. He cited regulations issued by the California Division of Occupational Safety and Health regarding appropriate use of N95 respirators.
- G. Wandralee Lindtzie, UCSF staff member, stated that the University had many income streams that could prevent layoffs, furloughs, and unnecessary pain and hardship disproportionately affecting the most vulnerable workers. It was clear that layoffs would affect service at UCSF and that laying off workers and increasing the workload of other workers would affect revenues and have unintended consequences. She criticized UC leadership for what she described as a latent, systemic contempt for the welfare of non-represented staff.
- H. Daniel Harvitt, assistant clinical professor in the UC Berkeley School of Optometry, stated that he would not submit to the flu vaccination order. He asserted that a forced vaccination policy was wrong, and UC should opt for making a recommendation instead. The science of vaccines was not settled, and this remained an active area of research. Many injuries were not recognized, tracked, or compensated. Studies were inadequate to demonstrate the public health benefit of vaccines.
- I. Krista Pederson, the mother of a daughter about to apply to UC, was strongly opposed to the flu vaccine mandate. Her daughter had a medical condition and was allergic to vaccines. Ms. Pederson was concerned that this exemption would not be honored by the UC system. She urged the University not to implement this mandate.

- J. Katherine Sutter stated that she planned to apply to UC next year, had reactions to vaccines, and expressed concern about the flu vaccine mandate.
- K. Sharon Kramer, Escondido resident, asserted that a paper published by a UC faculty member was being used to support a defunct litigation defense argument regarding mold issues. She asked that the Regents call for a retraction of this paper.
- L. Gabriel Mora, UCLA staff member, expressed opposition to mandatory flu vaccination and questioned the efficacy of the flu vaccine. He reported that he had a severe reaction to flu vaccine, and vaccination might compromise his ability to perform his work.

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

Upon motion duly made and seconded, the minutes of the meeting of June 17, 2020 were approved, Regents Drake, Guber, Lansing, Makarechian, Park, Pérez, Sherman, and Zettel voting “aye.”¹

Committee Chair Lansing welcomed President Drake. It was fitting that Dr. Drake, as a medical professional, was attending this Committee as his first meeting as President of the University. There was no one more qualified to serve as President, especially during the COVID-19 pandemic.

President Drake commented that these were unusual and trying times for UC and the world, with multiple simultaneous crises. He acknowledged the outstanding work being done in UC’s healthcare facilities, in hospitals and clinics around the state. Particularly in the last five-and-a-half months, the University’s response to the COVID-19 crisis had been inspiring, and it was gratifying to be a part of this. President Drake drew attention to the workers on the frontlines; nurses and those receiving patients in the emergency rooms, COVID-19 wards, and elsewhere; doctors; medical students; food service workers; and transportation workers—all who had been working around the clock to take care of Californians. In the medium term, in its clinical medicine work, UC was looking for better treatments for COVID-19 and communicating its results to others around the world while learning from others. In the longer term, UC was working to make the world safer. The University’s work on a vaccine and antivirals would help address the challenge of COVID-19, but also help prepare for the next viral pathogen that threatened to become a pandemic. President Drake recalled that, when he served as Vice President for Health Affairs, the position now occupied by Executive Vice President Byington, the University had about 14 medical schools and programs; now there were 20. The size and scope of the UC Health enterprise had continued to grow.

Executive Vice President Byington introduced Advisory member Dr. Andrew Bindman. Dr. Bindman was Professor of Medicine, Epidemiology, and Biostatistics in the Philip Lee Institute for Health Policy Studies at UCSF. He was an expert in health policy and a

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

primary care physician at San Francisco General Hospital. He had served as a health policy fellow on the staff of the U.S. House Energy and Commerce Committee where he contributed to the drafting of the Affordable Care Act (ACA). He worked for several years to implement the ACA as a senior adviser within the U.S. Department of Health and Human Services and as the Director of the Agency for Healthcare Research and Quality. He currently served as the co-editor in chief of the journal *Health Services Research*. Dr. Bindman was an elected member of the National Academy of Medicine.

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

[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 chart that had been recently published by the *Journal of the American Medical Association*. The chart showed numbers of deaths in New York City at the time of the 1918 influenza pandemic and during the current COVID-19 pandemic, as well as during the preceding years. She observed that the mortality trend of the first few months of the COVID-19 pandemic paralleled the 1918 pandemic. COVID-19 might turn out to be one of the largest pandemics ever faced.

Data from the previous week indicated that California had a significant increase in case numbers and a high rate of infections. The statewide percentage of COVID-19 positivity was 6.4 percent, and it would be desirable to bring this number below five percent or lower. San Francisco County had the lowest rate, 2.7 percent. The counties with the highest rates were Riverside County, with 12.4 percent, and Sacramento County, with 9.1 percent. Riverside County had experienced a decline compared to the previous week, but the rate in Sacramento County had increased. There were multiple outbreaks across the state.

Dr. Byington presented a chart showing the daily numbers of COVID-19 inpatients at UC medical centers. Most medical centers were on a downward trajectory. At this point, UC Davis had the highest number of COVID-19 patients. The total number systemwide on August 15 was 224, which was a decrease from the earlier peak number of 272. Nevertheless, this total was about 40 percent higher than in April or May. A chart with COVID-19 cases by age indicated that UC Health was seeing the largest number of cases in the range of 30 to 49 years of age, and was beginning to see more cases of children, both younger than two years of age, and in the two to 17-year age group. Another chart showed the mean age of patients who died of COVID-19 by month from February to August. The mean age was declining. In April, this age peaked at 72.45 years. Currently, in August, the mean age was 66.19 years.

Dr. Byington then reviewed the status of UC Health revenues and presented a chart indicating lost revenue by month from March through July. The figures for July showed an improvement over June. There were progressively smaller losses for the medical centers and UC medical school clinics from May through July. UC Health had also seen a small

increase in Coronavirus Aid, Relief, and Economic Security (CARES) Act funding. As of August 21, UC Health had received \$508 million in funding, or just under half of its total losses. The new funding, recently received, was \$14.7 million to the UCSF Benioff Children's Hospital in Oakland. This represented UC's share of CARES Act funds directed to freestanding children's hospitals.

An important goal for UC Health was to return to normal operations. Dr. Byington presented a chart showing UC Health patient census levels systemwide over the past year, with a steep decline in April and May. Census levels were increasing again and had almost reached 100 percent of average. Prior to the COVID-19 outbreak, UC Health census levels consistently ran higher than 100 percent. UC Health was experiencing a good recovery of ambulatory patient volume. Another chart indicated that in-person visits were increasing, while the volume of telehealth visits remained consistent. UC Health was approaching 175,000 telehealth visits per month.

In the last month, the University had mandated a requirement for influenza vaccination for students, faculty, and staff, to occur before November 1. The purpose of the mandate was to protect UC campuses from the interaction of influenza and COVID-19. Every fall and winter there is an increase in influenza, and this would occur along with COVID-19. The two together would create undue stress on the UC hospital system, on the campuses, and on the resources that UC has for testing, contact tracing, and quarantining. Dr. Byington expressed her support for the University's decision to mandate this requirement.

