

The Regents of the University of California

HEALTH SERVICES COMMITTEE

December 15, 2021

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

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

In attendance: Regents Leib, Lott, Reilly, and Torres, Secretary and Chief of Staff Shaw, Deputy General Counsel Nosowsky, Executive Vice President and Chief Financial Officer Brostrom, Vice President 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 October 20, 2021 were approved, Regents Drake, 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. Elizabeth Milos, UCSF medical interpreter and delegate of the San Francisco Labor Council, voiced concern that the mission of the Children’s Hospital Oakland might be jeopardized. The Council demanded that UCSF restore high-quality tertiary care and create a board and an executive leadership group for the hospital that was transparent and accountable, and urged UCSF to create a healthcare system that was committed to rooting out structural racism and correcting the inequities between San Francisco and Oakland. The Council demanded that UCSF commit to retaining the nurses, doctors, and other healthcare workers who had dedicated their careers to the care of the community served by Children’s Hospital Oakland.

B. Tonya Santiago, nurse practitioner at UC Irvine, expressed concern about the practice of diverting patients back to their homes to be remotely monitored. These patients receive only infrequent visits from outsourced non-clinicians. Health

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

systems across the U.S. had been implementing these so-called “hospital at home” programs under temporary Centers for Medicare and Medicaid Services (CMS) waivers that reimburse in-home care at the same rate as inpatient services for the duration of the COVID-19 pandemic. The industry was lobbying to make this practice permanent. Nurses were alarmed to learn that several UC medical centers have filed for waivers and that UC Irvine planned to deploy an in-home care program in which patient care would be outsourced to non-UC staff working for the contractor DispatchHealth. The “hospital at home” experiment would not improve patient care, but was meant to maximize profits by shifting overhead costs to patients and outsourcing care to untrained and unpaid family members. Sending acute care patients home would put their lives at risk. Registered nurses demanded that UC, the wider hospital industry, and payers like CMS abandon plans to send patients home alone.

President Drake drew attention to the challenges and uncertainties of the past and coming year. One did not know now how the latest variants of COVID-19 would affect the course of the pandemic but it was clear that vaccination and booster shots were the best line of defense. This was being demonstrated by the effect of the unvaccinated on the health of the entire U.S. The University had an important role to play in ending this pandemic. President Drake commented that, over the past months, he had had the opportunity to visit people working on the front lines in UC hospitals; most recently, he had visited UC Davis and UC San Diego. Day in and day out, these UC faculty and staff were doing the yeoman’s work of taking care of patients. He expressed the University’s gratitude for this hard work, thanking all UC Health staff for their compassionate and highly skilled care and for helping keep California communities safe. The University must continue to ensure that all those who work in UC Health have the equipment and facilities they need in order to do the best work they can. In cases where UC facilities were behind the times, UC must invest and ensure that it is fully prepared to meet future needs.

President Drake recognized the many years of service by UCSF Health Chief Executive Officer Mark Laret, who would be retiring at the end of the year; the institution was different because of his service and his career at UC had been extraordinary.

3. **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 began her discussion by noting that the world had reached another fork in the road of the COVID-19 pandemic at the start of winter. The U.S. had reached another grim milestone, with 800,000 pandemic-related deaths recorded. This was also the one-year anniversary of vaccine availability in the U.S. Even with the hope provided by vaccination, 40 percent of the U.S. population remained unvaccinated. The nation had just experienced a surge of the Delta variant, with 150,000 to 200,000 deaths that could have been prevented by vaccine. At this moment, more than 1,000 vaccine-preventable deaths were occurring each day in the U.S. Now, in the face of the Omicron

variant, Dr. Byington believed it was possible that there would be one million deaths in the U.S. by the end of the winter.

Scientists in South Africa recognized a new variant of COVID-19, and, soon after, on November 26, 2021, the World Health Organization classified the Omicron variant as a variant of concern. In the U.S., the Omicron variant was classified as a variant of concern on November 30, and the first case was identified on December 1.

Dr. Byington presented a slide with illustrations of the Delta and Omicron spike proteins. The Omicron variant contains many more mutations. The differences that these mutations make raised the concern that this variant would evade the immunity developed by people through previous infections or vaccination.

Dr. Byington presented a chart showing the pandemic trajectory in South Africa. In late November, few infections were reported. Following the recognition of the Omicron variant, there was a sharp increase in the trajectory. The R nought or reproduction number, an indicator of transmission, should be held below one, and South Africa had been maintaining this level in the pandemic. With the Omicron variant, the R nought level in South Africa was now above three and approaching four, indicating widespread community transmission. As in the rest of the world, the Delta variant had been dominant in South Africa for several months. Within two to three weeks, the Omicron variant replaced Delta in South Africa as most prominent variant due to ease of transmission.

A recent study from Africa indicated a 40-fold decrease in the effectiveness of the neutralizing antibody, developed either from infection or vaccination, against the Omicron variant compared to the original variant. Nevertheless, there was some good news. One can overcome some of this resistance and increase neutralizing antibodies with booster shots six months or more following the initial series of vaccines. It was not yet known what level of antibodies one needed to maintain to prevent infection or severe disease from the Omicron variant, or how long the antibodies would last. Even some antibody presence, as well as T cells and B cells, would assist against severe infection.

One was now learning more about the severity of the Omicron variant. Initial data from South Africa indicated that Omicron appeared to be less severe than Delta or earlier variants of COVID-19. Compared to the Delta variant, there were fewer hospitalizations, fewer patients in the intensive care unit, and fewer patients on ventilators due to the Omicron variant. At first sight this seemed like good news, but these data might reflect the fact that at least 90 percent of the South African population had had one or more infections of COVID-19 prior to the appearance of the Omicron variant. The immunity of the South African population might be different from that of the U.S. population. Dr. Byington was monitoring the situation in Europe as it entered the exponential phase of Omicron variant spread. Europe was about three weeks ahead of the U.S. in this spread, and developments in Europe might more closely resemble what would happen in the U.S., although there was a higher level of vaccination in Europe than in the U.S.

The Omicron variant had moved quickly from the first notification from South Africa to the first identification of Omicron in the U.S., which took place at UCSF and was led by Dr. Charles Chiu. UC Health collaborates with the California Department of Public Health on COVID genomic sequencing in the COVIDNet initiative.

At this moment, the Omicron variant had been identified in 77 countries and in 33 states of the U.S. Dr. Byington stated that the Omicron variant was now likely distributed worldwide and in every U.S. state, but not yet identified.

Forty-five percent of the world's population was now fully vaccinated, but the majority was still without vaccine protection. Sixty percent of the U.S. population was fully vaccinated. Although 45 percent of the world was fully vaccinated, vaccines were not distributed equally, and the rates of vaccination correlated with the relative wealth of different nations. Leaving some countries without immunity allowed for the ongoing transmission of the coronavirus and the development of variants of concern. The United States was not free from these concerns. About 132 million people in the U.S. were vaccine-eligible and not fully vaccinated. Children under the age of five were ineligible for vaccination and they represented about six percent of the population. Thirty-four percent had not been fully vaccinated, and almost 46 percent had been vaccinated but not received a booster shot. Only 14 percent had been vaccinated and received a booster shot as the nation entered what would be a difficult winter surge.

The prior month, there had been about 74,000 cases per day in the U.S. This rate had now increased to almost 120,000 cases per day, with Delta as the dominant variant. This rate would increase throughout the winter. Many cases were breakthrough infections and relatively mild, but there were also increases in hospitalizations and deaths. Case rates were also increasing in California, and Dr. Byington anticipated that hospitalization and mortality rates would rise as well. California had a higher proportion of its population vaccinated than was the case in the rest of U.S., about 69 percent, but this level was still not as high as desirable. There were millions of people in California without vaccine protection.

For a period of about eight weeks, UC Health facilities had experienced a plateau in the number of COVID-19 cases, with 130 to 140 cases a day. There were now more than 150 cases daily, and there was an upward trajectory. At the same time, UC Health was experiencing significant patient surges due to unmet medical needs that had built up over the last year. UC was also facing healthcare worker shortages and blood supply shortages. These factors would affect UC's ability to deliver high-quality care during the winter months.

