

The Regents of the University of California

HEALTH SERVICES COMMITTEE

October 20, 2021

The Health Services Committee met on the above date by teleconference meeting conducted in accordance with California Government Code §§ 11133.

Members present: Regents Guber, Lansing, Park, Pérez, Sherman, and Sures; Ex officio member Drake; Executive Vice President Byington; Chancellors Block, Hawgood, and Khosla; Advisory members Hernandez, Marks, and Ramamoorthy

In attendance: Regents Lott and Reilly, Regent-designate Timmons, Faculty Representatives Cochran and Horwitz, Secretary and Chief of Staff Shaw, Deputy General Counsel Nosowsky, Executive Vice President and Chief Operating Officer Nava, Vice Presidents Lloyd and Nation, Chancellors Gillman and Wilcox, and Recording Secretary Johns

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

1. APPROVAL OF MINUTES OF PREVIOUS MEETING

Upon motion duly made and seconded, the minutes of the meeting of August 18, 2021 were approved, Regents Drake, Guber, Lansing, Park, Pérez, Sherman, and Sures voting “aye.”¹

2. PUBLIC COMMENT

Committee Chair Pérez explained that the public comment period permitted members of the public an opportunity to address University-related matters. The following persons addressed the Committee concerning the items noted.

- A. Michael Cahn, representative of the UCLA Bicycle Academy, extolled the bicycle as a tool of personal, public, and planetary health and urged UC Health to adopt an active transportation policy. UC Health should consider the health benefits that result when an institution actively seeks out a mode of transportation that advances public health.
- B. Alexandra Falchi, a UCSF nurse working in the pediatric intensive care unit, expressed concern about a lack of proper staffing hospital-wide. She reported that her own unit was chronically short-staffed. Lack of appropriate staffing had only become worse during the COVID-19 pandemic and posed a risk to patient safety. UCSF management needed to make this a priority.

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

- C. Craig Cooper, a senior nurse anesthetist at the UC San Diego Medical Center, reported that two of his colleagues were recently laid off without notice and in spite of the fact that his department was short-staffed. These individuals were excellent clinicians and their work was needed. Mr. Cooper stated that a consultant had told UCSD Health management that part-time staff were less desirable. Laying off two part-time working mothers during a pandemic contradicted UC values. He called for the reinstatement of these employees.
- D. Michael Castello, a child neurology resident at UC San Diego Health, spoke on behalf of resident physicians represented by the San Diego House Staff Association (SDHSA) and the Committee of Interns and Residents of the Service Employees International Union (CIR/SEIU), who were now negotiating a contract. They were told that, because San Diego is a rural area, their contract would not be commensurate with contracts at UCLA and UC Irvine. The costs of rent, groceries, utilities, and child care in San Diego were not those of a rural area. Dr. Castello asked the University to make a fair contract offer to resident physicians.
- E. Sean Li, a plastic surgery resident at UC San Diego Health, stated that resident physicians represented by SDHSA and CIR/SEIU had been working tirelessly for their patients during the COVID-19 pandemic but were not treated as heroes at the bargaining table. The cost of living was high in San Diego, exacerbated by inflation during the pandemic, and residents and fellows were barely making ends meet. If UCSD Health wished to continue to recruit and retain the best physicians and to be competitive with UCLA and UC Irvine, UCSD must make a fair contract offer. Dr. Li asked the Regents to work with UCSD Health to bring about such a fair offer.

President Drake recognized the important work of all employees and staff at the UC medical centers. The COVID-19 pandemic had now lasted for more than a year and a half, and it was easy to become numb to its effects. The number of deaths that day from COVID-19 in the U.S. was 1,500. It was important not to lose sight of the sacrifices made every day by UC employees during this pandemic. Thanks to the efforts of these employees, UC Health has continued to deliver outstanding care. This was reflected in daily declining COVID-19 cases in UC hospitals and in California. UC campuses had largely been able to return to in-person operations, with 80-85 to 95 percent of classes in person, varying by location. The measures that have made it possible to regain some sense of normalcy were as important now as in the past months: masking, appropriate social distancing, and vaccination. The University was monitoring its daily COVID-19 numbers to ensure that there was no increase. UC must continue to focus on doing everything it can for the safety of the UC community. The University was still learning about the virus and how it was changing. The daily dedication and perseverance of UC healthcare workers gave President Drake hope for the future. He thanked them and UC students, faculty, and staff for doing the right thing to keep the UC community safe.

3. OVERVIEW OF THE CLINICAL ENTERPRISE MANAGEMENT RECOGNITION PLAN (CEMRP)

This item was not discussed.

The Committee recessed at 10:20 a.m.

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The Committee reconvened at 10:55 a.m. with Committee Chair Pérez presiding.

Members present: Regents Guber, Lansing, Park, Pérez, Sherman, and Sures; Ex officio member Drake; Executive Vice President Byington; Chancellors Block, Hawgood, and Khosla; Advisory members Hernandez, Marks, and Ramamoorthy

In attendance: Regents Lott and Reilly, Regent-designate Timmons, Faculty Representatives Cochran and Horwitz, Secretary and Chief of Staff Shaw, Deputy General Counsel Nosowsky, Executive Vice President and Chief Financial Officer Brostrom, Vice President Nation, Chancellor Wilcox, and Recording Secretary Johns

4. APPROVAL OF INCENTIVE COMPENSATION USING HEALTH SYSTEM OPERATING REVENUES FOR FISCAL YEAR 2020-21 FOR CARRIE BYINGTON, M.D. AS EXECUTIVE VICE PRESIDENT – UC HEALTH, OFFICE OF THE PRESIDENT AS DISCUSSED IN CLOSED SESSION

The President of the University recommended that the Health Services Committee approve the Clinical Enterprise Management Recognition Plan (CEMRP) incentive award for Carrie Byington, M.D. as Executive Vice President – UC Health, Office of the President, in the amount of \$260,940, which is comprised of a short term incentive award for the 2020-21 CEMRP plan year. The total recommended incentive award is 30 percent of Dr. Byington’s base salary as of June 1, 2021 (\$869,800).