New technologies were being developed at UC in response to COVID-19. The SwabSeq diagnostic testing technology was validated at UCLA by Eleazar Eskin and others and had been awarded emergency use authorization by the U.S. Food and Drug Administration (FDA) about ten days prior. This technology allows collection of specimens from the nose as well as saliva collection. Saliva collection is easier and less painful for the patient. Patients themselves can collect saliva specimens. Once the specimen has been collected, it receives a barcode. Multiple samples can be pooled and tested together, and the barcoding allows for identification of any positive samples in the pool. There were many advantages to this technology: the use of saliva, the ability to barcode and pool specimens, the automated nature of the process, and the ability to test thousands of specimens, up to 100,000, per day. Having this technology in the UC system would allow for epidemiological surveillance, which meant testing of those without symptoms.

Dr. Byington then presented a short video which explained AeroNabs, a new technology being developed at UCSF which might help prevent COVID-19 infection. This technology might be deployed along with a vaccine, or until a vaccine is developed. The UCSF faculty working on the technology referred to it as "molecular personal protective equipment." They had engineered a molecule that appears to prevent COVID-19 by neutralizing coronavirus in the body. SARS-CoV-2, the virus that causes COVID-19, was named "coronavirus" because of the spiked proteins that cover its surface, giving it a crown-like appearance when viewed through a microscope. Once inside the airway, the spiked protein opens like a flower and fits perfectly into the ACE2 receptor of a lung cell. This allows the virus to enter the cell and release its RNA, forcing the cell to create more coronaviruses.

COVID-19 infection is only possible if a spiked protein is able to interact with ACE2. Peter Walter and Aashish Manglik of UCSF set out to prevent this interaction by using nanobodies, or tiny antibodies, originally found in camels and llamas. They tested two billion different synthetic nanobodies against SARS-CoV-2, found one that binds exceptionally well to the spiked protein, and engineered it to make it even more potent. The result was AeroNabs. When AeroNabs binds to the spiked protein, the virus cannot attach to ACE2 and loses its ability to infect cells. Vaccines typically require years of research and production, but AeroNabs could be available much sooner, would likely be cheaper to produce, and could be self-administered with an inhaler or nasal spray. Clinical trials might begin soon.

Dr. Byington then commented on one of the clinical trials UC was involved in. This was ACTIV, a public-private partnership between the National Institutes of Health, many universities, and industry partners. ACTIV's goal was to identify different therapeutics which could be used at various points in time during the infection, at different viral loads, when fighting the virus or when fighting the inflammation caused by the virus, for patients ranging from those with no symptoms to those with severe symptoms. ACTIV was especially focused on trials for asymptomatic patients who were not hospitalized or those with mild symptoms. Outpatient treatments were in a rubric named ACTIV-2. The first trial to come to fruition in this category was a monoclonal antibody therapy being tested at many institutions and led by UC faculty. The study team was led by Davey Smith of UC San Diego. Kara Chew and Eric Daar of UCLA were serving as protocol vice chairs. The entire network was led by Judith Currier of UCLA. UC faculty were on the cutting edge of the most promising clinical trials in the U.S.

In July, UC Health leadership had a virtual strategy session to discuss recovery and the re-making of UC Health after COVID-19. One promising proposal was to create a Pharmacy Benefits Manager internal to UC. The financial benefits of doing so would include cost reduction through "spread," the difference between what the Pharmacy Benefits Manager charges and the amount reimbursed to the pharmacy, as well as through rebates and administrative fees. If UC ran its own Pharmacy Benefits Manager, it would only have the cost of running the process and could retain the spread, rebates, and administrative fees within the UC system. There would be quality-related benefits to patients. Data show that patients have better outcomes when they receive their services from UC specialty pharmacies. Under this scenario, UC would be able to develop direct agreements with manufacturers, including large manufacturers such as Pfizer. These agreements would leverage UC outcome data and return value to the UC system. UC Health had carried out financial modeling showing potential additional profit margin if UC were to institute its own Pharmacy Benefits Manager. This was one of UC Health's highest priorities for the upcoming year.

In the context of telehealth, UC Health had articulated a mission of providing innovative and seamless continuity of care by UC providers, a concept it was calling "UC Health Anywhere." There would be additional investment in and infrastructure development for this concept over the next year.

UC Health was working with its self-insured health plans, the UC Health Benefits Advisory Committee, and the Executive Steering Committee on Health Benefits to develop a five-year roadmap for UC health plans to leverage UC's collective position of employer, payer, and provider for the maximal benefit of employees and the University itself. UC Health would like to see UC-branded health plans be the clear choice for all UC employees, retirees, and their families through UC's ability to offer innovative, differentiated, affordable, and comprehensive health plans. UC Health would like to build on the success of these UC-branded health plans by eventually offering them to other public and private employers. Dr. Byington concluded her remarks by presenting a number of versions of the proposed "University of California Health" logo.

Regent Makarechian asked about the number of COVID-19 cases at UC Riverside. Dr. Byington explained that the Riverside patients were cared for in hospitals not owned and operated by UC, so UC Health was not able to gather their data.

Regent Makarechian asked about the reasons for the high positivity rates in Riverside and Sacramento Counties, compared to other counties as shown on a chart earlier. Dr. Byington observed that county positivity rates varied over time. Local health departments were trying to identify relevant factors in order to best respond to COVID-19. One reason might be the number of essential workers in a region who work outside the home. Case numbers had increased due to outbreaks among essential workers, in prisons, and in nursing homes. UC Davis Human Health Sciences Vice Chancellor David Lubarsky reported that the increase in the Sacramento region was related to the fact that testing supplies had been cut in half by Roche, following which UC Davis decreased the amount of surveillance and asymptomatic testing. Due to the lack of a steady state testing algorithm and testing supplies, one could not draw conclusions from increased rates. Hospitalization rates were a more reliable statistic. UC Riverside School of Medicine Dean Deborah Deas commented that the positivity rate in Riverside had now decreased. It had been as high as 16 percent. She had been in regular communication with County public health officials. One reason for the high rate was that Riverside County had opened its lockdown early. Testing sites were overwhelmed and testing results were not available as quickly as desired. The rates had now decreased from 16 to 13 percent, and UCR Health was working to bring these rates down.

President Drake observed that these positivity rates were the result of a numerator and a denominator, which changed due to circumstances. One rate which was useful to consider was the positivity rate of elective surgery patients coming into hospitals. This rate should not change based on the other factors that had been mentioned. He asked Dr. Byington if there were any data on this point. Dr. Byington responded that UC hospitals tested incoming patients. For asymptomatic patients, the positivity rate was low, usually less than one percent systemwide, and this was a good sign. President Drake opined that this statistic would be a good basis for comparing different communities. Dr. Byington noted that, during the peak of the COVID-19 outbreak in New York City, 15 percent of pregnant women coming into hospitals for delivery tested positive. This indicated a high rate of community transmission.

Committee Chair Lansing asked about the current percentages of elective versus COVID-19 patients. Dr. Byington responded that UC Health still had more than 200 COVID-19 patients, more than in spring, but this number was spread across the UC Health system, which had 4,000 beds. The majority of UC patients at this time were non-COVID-19 patients.

Committee Chair Lansing asked about UC Health's total financial loss at this point, taking into account federal funding received. Dr. Byington responded that UC Health had recovered about 45 to 46 percent of its losses.

Regent Makarechian asked if mortality rates overall had decreased and about mortality rates for different age groups. Dr. Byington responded that UC Health was working on these data, which she might bring for her next presentation. The mortality rate appeared to be declining in UC hospitals over time. This might reflect the fact that UC Health had become better at taking care of patients or the fact that there were now younger patients in the hospitals. She pointed out that it takes time for mortality rates to mature. For example, the data for the current month of August, not yet finished, indicated that the mortality rate was slightly above two percent; however, this might increase moving into September because patients who are very ill often remain ill for a long time before dying.