UC had emphasized public health measures. Implementation of the University's COVID-19 vaccine mandate was progressing well, with high rates of compliance—almost 98 percent for employees and above 99.5 percent for students. The UC vaccine mandate included a requirement for booster shots as these became available. That day, President Drake had sent a message to the UC community, encouraging everyone to receive a booster shot as soon as he or she is eligible.

The U.S. Food and Drug Administration (FDA) and the Centers for Disease Control and Prevention (CDC) had recently approved booster immunization for adolescents 16 to 17 years old. The FDA had approved a long-acting antibody preparation from AstraZeneca for immunocompromised people, who are not able to respond to vaccines; it would provide protection for up to six months. FDA advisors have recommended approval for Molnupiravir, an antiviral medication from Merck. The FDA had not yet given final approval for this antiviral. Pfizer had submitted its antiviral Paxlovid for approval to the FDA, and Dr. Byington expected that the FDA would vote on this later in December or in the first part of January 2022. Antivirals would be important tool in the next phase of the pandemic.

Dr. Byington then briefly discussed other ongoing UC Health activities. UC Health was continuing to work systemwide to implement both the Regental and Presidential policy on UC Health affiliations. An implementation working group had been convened at every UC Health campus. The University had been successful in amending contracts with Adventist Health and was working on this with Dignity Health/CommonSpirit. Dr. Byington anticipated that UC would begin negotiations in January with the Department of Veterans Affairs and the Indian Health Service. UC Health had created a template process for formal status reporting to the Regents and was developing education and communication for all providers, students, trainees, and patients.

UC Health Chief Data Scientist Atul Butte addressed the U.S. House Committee on Energy and Commerce on the UC Health data warehouse, how it was now used and how it might be used in the future, especially with regard to health equity.

A number of UC Health capital projects recently broke ground. One was a cancer center in Walnut Creek, a partnership of UCSF and John Muir Health. UC Davis had opened a center in Midtown Sacramento focused on healthy aging for seniors. UC Irvine broke ground on its new health campus, which would include new hospital beds, an ambulatory care center, and a cancer center. UCLA had opened a hematology/oncology clinic in Santa Barbara and an imaging center in Santa Clarita. UCLA had recently acquired the Olympia Medical Center in the Mid-Wilshire neighborhood of Los Angeles and would use this site for mental health services. UC Riverside broke ground for its new School of Medicine Education Building II, and UC San Diego broke ground for its multi-phase, multi-billion-dollar redevelopment of the Hillcrest medical campus.

In 2021, Vizient ranked three UC medical centers in the top ten nationally for quality and safety. Four UC medical centers were ranked in the top ten for lowest mortality, and this during a very difficult year.

Dr. Byington wished everyone a safe and healthy holiday season. She drew attention to significant current challenges to UC Health operations: the COVID-19 virus, the exhaustion of UC's healthcare workers, staffing shortages, and a shortage of blood supply. Under the best case scenario, the Omicron variant would prove to be mild; many people might become infected and thus develop immunity to future variants. There would still be significant losses under this scenario. Dr. Byington hoped that these losses would change

attitudes in the world and increase the will to vaccinate everyone and to ensure equity as one continued to fight this pandemic. The price to be paid in the next few months would be high. The University would do all it could to protect patients, staff, faculty, trainees, and students.

Dr. Byington presented quotations from “The Plague” (1947) by French author Albert Camus (1913-1960): “Looking from his window at the town, outwardly quite unchanged, the doctor felt little more than a faint qualm for the future, a vague unease.” “Only the sea, murmurous behind the dingy checkerboard of houses, told of the unrest, the precariousness, of all things in this world.”

Regent Lansing asked about data on COVID-19 transmission among people who had received booster shots, and the severity of disease in these cases. Dr. Byington responded that so far, infections reported among this population had been mild, without hospitalizations. But it was still early in the Omicron variant, and most data came from South Africa, where people had not had the opportunity to receive booster shots. One would have to continue to monitor developments in Europe closely.

Regent Lansing asked if there were data from Israel on people who had received booster shots. Dr. Byington responded that Israeli data indicated milder infections.

Regent Lansing asked if milder infections were also being observed among older people. Dr. Byington responded that there were fewer data for this population. The Omicron data from South Africa pertained to younger populations. The Omicron outbreak in South Africa began among the college-age population. More time would be needed to see the effects among higher-risk populations.

Regent Lansing asked Dr. Byington to share new, emerging information and updates with the Health Services Committee as these data became available.

Regent Lansing asked about the accuracy of COVID-19 tests now available. Dr. Byington responded that the BinaxNOW test, currently readily available, was sensitive and specific for COVID-19 and appeared to detect the Delta, Omicron, and all variants experienced so far. This test was less accurate than the polymerase chain reaction (PCR) test, but not to such a degree that it would not be considered useful. Testing every two to three days would increase the accuracy of this test. Tests should be made free and widely available in the U.S.

Regent Lansing asked about the accuracy of one test alone. Dr. Byington responded that, if an individual had a high viral load in their nose, enough to be transmitted to others, the accuracy of the test was high, in the range of 80 to 85 percent.

Regent Lansing asked if a person with a low viral load would not be able to infect a person who had received a booster shot. Dr. Byington responded that this was generally correct. Vaccinated people without symptoms who tested negative were at low risk of transmission to others, even if they were infected.

UC San Diego Health Chief Executive Officer Patricia Maysent referred to Regent Lansing's earlier question about booster shots and breakthrough infections. The prior week, UC San Diego identified its first breakthrough infection and the first case of a community-acquired infection received at an outdoor holiday party. By the following Monday, 26 percent of the positive cases UCSD identified were of the Omicron variant. These people would not end up in the hospital, but staff would be removed from the work environment. This was occurring at a time when all the medical centers were experiencing unprecedented patient census levels. Ms. Maysent expressed concern about healthcare workers who had received booster shots but who would become infected and take leaves of absence.

Dr. Byington echoed this concern about healthcare workers and noted that it should be a concern about all essential workers. Even if cases were mild, this would result in significant disruptions. One notable event with spreading of infection occurred in Spain, at a holiday party with 150 healthcare workers who were all from the same critical care unit. They were vaccinated and had received booster shots but were not wearing masks. They had mild disease but could not come to work. Losing 150 individuals in a critical care unit was devastating. Events like this would occur in other countries, and this as the reason for emphasizing the importance of booster shots, wearing masks indoors, and avoiding large events.

Regent Sures asked about staffing shortages at UC Health and if UC had a long-range plan to address this or if this was simply a fact of life now. Dr. Byington responded that, at this time, this was a fact of life across the U.S. Data were published this month indicating that 20 percent of healthcare workers in the U.S. had left their jobs since the COVID-19 pandemic began. The winter surge, which she expected would be very difficult, would not make this situation easier. UC Health leadership was discussing how to improve this situation. Dr. Byington believed that this would require and result in a transformation of how health care is delivered in the U.S. and what kind of healthcare workers are needed. UCLA Health President Johnese Spisso reported that UCLA last year had begun holding additional virtual recruitment forums, in particular for nurses. Over the last six months, UCLA had hired 400 additional nurses and healthcare professionals. The challenge for UCLA Health and the other UC health systems was that patient volumes were now higher than they had been before the pandemic. There were key shortages in certain areas, such as cardiac perfusionists and surgical nursing. The job market was in an unusual state. A week prior, UCLA perfusionists were being offered a \$50,000 sign-on bonus to work with a travel healthcare agency. Two years ago, UCLA Health, in combination with UCLA Extension, developed a curriculum for and funded a medical assistant training program. UCLA needed to train its own medical assistants for the 200 clinics it has in Southern California.

Regent Sures asked how much education and training was required to become a medical assistant. Ms. Spisso responded that UCLA's program for medical assistants was a one-year training program. Trainees receive a certification after one year and can work in UCLA clinics. Medical assistants were the main support for physicians in clinics except in

specialty areas such as oncology. There was philanthropic support to provide scholarships for the program, which had a \$20,000 cost and was functioning effectively as a pipeline.