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

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

Vice President Lloyd explained that this item sought approval for a Clinical Enterprise Management Recognition Plan (CEMRP) incentive award for Executive Vice President Byington in the amount of \$260,940 for the 2020–21 CEMRP plan year. Dr. Byington was a Level One member of the Senior Management Group and her award would be funded by health system revenue only, with no State General Fund support. The plan document for

CEMRP notes that, because the Executive Vice President – UC Health is a direct report to the President of the University, the award for this individual requires Regental approval. Due to the funding source, the award falls under the oversight responsibilities of the Health Services Committee as stated in the Committee’s Charter.

Dr. Byington’s award for the 2020–21 plan year was a short-term incentive award for performance against pre-established systemwide objectives. Dr. Byington was also eligible to participate in the long-term incentive portion of CEMRP, but her first possible long-term incentive award would occur after the end of a three-year period from 2019–20 to 2021–22, based on the results of a long-term objective pre-established in 2019.

Regent Lansing expressed enthusiastic support for the item. Dr. Byington had performed at the highest level in all CEMRP categories.

Upon motion duly made and seconded, the Committee approved the President’s recommendation, Regents Drake, Guber, Lansing, Pérez, Sherman, and Sures voting “aye.”

5. **UPDATE FROM THE EXECUTIVE VICE PRESIDENT OF UC HEALTH**

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

Executive Vice President Byington reported that the Interim Presidential Policy on Affiliations with Certain Healthcare Organizations went into effect on September 22. UC Health was working to implement the policy systemwide, including requirements such as affiliation due diligence and contract review. UC Health was working to amend all existing agreements, providing training, communicating about the Policy’s requirements, and preparing for an annual report to the Health Services Committee.

Committee Chair Pérez asked if compliance with this Presidential policy would be consistent with Regents policy. He asked if the Presidential policy was more detailed than the broad-based Regents policy. Dr. Byington responded in the affirmative. The two policies were alike.

Dr. Byington then discussed the current state of COVID-19, which was moving into a new phase. The seven-day average in the U.S. was now about 86,000 cases per week, an improvement over the situation at the end of September, when there was an average of 126,000 cases per week. This was now the fourth surge of COVID-19 in the U.S. Dr. Byington presented a graph which showed that this surge was smaller than the third surge in January and February. The third surge occurred before the widespread availability of vaccination and before the Delta variant was prevalent in the U.S. The fourth surge had been blunted because of vaccination. Fifty-seven percent of the U.S. population was now fully vaccinated. The U.S. had crossed the threshold of 50 percent vaccinated in July, and Dr. Byington expressed concern that there had been little progress in increasing this number since then.

Thirty-seven percent of the world population was fully vaccinated. Dr. Byington was concerned that the U.S. ranking in the world for percentage of vaccinated population was dropping day by day. The U.S. had invested significant funds into vaccine development, and technology developed in the U.S. had become the basis for many of the successful vaccines. The U.S. had purchased sufficient quantities of the vaccine to immunize its entire population. Early on, the U.S. had been among the top nations in full vaccination status, but was now at number 50 in the world. This was an urgent issue.

California was faring better than the national average, with 72 percent of the state fully vaccinated. At this moment, California had the lowest transmission rate in the U.S., due to vaccination rates and other public health measures. UC Health was benefiting from this, with the number of COVID-19 inpatients declining and now below 150 systemwide. Nevertheless, UC Health was dealing with huge patient volumes and needs for care that had been deferred during the pandemic. UC Health occupancy rates were above 100 percent.

There was a high rate of compliance with the vaccine mandate at the University, with 95.4 percent of employees vaccinated, and 98.6 percent of students. These were enviable numbers and contributed to safe environments on UC campuses, where there were very low rates of transmission.

Dr. Byington acknowledged that there was much concern about breakthrough cases of COVID-19 among vaccinated people. She drew attention to the fact that, across the state, more than 99 percent of COVID-19 cases and hospitalizations were occurring in the unvaccinated population. UC Health had information on more than 2.6 million vaccinated individuals in its electronic data warehouse. Of these, about 231,000, or 8.6 percent, have had a test for COVID-19 at least 14 days after the last dose of vaccine. Of these tested individuals, 2,685 tested positive, or 0.1 percent. One out of every 1,000 vaccinated people in UC's patient population had a positive test result. Of these people, the number who required hospital admission was even lower—492 individuals, 0.018 percent, or approximately two out of every 10,000 vaccinated people. Dr. Byington underscored that this was a remarkable success rate for the vaccine. This information needed to be provided to everyone who was unvaccinated as winter approached.

Dr. Byington presented data on the relative effectiveness of the Janssen/Johnson and Johnson, Pfizer, and Moderna vaccines. All three vaccines had shown remarkable efficacy, but there was a difference among the three. The Moderna vaccine was showing the greatest protective effect—92 percent effective against the need for an emergency department or urgent care visit and 91 percent effective against hospitalization. These data came from a large national study including Kaiser Permanente patients in Northern California and other large health systems. The Pfizer vaccine showed 89 percent efficacy against an emergency department visit and 87 percent efficacy against hospitalization. The Janssen/Johnson and Johnson vaccine provided lower rates of protection—73 percent against an emergency department or urgent care visit and 68 percent against hospitalization.