Regent Makarechian asked if lower mortality rates were due to a change in the definition of COVID-19 mortality or due to more effective treatment. Dr. Byington responded that UC Health had not changed the definition of COVID-19 mortality. There was active discussion about what this definition should be for mortality from COVID-19 as opposed to mortality with COVID-19. There might be questions about the cause of death if a patient had COVID-19 in one month and died several months later. Currently, UC Health was reporting data for the first 30 days, but this period might need to be extended.

In response to another question by Regent Makarechian, Dr. Byington confirmed that the University was being paid for telehealth visits. Questions about parity for in-person and telehealth visits were being discussed. Regent Makarechian asked if UC was losing money on telehealth visits. Dr. Byington believed that UC was losing some money on telehealth; the work to optimize this was important.

Regent Sherman asked about the volume of telehealth visits after UC hospitals began taking non-COVID-19 patients again and how UC could keep the momentum of telehealth going, since telehealth appeared to be very efficient. Dr. Byington responded that there had been a large increase in telehealth volume in April and May. Since then there had been a decline in volume, but telehealth visits were now at a steady state, and they might increase as UC Health considered which visits were best to maintain as telehealth visits and how telehealth can be implemented for greater efficiency and to increase access. UC Merced and UC Santa Cruz were interested in having more telehealth options from UC providers.

Regent Muwwakkil asked about an enforcement mechanism for the University's influenza vaccination mandate for students, faculty, and staff with a deadline of November 1. He asked if enforcement would be campus-specific. Regent Muwwakkil also asked about an

overlap or correlation between the flu and COVID-19, and if flu vaccination would help mitigate the spread of COVID-19. Dr. Byington responded that the flu vaccination mandate was systemwide. There was already a mechanism for students to report their vaccinations at each campus. Each campus was also working on a way to verify employee vaccinations. Verification would occur at the campus level. Dr. Byington noted that speakers during the public comment period at the beginning of the meeting had expressed concern about medical exemptions. Medical exemptions were allowed and had always been allowed. With regard to the question of how flu overlapped with COVID-19, the overlapping of symptoms was significant. Some of the most common symptoms for both COVID-19 and the flu were fever and cough. At this point, anyone with these symptoms needed to be tested for COVID-19 and go into isolation. Having many flu cases on UC campuses would tax the University's resources for dealing with COVID-19. More people would need to be tested and there would have to be more case investigations, isolation, and quarantine. There were reports from China of patients with both COVID-19 and influenza, because the COVID-19 outbreak there occurred during the flu season. Patients with both viruses can experience exacerbated effects on the lungs and potentially other organs. There was an overlapping of symptoms and the possibility of being infected by both COVID-19 and the flu at the same time.

Regent Stegura underscored that testing with a quick turnaround and contact tracing would be important for students, faculty, and staff to be able to return to campus safely. She asked about a high throughput technology being developed at UC Davis which drew on animal genetics and would not compete for scarce reagents. Dr. Byington responded that she did not have information on this specific technology, but the high throughput testing she had described earlier did not use RNA extraction, which was a limiting factor and had affected the supply chain. The high throughput technology used sequencing machines to sequence the genome of the pathogen and could process thousands of tests a day. These were complex tests carried out either in a Clinical Laboratory Improvement Amendments (CLIA)-certified laboratory or a basic research laboratory with significant expertise. Point-of-care tests for COVID-19 did not involve high throughput; they were similar to rapid strep throat tests, and were best done one by one. High throughput tests would run a thousand samples at the same time. Both types of tests would be used in planning for and optimizing testing.

Staff Advisor Jeffrey commented that the SwabSeq technology would be a "game changer" in allowing for effective pooled testing, including testing for asymptomatic individuals. Students were now returning to the Berkeley campus. Since emergency use authorization from the FDA for SwabSeq had come about ten days earlier, Ms. Jeffrey asked how much time would be needed to expand this technology to scale. Dr. Byington responded that there were a number of requirements in order to implement the technology. One needed the right equipment. UC Health had reviewed its laboratories and ascertained that UC had 80 next generation sequencers. One needed to train personnel, and UC might also have to hire personnel to keep testing laboratories open and functioning. Personnel would have to be trained not just to run laboratory testing, but also to prepare the infrastructure to receive the tests, and to ensure correct data entry and matching of the results. Another requirement concerned reporting the results, and UC Health was working with the Office of the General

Counsel and the State on this question. There were rules about what can be reported through surveillance versus diagnostic testing. UCLA Health Sciences Vice Chancellor John Mazziotta observed that the contribution of scientists had been to prove that this technology works, and the FDA had agreed with this conclusion. Dr. Byington had outlined the key logistical factors in implementation. Currently, at UCLA, four basic scientists and graduate students were working on SwabSeq and proving the principle of the technology, but making the technology operational would require different personnel, different discipline, and redundant equipment, rather than one set of equipment, so that testing does not fall behind. Testing would need to be run by an organization used to this kind of effort, not scientists in a research laboratory. The University needed to find a partner for this effort, and the private sector was not a viable solution. While private sector entities had the appropriate infrastructure and mindset, they also had to answer to boards, stockholders, and other investors, and would not be motivated to provide a test at low cost when they could sell at a higher price. UC Health was in discussions with the California Department of Public Health and the California Coronavirus Testing Task Force, established by the Governor. These discussions had been promising, but slow and inconclusive. UC Health had suggested that UC could serve as a statewide network, with appropriate indemnifications, recruitment, and financial backing. There had not yet been a result, and the University needed a partner and clear plan to execute. There was not yet a clear path to making this testing technology operational. Dr. Mazziotta felt that the State government would be an appropriate partner, and California might be a model for other states in opening the University, major sectors of the economy, and the school system. Dr. Byington expressed agreement with this view.

Committee Chair Lansing asked about the status of plasma treatment. Dr. Byington explained that plasma treatment has been used to treat many viruses and was one of the tools to address a new, emerging virus. This was a potential treatment. Currently there were incomplete, randomized, controlled clinical trials. In developing a treatment, the medical community relies on randomized, controlled clinical trials as the gold standard. These trials had not been completed in the U.S. A number of plasma clinical trials were ongoing at UC San Diego, UCLA, and UCSF. There was concern across the scientific community that, because there was now emergency use authorization, patients would take the treatment and trials might never be completed.

Committee Chair Lansing asked about statistics that had been reported about patients who had been helped by plasma treatment, as much as 35 percent. Dr. Byington responded that those statistics came from the analysis of a small group of patients.

Faculty Representative Gauvain asked about the rate of COVID-19 infection among students and if this rate was increasing as it appeared to be increasing among this age group. Dr. Byington responded that the campuses were tracking their students, and, so far, UC had been fortunate. There had been outbreaks at the University of North Carolina at Chapel Hill and at the University of Notre Dame. Infection rates on these campuses had been two to three percent during the summer term and then quickly rose to 19 or 20 percent. UC must be prepared for this scenario as students return. The rapidity of transmission was significant, since one on-campus party could result in multiple infections.