Regent Sures wished to ensure that UC Health had a plan to keep its facilities well-staffed with appropriate people. Ms. Spisso recalled that UCLA had been through three COVID-19 surges in the last two years. Staff used a great deal of leave time, and it was challenging to cover for this leave time. Numbers of absences were declining. Ms. Spisso hoped that there would now be recovery time for staff. UCLA Health was overwhelmed with non-COVID-19 patients.

Staff Advisor Tseng commented that many staff members who had been working remotely had now transitioned to a hybrid work mode. She asked if this was worth the effort for staff who were still working remotely. Dr. Byington responded that UC Health was continuing to monitor the pandemic very closely and working with Human Resources teams to prepare the return to work. UC had done an extraordinary job so far in protecting its workers, both at the medical centers and on the campuses. UC would proceed with its plans, which included vaccines, booster shots, and testing for its workforce, shifting days when employees come in to work to address density, and continuing to monitor for indications that the plan should be changed. The University had followed science and would continue to follow science in these plans. Ms. Maysent added that, for the work of UCSD Health, over 90 percent of staff must come in for work. For the remaining less than ten percent who do not have to come in for work, there had been careful review of hybrid versus remote work options. UCSD left flexibility for executives in different areas to make modifications if this made sense. UCSD was actively managing this situation.

Staff Advisor Tseng asked if Ms. Maysent was aware of any supervisors encouraging employees to work remotely. Ms. Maysent responded that this depended on the function. Some functions lend themselves to remote work. She believed that a hybrid work arrangement had the benefits of remote work but also improved staff interaction because staff were in to work a few days a week, and UCSD Health would like to be in this mode, but there would be no consequence of moving back to remote work.

Committee Chair Pérez referred to information provided earlier on a slide about compliance with UC's vaccination mandate, indicating 97.96 percent compliance for employees and 99.49 percent for students. He asked about the difference between these rates of compliance and vaccination rates. Dr. Byington responded that the difference was small, about two to three percent. Individuals who received exemptions on medical or religious grounds were compliant with policy. Committee Chair Pérez requested these figures.

4. **UC HEALTH CAPITAL FINANCIAL PLAN**

The President of the University recommended that the Health Services Committee waive its authority to review the UC Health-related projects included in the 2021-27 Capital Financial Plan approved by the Regents in November 2021, subject to the following conditions:

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

Campus	CFP Projects	Amount \$000
Davis	California Tower (Sacramento Campus)	\$3,444,000
	Sacramento Ambulatory Surgery Center	\$563,000
Los Angeles	Mid-Wilshire Inpatient Bed Expansion /Renovations	\$350,000
San Diego	Hillcrest Replacement Hospital	\$1,416,000
	Hillcrest Mixed-Use Residential and Wellbeing Center	\$515,000
San Francisco	New Hospital at Helen Diller Medical Center at Parnassus	\$4,181,600
	Benioff Children's Hospital Oakland Master Facilities Plan Phase 2 including New Hospital Pavilion	\$1,100,000
	Parnassus Research and Academic Building and West Campus Site Improvements	\$711,800
	Clinical Space Renovation and Expansion Program	\$506,740

B. The Health Services Committee's waiver shall apply only to the extent of UC Health-related projects at the medical centers and campuses occurring during fiscal years 2021-22 to 2026-27 (Waived Projects).

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

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

Executive Vice President Byington explained that this item had been brought to the Committee annually for the past three years. The item recommended that the Health Services Committee waive its authority to review the UC Health-related projects included in the 2021-27 Capital Financial Plan, approved by the Regents in November 2021. The waiver would not apply to certain projects because of their size, scope, or strategic significance. Executive Vice President and Chief Financial Officer Brostrom added that the waiver would not apply to the large projects planned at the medical centers: new bed tower at UC Davis, the Hillcrest replacement hospital at UC San Diego, the new hospital on the Parnassus campus at UCSF, and the expansion of the Benioff Children's Hospital Oakland, in addition to some others; together, these projects represented about 60 percent of the UC Health capital financial plan.

Committee Chair Pérez asked what the disadvantage would be in not waiving review of these projects and instead treating these items as consent items. They would be readily approved as a matter of course, but the Committee could raise issues. Mr. Brostrom responded that, even when the Health Services Committee waives review, these items have

to go through detailed analysis by the Finance and Capital Strategies Committee, with review of preliminary funding, budget, design, California Environmental Quality Act compliance, and external financing.

Committee Chair Pérez stated his opposition to continuing to waive Health Services Committee jurisdiction. If jurisdiction by this Committee did not make sense, he was more inclined to have the relevant governance documents changed to eliminate the jurisdiction of the Committee.

Regent Sures expressed agreement with Committee Chair Pérez. He asked why the Committee waives its authority in this item, whether to make things easier for the Office of the President, to have less paperwork, or because it was too confusing to have two committees with authority over these items. Mr. Brostrom responded that it was based on a time consideration. The administration and the Finance and Capital Strategies Committee were considering ways to streamline the approval process. Currently, item approval took place sometimes over the course of three or four meetings, which added delays and cost. The University was considering having the initial agenda item for a project include discussion and action on preliminary funding.

Regent Sures asked for an example of a project that was held up between the two committees. Mr. Brostrom responded that projects were not held up, but that time elapsed between meetings.

Regent Sures stated that he understood this concern, but was not sure that this was a compelling reason for the Health Services Committee to waive its authority.

Committee Chair Pérez asked what the effect would be, and if UC Health would lose anything, if the Committee did not take action on this item today but deferred it until the February 2022 meeting to allow more time to discuss this matter. Mr. Brostrom responded that he did not believe there would be any loss if the item were deferred. Associate Vice President David Phillips explained that the existing waiver from the prior year would still be in effect. There had not been major changes in UC Health projects from year to year. Projects for which authority had been waived in the past year would remain in that status.

Committee Chair Pérez suggested that the Committee defer this item, study the matter, and achieve resolution by the time of the February meeting. If one found that it was still advisable to take this action, the Committee could take action in February.

President Drake observed that, if the normal procedure is to present an item to the Committee and to have the Committee waive the item, then the Regents should consider amending the process to avoid this step entirely.

5. **UC SAN FRANCISCO HEALTH SCIENCES STRATEGY, SAN FRANCISCO 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 noted that this would be the last meeting for UCSF Health Chief Executive Officer Mark Laret, who would be retiring after more than 40 years in the University of California system. UCLA Health Sciences Vice Chancellor John Mazziotta stated that it had been an honor to have Mr. Laret as a colleague, mentor, friend, and role model. He was a statewide and national healthcare expert who had conveyed the principles and mission of UC Health to those wide audiences. His UC career spanned four decades and three campuses, starting as an undergraduate at UCLA and concluding as Chief Executive Officer at UCSF for more than 20 years. His accomplishments at UCSF were impressive and included the acquisition of Children's Hospital Oakland to improve care for children in the East Bay and beyond, the establishment of the Canopy network to extend the reach and quality of health care by UCSF in the region, and the establishment of the Mission Bay campus, which had transformed the City of San Francisco for the better. Mr. Laret had been an outspoken advocate for always putting the needs of the patient first and for fulfilling the public service mission of the University by enhancing care to the underserved. Mr. Laret should be proud of all that he had accomplished. Dr. Mazziotta underscored that, due to choices made by Mr. Laret, many people had better, healthier, and longer lives. These people would never know Mr. Laret's name but were better off because of his work. This was the most important benchmark of all.

Chancellor Hawgood expressed appreciation for Mr. Laret's partnership over the last 21 years and his achievements as enumerated by Dr. Mazziotta. Mr. Laret had contributed not just to UCSF, but to UC Health and to the national community of leaders of academic health systems.

Mr. Laret reflected that UCSF had fared well over the last several years in terms of all industry benchmarks. He credited this success to the Regents, who supported UCSF as it built a network, brought Children's Hospital Oakland into its network, engaged in a partnership with John Muir Health in the East Bay and an affiliation with Washington Hospital in Fremont, and built the Canopy Health network. He hoped that the Regents would continue to support the outstanding ideas and work of all the UC Health campuses.

