

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.”<sup>1</sup>

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

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



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













