Regent Leib referred to reports that influenza rates in South America were lower than usual this year and asked if this information was accurate. Dr. Byington responded that the same measures that protect against COVID-19—wearing masks, hand hygiene, and social distancing—also protect against influenza. During the spring lockdown in California, the number of flu cases decreased. Dr. Byington opined that, as long as COVID-19 transmission occurred, flu transmission would occur as well.

Faculty Representative Bhavnani asked about plans for opening campuses on the quarter system. Dr. Byington responded that the UC Systemwide Testing and Tracing Task Force had recently updated its recommendations. It now recommended requiring testing of students before they come on campus and asked campuses to begin a program of surveillance testing. A discussion of this matter was scheduled for later that week with President Drake and the chancellors.

4. **OVERSIGHT EXPECTATIONS UNIQUE TO HEALTH CARE BOARDS**

[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.]

Deputy General Counsel Rachel Nosowsky recalled that, 30 years prior, the Institute of Medicine, now called the National Academy of Medicine, defined healthcare quality as “The degree to which health care services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge.” A decade later, the National Academy issued a key report titled “Crossing the Quality Chasm: A New Health System for the 21st Century,” which identified practices that impede the quality of care and offered recommendations for system-level change. Healthcare quality is a holistic, multi-dimensional concept. It can be conceived of within six significant domains defined by the National Academy and widely adopted throughout the healthcare industry. In line with these six domains, U.S. healthcare systems work to ensure that their services are safe, effective, equitable, patient-centered, timely, and efficient.

The University’s commitment to quality is included in its core values, similarly defined across all UC Health locations, and in the understanding that quality is a function of overall value. Dr. Byington had articulated an understanding of value as a product of quality plus service divided by cost, where service includes equitable access and value is integrally linked to core values. Although the focus of the six quality domains defined by the National Academy tends to be at the individual level, UC Health also works to evaluate and improve outcomes and reduce disparities across entire populations at the local, regional, and state levels.

Safety at the patient and workforce level, quality, patient experience, and workforce engagement are interdependent domains and linked to overall success. Ms. Nosowsky presented some figures illustrating the importance of quality to overall performance, published a decade earlier in a study in the journal *Health Affairs*. The authors reported that 87 percent of board chairs at high-performing hospitals stated that their boards had

moderate or substantial expertise in quality, compared to 66 percent at low-performing hospitals. Board training on clinical quality was far more common at high-performing hospitals than at low-performing hospitals, 49 percent versus 21 percent. More than half of board chairs chose clinical quality as one of the two top priorities for board oversight. Board chairs at high-performing hospitals said that they used quality as a criterion in evaluating chief executive officer performance more than twice as often as board chairs of low-performing hospitals. Board chairs at high-performing hospitals were four times as likely to report that the hospital board had an influence on quality, and were significantly more likely to report being somewhat or very familiar with major quality standards. Among low-performing hospitals, no respondent reported that their performance was worse or much worse than that of the typical U.S. hospital, while 58 percent reported their performance to be better or much better. Fifty-four percent of high-performing hospitals and 34 percent of low-performing hospitals reported that clinical quality took up at least 20 percent of board time.

At UC, no one committee or individual holds all of the responsibilities of a typical hospital board of directors. Instead, core responsibilities for quality and safety oversight are divided across governance and administrative silos. At the Regents' level, the Health Services Committee generally oversees the health system, similar to a corporate board for a private health system, but the Compliance and Audit Committee approves medical malpractice and other legal settlements, and the Finance and Capital Strategies Committee approves budgets and capital projects. Local executives or governing bodies at the campus level approve quality and safety plans and receive quality and safety reports. Until very recently, there was no systematic plan or process to report on quality at the level of the Regents. UC Health's first attempts to improve Board engagement included the development of the Clinical Quality Dashboard, which is regularly presented to the Health Services Committee. There were broader plans in place for continued improvement, and these were being developed by the Working Group on Clinical Quality, Population Health and Risk Management.

The Institute for Healthcare Improvement had recently identified a framework for prioritizing quality culture and commitment at the board level. The intention of this framework is to ensure that quality is appropriately prioritized and that boards are actively engaged in quality oversight. The importance of board engagement in issues of quality could not be overstated.

The Working Group on Clinical Quality, Population Health and Risk Management had discussed review of systemwide quality criteria compared to external benchmarks, such as Vizient; setting systemwide goals and reviewing performance against them at the Board level; and close review of individual academic health center metrics at bimonthly meetings, including State-reportable adverse events, consideration of including a budget review component, and consideration of rotating meeting sites, when meetings in person can recommence.

Regent Park referred to an article by Gary Yates, M.D., provided in the background materials and published by the American Hospital Association Trustee Services on

“Helping Boards Have Productive Discussions about Quality of Care.” The article discussed areas that should be discussed by health system boards, including patient experience of care, workforce engagement and safety, continuum of care, and community health. The article indicated that one can take a broader view of what constitutes quality. Regent Park stated that this broader view would be relevant for UC Health and suggested that the criteria listed in the article be discussed by the Health Services Committee. Ms. Nosowsky expressed agreement with this suggestion. The UC Health Division at the Office of the President has discussed developing a report on these various elements for each Health Services Committee meeting in a dashboard form, as well as focused conversations at least once annually on those different elements.

Committee Chair Lansing asked about the sequencing of these discussions. It would make sense to focus on one area at each meeting, rather than trying to cover all areas at one meeting. Ms. Nosowsky responded that a dashboard report could include all areas, in case of sudden increases or trends that caused concern, but there would be focused discussion on one area at a time. Committee Chair Lansing expressed support for this idea. She asked Dr. Byington and Ms. Nosowsky to schedule this into the Health Services Committee meetings.

Advisory member Bindman noted that UC Health has been involved in policy discussions about the appropriate size of UC Health and its impact on population health in California. He suggested including measures in the dashboard showing the impact that a larger, expanded role for UC Health in caring for the population of California would have on the health of California. Arguments had been made that, because of the excellent care provided at UC hospitals, an expansion of UC Health could have an impact on population health. The development of statistical measures in this area could guide policy decision-making. Dr. Byington responded that this has been a topic of discussion within UC Health. Regent Pérez agreed with Dr. Bindman. This idea of an expansion of UC Health could change discussions with State officials.

President Drake commented on the usefulness of dashboards, which allow one to follow the performance of different factors over time and detect trends. This was a useful exercise. When UC examined the experience of its various patient populations, it was interesting to see the reasons people had for choosing where to receive care. One might expect quality of care to be the most important factor in these decisions, but this tended not to be the case. Cost of care was sometimes a major factor, but in some circumstances this had little or no measurable effect. Convenience was sometimes an important factor, but at other times people would drive long distances for care. Quality, cost, or convenience were not necessarily the motivating factor. UC Health was trying to get a larger fraction of UC employees as patients. President Drake stressed the overall importance of health plan member experience. This factor should be examined and measured. Good patient experience can be more important than convenience or cost. Considering all these factors together would help UC Health to put forward the best product and expand to a greater number of people.