UCSF Health Senior Vice President and Chief Strategy Officer Shelby Decosta presented UCSF Health's Vision 2025 strategic plan. Over the past decade, UCSF Health had developed and implemented strategic plans that had moved UCSF from being a standalone medical center to an integrated health center now known as UCSF Health. This health system had brought together caregivers, researchers, educators, trainees, and patients and their families with the aim of delivering seamless and coordinated care. This was done in response to demand from healthcare purchasers, such as government, employers, and individuals for more patient-centered and affordable care. UCSF Health has expanded its regional care site and brought together many partners who share UCSF's vision for high-

quality, affordable health care. The current challenge for UCSF was to pursue a similar level of integration across this Bay Area network. One of the main reasons UCSF Health has been able to implement its strategies is its partnership and collaboration with the School of Medicine. The executive leadership, known as the Office of UCSF Health, includes the President and Chief Executive Officer of UCSF Health and the Dean of the School of Medicine and Vice Chancellor for Medical Affairs, who both report to the Chancellor. Health system administrators and clinical leaders serve on a number of committees, including the UCSF Health Leadership Council, and advise the Office of UCSF Health. The health system executives are further supported by external advisors, the UCSF Health Executive Council, which includes current and former chief executive officers, managing directors, and board members of leading national, public, and private equity companies.

This partnership in implementing strategies has driven significant growth across UCSF Health. Over the past seven years, outpatient visits had more than doubled to nearly 2.4 million. Inpatient admissions had grown by 45 percent, and revenue had doubled from \$2.4 billion to \$5 billion. Growth was continuing, and the current strategic plan had three primary priorities: first, to expand access by growing and integrating the UCSF Health network through development of UCSF's own new sites and through partnerships with other health systems and providers; second, to expand capabilities and capacity to provide more complex care for patients with the most challenging diseases; and third, to pursue innovation at scale, including digital health adoption. UCSF developed this strategic plan in 2019, and, at the time, assessed the current healthcare landscape and identified national and local challenges. National issues included rising costs in nearly every category, a desire for more affordable health care from purchasers, and increased competition from both traditional providers and new startup entrants. Local challenges for UCSF included operating in the extremely costly Bay Area region, which makes recruitment and retention of critical employees especially difficult amidst burnout and competition from well-capitalized local competitors. UCSF also struggled with limited capacity on the Parnassus campus, which caused UCSF to turn away hundreds of transfer patients. To address the need for capacity and to meet seismic safety requirements, UCSF had planned major capital investments, including the rebuilding and expansion of the Helen Diller Medical Center at Parnassus Heights as well as the rebuilding of UCSF Benioff Children's Hospital in Oakland. These two hospital projects had a combined cost of over \$5 billion. In addition to these national and local forces, consumers continued to raise the bar as they sought more information about diagnoses, treatments, and costs and more convenient access to high-quality care outside traditional settings. The COVID-19 pandemic had added significant challenges which only intensified the factors that UCSF had identified in 2019.

UCSF Health's strategy includes the achievement of health equity, recognition of the significant need for behavioral health services, and an infusion of UCSF's academic culture into its network for mutual benefit. This aligned with UC Health's mission to improve the health of all people living in California and to promote health equity through the elimination of disparities.

The UCSF Health network included Canopy Health, a partnership with over 20 hospitals and 5,000 providers. It served as a vehicle for 50,000 members, including many UC

employees and their families to access UCSF care. In addition, UCSF had built relationships with some Canopy members. These members were largely independent; in many cases public, government, district health systems. UCSF was working to increase much-needed services across the Bay Area and would return to the Regents in the future for approvals to expand access to care through UCSF and joint investments.

Ms. Decosta outlined four network initiatives. John Muir Health was UCSF's largest affiliate and the initial co-founder of Canopy Health. UCSF and John Muir Health have established a new company which developed a full-service outpatient center in Berkeley with primary care, specialty care, laboratories, and imaging and soon, an expanded cancer center and an ambulatory surgery center. Many local UC employees and their families received care at this location, which had both UCSF and John Muir Health physicians and staff.

UCSF and John Muir Health were also collaborating in Contra Costa County. John Muir Health's family medicine residency program was affiliated with UCSF and had 24 residents in 2019. In 2024, UCSF and John Muir Health would open a new, state-of-the-art cancer center in Walnut Creek. The racial makeup of Contra Costa County had changed dramatically over the last 30 years, with the Asian American and Hispanic populations doubling to 20 and 27 percent of the total, respectively. The White population declined from 70 to 39 percent of the population over the same period. There were higher mortality and disease rates in county communities with the highest percentages of low-income and non-White residents. With the rising cost of rent, homelessness in this county had increased by 43 percent since 2017.

In a second initiative, UCSF and Washington Hospital have collaborated to bring a number of specialty services to the Fremont community: cancer services, cardiac surgery, cardiology, clinical trials, maternal-fetal medicine, and neonatal intensive care. UCSF and Washington Hospital had recently committed to develop an outpatient center to provide comprehensive ambulatory services. The center was planned to open in 2024. The Fremont area was also racially and ethnically diverse, with over half of residents identifying as Asian and nearly 17 percent as Hispanic. Within the Asian population, there was significant shame associated with mental illness and mental health problems. The rate of severe mental health emergency room visits per 100,000 population in Alameda County was more than 50 percent above the state average.

In a third initiative in the North Bay, UCSF Health has developed a strategic alliance with MarinHealth, pursued clinical integration with over 200 primary and specialty care providers, and built a number of programs in vascular surgery, orthopedic services, pediatric services, and women's health. Marin County was one of the fastest-aging regions in California. It was predicted that persons over 60 would account for a third of the county's population by 2030. At the same time, about 24 percent of Marin County children were considered low-income, living at or below the federal poverty level. While noted for its affluence, Marin County was also home to the Canal district of San Rafael, one of the most racially segregated neighborhoods in the Bay Area, with over 90 percent Hispanic and Latino residents. Multigenerational housing and high-risk occupations placed a

disproportionate burden of COVID-19 on Canal district residents, and the Hispanic population accounted for 16 percent of Marin County's overall population but 45 percent of the county's COVID-19 cases, and notably, 80 percent of cases in summer 2020.

A fourth initiative was in San Mateo, where UCSF had established clinics at four sites and was planning a complementary outpatient center to provide additional imaging, laboratory, infusion, and ambulatory services. Compared with many other Bay Area counties, San Mateo County had a less vulnerable population, but faced several critical challenges. San Mateo County had the greatest income inequality of any county in California. The average income of the top one percent of county residents was nearly 50 times greater than the average income of the lower 99 percent. Thirty-nine percent of families with children lived below the self-sufficiency standard, and San Mateo County had experienced a 41 percent increase in food stamp enrollment since January 2020, the highest increase in the state. UCSF's regional expansion was critical to improving access broadly, but, along with its affiliates, UCSF would carry this out with attention to the disparities in each of these communities.

As it established and grew partnerships, UCSF was extending its quality and improvement system, benchmarking itself and its partners against similar organizations and collaborating on best practices. In many cases, UCSF not only contributed best practices but also brought back learning from the network to UCSF sites. The result of this sharing of best practices was the ability to deliver high-quality care in more communities across the Bay Area.

In support of the UC Health strategic plan to extend UC Care to all campuses, UCSF was actively extending care through new primary and specialty care services in Berkeley and collaborating with the UC Berkeley School of Optometry. UCSF had extended Canopy Health to Santa Cruz, where there were approximately 2,500 members, and was in early discussions to supplement primary care and specialty care access in Merced.

UCSF Health was also making investments to foster more synergies with the School of Medicine. Together, UCSF Health and the School of Medicine provide patients and the community with health care often not available anywhere else. UCSF teaches generations of healthcare professionals with a focus on future needs and conducts research and evolves technology that improve lives. One example was the recently opened Weill Neurosciences Building, which would support clinical activities and research. UCSF investments help clinical leaders, like UCSF Neurological Surgery Chair Dr. Edward Chang, continue his breakthrough development that allows paralyzed patients to communicate through their brain even when they are unable to speak. UCSF Health was excellent in large part because of faculty, research, and training provided by the School of Medicine, and the School benefited from the investments in clinical facilities and support from the health system.