The Centers for Disease Control and Prevention (CDC) and the U.S. Food and Drug Administration (FDA) had been evaluating recommendations for booster vaccinations based on these data. The FDA had recently issued recommendations for people who have received the Moderna vaccine, and these were the same as the recommendations with regard to the Pfizer vaccine because the two vaccines are so similar. The FDA currently recommended booster immunization for those 65 years and older and for those between 18 and 64 years of age with underlying medical conditions or who have occupational exposure to COVID-19, such as healthcare and other essential workers. The booster shots should be administered six months or later after the last dose. The FDA recommended booster immunization for all people 18 years of age and older who have received the Janssen/Johnson and Johnson vaccine at least two months after the first vaccination. Dr. Byington provided her own understanding and interpretation of this recommendation: had the Janssen/Johnson and Johnson vaccine been issued as a two-dose vaccine, it would have achieved rates of efficacy much closer to those of the mRNA vaccines. She viewed this booster shot following the Janssen/Johnson and Johnson vaccine as more like the second dose of a primary series.

Dr. Byington then discussed the “mix and match” process in booster immunization, so that an individual receives one vaccine for the primary series and another vaccine for the booster. A study conducted by the National Institutes of Health considered every possible combination of the three vaccines and found that every booster combination was effective and that individuals who had received the Janssen/Johnson and Johnson vaccine had better, higher antibody responses if they received an mRNA booster.

The FDA would hold a meeting the following week to discuss the Pfizer vaccination for children aged five to 11, a group which accounted for about 25 percent of COVID-19 infections across the U.S. The final step in the booster approval process would occur this week, when the CDC would issue final recommendations for Moderna and Janssen/Johnson and Johnson booster shots. UC Health was awaiting these recommendations and would be ready to administer booster shots when this became possible.

There was now a therapeutic for COVID-19, Molnupiravir. This was an antiviral agent produced by Merck and named after Mjöllnir, the hammer of the thunder god Thor in Norse mythology. Molnupiravir had completed clinical trials and reduced mortality by 50 percent. The data from the trial had been submitted to the FDA, and UC and others were awaiting review for emergency use authorization. If authorized, this would be the first oral antiviral treatment for COVID-19. Although the availability of this treatment was encouraging as another weapon in the fight against COVID-19, the strongest weapons were vaccination and prevention.

Given the increase in vaccinations that has occurred during the spread of the Delta variant and the administration of booster shots, pending continued immunity and duration of immunity, and if one could avoid new transmissible variants, the U.S. was on a good trajectory for spring 2022. The estimate for that time would be 9,000 cases per day, compared to the current rate of 85,000 cases per day.

Dr. Byington briefly mentioned a new National Institutes of Health initiative in artificial intelligence and machine learning to advance health equity, 11 UC Health faculty and affiliates who were named fellows to the National Academy of Medicine, and the awarding of the 2021 Nobel Prize in Physiology or Medicine to David Julius of UCSF and Ardem Patapoutian, also with UC affiliations, for their research on human receptors for temperature and touch.

Regent Sherman referred to the data on booster shots and mixing and matching. For individuals who had received the Janssen/Johnson and Johnson vaccine, the Pfizer or Moderna booster shot was highly effective. He asked if there was any significant difference between the Pfizer and Moderna vaccines as boosters. Dr. Byington responded that there was not much difference between the mRNA vaccines. People who had received the Janssen/Johnson and Johnson vaccine should receive a booster of either Pfizer or Moderna.

Regent Lansing asked if there had been any breakthrough cases in people who have received booster shots. Dr. Byington responded that it was still too early to tell. This might be possible. So far this had not been reported.

Regent Lansing observed that antibody levels decrease faster for people with severe underlying conditions and asked if a second booster, or a fourth shot, would be necessary. Dr. Byington responded that one did not know if the booster shots now being given would be the last booster shots. Immunocompromised people did not respond to the vaccine as vigorously as people with healthy immune systems. For this reason, the CDC and FDA had recommended a third dose as part of the primary vaccination series for immunocompromised people.

Regent Lansing asked about the difference in effectiveness between Moderna and Pfizer. She asked if the demonstrated difference would depend on the subset of people who received these vaccines. Pfizer was approved first for people over 65 with underlying conditions. This pool might have been a more difficult pool than that for testing Moderna, which came later. This might have been weighted against Pfizer. Dr. Byington acknowledged that the Moderna vaccine was approved later, but stressed that she was grateful for all the existing vaccines.

Regent Lansing asked if the protocol for the Janssen/Johnson and Johnson vaccine would be reexamined. Dr. Byington opined that, if these people had received two shots of this vaccine, their responses would likely have been similar to those for the Pfizer and Moderna vaccines. In her view, the Janssen/Johnson and Johnson vaccine is probably a two-shot vaccine.

Regent Lansing asked if California had achieved herd immunity, since the vaccination rate was at about 70 percent. Dr. Byington responded in the negative. This would require a higher than 70 percent vaccination rate.

Regent Lansing asked what number would need to be reached to achieve herd immunity. She also asked about the Lambda and other variants. Dr. Byington responded that a number

of new variants were being tracked. So far, no variant could compete with the Delta variant. The vaccines were effective against the Delta variant. For this reason, it was important to have as many people vaccinated as possible to prevent the development of a variant that could outcompete Delta. With regard to herd immunity, it was difficult to determine a number or percentage of the population that would need to be immunized. Because the R nought of the Delta variant was higher than that of the original strain of the coronavirus, immunization would have to be above 90 percent. Dr. Byington preferred to speak of the transition from pandemic to endemic, when COVID-19 would not be gone, but would be under control.

Faculty Representative Horwitz asked if the oral antiviral would produce ongoing immunity. Dr. Byington responded in the negative. The oral antiviral would be a treatment for acute illness; it would not induce immunity.