5. **SPEAKER SERIES – COMMUNITY IMPACT DURING COVID-19: UC IRVINE’S WORK WITH AGING POPULATION CENTERS AND LOCAL SCHOOLS**

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

UC Irvine Health Professor in the Division of Infectious Diseases and Medical Director of Epidemiology and Infection Prevention Susan Huang, M.D., reported on the work of the Orange County Nursing Home COVID Prevention Team. She recalled that nursing home residents were some of the most vulnerable patients, with severe COVID-19 symptoms and deaths. This was largely due to old age and serious chronic illnesses. At this time, there were more than 1.4 million nursing home residents in the U.S. To date, there had been 190,000 COVID-19 cases and 48,000 deaths in nursing homes, a case fatality rate around 26 to 28 percent. During this time of the pandemic, nursing home residents were not allowed to go out into the community and visitors were not allowed to see them. For this reason, staff members were the main conduit for importing COVID-19 into nursing homes. In order to keep residents safe, one needed to keep staff safe. With regard to nursing home staff, Dr. Huang noted that few of them were nurses; the majority were certified nursing assistants with a high school degree, or housekeepers, or kitchen support staff. Many were socioeconomically disadvantaged, working multiple jobs. They were almost uniformly underinsured, with few paid sick days. For this reason, they would often work while ill, even before the arrival of COVID-19, and would not speak up about symptoms in order to avoid being sent home without pay.

In April, UC Irvine received urgent calls from the Orange County Health Care Agency and from CalOptima, the Medicaid insurer in Orange County. Both requested a proposal for COVID-19 prevention in nursing homes. They had teams for response but not for prevention. Orange County nursing home cases were clearly climbing at that point, and there was fear about the possibility of severe outbreaks. These entities contacted UC Irvine because of UCI’s 12 years of experience in carrying out nursing home prevention studies to reduce antibiotic-resistant bacteria. UCI studies had shown that 65 percent of nursing home residents had a multi-drug-resistant organism in their body. In doing this work, UCI had established a close relationship with the County Health Care Agency. CalOptima’s decision to contact UC Irvine was due to, among other things, Orange County SHIELD, a recent project involving 17 nursing homes. This was a straightforward project that replaced ordinary bathing soap with an antiseptic soap and added application of an iodine-based nasal antiseptic to try to get rid of common antibiotic-resistant bacteria. As a result, there was an approximately 30 percent reduction in the amount of multi-drug-resistant bacteria on the skin of nursing home residents. CalOptima data showed that, following the Orange County SHIELD project, there was a 44 percent decrease in hospitalizations due to infection from the nursing homes that took part in the project, a dramatic reduction. For CalOptima, this translated into a 53 percent decrease in Medicaid expenditures due to infection. CalOptima was eager to continue this project after funding by the Centers for Disease Control and Prevention had ended, and so, Orange County SHIELD became a Medicaid-funded program in Orange County. It was this rapport that led to the current collaboration to address COVID-19.

The Orange County Nursing Home COVID Prevention Team was funded half by the Orange County Health Care Agency and half by Medicaid. The team decided to create a practical toolkit, which would include signage and posters, protocols, and answers to frequently asked questions, and would be publicly available. The team would also provide webinars and consultative support.

Nursing homes were under-resourced. Infection prevention had been a regulated part of hospital operations for more than 20 years, but this was the first year that it had been regulated for nursing homes. A second wave of COVID-19 was anticipated as schools reopened in the fall. For these reasons, the team also decided to provide enhanced training for 12 nursing homes.

Dr. Huang provided an overview of the online prevention toolkit. One of three sections was devoted to nursing home staff and ensuring they have a good understanding of COVID-19. The second section concerned how to care for others and proper use of personal protective equipment, and the third section was about cleaning. The toolkit also included short instructional videos.

Experience in hospitals and nursing homes had shown that the most dangerous time of day was not when nurses or nursing home staff were caring for COVID-19–positive patients or residents, but when they took off their masks to eat or take a break and sat with their co-workers at distances of less than six feet. The toolkit included a number of videos about breakroom etiquette and safety.

Dr. Huang described the onsite training UCI was providing at 12 nursing homes. UCI also provided weekly testing sweeps for three weeks in a row. This required a great deal of preparatory work, such as explaining to nursing home residents why they should agree to receive a swab test. There was resistance and unwillingness by some residents, but most, more than 90 percent, were willing to receive a swab test.

UCI also provided high-quality video cameras for these 12 nursing homes in order to observe staff in a randomized way and provide feedback on staff safety, hygiene, and appropriate procedures, such as appropriate use of personal protective equipment. UCI made it clear that this measure was for staff member safety, and all staff were aware that these cameras were in place. UCI was watching but not listening. The goal was to achieve maximal safety by the time of the next COVID-19 wave.

UCI was also testing effective cleaning at these facilities by using ultraviolet markers. These markers leave an invisible trace that can only be seen under ultraviolet light. Marks were put only on objects that should be cleaned, and staff could then see, under ultraviolet light, which objects were missed and not cleaned. The results of these tests had shown that cleaning in nursing homes was not nearly as thorough as it should be and that there was room for improvement in this area.

Dr. Huang concluded that the Orange County Nursing Home COVID Prevention Team effort hoped to improve knowledge for urgent COVID-19 prevention, to assess the value

of the intensive training it had provided at the 12 nursing home sites, and to reduce the size and frequency of clusters of COVID-19 outbreaks at nursing homes.

UC Irvine Associate Vice Chancellor for Clinical and Translational Science Dan Cooper, M.D., then reported on work being done to allow for a safe reopening of K–12 schools in Orange County. Some good news was that, in general, children appeared to have much milder symptoms of COVID-19 and were not becoming as ill as adults were. He outlined reasons for the University’s involvement in this issue. There was mounting evidence that school closures adversely affected the health and learning of children and adolescents. It was important to determine if children and adolescents would become infected and sick as they gathered in schools again and to determine the risk for school personnel. One must determine if K–12 students could spark outbreaks throughout the neighboring communities and consider the influence of socioeconomic factors, race, ethnicity, and the special needs of some students, such as students with Down syndrome or learning disabilities, on how schools would reopen. The closure of schools had a number of consequences, including poor nutrition, parents unprepared for distance and home schooling, and social isolation.

UC Irvine planned to study four schools which represented a spectrum of situations that one might see as schools reopened. One of these was a public school in Santa Ana, an area that was experiencing a surge of COVID-19. The second was a charter school in Santa Ana where more than 80 percent of the students relied on the school for food security. The third school was a charter school in Orange that cared for students with special needs, such as autism spectrum disorder or Down syndrome. Appropriate physical distancing and hand washing would be difficult to maintain in this environment. The fourth school was a private school in Newport Beach, with a population of students predominantly from middle and upper middle class families. This school had spent \$1 million in preparing for reopening.

Dr. Cooper outlined what the team from UC Irvine could contribute. UC had many years of experience with National Institutes of Health-funded studies of health in schools. UC can sound the alarm on important issues. Dr. Cooper, Executive Vice President Byington, and others had co-authored a commentary article in the *Journal of Pediatrics* in May on the safe reopening of schools, underscoring that this would not be an easy task. At that point, they did not realize how much this would become a political issue. UC can plan innovative and necessary research. With the support of the Orange County Health Care Agency, UC Irvine intended to begin research in the schools with two aims. The first was to measure viral transmission in students and personnel as schools reopen, with a focus on basic virology, epidemiology, and the impact of socioeconomic status on the schools’ ability to reopen safely. UCI also hoped to find answers to questions about the differences between the symptoms in adults and children and why children generally had milder symptoms. The second aim was to measure the fidelity of mitigation protocols employed by the schools. The ability to adhere to mitigation measures would play a role in viral transmission.