UCSF Health was building on this partnership with the School of Medicine to support investments in new behavioral health facilities, ambulatory facilities, and ultimately two replacement hospitals in Oakland and San Francisco. UCSF Health was also supporting the School of Medicine's Differences Matter initiative with the understanding that, in order to make meaningful changes throughout the organization, health equity must be an

operational and strategic priority for all. In pursuit of this aim, UCSF Health established the Health Equity Council to develop and promote strategies that measure and address racial, ethnic, and other demographic and other cultural differences that affect health care. The Council's initial areas of focus included advance care planning and COVID-19 infection in the Latino population, and hypertension control and influenza immunization in the African American population. Discussions were underway on how best to share these interventions, learning practices with network partners for greater impact on health disparities in the Bay Area. UCSF Health was similarly working with its UC Health colleagues to further extend collective learning and affect equity across the state.

Implementation of the Vision 2025 strategic plan would drive the financial performance required to meet objectives, including support of UCSF's clinical, research, education, and community benefit mission. Today, UCSF Health accounted for about 60 percent of UCSF's total revenue, and this was expected to increase to 70 percent by 2030. The close collaboration with the School of Medicine was the foundation for further collaboration with the Schools of Nursing, Pharmacy, and Dentistry.

Ms. Decosta concluded her presentation by remarking that the support of the Regents has been critical to the development of UCSF Health and would continue to be critical as UCSF pursued further transformation of its health system and network to reach more patients with high-quality, equitable, and appropriate care.

Committee Chair Pérez referred to concerns raised by one of the speakers in the public comment period, earlier in the meeting, about UCSF Benioff Children's Hospital Oakland. The comments suggested that UCSF was not meeting its goals or vision at the Oakland hospital. Chancellor Hawgood responded that UCSF was now six years into its affiliation with Children's Hospital Oakland. This was an affiliation between a university and a proud community hospital with a history of independence for over 100 years. The reason UCSF entered into the affiliation was that, at that time, Children's Hospital Oakland was under severe financial duress and had been seeking a partnership with Stanford Health Care that Stanford ultimately elected not to pursue. UCSF stepped in and created the affiliation. There were natural concerns about a large enterprise taking over an independent community hospital. This was largely manifested by unhappiness about what was then a private medical staff in 24 separate corporations, under contract with Children's Hospital Oakland to provide care. UCSF has worked steadily and conscientiously with the medical staff to bring the majority, but not yet all, onto UCSF faculty as full UCSF employees. This process had been fractious at times, but over the last two to three years had moved in a positive direction. The affiliation was structured in such a way that the University and the Regents became the sole member-owner of the 501(c)(3) that was now the hospital, but maintained the hospital as a private hospital licensed separately from other UCSF facilities, in order to continue to receive very significant supplemental funding from the federal government that would be put at risk if UCSF did not maintain a separate license. This meant that the governance structure was complicated. Nurses and most of the represented staff were employed by the private hospital but overseen by UC. There was a separate fiduciary board because of the private hospital status. The comments heard during the public comment period suggested a lack of transparency and the sense that UC was not

appropriately investing in the hospital in Oakland. Chancellor Hawgood noted that there were two unsettled labor issues with unions at the Oakland site. UCSF has invested hundreds of millions of dollars in facilities and programs at Children's Hospital Oakland and was proposing to the Regents to commit another \$1 billion for facilities. UCSF had done a significant amount for the hospital. The early days of the affiliation were not without stress and some conflict. The narrative according to which UCSF was moving private patients from Oakland to San Francisco was false. Patients were only moved when there was a need for equipment, facilities, or expertise present in San Francisco but not in Oakland. There was no financial incentive for UCSF to move patients.

Committee Chair Pérez stated that moving a patient to the facility that best aligned with the patient's needs would seem to be a best practice. Chancellor Hawgood agreed. UCSF was building programs in Oakland with expertise that did not exist in San Francisco, so that patients might be moved to Oakland in some cases. In the new facility being proposed in Oakland, UCSF would build the only inpatient facilities for children with severe psychiatric behavioral issues in the Bay Area. Currently, preadolescent children with that kind of requirement must leave the Bay Area. UCSF was proud of its sickle cell and hemoglobinopathy program in Oakland, which was one of the best in the world. UCSF was investing additional resources there and was just awarded a \$17 million grant by the National Institutes of Health to start a unique CRISPR-based therapy that, it was hoped, would be curative for sickle cell disease. This program would be based solely in Oakland. Chancellor Hawgood stated that he understood the background of the concerns voiced during the public comment period. UCSF hoped to address outstanding labor issues with the unions soon. UCSF would not engage in rhetoric but would let its actions speak for it.

Committee Chair Pérez recalled that the Oakland hospital had a separate fiduciary board. He asked about this Committee's and the Regents' role. Chancellor Hawgood responded that the Regents, through UCSF, were the sole member-owner of the 501(c)(3). Through delegated authority, the UCSF Chancellor appointed the Oakland hospital board. The board carried out California Code Title 22 actions, such as approving medical staff appointments. Deputy General Counsel Rachel Nosowsky explained that the University retained certain key powers in the affiliation, including approval of the management of the strategic plan and budget. The Board of Regents exercised the same powers it would with respect to other UC medical centers because the key powers were retained by the Regents.

Committee Chair Pérez commented that the Regents had a different role with respect to collective bargaining matters than they had at the main UCSF campus. Ms. Nosowsky confirmed that this was the case. For regulatory reasons, nursing and other staff needed to be kept separate in each licensed facility. In order to maintain the separation as a private hospital, the University had a separate legal entity that employed most of the employees at the Oakland hospital.

Regent Reilly asked about the charge and membership of the Health Equity Council. Ms. Decosta responded that the Council had a number of representatives from UCSF faculty and many UCSF Health entities. The group was charged with identifying best practices in order to target disparities and develop interventions. Part of the goal was to

publish findings in order to improve care not just for UCSF patients, but in communities into which UCSF was expanding along with its affiliates. UCSF was sharing this knowledge nationally and learning from other health equity councils.

Regent Reilly asked where the findings were published and if there were goals associated with narrowing gaps in access to health care. Ms. Decosta responded that findings were published on the UCSF website. Each identified disparity had specific goals for specific populations. Chancellor Hawgood added that, in addition to UCSF faculty and staff, the Health Equity Council also included community members as advisors. In monthly governance meetings with the leadership team of UCSF Health, Chancellor Hawgood tracked and reviewed specific outcomes on the quality and safety dashboard. UCSF had specific numeric goals to close these gaps. UCSF School of Medicine Dean Talmadge King stated that the Council was focused on identifying actions that can be taken to close gaps and taking a systems approach. One issue was being able to develop criteria for ascertaining when a problem has been addressed.

Regent Reilly requested an update at a future meeting on the progress of the Health Equity Council. Dr. King responded that UCSF would be happy to present on this topic.

Regent Park referred to the partnership and shared governance model for UCSF Health and the School of Medicine. She asked if other health professional schools had been considered for inclusion in this integration but not included. Chancellor Hawgood responded that the alignment of the School of Medicine and what UCSF used to call the Medical Center was probably the most important thing he achieved as Dean of the School of Medicine in 2013-14. Prior to that, as was common at most academic medical centers, there was a separate faculty practice plan, known as the UCSF Medical Group, an incorporated legal entity with its own governance. The UCSF Medical Group worked cooperatively with Medical Center leadership. In 2014, the board of the Medical Group, which consisted of 20 UCSF clinical chairs, voted themselves out of existence as a separate, freestanding medical group and completely aligned with the Medical Center; this was the birth of the term “UCSF Health.” There was now a single leadership council. This included the executive team of the health system and the leadership of the clinical departments to make all decisions, including financial investment decisions, for UCSF Health. Over time, UCSF has begun to include other three Schools. The Deans of each of these three schools—Nursing, Pharmacy, and Dentistry—had the Vice Chancellor title and had become members of the leadership council of UCSF Health. They did not sit in the office of UCSF Health at this time due to the markedly different scale and scope of these programs. Most recently, UCSF Health has been working closely with the School of Dentistry to bring in the clinical division of the School as a full member of UCSF Health. Chancellor Hawgood believed that this was the first time this type of administrative integration would occur in the U.S. Currently, the dental clinics were managed by the School of Dentistry. They were being moved into the electronic health record system, and UCSF was exploring co-investments in an expanded dental network in the Bay Area. This was a work in progress, and Chancellor Hawgood anticipated further integration as time goes on.