Mr. Horwitz anticipated a public health messaging problem, because people might think that this medication was an alternative to the vaccine. Dr. Byington commented that the pandemic had made clear the need for clear and effective communication. There were people who believed that they did not need vaccination because they had received monoclonal antibody treatment. This was a risky proposition, because there was no guarantee that these people would survive infection.

President Drake asked about trial data for the effectiveness of the antiviral Molnupiravir shown earlier on a slide. Dr. Byington confirmed that the rates of hospitalization or death were about seven percent for patients who received the antiviral and 14 percent for patients treated with a placebo.

President Drake observed that this medication would work much better than monoclonal antibodies. Referring to Regent Lansing's earlier question about herd immunity, he noted that vaccination rates were at 95 percent or above on some UC campuses. This was a demonstration of effectively moving toward an endemic and manageable number of infections.

6. **UC RIVERSIDE SCHOOL OF MEDICINE STRATEGY, RIVERSIDE CAMPUS**

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

Executive Vice President Byington introduced this presentation, one of a series in which each UC academic health system would present its strategic plans.

UC Riverside School of Medicine Dean Deborah Deas described the situation of the School in Inland Southern California, a region with a population of 4.6 million, one of the fastest-growing regions in the U.S., and one with significant healthcare needs. The Inland Empire region had 35 primary care physicians per 100,000 inhabitants, compared to a state average ratio of 72 physicians to 100,000 inhabitants. The UCR School of Medicine (SOM) was established to address the needs of the Inland Empire with a mission to train a diverse physician workforce and engage in research and clinical programming to serve the

population of Inland Southern California, a mostly underserved population. The SOM strives to train students from the region who are representative of the population the SOM serves, and who will stay and work in the region.

The UCR SOM was a community-based medical school, unlike the other five UC medical schools. UCR SOM was one of only 35 community-based medical schools in the U.S. The School had a distributed model of education. Students were distributed throughout the region in clinical affiliate spaces for their training. UCR SOM did not own or operate a hospital. The clinical affiliates were for-profit, County, nonprofit, Department of Veterans Affairs (VA), and other entities. While this model was known to be effective in training future physicians who will ultimately serve underserved populations, there was an inherent tension. If a partner decides to end the relationship with UCR SOM, the School must be immediately prepared to move its students and residents in order to avoid disrupting their education and training.

The community-based medical school model also did not have a traditional funds flow. UCR SOM did not have an academic funds flow from its community partners, which it would have if it owned a hospital. In a model with its own hospital, there would be a funds flow from the health system to support deficits in clinical departments, strategic initiatives, and academic initiatives.

The UCR SOM had experienced tremendous growth over eight short years. The SOM began with a class of 50 students; it now had 328 medical students. Research award funding in 2016 was \$4 million and had now increased to \$18.3 million. The SOM had 128 residents and fellows, and had recently received Accreditation Council for Graduate Medical Education (ACGME) continued institutional accreditation. All SOM programs were fully accredited, and some received accreditation with commendation. Of the 120 resident physicians and fellows who have graduated from UCR SOM, 47 percent have remained to practice in the Inland Empire.

UCR SOM was well on its way to creating a more diverse healthcare workforce and addressing the shortage of physicians in its region. Forty-eight percent of the School's medical students and 41 percent of biomedical sciences Ph.D. students were from groups underrepresented in medicine, and 65 percent of medical students had ties to the Inland Empire. In addition, 18 percent of SOM students were Mission Award recipients. The Mission Award, funded by donors, pays tuition and fees for three or four years; students make a commitment to return to the Inland Empire after completing their residency.

The UCR SOM strategic plan set forth several imperatives for the next three to five years that would move the institution from start-up to sustainability. In its strategy for education, the School planned to expand class sizes. The State has provided funding to increase class size to 125 students annually, for a total of 500 students over the next few years. While maintaining its community-based faculty, the SOM would hire more UC-employed faculty for increased stability. The new SOM Education Building II would provide necessary space for facilities and expanded class size, and UCR would break ground on this project that same week. UCR SOM would continue to strengthen and grow its graduate medical education program. To ensure future stability for larger class sizes and growing graduate

medical education, UCR SOM was pursuing a two-prong strategy. On the one hand, the School was cultivating and nurturing broader partnerships, including undergraduate and graduate medical education and clinical partnerships with affiliates who have demonstrated alignment with the UCR SOM mission; on the other, UCR was exploring whether owning or operating a hospital would be a viable strategy to increase stability and provide further, long-term support.

In its research strategy, the UCR SOM would continue to focus on projects that are of benefit to the people of the region. The School would like to deepen its commitment to clinical and population health research. UCR SOM received \$16 million from the National Institutes of Health (NIH) to establish the Center for Health Disparities Research, which promotes collaborations among UCR and community researchers. The Center for Healthy Communities and other units in the SOM completed over 180 separate community outreach engagements in the past year, despite the COVID-19 pandemic.

The UCR SOM mission to train a diverse workforce flows through all components of its operations. The School has achieved a high level of diversity in its academic, clinical, and administrative leadership—40 percent were female and 32 percent were from groups underrepresented in medicine. Staff diversity reflected the community that the School serves. UCR SOM planned to implement innovative curricula, such as the health equity, social justice, and anti-racism thread, in which all students participate. Thanks to State funding, UCR SOM would start a Program in Medical Education (PRIME) that would be focused on the African American population.

UCR Health Chief Executive Officer Donald Larsen recalled that UCR Health, the clinical enterprise for the UCR SOM, was established in 2016. UCR Health had ambulatory clinics across Riverside County with services provided by employed UCR SOM faculty. The clinics were the primary ambulatory graduate medical education teaching sites for psychiatry, family medicine, neurology, and cardiology residents and fellows. UCR SOM had more than 100 clinical faculty providing care to patients. About half worked in the UCR Health clinics, and the other half in affiliated hospitals through service agreements and contracts. UCR Health had established over 140 clinical affiliation agreements.