The University can work in partnership with schools and provide assistance in challenging areas. UC can provide content expertise and information assessment, such as rigorous review of literature and updates on COVID-19 clinical issues. UC can assist with start-up

plans and monitoring, providing feedback to individual schools as they developed plans for reopening. Dr. Cooper noted that all UC medical centers were working to provide help to schools in their area.

The University can assist school districts in evaluating data. Vast amounts of data had been generated about COVID-19, but some of this was misinformation, half-truths, or differences of opinion. In order to address the matter of reopening schools, there was a need for complete honesty and transparency about possible consequences and outcomes. Dr. Cooper drew attention to examples of conflicting information presented in the news media about whether or not schools could reopen safely. He concluded by stressing that schools must be a healthy place for students and staff. The UC system can play a key role in ensuring the healthiest possible reopening of schools for K-12 students, school personnel, and their families.

Committee Chair Lansing asked about where nursing home workers had the greatest chance of catching COVID-19. Dr. Huang responded that this was in the breakroom, when they removed their masks and were eating with co-workers.

Regent Makarechian asked about the results of the Orange County SHIELD project and its recommendation for use of antiseptic soap. Dr. Huang responded that there had been four major trials of topical antiseptic soap. In hospital intensive care units, this was shown to reduce infections by almost half. This was now the standard soap used in intensive care units across the U.S. There were also studies of hospital environments outside the intensive care unit and of patients for a year after discharge. For these patients, use of antiseptic soap and mouthwash reduced infections and re-hospitalizations. The trial in the nursing homes had just ended. Data from the Orange County SHIELD project would be presented in October at a meeting of the Infectious Diseases Society of America. She hoped that word would get out that, even for highly vulnerable patients, something as simple as bathing soap could make a difference.

Regent Makarechian suggested that these best practices for nursing homes should also be introduced in UC dormitories. Dr. Huang responded that the reason for using antiseptic soap in intensive care units, pre-operative settings, and nursing homes was to try to prevent something that was already on the skin, in the throat, or in the nose from producing infection, to prevent one's own bacteria from causing trouble. With regard to COVID-19, the hope of medical professionals was that people avoid exposure altogether and the focus was on measures to prevent transmission from occurring.

Regent Makarechian asked about schools that had opened with alternating days for students to reduce student volume. Dr. Cooper responded that one approach was to try to keep the numbers of students relatively small and to keep them in groups. Using this model, public schools, which generally had larger numbers of students, could have smaller in-person classes and keep student groups smaller. Dr. Cooper remarked that there would be outbreaks and that this could not be avoided, but that these efforts were focused on mitigating the danger as much as possible. This model would help avoid a situation in which all schools would have to close and then reopen, which would be very disruptive.

Regent Makarechian asked if the UCI study would also examine the psychological and financial effects of COVID-19 on students and their families. Dr. Cooper responded that the focus of the study was on the virus, but that the researchers were very much aware of these other factors. The other factors were not a formal part of the study. Regent Makarechian suggested that these other factors were as important as containing the spread of the virus. Dr. Cooper expressed agreement. UC Irvine Vice Chancellor Steven Goldstein added that these aspects of the pandemic were being studied in various departments across UC Health and the University.

Faculty Representative Bhavnani asked about nursing home staff members' reluctance to report if they were sick and if this was because they would not be paid. Dr. Huang responded that, before COVID-19, these workers received about six paid sick days. Many worked multiple jobs and would be using up a sick day for all these jobs. There was a tendency to be fearful. These workers did not trust the system, and the system has not always been kind to them. The turnover rate for administrators of nursing homes was 50 percent a year; the turnover rate for staff was higher. It was important for staff to learn that they had support. The recommendation for broad screening was due to a lack of trust and the fact that these workers would not speak up if they had symptoms.

Ms. Bhavnani asked how one could address the issue of trust and ensure that these workers receive sick pay. Dr. Huang responded that there was a need for stability in the administration of a nursing home, with an administrator remaining at a location for years and building a rapport with the employees. There was conflicting information in the news media, and this frightened people. There was a need for deep and abiding trust which would only be achieved when a team remained in place over time. Nursing homes were understaffed and under-reimbursed.

Regent Park asked if insights gained in the nursing home study could be applied in the K-12 setting. Teachers were also caregivers. Dr. Cooper responded that infections might occur in teachers' break rooms, just as in staff break rooms in nursing homes. Many teachers were older and had comorbidities. This was one lesson learned from the nursing home environment that the UCI researchers were conveying to the schools. Dr. Huang added that the University could be a lifeline and help to build community trust. These efforts by UCI could build trust in the UC system.

Regent Muwwakkil commented that the information in this presentation intersected with Regents' discussions about the basic needs of UC students and staff. He thanked the presenters for the work they were doing.

UC Irvine Health Chief Executive Officer Chad Lefteris thanked Drs. Huang and Cooper for their work in helping the community. Dr. Goldstein noted that they were helping the Irvine campus to reopen and advising businesses in the community about reopening.

Committee Chair Lansing expressed gratitude to Drs. Huang and Cooper for their work.

6. **UC HEALTH LABOR AND OCCUPATIONAL HEALTH CONSIDERATIONS DURING COVID-19**

[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 stressing that UC Health knew its healthcare workers and was aware of the risks they take. UC valued them and their service. Throughout the COVID-19 pandemic, UC Health worked systemwide to protect them, using the best information and science available. Dr. Byington presented a map showing that California still had a high rate of hospitalizations compared to other states in the U.S. As long as UC had COVID-19 patients in its hospitals, it needed to protect all its healthcare workers and patients.

Since February, Dr. Byington had been meeting regularly with UC union leaders, representatives of UC Environment, Health and Safety, and occupational health, to listen to labor leaders' and employees' concerns. Early in the pandemic, there were concerns about the availability of personal protective equipment, and the use of personal protective equipment increased by 25 times systemwide. There were concerns about the use of masks and N95 respirators. UC has implemented universal testing of patients in order to appropriately segregate patients with COVID-19 and ascertain which workers need personal protective equipment against COVID-19. UC has implemented universal use of masks and face coverings in UC facilities and appropriate use of N95 masks as more is learned about risks. There were concerns about workers' exposure and testing, and the desire for a single, uniform definition of exposure and the degree of exposure that would trigger follow-up testing. Dr. Byington stressed the concern of UC Health leadership about its workers' wellness and resiliency. UC healthcare workers had been responding to the COVID-19 pandemic since January, many with the stress of caring for their own families while dealing with higher-than-usual mortality rates in the hospital and, for patients who were isolated in the hospital, serving as the bridge to patients' families.

UC Health has been monitoring the number of employees who are tested, either by UC or an outside organization. UC offered testing to its employees and tracked those who tested positive. There were almost 100,000 employees across UC Health. To date, UC had tested about 31,000 of those employees for COVID-19, because they were exposed, had symptoms, or were part of an asymptomatic testing study. Overall, of the tested employees, 3.9 percent tested positive. This percentage was lower than in the state overall, with variation among the campuses. The employees who tested positive represented slightly over one percent of all UC Health employees. UC Health anticipated running approximately 1,400 to 1,500 tests a week.

In California, if a healthcare worker contracts COVID-19, it can generally be assumed that the individual acquired the infection at work, and this is recognized in the context of State law. When cases are investigated, however, employees are sometimes found to have had contacts outside work, and some cases of COVID-19 were acquired in the community. UC Health employees were not becoming infected through caring for patients. Employees were

using personal protective equipment appropriately. Infections at work tended to occur in the break room, with transmission from colleague to colleague. UC Health was educating staff and trying to ensure that public spaces and break spaces are safe. Since March, there had been a total of 319 cases of COVID-19 among UC Health employees. A recently published paper on hospital-acquired transmission of SARS-CoV-2 from patients to healthcare workers suggested that transmission occurred through close contact and respiratory droplets rather than via long-distance airborne transmission. Dr. Byington described this as reassuring information.