Regent Park thanked Mr. Laret for his public service. He had the ability to get to the heart of a matter, and she expressed appreciation for the perspective he brought to discussions and challenges.

Regent Lansing commented that she had had the privilege of working with Mr. Laret for several decades. His leadership had been inspirational to watch. Mr. Laret always put patients first. She thanked him for answering all her questions with great patience. His resilience in facing great obstacles was remarkable. She thanked Mr. Laret on behalf of all the Regents but especially on her own behalf.

Regent Reilly thanked Mr. Laret for his many years of service to UC.

Mr. Laret stated that it had been a privilege to be associated with the University. Attending UCLA as an undergraduate had changed his life and he had enjoyed his career at UC. He recalled that he first began attending Regents meetings in the late 1980s, when the first Medi-Cal contracts were being negotiated in the state. He expressed gratitude to the Regents for the energy and time they put into learning about UC Health issues. The Regents and the University must find a balance between the political environment and business imperatives, and finding the right position for the University to take in these matters was not easy. As the Regents continued their work with UC Health, Mr. Laret urged them to be mindful of the fact that UC's health systems were large but fragile. A former Regent described the health systems as high-dollar but low-margin businesses. Even a small increase in expenses can cause trouble for a health system. In the last two decades, State support for the University had waned. In the health sciences, this loss of support has been made up by clinical income. Increasingly, the University was dependent on clinical income to support the entirety of its mission. Mr. Laret emphasized the enormity of the chancellors' and UC Health leadership's responsibility. These leaders were relying on the Regents to help maintain UC's ability to recruit and retain talent. Mr. Laret believed that the single most important issue for UC Health in the coming decades would be health inequities. This was a terrible problem, and it was embarrassing that it took so long for this problem to be moved to the top of the agenda. There was no excuse for health inequities in this day and age. Mr. Laret thanked the Regents for their leadership.

6. **THE MEDICAL EDUCATION LANDSCAPE IN CALIFORNIA AND CONTEXT FOR FUTURE GROWTH**

[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 discussion of the medical education landscape in California and commented that the current stature of UC Health was the result of decades of planning. The overall medical education system in California presented opportunities and challenges that must be recognized, funded, and addressed in order to ensure that UC has ongoing resources to meet the needs of the state.

Vice President Nation began her presentation by referencing the national context. California ranked 20th in the nation in its proportion of active physicians, with roughly 243.8 per 100,000 population. Seven million people in California lived in federally designated Health Professional Shortage Areas with insufficient access to care. The physician workforce was aging, with nearly one-third of California doctors now at age 60 or older. A wave of retirements was imminent. California was the most diverse state in the nation by race, ethnicity, and language, yet fewer than ten percent of California's active and licensed physicians identified as Latino or African American. There were approximately 110,000 active physicians in California. Dr. Nation noted that "active" in this case meant holding a valid license to practice; not all these physicians were working full-time. Of these, 76 percent had attended medical school outside the state—48 percent had studied medicine in another state, 28 percent in another country, while only 23 percent had attended a California medical school. The in-migration of physicians from elsewhere had failed to meet the needs of medically underserved areas of the state.

Dr. Nation recalled that the final report of the California Future Health Workforce Commission had been issued in February 2019, and this report was discussed with the Committee. The report projected that, by 2030, California would have a shortage of 4,100 primary care clinicians and only two-thirds of the psychiatrists that would be needed. Based on review of much state and national data, the Commission recommended that, by 2030, UC expand medical student enrollment by about 20 percent. The Commission identified three primary strategies for meeting overall statewide health professions needs. The first was to build and sustain pipeline programs; the second was to align and expand public higher education health professions development programs; and the third was to strengthen the capacity and improving the well-being of providers, who, even prior to the COVID-19 pandemic, were reporting unprecedented levels of stress and burnout.

California had a relatively small medical education system when compared to the size of its population and geography. There were approximately 8,040 students enrolled in California's 15 medical schools. California ranked at the very bottom of the nation for students enrolled in public medical schools per capita (8.8 per 100,000 population compared to the median of 21.3).

In light of the comparatively small medical education system that California had, it was particularly important to note that California led the nation in the retention of medical school graduates. Sixty-nine percent of UC medical school graduates remained in the state to practice, while 31 percent went out of state. This boded well for the physician pipeline. The state retention rate was slightly lower when one counted both UC and private medical school graduates, at 63 percent.

The UC medical schools grant the M.D. degree and are known as allopathic schools of medicine. Among the private M.D.-granting schools, Loma Linda University, the University of Southern California, and Stanford University are longstanding, non-profit schools of medicine. California Northstate University was the state's first for-profit M.D.-granting medical school. The California University of Science and Medicine and the Kaiser Permanente Bernard J. Tyson School of Medicine are non-profit schools that were recently

opened in Southern California. There are also osteopathic medical schools, offering the D.O. degree. These are Touro University, the Western University of Health Sciences, and the newest and first for-profit osteopathic medical school, California Health Sciences University – College of Osteopathic Medicine.

In recent years, six new schools have been proposed for California; four have opened, of which two are for-profit. Dr. Nation noted that this was after a period of about 40 years during which the size of the state’s medical education system did not change. With the exception of the Kaiser Permanente School, the new schools did not own or operate their own teaching facilities and were thus reliant on clinical partners and teaching hospitals in their regions. This has created some pressure with respect to placement of UC medical students.

By all measures, UC plays a vital role in training and retaining doctors in California. UC trains more than 3,200 medical students at its six Schools of Medicine and approximately 5,266 medical residents and fellows, or nearly half of the state’s total. The retention of medical graduates in the state was due to the long practice of prioritizing admission of California students who wish to be California doctors. UC schools of medicine were ranked in the top ten nationally for diversity by *U.S. News and World Report* in 2021. UC Davis was ranked number four, UC Riverside number six, and UCLA and UCSF were tied at ninth place. The UC Programs in Medical Education (PRIME) had contributed substantially to this overall diversity. In 2021, 366 students were enrolled in PRIME programs, with 68 percent from groups underrepresented in medicine.

The graduate medical education profile of California has important predictive value for retention and the workforce. In 2020-21, 11,121 medical residents and fellows were enrolled in California’s residency training programs. Of these, nearly 5,300, 47 percent, or nearly half of the state’s total were enrolled in UC-sponsored residency and affiliated family medicine programs.

There was a significant return on investment in graduate medical education for California. California ranked first in the nation with the highest graduate medical education retention rates. California ranked first in the nation in the percentages of both medical students and residents who remain in the state to practice—63 percent of medical students and 77 percent of residents, compared to 47 percent of residents nationwide.

Recognizing the return on investment in graduate medical education for the state, California voters in 2016 passed Proposition 56, which provides \$40 million annually to expand and sustain graduate medical education programs statewide. To date, Proposition 56 has supported 545 residency positions; this was much-needed support for the uncovered costs of graduate medical education. From 2005 to 2017, California was one of only eight states without an explicit Medicaid graduate medical education funding program. Only since 2017 have designated California public hospitals, including UC medical centers, begun receiving Medi-Cal supplemental payments for graduate medical education.

From 1997 to 2020, the U.S. population grew by 21 percent and the California population grew by 26 percent, but there was no increase in Medicare funding, the single largest source of funding for direct and indirect medical education costs. Of the nearly 5,300 physician residents in training at UC Health, 839 slots received no federal graduate medical education support. According to UC's graduate medical education reimbursement directors, these slots generate approximately \$100 million in unreimbursed expenses. These positions are critically important for the ability to deliver patient care across UC Health and for the maintenance of the medical education program. This was a point for consideration in future advocacy efforts.