UCR Health patient volume had increased in 2021 to more than 42,000 patient visits. UCR Health has a significant focus on serving the underserved. Fifty-three percent of its patients have either Medi-Cal or Medicare coverage. Clinical faculty served as hospitalists as well or provided other specialty services, such as inpatient pediatrics, psychiatry, cardiology, and interventional cardiology at various affiliate hospitals. Through these activities, UCR Health provides access to high-quality care. Nevertheless, these revenue streams could not provide a funds flow that could sustainably support investments in the academic or clinical enterprise. Therefore, UCR Health's clinical strategy was focused on securing the training platform for SOM students, residents, and fellows, and on clinical service initiatives that would provide access to care for the region and include clinical net revenue to help support greater clinical investment and the academic mission of the SOM.

In expanding and optimizing clinical services, UCR Health had increased access to family care and specialty services. UCR Health had a pediatric clinic in La Quinta, in the eastern Coachella Valley, an underserved area, and a pediatric hospitalist service at the Eisenhower Medical Center. UCR Health had a women's health center in Riverside which offered urogynecology, gynecologic oncology, maternal-fetal medicine, and other subspecialties. UCR Health had expanded access to cardiology services in San Bernardino. In family medicine, UCR Health had recently established a nursing home service and a street medicine program in the Riverside area. Using \$15 million in one-time State funding in the State Budget Act of 2018, UCR Health has expanded its telepsychiatry services. More recently, UCR Health has established a partnership with the City of Riverside to develop a primary care clinic for the medically underserved and unhoused population, the Hulen Place clinic, which would open in spring 2022. UCR's long-term strategy would be to convert this clinic to a Federally Qualified Health Center (FQHC) to ensure a more sustainable ongoing revenue stream. Another strategy was to collaborate with other UC campuses to bring important services to the region. Before the COVID-19 pandemic, UCR had begun work with the other three Southern California UC medical centers on a partnership to develop an outpatient cancer center in Moreno Valley. There would be further discussions to explore this idea. Over time, UCR Health would seek to expand its ambulatory clinics in San Bernardino County and to have a greater presence in the Coachella Valley. UCR Health would continue to work to improve its relationships with its established hospital partners with the goal of solidifying one or two major partnerships. As mentioned earlier, UCR was exploring the idea of whether owning and operating a hospital would allow UCR Health to better serve the region and expand and secure its programs in the future.

Dr. Deas concluded by enumerating some continuing challenges for UCR Health. To date, UCR had received no inflationary increases on State funds and was seeking sustained increases. UCR Health would like to expand the Mission Award, which incentivizes students to practice in the region. UCR was pursuing consistent funds flow to support the academic enterprise. While State support was much needed and appreciated, for long-term sustainability, UCR Health must achieve an additional consistent funds flow to support the academic enterprise, either through clinical affiliation agreements or other means, and, as mentioned, was exploring the possibility of owning and operating a hospital.

President Drake recalled the UCR/UCLA Biomedical Sciences Program, in which students completed undergraduate studies at UCR and transferred to UCLA for medical school, prior to the establishment of the UCR SOM. He recalled statistics about students who entered and graduated from the Program; in three decades, there had been only eight graduates from underrepresented minority groups. The vision for the UCR SOM was that the function and focus of the enterprise be something like a PRIME program, focused on the needs of the medically underserved population of the Inland Empire, especially low-income and underrepresented minority residents. In the founding of the UCR SOM, there was recognition of the need for a different direction.

President Drake referred to information presented earlier on UCR Health annual patient visits and clinical revenue. Between fiscal years 2019 and 2021, the number of patients had

approximately doubled, from 19,915 to 42,709, but clinical revenue from professional fees and service agreements had remained the same, about \$21 million. He requested clarification of these figures. Dr. Larsen responded that the figures for revenue from service agreements reflected the instability of UCR Health's affiliates. Some affiliates had abruptly terminated service agreements with UCR. Clinical revenue from professional fees had continued to increase.

President Drake commented that, although clinical revenue from professional fees had increased by about 40 percent, these were challenging numbers. He asked if UCR Health operations were breaking even; they might not be. In seeking to establish a sustainable base for the future, UCR should consider whether it needs an inpatient facility to provide such a base.

Advisory member Ramamoorthy referred to UCR relationships with community hospitals and asked if the faculty there were UCR faculty or if they received appointments at UCR. She asked about protections for faculty written into the contracts with these hospitals. Community hospitals might decide to hire their own specialists, causing the University to lose part of its practice. Dr. Deas responded that the SOM used community faculty as well as full-time UC faculty. Community faculty members had appointments at UCR SOM. As one example, specialists in obstetrics-gynecology were full-time UC specialists, conducting their outpatient clinical practice in UCR Health clinical space and surgeries at community-based hospitals. Their contract was not based on their service at the hospitals per se, but an agreement allowing them to perform surgeries at the hospitals and collect the physician's fees, while the hospitals collect their fees as well.

In response to another question by Dr. Ramamoorthy, Dr. Deas confirmed that these hospitals could decide to hire their own specialists. Chancellor Wilcox added that the Inland Empire region had struggled over the years to recruit specialists. The risk identified by Dr. Ramamoorthy was not a risk that UCR felt immediately, but, once a base had been established and the region became a more appealing destination for specialists, this might be a risk for UCR. Dr. Deas concurred that the presence of both UCR and community hospital specialists might limit the patient base.

Regent Reilly reported that she had recently visited UCR and met with SOM administrators, students, and community members. The growth and potential of UCR Health and the SOM, and the impact of UCR Health in the Inland Empire, were inspiring. Investment in these programs was an excellent investment by the University.