UC Health was also developing an emotional support and mental health response plan for its healthcare workers during the pandemic. Dr. Byington presented a chart which represented UC Health's response to union requests for a single definition of "exposure" that would be used systemwide and how it would trigger testing. This would serve as guidance for the UC system in health system and campus settings about exposure and testing. It had been through multiple levels of review and would be disseminated to the campuses.

Interim Vice President Lloyd noted that Dr. Byington has been communicating regularly with unions about the pandemic and provided an overview of UC labor relations. There were seven systemwide unions and they varied significantly in size, ranging from more than 15,000 members to fewer than 400. The unions were the American Federation of State, County and Municipal Employees (AFSCME), the Teamsters, University Professional and Technical Employees (UPTE), the California Nurses Association (CNA), the United Auto Workers (UAW), the University Council-American Federation of Teachers (UC-AFT), and the Federated University Police Officers Association. Systemwide units spanned ten campuses, five medical centers, and the Lawrence Berkeley National Laboratory (LBNL). The systemwide clerical unit included all represented administrative support employees in a single bargaining unit. Local units, at a single campus, were generally much smaller. The campus-based units consisted of job classifications which were closely grouped together, such as medical interns and residents or skilled trade employees. UC had a systemwide labor relations office at the Office of the President (UCOP) with 11 professionals who had primary responsibility for negotiating and administering the systemwide labor contracts. The campuses, medical centers, and LBNL each had their own labor relations office. These offices were responsible for ensuring contract compliance and bargaining local contracts.

Executive Director of Labor Relations Peter Chester explained that Labor Relations at UCOP had primary responsibility for negotiating and administering systemwide contracts. Some bargaining units were very large. The nurses' unit and the patient care technical unit had over 15,000 members each. These employees worked mostly at the medical centers. The campus and medical center labor relations offices worked with their union counterparts on a day-to-day basis. The local offices advised UCOP when there were problems with contract language or grievances. Likewise, the unions had both local union representatives and systemwide leadership. UCOP communicated regularly with systemwide union leadership.

Mr. Chester outlined strategic principles in UC labor relations. Most importantly, the University sought to manage labor relations in order to facilitate the University's mission and to be in alignment with that mission. A recent example of this was the mandatory flu vaccination program. He hoped that this program would be successful and that the unions would cooperate. Another principle was to minimize disruptions to UC operations. The University worked to ensure that there was not strike activity, in particular at the medical centers. By complying with contracts and fostering good relationships with the unions, the University minimized strike activity. A third principle was treating represented and non-represented employees equitably. UC tried to manage labor relations so that employees were neither advantaged nor disadvantaged by being unionized. A fourth principle was the UC wished to resolve labor issues as quickly as possible at the lowest possible level, and a fifth was to maintain good working relationships with union colleagues. A final principle was to ensure that UC administrators understood contractual provisions governing management of UC's unionized workforce. The UCOP Labor Relations office provided contract administration manuals and training for managers and supervisors. Ms. Lloyd concluded by emphasizing UCOP's role in supporting the local labor relations offices.

Medical center representatives then commented on local worker wellness and resiliency programs. UCLA Health President Johnese Spisso reported that, throughout the pandemic, UCLA Health made a particular effort to recognize the frontline care providers and support staff. She thanked community donors for their generous support. Professional sports teams in Los Angeles and the Los Angeles business community provided amenities for UCLA Health staff. More than 36,000 meals were provided to staff in hospitals, and 22,000 of these were provided by a Los Angeles family who partnered with local restaurants. The Los Angeles Lakers provided significant support for 800 of UCLA Health's lowest-paid workers in the form of free groceries. UCLA Health implemented a wellness program with resources and counselors to help individuals manage stress and a plethora of online resources including meditation, music therapy, visits with therapists, and webinars. UCLA was able to provide support for child care and temporary lodging support for healthcare workers from COVID-19 units who wanted to stay away from their families. UCLA made arrangements with local groceries to allow these employees to shop early in the morning before others were allowed in the store. Ms. Spisso stated that staff morale was at a good level. With regard to personal protective equipment, she noted that, early on in the pandemic, UCLA leased a warehouse in Van Nuys for storing additional equipment. UCLA received \$16 million in donations for purchasing personal protective equipment and ventilators and for a fund to support staff, patients, and their families.

UC Irvine Health Chief Executive Officer Chad Lefteris remarked that the pandemic was a unique opportunity to leverage all available resources. The Anaheim Ducks organization's players and families organized efforts to feed UCI Health staff on every shift at every location. UC Irvine set up an on-site commissary for healthcare workers, providing free staple groceries for six to eight weeks during the height of the outbreak, and delivered groceries to employees who were quarantined at home. Wellness programs for more than 1,500 employees were provided by the Samueli Integrative Health Institute. UC Irvine also provided resources for financial counseling. Counseling support was also

provided by the Department of Psychiatry. UC Irvine Health was taking a holistic approach.

Regent Pérez asked about efforts to maintain a positive relationship with unions and the experience of labor-management meetings as a venue for positive conversations rather than for grievances or negotiations. Mr. Chester responded that there were quarterly meetings at the campus level which were required by contract. These meetings were not always positive, but often were positive and included problem-solving. At the systemwide level, meetings were not as regular, but were held to discuss issues of mutual concern, such as benefits. Unions often have helpful suggestions about desired changes to benefits. The most positive engagement occurred in discussions of large-scale issues. Discussions about COVID-19 had generally been positive. The unions were appreciative of the participation of Dr. Byington and other UC experts in these discussions. Ms. Lloyd noted that, at these meetings, the administration provides transparent information about the status of COVID-19 at the locations, including number of cases, outbreaks, and UC's response.

Regent Makarechian referred to a map presented earlier showing especially high hospitalization rates in California, Texas, and Florida. He asked about the reason for this and what UC was doing to mitigate this. Dr. Byington stated that UC Health was doing all it could to mitigate this. Hospitalization rates changed during different stages of the pandemic. In an early stage of the pandemic, the Northeastern U.S. was hit much harder than the rest of the nation. In June, July, and August there had been rolling outbreaks in the South and West. California was one of the most populous states and had one of the largest numbers of inpatient admissions. In July, the number of admissions in California had been almost 9,000, but admissions had declined since then, which was a positive development, but Californians still needed to follow public health recommendations to decrease transmission. The same was true for Texas, Florida, and other states with larger numbers of hospitalizations.

Regent Makarechian asked about the differences between New York and California. Dr. Byington responded that New York had many more hospitalizations than California early in the pandemic, and much more transmission in the community. There were now higher levels of antibodies in New York than in California. These higher levels of antibodies in the community might be able to slow down transmission. In certain community pockets in New York, 20 percent of individuals had antibodies. People in New York and New Jersey had seen family members die, and these traumatic events had informed their approach to public health recommendations. Not all Californians had been affected as directly by COVID-19.

Committee Chair Lansing stated that hospitalization rates also reflected whether people were adhering to public health recommendations.