The University had been fortunate in recent State investments, after decades of little investment in medical student education programs. The 2020 State Budget Act provided an increase of \$25 million in ongoing funding for the UCR School of Medicine, which would allow the School to grow its class sizes. UC received an increase of \$15 million in ongoing funding for development and expansion of the medical education program in the San Joaquin Valley. This was a unique partnership of UCSF, UCSF-Fresno, and UC Merced. In the 2021 State Budget Act, Governor Newsom had approved \$12.9 million in ongoing funding for UC PRIME programs. This would provide resources for new PRIME programs that would focus on Native American and African American communities and would allow PRIME enrollment to increase. The budget also included one-time funding for the UCR School of Medicine and for the UC San Diego Hillcrest medical campus. Senate Bill 395, the Healthy Outcomes and Prevention Education Act (HOPE Act) imposed a new tax for e-cigarette products. The University would receive seven percent of the money received in the California Electronic Cigarette Excise Tax Fund to help support the San Joaquin Valley medical education program.

Dr. Nation presented a chart with projected enrollment increases at UC medical schools. The total increase by 2030 was estimated to be 520 students or 16 percent, which fell somewhat short of the 20 percent increase recommended by the California Future Health Workforce Commission.

Dr. Nation concluded her presentation by outlining next steps. There would be a need for greater advocacy to help UC produce the health workforce that the state would need. UC Health would launch new PRIME programs and increase enrollment at the UCR School of Medicine, would continue to secure resources for the San Joaquin Valley medical education program, would continue to advocate for increases in State and federal funding, and would seek to improve diversity, equity, and inclusion in its programs and practice.

Committee Chair Pérez recalled that fewer than ten percent of physicians in California identified as Latino or African American. He requested a breakdown of this percentage for the two groups. Dr. Nation responded that she did not have these figures but could provide them.

Committee Chair Pérez asked how long it would take to make progress on these numbers, given the new infusion of State investment in PRIME. Dr. Nation responded that UC medical school programs led the nation in diversity. This boded well for Latino and African

American participation in UC's graduate medical education training programs. The new investments in PRIME would increase the diversity of UC medical students.

Committee Chair Pérez asked about diversity targets. Dr. Nation responded that 68 percent of PRIME participants were from groups underrepresented in medicine. She believed that it was likely that, within four to five years, the percentage of UC medical student enrollment from groups underrepresented in medicine might increase to 50 percent.

Committee Chair Pérez expressed frustration with the fact that only about 4.8 percent of physicians in California were Latino, while Latinos made up more than 30 percent of the state's population.

Regent Park observed that, in order to reach California's goals for expansion, improvement, and diversity of medical care, one could increase the number of slots for medical students and for residents, and import physicians from out of state. Importing physicians from elsewhere was the fastest means, while the education of students and residents took a long time. She asked if UC Health had a strategy for fixing the inadequate distribution of physicians and medical care in the state, such as in the Central Valley. Lack of funding was a barrier to increasing the number of residents. Regent Park asked if there were other barriers, related to infrastructure, which impeded increasing the number of residency slots. She asked about the diversity strategy for residents and about federal lobbying. With regard to inadequate distribution and UC strategy, Dr. Nation responded that a critical element of the PRIME programs was the recruitment of students from the same communities in which they would serve. This was the central mission of the UCR School of Medicine, which prioritized admission of students from the Inland Empire who would return there to practice. The San Joaquin Valley medical education program was pursuing the same goal. This was recognized as a best practice by the California Future Health Workforce Commission. Proposition 56 funding was not sufficient to meet the medical training and residency needs of a state as large as California.

Regent Park reiterated her question as to whether funding was the only barrier to creating more residency positions, or if there were other infrastructure barriers. Dr. Nation responded that there was increasing pressure in the state for access to clinical teaching sites. Faculty must be in place to ensure appropriate training and supervision of residents. Like the medical schools, residency programs must meet national requirements for accreditation, including adequate numbers of faculty and an adequate patient base. UC San Diego Health Chief Executive Officer Patricia Maysent commented that UC had the necessary scale and infrastructure; the most significant barrier to increasing residency positions was funding.

Regent Park repeated her question about federal advocacy efforts for UC Health medical education programs and how one could increase these efforts. She asked if UC was leaving money on the table. Committee Chair Pérez suggested that this topic be discussed in more detail at a future meeting.

Advisory member Ramamoorthy commented that current statistics might not reflect the actual numbers of resignations among healthcare workers, in particular physicians and women physicians. This would affect the number of UC health professionals over the long term. She asked about advanced practice providers and if UC was also encouraging students from groups underrepresented in medicine to train to be advanced practice providers. Dr. Nation responded that one of the priority recommendations of the California Future Health Workforce Commission was that there be changes in the scope of practice of advanced practice providers, which could be a partial solution to bridging the gap in areas of need. This might also have a positive impact on the return of nurse practitioners who have left California. The University was seeking \$9 million in one-time funding to train a cohort of 300 psychiatric/mental health nurse practitioners, with a focus on underserved communities and prioritization of diversity.

Regent Reilly referred to the goal of increasing medical school enrollment by 20 percent by 2030. She asked about the cost of achieving this goal and how realistic it was, given costs for faculty and infrastructure. Dr. Nation responded that, with the new funding for the UCR School of Medicine, there would be an increase in enrollment to a total of 500 across all years. Currently, class sizes were about 80. Enrollment increases at UCR would be a key part of meeting this goal. The new PRIME programs would add 96 medical students. The medical schools at UC Davis and UC Irvine have expressed interest in some additional growth, which would be feasible within existing infrastructure. She recalled that, according to UC Health's own projections, enrollment growth would fall somewhat short of the 20 percent goal. The past year, the State had approved funding for PRIME students of about \$36,000 per student per year. This would serve as a benchmark for developing future budgets. UCLA and UCSF did not have capacity for additional growth in enrollment.

Regent Reilly asked if UC Health would continue to evolve its plan to reach the 20 percent goal. Dr. Nation responded that, in discussions with State officials, she was asked about the implications of the increase in the number of medical schools in California. While the new for-profit medical schools would attract students, she was not confident that they would prioritize the issues discussed in this item. UC Health would monitor this and seek to close the gap.

Dr. Byington responded to Committee Chair Pérez's earlier question about parity and Latino physicians in California. There was a nine fold difference per capita, with non-Hispanic White physicians at 405 per 100,000 population, and Latino physicians at 45 per 100,000. This resulted in a shortage of 54,000 Latino physicians in California. On the current trajectory, the time required to reach parity would be five centuries.

Committee Chair Pérez emphasized the urgency of this problem, given its impact on population health. There were compelling data on health disparities in California. These were not questions about diversity for diversity's sake, but had implications for the management of population health and the economic stability of the state. UC Health must focus on these urgent questions.

UC Davis Human Health Sciences Vice Chancellor David Lubarsky reported that 34 percent of the entering class of the UC Davis School of Medicine was Hispanic. There had been a long discussion with faculty, who were resistant to giving credence to life experiences and different pathways to medical school versus traditional standardized test score entry criteria. Faculty control the admissions committee. The administration cannot simply dictate that the School will accept more students via alternative pathways; this was a long negotiation. There were plans for expansion, but there was no concerted effort to increase the number of full-time equivalent faculty. It would be helpful for UC Health to develop a plan to match needs for additional faculty to additional students. Expansion would require additional funding from the State.

In the interest of full transparency, Committee Chair Pérez read out messages that had been typed into the online video conference chat space during the discussion. UCSF School of Medicine Dean Talmadge King wrote that Latinos make up 4.8 percent of all physicians in California, while making up 30.4 percent of the state's population. The same study projected that the number of Latino physicians in California would decrease by six percent by 2020. Dr. Servis wrote that Latino students made up the plurality of the matriculating class in 2021 at the UC Davis School of Medicine, more than Asian Americans, Whites, African Americans, and others.

7. **SPEAKER SERIES – INNOVATIONS IN MEDICAL EDUCATION**

[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.]

UCSF Professor and Vice Dean for Education Catherine Lucey invited the meeting attendees to imagine a world in which all people and communities in California had access to the types of doctors that the attendees would personally choose for a loved one, and to imagine that physicians working in California communities came from those communities, or had lived experiences that mirrored those of the state's residents. This was not the world one lived in now, but UC medical schools were committed to transforming medical education so that their medical students are prepared to make this vision a reality. UC medical students were overwhelmingly from California and were increasingly diverse.