Committee Chair Pérez raised the question of an equitable federal and State funding model, if UCR proceeded to acquire a hospital. A speaker during the public comment period earlier that day had referenced the fact that San Diego was classified as "rural" by the Centers for Medicare and Medicaid Services, and so UCSD Health received lower reimbursement rates. He asked if UCR would face the same challenges with a hospital of its own, and how this might inform discussions with State and federal leaders to avoid a situation of underfunding. Dr. Deas responded that UCR had engaged a consultant in exploring the possibility of acquiring a hospital in order to answer questions like those raised by

Committee Chair Pérez concerning revenue and feasibility. It was known that many patients from the Inland Empire go to the coastal areas of Southern California for medical treatment and that the region did not have a sufficient number of hospitals. Chancellor Wilcox added that UCR had been approached by potential partners in the past, niche or special purpose hospitals interested in having the UCR name; UCR had declined to affiliate with them. There were now other potential partner hospitals more closely aligned with UCR's mission. The acquisition of a hospital by UCR might serve to broaden the discussion of an equitable funding model. UCR might serve as a template or model for the region.

Advisory member Marks commented that even very well established medical schools struggled with clinical revenue to support their academic mission. She asked about the reasons for the abrupt cancellation of contracts by clinical affiliates, whether hospitals were hiring new and competing staff and did not need UCR clinicians, or for other reasons. She also asked if UCR's strategy included developing UCR's own clinical faculty and physician group, and the necessary infrastructure, so that they can contribute to the clinical revenue stream. Dr. Deas responded that the abrupt cancellation of affiliations was often due to financial factors; some hospitals stated that UCR Health's services were too expensive. UCR was trying to find partners who were in alignment with UCR Health's mission and values. Most of these entities were for-profit organizations. One of UCR Health's best partners was St. Bernardine Medical Center in San Bernardino, and UCR had about 16 other hospital affiliations. UCR was building its clinical departments, but not all clinicians were needed to teach. UCR Health was striving for a balance and wished to avoid a situation of too many physicians and not enough patients.

Ms. Marks observed that finding hospital partners who wished to participate in UCR Health's mission, rather than just having the benefit of the UCR name, was a great challenge, perhaps the main challenge, for this strategic plan. Dr. Deas expressed agreement and her pride in what the UCR SOM had accomplished in a short time.

7. **SEAKER SERIES – THE IMPACT OF COVID-19 ON THE LATINO COMMUNITY IN CALIFORNIA, LOS ANGELES CAMPUS**

[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.]

David Hayes-Bautista, Professor of public health and of medicine, and Director of the Center for the Study of Latino Health and Culture at the School of Medicine, UCLA, spoke about the impact of COVID-19 on the Latino community in California. He began his presentation with some background information on Latino Gross Domestic Product. The Latino population in the U.S. was currently 60 million, and, if they were recorded as a separate economic entity, they would represent the world's seventh largest economy at \$2.7 trillion. Latinos in the U.S. are an important and growing part of the U.S. economy.

In order to understand the impact of COVID-19 on the Latino community, it was necessary to distinguish between chronic and communicable diseases. Chronic diseases, like heart

disease, cancer, and stroke, are style of life diseases that depend on various factors over decades. Professor Hayes-Bautista presented comparative statistics on mortality rates among Latinos and non-Hispanic Whites in California for the five top causes of death. The rate of death from heart disease for non-Hispanic Whites was 157.4 per 100,000 population, while the Latino rate was 30 percent lower, at 110.5. The death rate for cancer was 25 percent lower for Latinos than for non-Hispanic Whites, the rate of death from unintentional injuries was 30 percent lower, the rate for chronic lower respiratory disease was 60 percent lower, and 15 percent lower for stroke. Age-adjusted death rates for all causes had been consistently lower, about 30 percent, for Latinos than for non-Hispanic Whites for a number of decades.

COVID-19 is a communicable disease, and detection and prevention of communicable diseases depends on the healthcare infrastructure. A graph with age-adjusted mortality rates for Latinos and non-Hispanic Whites in Los Angeles County from 2011 to 2020 showed a consistently lower rate for Latinos until 2020, when, for the first time in recorded history, the mortality rate for Latinos rose to a level higher than that for non-Hispanic Whites, and much higher than it had been in 2019. Latinos in California had a close to three-year longer life expectancy than non-Hispanic Whites; in the U.S. as a whole, this life expectancy was slightly longer than three years. COVID-19 had reduced life expectancy for all groups. For Latinos, life expectancy was now only a few months longer than for non-Hispanic Whites.

COVID-19 had this effect on the Latino population due to a number of healthcare disparities. COVID-19 prevention measures that were taken were appropriate for people who could work from home with a laptop computer, but not for those whose work required being on site, such as workers in packing houses and farm workers. In these jobs, one has to work with large groups or interact with the public. Many of these workers would not be paid if they did not come to work, might lose their health insurance, or experience other serious consequences. Latino farm workers are essential workers, but at the beginning of the pandemic, the understanding of “essential workers” who needed personal protective equipment was limited to healthcare workers. Many Latinos worked in occupations and industries that rarely offered health insurance. Latinos in California were still twice as likely as other Californians to not have health insurance. There was a shortage of Latino physicians. In California in 2015, there were nearly 15 million non-Hispanic Whites and about 60,000 non-Hispanic White physicians. Compared to a population of 15 million Latinos, there were just under 7,000 Latino physicians. There was a shortage of 54,000 Latino physicians in order to achieve parity. The numbers of Spanish-speaking providers were even smaller, in spite of the fact that medical care services have been provided in Spanish in California for 252 years; provision of medical care in Spanish was not something new for the state.