President Drake observed that New York and New Jersey had experienced a high vertical spike early in the pandemic. A large fraction of the population was affected early on, and there was a high rate of COVID-19 positivity among pregnant women in the hospital for delivery. Society was crippled. In places where the spike was slower, people might have

been more casual in their response. Places with a slower spike would experience a longer curve spreading out. In California, this was exacerbated by a surge in July. With the right public health measures, California should see a decrease.

Regent Makarechian suggested that positivity rates among healthcare workers might be useful in comparing New York and California. He asked if there were any statistics. Dr. Byington responded that there were a number of studies of healthcare workers. Being a healthcare worker was a risk factor for COVID-19. The percentages of UC Health employees affected were lower than in the general population in California and across the U.S. This was not true for all hospitals in California.

Regent Park asked about the role of chancellors and medical center chief executive officers in the labor relations engagement strategy at either the systemwide or local level. Mr. Chester adumbrated the role of campus senior leadership in strategy and communications among campuses and with the President. Vice chancellors and chief human resource officers were also involved in developing strategy. There were regular systemwide meetings of chancellors, vice chancellors, and chief human resource officers.

Regent Park presented a scenario in which CNA wanted to know how many of its members had tested positive for COVID-19. She asked where the union would receive an answer to this or other issues of general concern, outside of bargaining. Ms. Lloyd responded that, if there were a local issue, the union would bring it to the local labor relations office at the hospital. Systemwide concerns would be raised at a systemwide meeting.

Regent Park asked what would happen if the local office was unresponsive. UC San Diego Health Chief Executive Officer Patricia Maysent responded that an unresolved issue would be brought to the attention of the chief executive officer. If the chief executive officer could not resolve the issue, it would go to the chancellor. Ms. Spisso added that there were routine joint labor-management meetings at UCLA. UCLA's chief nursing executive meets with CNA. The union can add any issues of concern to meeting agendas. Ms. Spisso stressed that, especially during the pandemic, concerns arising at one site and responses or best practices were shared systemwide.

Regent Park observed that an issue of concern arising at one campus could very likely arise at other locations as well. Ms. Spisso expressed agreement. Mr. Chester added that unions identified best practices that they wished to see implemented systemwide. Dr. Byington noted that the unions had asked that the University have a single definition of exposure and a uniform manner for testing, and this had been implemented. This was one of many such issues brought to and discussed by the chief executive officers and vice chancellors. Ms. Maysent observed that some requests were difficult to fulfill. In one instance, a union wanted the names of COVID-positive employees. The University would not release individual names, but provided an aggregate report.

Regent Park asked if staffing levels were a labor concern. Dr. Byington responded that UC Health had heard concerns about staffing, particularly from CNA, which was concerned that the University might change staffing ratios. She emphasized that the UC system had

not changed staffing ratios and continued to operate as it had prior to the pandemic. The union was also concerned about possible State legislation that would affect nursing ratios, but UC was not involved in these State deliberations. Ms. Maysent noted that the State had allowed for a waiver of enforcement of nurse-to-patient ratios, but UC had not participated in this. Another major concern for the union was possible future layoffs. UCSF Health Chief Executive Officer Mark Laret reported that, when UCSF had empty units in March and April, it sent nurses home. UCSF made a decision, in partnership with CNA leadership, about support staff levels. UCSF had reduced some support staff levels, and this had changed the work environment for frontline staff, but UCSF was still within mandated ratios and at least as generous as competitors. UCSF tried to maintain a high standard of service to patients. Financial circumstances sometimes dictated hard decisions. UCSF administrators had regular meetings with the unions, in particular with the leadership of CNA and AFSCME. In his view, the relationships were good. The decision to set up a dedicated COVID-19 unit was made in partnership with labor leaders, and this had worked out well. UCSF had regular discussions with labor leaders about personal protective equipment standards in advance of implementing any policies. Some speakers during the public comment period had mentioned that staff were being given non-medical-grade masks. UCSF's policy was to distribute medical-grade masks at all entries. UCSF published information online about how many days of surgical masks were available. Mr. Laret acknowledged that there had been a breakdown in communications with middle management. Middle managers were not always conversant with all the terms of a new labor contract. This was a process improvement issue. As soon as there were new labor terms, UCSF must ensure that it was implementing them. In recent years, UCSF had added race and union membership as categories to its employee engagement survey. The results were not what UCSF had wished. Latino(a) and African American employees had a lower level of engagement than white and Asian employees. Non-unionized employees had a higher level of engagement than unionized employees. UCSF was aware of this issue and was working to address it. Mr. Laret observed that there were two pandemics going on at this time. The racial injustice pandemic was more significant for UCSF employees than the COVID-19 pandemic; at this point, UCSF had 30 COVID-19 patients compared to an overall census of over 750 inpatients. The issues of racial injustice and health inequity had triggered an unprecedented level of interest. Mr. Laret and the chief human resources officers had sessions with frontline staff, particularly unionized staff, to talk about UCSF's commitment to ensure an environment that was not just free of these issues but truly anti-racist.

Regent Park recognized that the circumstances of COVID-19 were challenging and required a certain flexibility on the part of both employees and management. Because the University was such a large organization, communication was an ongoing challenge. One should pay attention not only to the line of communication from UCOP to the campuses, but to how communication radiates throughout the organization. Mr. Laret's remarks raised the question of whether middle managers were getting the message. Some relationships might have become more adversarial than they were intended to be, and UC's labor relations strategy should consider this. Regent Park suggested that UC, and the Health Services Committee, should pay the same attention to racial inequities and health disparities as it paid to COVID-19 and its impact. Dr. Byington reported that health

disparities had been an overriding theme of the UC Health leadership retreat in July. She agreed about the need for action in this area. An article published about ten days prior showed that mortality rates for African Americans under normal circumstances were higher than rates for white Americans during the COVID-19 pandemic. It was as if the Black population of the U.S. was living through a pandemic every year. Various aspects of health disparities could be a standing item for the Committee. There were many topics to be discussed in the realms of education, clinical care, research, and the workforce. Committee Chair Lansing asked that these discussion topics include a plan of action.

Regent Sherman noted that the map shown earlier had listed absolute numbers of hospitalizations in each state. He asked how these numbers might change if they indicated hospitalizations as a percentage of population and relative to the number of available hospital beds. He asked if this would reveal major discrepancies in resources or in populations affected. Dr. Byington responded that the numbers for rural areas would be of greater concern due to resources. While California had about 6,000 hospitalizations, it had 72,000 hospital beds, so that this situation was significant but not overwhelming. This would not be the case in rural areas. All these numbers, as a percentage of population or some other denominator, would be different.

Regent Sherman asked that data on COVID-19 being presented to the Committee on a regular basis include breakdowns by race and geographical location, in order to make clear possible misallocation of resources. Dr. Byington responded that this pandemic had shown lack of resources particularly in the Imperial Valley and the Navajo Nation. Committee Chair Lansing stressed that this pandemic has provided a stark demonstration of health inequities. It was UC's mission to serve the underserved, and the University should take a hard look at what it was doing and what more it could do in outreach.

Dr. Byington concluded that UC Health was striving to be not only the best provider, but also the best employer, and wanted to have a respectful partnership with labor. Being as transparent as possible and sharing data were among her goals.

Regent Pérez praised UCLA's staff wellness efforts, because the toll on all the frontline workers was huge.

The meeting adjourned at 2:35 p.m.

Attest:

Secretary and Chief of Staff