Accomplishing this transformation would require re-engineering all aspects of medical education, including pipeline programs, admissions, financial aid, curricular design, and career planning. UC medical students would form a workforce of physicians in a diversity of roles, from primary care physicians to neurosurgeons, physician-scientists, and policy advisors. The innovative programs at UC medical schools would prepare them to take on these roles. UC Health was focused on understanding the types of health problems experienced in California communities. UC Health curricula were designed to prepare all graduates to deliver outstanding patient care to all patients, regardless of power and privilege, and to do so in a manner that was aligned with UC's values as a public institution. UC medical schools have developed a series of tracks and programs to prepare students to be leaders in advancing science, optimizing care delivery, influencing public policy, and improving public health infrastructure.

There was a lack of access to high-quality physicians in many communities in the state. UC medical centers have worked together and partnered with other stakeholders to enable aspiring students from these underserved areas to attend medical school. Dr. Lucey described the UCLA-Charles R. Drew University relationship, which was designed to produce a physician workforce for South Los Angeles, as the grandfather of these partnership programs. Newer programs were working to increase the number of medical students from different communities and to build medical school and residency pipelines in underserved areas. UC Davis has partnered with Oregon Health and Science University to address healthcare disparities in Northern California and Southern Oregon. UCSF has partnered with UC Merced and UCSF-Fresno to build a “college to residency” program, including medical school, all in the San Joaquin Valley. The UC Riverside School of Medicine was founded to address the needs of the Inland Empire.

Underserved communities needed doctors who were trained to build trusting and caring relationships with patients. In acquiring these skills and becoming these doctors, students would undergo a major transformation from the time they begin medical school to the time of graduation and preparation for internship and residency. This transformation could be best accomplished through students’ experience with patients and close work with UC faculty master clinicians. It was also clear that building trusting relationships with patients requires physicians who understand the history of structural racism and who are committed to dismantling it. The UC medical schools were all undergoing significant expansion of their work in social justice and were leading the way in the work needed to increase equity, inclusion, and anti-racism in medicine and medical education.

California’s physician workforce must be prepared to eliminate healthcare disparities. This would require physician leaders with strong ties to underserved communities. The UC Programs in Medical Education (PRIME) and related programs were designed to accomplish this. These programs had allowed UC Health to increase the diversity of its medical student population. It was also important to diversify the faculty of medical schools and to build a strong pipeline from the diverse student body to residency programs and to the hiring of faculty. The benefits of a more diverse faculty included changes in basic and clinical science research, and the questions one asked about the nature of illness in all populations. On behalf of UC medical education leaders, Dr. Lucey thanked the Regents and the Office of the President for their support of UC Health medical education.

UC Davis Health Vice Dean for Medical Education Mark Servis discussed the work, across all six UC medical schools and over the last three years, of the UC Opioid Workgroup. This was a collaborative effort to target the opioid crisis. In 2011, the Centers for Disease Control and Prevention (CDC) declared that there was a national opioid epidemic. Opioid overdose became the leading cause of accidental death, greater than motor vehicle accidents, which was an unprecedented statistic. There were many contributors to this situation. One very clear identified factor was the over-prescription of opioids. Prescription sales quadrupled in the period from 1999 to 2014. The opioid crisis has received significant attention in the news media.

There were currently more than 130 deaths a day in the U.S. from opioid overdoses. There were nearly 100,000 opioid-related deaths in 2020, a significant increase from 2019, when there were only 70,000 deaths. The COVID-19 pandemic had only added to this problem, and the U.S. was experiencing record numbers of deaths due to opioid overdose. Given its population and size, California had the highest total number of opioid deaths in the country, although not the highest percentage.

UC medical school deans and vice deans convened the UC Opioid Workgroup in 2018. The vice deans identified experts from all six medical schools in 18 different subspecialties to participate. These were experts in fields including addiction medicine, psychiatry, anesthesiology and pain medicine, pediatrics, general internal medicine, family medicine, psychology, social work, bioethics, and anthropology. This was a unique opportunity for them to work collaboratively across the UC system. The Workgroup had concluded its work in the past September. The Workgroup developed recommendations and a UC opioid competency, 54 learning objectives that every UC medical student should know. There were three primary domains: pain management, substance abuse disorder, and social determinants of public health.

The Workgroup recommendations were unanimously endorsed by UC medical school deans. There were six primary recommendations. One was to adopt the competencies mentioned at each UC medical school. The competencies would serve as a framework or road map for what students would be expected to learn and know, as well as for assessment. Another recommendation was to establish pain management and substance abuse disorder threads throughout the curriculum. The third recommendation was to use public health competencies to teach about social determinants of health and aspects of health disparities, such as the criminalization of substance abuse, poverty, structural racism, and regulatory mismanagement. The fourth recommendation was to require all medical students to complete an eight-hour online course on opioid issues. This course was offered by the Providers Clinical Support System, a coalition of 23 national organizations funded by the Substance Abuse and Mental Health Services Administration, of the U.S. Department of Health and Human Services, to address the opioid crisis. In 2018, the Providers Clinical Support System had developed a module for physicians, and, while the Workgroup was underway and in part due to the Workgroup's encouragement, tailored the course for medical students. One intent of the course was to increase the prescribing of buprenorphine, a medication to treat opioid abuse disorder. The course was an excellent resource and free of charge. The fifth recommendation was that residents should also complete this course. Several UC graduate medical education programs were already teaching about buprenorphine prescribing. The sixth recommendation concerned assessment and the statewide clinical skills examination, the Clinical Performance Examination. The recommendation was to develop a State standard for the clinical skills expected of UC Health graduates. Incorporating these opioid competencies into the examination would motivate students to learn, since they knew they would be tested on the competencies. UC medical schools require students to pass the Clinical Performance Examination in order to graduate.

Dr. Servis shared his own reflections on the Workgroup's three years of activity. The expertise available in the UC system was impressive, and the collective intellect and talent of the UC medical schools was exceptional. It was challenging to develop a common curriculum across the medical schools, but the use of the opioid competencies could effect change in medical education, and one could adopt an iterative process for input and ideas over time. The Workgroup could serve as a template for collective and collaborative work across the UC medical schools in other areas of medical education that would benefit patients in California and in the nation.

Regent Park referred to the ideas discussed about redesigning the medical school curriculum. She asked if there was a tension within the medical schools regarding the path to the future. Dr. Lucey acknowledged that there was sometimes concern on the part of some faculty who were proud of the medical education they had received and who questioned the need for change. Part of the work of the deans of medical education was to create an environment where one can explicate the need for change and explain how the medical education received by faculty in the past might have been ideal for the time when those faculty trained, but that the types of problems UC medical students and graduates would be dealing with for the next 40 years would be very different from problems faced in the past. There was an effort to move the discussion toward points on which everyone could agree, such as patients' rights, meeting patient needs, and the impact of COVID-19, diabetes, hypertension, cancer, substance abuse disorder, and healthcare disparities. There were some physicians and faculty who found it difficult to move away from pure reliance on the Medical College Admission Test (MCAT) in admissions. UC medical schools practiced holistic admissions, considering academic criteria like MCAT scores and grade point averages, but also the life experiences students have had and which bring them to medical education. There was tension, but UC Health was navigating through this tension by focusing on what communities need and how UC can best contribute to the health of the state and the nation.

UC Riverside School of Medicine Dean Deborah Deas commented that the Liaison Committee on Medical Education sets standards for medical school curricula. Curricula change over time in response to changing conditions. In light of recent racial reckoning in the U.S., many medical schools have introduced curricular threads on health equity, social justice, and racism.

Regent Park noted the difference between the response to the COVID-19 pandemic and the response to the opioid crisis. She asked how UC Health could make the response to the opioid crisis more like a pandemic response, with the same sense of urgency. Dr. Servis responded that one was slow to respond to the opioid crisis, although the medical profession had some notion that the over-prescribing of prescription opioids was a problem. One could develop an early alert system for health crises. Working together, UC medical schools were considering and reviewing curricula in terms of patient needs in California. He hoped that this process would lead to faster responses to these problems.

8. **UC HEALTH COLLABORATIVE PROGRAM DEEP DIVE – LEVERAGING SCALE FOR VALUE**

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

This item was deferred.

The meeting adjourned at 2:00 p.m.

Attest:

Secretary and Chief of Staff