In spite of the many difficulties presented by the pandemic, Latinos had risen to the challenge. One way was in labor force participation; the rate of labor force participation was higher for Latinos than for others in California and had remained so even during the worst months of the pandemic. Another criterion for resiliency was seen in remittances sent to Mexico. The amount of these remittances was just under \$3.5 billion per month at the end of 2019, decreased to \$2.5 billion at the beginning of 2020, and rose to \$4 billion

in March 2020. Remittances dropped to \$3 billion in April, but had increased to \$3.5 billion in May. Remittances had now increased to over \$4.5 billion per month. Similar trends have been observed for remittances sent to Central America and the Caribbean. In surveys, Latinos have consistently expressed greater optimism about the nation's direction or life in general than the U.S. total. The levels of optimism expressed by Latinos had recovered in 2021, in spite of the pandemic, and this reflected resiliency.

Professor Hayes-Bautista then discussed UC's engagement with Latino health. He briefly presented statistics on the shortages of Latino physicians, dentists, and nurses. In 2000, there were 64 Latino medical students at UC, about ten percent of first-year students. In 2020, this number had grown to 162 students, about 20 percent of first-year students. Latino medical students were 40 percent of those in UC's Programs in Medical Education (PRIME). The PRIME programs were one way to address the shortage of Latino physicians. Another way was UCLA's International Medical Graduates Program, in which graduates of Latin American medical schools come to California to complete their residency and then practice in underserved areas. This program now had 160 graduates. UCLA also had the Médicos, Enfermeros y Dentistas para el Pueblo (MEDPEP) Program, a community college to medical school pipeline program for medical professional education, which had been in existence for almost 20 years. There were medical students at the UCLA School of Medicine who were graduates of the MEDPEP Program.

Committee Chair Pérez recalled data on excess mortality during COVID-19 presented at a past meeting by Executive Vice President Byington. Excess mortality had increased for Latinos about one-and-a-half times more than the average increase for the working age population in California, and six times higher than for non-Hispanic Whites. He asked about the impact of this loss on the economy of California. Professor Hayes-Bautista responded that this posed a challenge, in particular because older adult workers, aged 50 to 64, had been especially hard hit by COVID-19. He anticipated that there would be reverberations in the state's Latino Gross Domestic Product, but underscored the resiliency of the Latino population.

Dr. Byington added that Black and Latino patients were dying at younger ages than Whites, and many were parents. At least 140,000 children had lost parents in the U.S., most of them Black or Latino. She asked about the impact on Latino children and what could be done to address the situation of orphans. Professor Hayes-Bautista emphasized that COVID-19 had ripped through Latino households. The very factors that contributed to Latino Gross Domestic Product—high labor force participation and larger families—were weaknesses in the pandemic, as well as the fact that many Latino families lived in apartments where isolation or quarantining was impossible. Post-pandemic recovery was possible, but it required immediate investment.

Committee Chair Pérez observed that some interventions either failed or failed to be optimized. When vaccine became available, there were gaps in reaching certain populations. He asked how one could ensure that this type of underperformance was not replicated in another pandemic. Professor Hayes-Bautista Hayes stated that there was no doubt that another pandemic or epidemic would occur, and one hoped that the lessons

learned in this pandemic would be applied. California decision-makers, based on their experience, had devised measures that were effective in well-to-do communities but did not consider how to offer the same level of protection to people in other living and working situations. Healthcare organizations needed to learn to positively engage the Latino population.

Regent Lansing urged the University to find sources of funding to increase the number of its mobile vans providing medical services in underserved communities. These vans could provide information, testing, and vaccinations. Professor Hayes-Bautista Hayes noted that use of telehealth had increased during the pandemic, but there was an assumption that everyone had access to a desktop computer; telehealth should be available via mobile phone and widely used applications and platforms.

Regent Reilly referred to the need for investment to address health inequities that had been highlighted during the pandemic. She asked what the best investment would be that the University could make. Professor Hayes-Bautista Hayes responded that investment should be made into research, such as research into the reasons for the lower mortality rates from chronic diseases among Latinos, which would benefit everyone.

Professor Hayes-Bautista Hayes observed that, of the top ten world economies, the U.S. was the only one with youth and population growth. The U.S. could advance its economic preeminence in the 21st century by investing in the health of its Latino population, which would benefit all.

In response to another question by Committee Chair Pérez, Professor Hayes-Bautista confirmed that the mortality rates presented earlier were age-adjusted.

Committee Chair Pérez asked about differences in health outcomes between generations, for example, between first-generation immigrants and their children. Professor Hayes-Bautista Hayes responded that, generally, U.S.-born Latinos tended to drink and smoke more and have slightly higher mortality rates. The rates were not statistically significant but trending in that direction. He commented that the situation of Latinos had changed significantly over the past few decades. Educational attainment levels were increasing. Ninety percent of Latinos in the U.S. graduate from high school, and about half of these graduates continue to college.

Committee Chair Pérez concluded the discussion by emphasizing the importance of this research.

8. **DEBT CAPACITY FRAMEWORK AND AFFORDABILITY REVIEW**

[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 and Chief Financial Officer Brostrom recalled that, in 2007, UC developed a revenue bond finance vehicle that combined all five academic medical centers

into one obligated group for financing purposes. By creating this pool, UC was able to capture the size, scope, and geographic diversity of the UC system to create a stronger and higher-rated credit than any single medical center could realize on its own. Prior to the creation of this obligated group, each medical center financed capital needs as a standalone credit entity, which resulted in higher cost of capital, more financial restrictions, and a much more limited debt capacity. The pooled approach has realized many significant benefits. It has led to higher credit ratings, lower borrowing costs, and fewer financial covenants. It has greatly increased the debt capacity and provides greater flexibility. Because it captures medical centers across this large state, the pool spreads the risk that would otherwise be maintained by a single medical center. Even with this pooled approach to financing, however, each medical center still maintained its own financial autonomy and made its own financial utilization decisions.

Director Meghan Gutekunst reported that, in recent years, medical center revenue growth had outpaced the increase in leverage. This dynamic helped give the medical centers capacity for upcoming capital needs in order to meet seismic safety requirements and for future strategic growth. Currently, the medical centers had just under \$5 billion in debt outstanding; this was expected to grow significantly over the next decade. UC began planning for upcoming financing needs in early 2019. The culmination of that planning was the 2020 Series N bond transaction. With that transaction, UC was able to pre-fund a portion of upcoming construction, such as the outpatient pavilion project at the UC San Diego Hillcrest campus. Subsequently, in fall 2020, UC began work on a two-phase process to continue to plan for upcoming capital needs. The first part of that process was the development of a ten-year systemwide capital plan for UC Health and a methodology to inform a systemwide assessment of debt capacity, completed in the past summer. The next step in the process would be to establish a peer-based governance approach for the medical centers for the allocation of debt across the five medical centers; work on this had begun.

The debt capacity analysis in the first phase of the process was completed in summer 2021. The Office of the President (UCOP) worked extensively with the medical center chief financial officers to identify systemwide capital needs over the next decade. These included projects such as the UCSF Parnassus Heights project, the new hospital tower at UC Davis, and the hospital on the Irvine campus. In total, these projects were estimated to cost about \$13.7 billion, and the University expected that debt would finance about \$8.8 billion of this cost.

In developing a framework to evaluate the system's capacity to take on this additional debt, UC wanted to distinguish between external debt capacity and internal debt affordability. Investors, rating agencies, and other external parties measured debt capacity at the systemwide level, while affordability was a concept linked to individual projects and medical centers. UC developed a debt capacity methodology which captures UC Health's commitment to financial equilibrium as well as its size and scope, which are key factors in the credit strength of the medical centers. Ms. Gutekunst believed that this methodology appropriately accounted for both the amount of debt that would be issued and the credit strength. This debt capacity assessment indicated that UC Health would be able to meet

the \$8.8 billion in external financing needs over the next decade. This would depend on careful management of margins and liquidity. Faster revenue growth would expand capacity, while a drop in liquidity or margins would put pressure on the rating. UCOP was working closely with the medical centers to develop a peer-based governance model for debt issuance. This model would operate within UC affordability guidelines as articulated in the UC Debt Policy.

Chancellor Khosla asked where the University was in the process of developing the peer-based governance model. Ms. Gutekunst responded that this process had just begun. Discussions with all the medical center chief financial officers were scheduled in the coming weeks. Chancellor Khosla commented that, because the campuses were responsible for debt, the chancellors should be involved. Ms. Gutekunst responded that UC was now in the design process; a proposal would be presented to Executive Vice President Byington and the chancellors at a future point. Mr. Brostrom explained that this model would be an extra layer of oversight and review, and more robust review. Chancellor Khosla emphasized that the chancellors needed to be included at the table for this discussion. Mr. Brostrom responded that this would be done.

Chancellor Hawgood noted that major UC hospital projects were on the horizon, and that, normally, debt is not issued until full funding for a project has been approved. Given the current state of capital markets and interest rates, he asked how much flexibility was allowed in Regents policy with regard to the timing of debt issuance. Ms. Gutekunst responded that UC was planning a medical center transaction in the coming year. This would be carried out in a way that would allow all medical centers to participate and have a portion of the transaction. Mr. Brostrom added that there were also other tools to lock in current interest rates; one of these was the use of taxable debt. Tax-exempt debt must be spent down in three years, but this was not the case for taxable debt. The spread between taxable and tax-exempt debt was currently low, so UC would try to maximize the use of taxable debt. UC might also use a forward starting swap, with debt it would not issue for two or three years locked in at the current rate. UC would use these tools to lock in the lowest possible rates.

Referring to Chancellor Khosla's concern, Dr. Byington commented that transparency was incorporated in UC Health's Clinical Enterprise Management Recognition Plan (CEMRP) goals. Chancellors have the opportunity to weigh in, and UC Health would look for opportunities for shared governance in this vital area. It was important to develop a working debt capacity framework for the medical centers, including for UC Riverside as community-based health system, and for UC Merced, which might follow this path.

Committee Chair Pérez stated that key members of this governance model must be engaged in the process from its early stages. Financial risk was borne at the campus level. It would be desirable to have an earlier and deeper engagement by the chancellors in the process to ensure appropriate alignment, and to ensure that those who were most responsible for managing campus debt had the greatest level of engagement.

President Drake saw UC Health one enterprise with the State of California as its platform. He expressed agreement with the need to ensure that chancellors were actively involved in the planning and envisioning of changes, which would be massive, with important implications for the future. There was a need for a broad conversation and to think broadly about the future of UC Health, and how obligations in one part of the University affect other parts of the University.

9. **UPDATE FROM THE UNIVERSITY OF CALIFORNIA HEALTH CLINICAL QUALITY COMMITTEE**

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

Chief Clinical Officer Anne Foster recalled that the Health Services Committee, at its December 2020 meeting, had endorsed the recommendations of the UC Health Working Group on Clinical Quality, Population Health, and Risk Management, which included the establishment of the UC Health Clinical Quality Committee. The Clinical Quality Committee would coordinate and oversee the quality performance of UC academic health centers and report to the Health Services Committee. Dr. Foster reported that the Committee had now been formed. It was led by Drs. Robert Cherry of UCLA and Christopher Longhurst of UC San Diego. The Committee would focus on systemwide metrics such as healthcare disparities, patient and family experiences, population health, access, quality and safety, and risk management.

The meeting adjourned at 2:00 p.m.

Attest:

Secretary and Chief of Staff