

The Regents of the University of California

**HEALTH SERVICES COMMITTEE**

April 6, 2021

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

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

In attendance: Regents Leib, Muwwakkil, Reilly, and Stegura, Regents-designate Lott and Torres, Faculty Representatives Gauvain and Horwitz, Secretary and Chief of Staff Shaw, Deputy General Counsel Nosowsky, Executive Vice President and Chief Financial Officer Brostrom, Vice President Nation, Chancellor May, and Recording Secretary Johns

The meeting convened at 10:00 a.m. with Committee Chair Lansing presiding.

**1. PUBLIC COMMENT**

Committee Chair Lansing 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. Troy Ruff, student at the UC Riverside School of Medicine, noted that the School was committed to increasing access to medical care for vulnerable communities in the Inland Empire and had successful outreach programs with K–12 schools and community colleges. The School was poised to increase enrollment over the next several years and relied on partnerships with local community hospitals, which provided valuable teaching environments for future physicians. Students who plan to stay in the region often choose to spend their elective year in facilities where they might pursue residency training or seek future employment. Loma Linda University was a major employer of physicians in the region and a popular elective choice for medical students. Mr. Ruff asked for the Regents' support in expanding these partnerships, which enrich students' clinical experience.
- B. Asma Jafri, Chair of the Department of Family Medicine at the UCR School of Medicine, noted that the Inland Empire had often suffered from a shortage of physicians compared to other parts of California. To address this shortage, and rather than owning and operating its own hospital, the School had adopted a community-based model based on partnerships with local hospitals which serve as training sites. The School has developed an array of educational affiliation agreements with County, for-profit, and non-profit hospitals in the area. Most of the School's training programs reside in facilities such as the Dignity–

St. Bernardine Medical Center, UCR's primary affiliate for its family medicine and internal medicine residencies and fellowships. These affiliations would be prohibited if Senate Bill (SB) 379 were to pass. The School currently did not have any options for a replacement hospital partner for these programs, and would not be able to have another partner in place in time, should SB 379 take effect. Potential partners such as Riverside University Health System Medical Center and Riverside Community Hospital operated their own residency programs and were not interested in hosting a UCR-sponsored training program. Without a timely affiliation, the School could lose its Accreditation Council for Graduate Medical Education (ACGME) accreditation for these programs, losing 76 out of the 109 current training positions at the School. The family medicine and internal medicine programs provide primary care physicians to the area, and more than 50 percent of the School's graduates remain to practice in the Inland Empire. SB 379 would have a negative impact on the School. Dr. Jafri asked for the Regents' support to continue these affiliation programs.

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

Upon motion duly made and seconded, the minutes of the meeting of January 19 and February 10, 2021 were approved, Regents Drake, Guber, Lansing, Park, Sherman, and Sures voting "aye."<sup>1</sup>

Committee Chair Lansing welcomed Regent Sures as a member of the Committee.

President Drake noted that the past month had marked a year since the COVID-19 pandemic had led to widespread and disruptive changes to everyone's life. Countless lives had been lost, and many people had suffered financial stress and mental health struggles. UC faculty, staff, and students had to shift quickly to mostly virtual teaching, learning, and campus operations, and they did so with grace and patience. The UC Health enterprise had stepped up to the challenge of caring for growing numbers of COVID-19 patients, conducting urgent research on treatment and prevention methods, and, more recently, undertaking the important work of vaccinating. As of the past month, UC had administered more than 600,000 vaccine doses. UC Health's frontline workers—doctors, nurses, research scientists, food service employees, and custodians—had been an inspiration, doing the difficult work of keeping communities healthy, day after day. The University could take pride in the many ways its campuses had stepped up to help local communities. President Drake expressed confidence that the University would come back from this pandemic stronger and better than ever before. It was encouraging to see that COVID-19 vaccinations were becoming available to more people across the spectrum of age groups. Many counties were relaxing their public health-related restrictions, but as one began to take small steps toward a more normal life, it was critical to keep up one's guard against the pandemic. Some European countries were experiencing a fourth surge; one should work to try to break the cycle of surges and prevent this in the U.S. and keep practicing the safety protocols recommended by health experts.

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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.

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

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

Executive Vice President Byington began the discussion by reflecting on the human toll of the pandemic. In 2020, COVID-19 was the third leading cause of death in the U.S. after heart disease and cancer, and was responsible for about 345,000 deaths. About 40,000 children in the U.S. had lost one or both parents from COVID-19 infection. This legacy of loss would continue for another generation.

Dr. Byington presented maps of COVID-19 hot spots in the United States, comparing March and April. A notable surge was taking place in Michigan, and there were other scattered pockets of increased transmission. This must be contained in order to avoid a fourth surge. California was faring well, better than a month earlier, and currently had the lowest test positivity rate in the country, at just over one percent. At this time, the worst test positivity rate was in Idaho, where it was over 27.8 percent. The numbers of confirmed cases and deaths in California were declining. The risk level assignments for counties in California was improving, with more counties moving into the “Moderate” and “Substantial” tiers; only Merced County was still assigned to the “Widespread” tier.

As of this day, there were 112 COVID-19 inpatients in the UC system, which was similar to the situation in April 2020. UC Health would continue to work to reduce this number in the coming weeks.

Dr. Byington reported on new developments concerning the AstraZeneca vaccine, which was being evaluated for use in the U.S. Seventy-six percent efficacy against symptomatic COVID-19 had been reported for this vaccine, and 100 percent efficacy against severe disease. These numbers came from a Phase Three trial in the U.S., Peru, and Chile. This vaccine is given in two doses, four weeks apart. There had been concerns about the testing of this vaccine: incorrect dosing in the initial United Kingdom trial; efficacy data that were reported, retracted, and then reissued; blood clotting associated with the administration of this vaccine reported in a handful of cases in Europe, 15 to 20 cases, but which warranted further study; and reports that the vaccine was not effective in South Africa. One needed to wait for careful review by the U.S. Food and Drug Administration (FDA) in the next month or so.

In the vaccine candidate process, there were three vaccines under FDA emergency use authorization, the Pfizer, Moderna, and Johnson and Johnson vaccines. Pfizer was likely to submit data for full licensure of its vaccine by the end of April or in early May. Pfizer was likely to be the first of the three mentioned vaccines to receive full licensure, since it had reported six months of safety data, which was required for full licensure by the FDA. Two other vaccine candidates had completed pivotal Phase Three trials and would seek emergency use authorization in the U.S., the AstraZeneca and Novavax vaccines.

Vaccine delivery in the U.S. and in California was accelerating. There were seven-day averages of more than three million doses per day in the U.S., and over the past two to three days, more than four million doses had been administered per day, or about one percent of the U.S. population. This rate of vaccination would allow the U.S. to win the race against the COVID-19 variants and allow for a safer reopening. At least 100 million people in the U.S. had now received at least one dose, and 56 million were fully vaccinated—22 percent of all U.S. adults 18 or older, and 55 percent of all adults 65 or older. Forty-three million people were partially vaccinated and therefore carried some immunity; Dr. Byington emphasized how important it was that they complete their vaccination. To date, California had administered about 20 million vaccine doses, and the UC system had administered nearly 800,000 of these doses. She anticipated that this last number would rise to one million in the coming weeks.

A recent study of immunity and variants indicated that immunity during and after infection, and from the vaccine, appeared to be higher against the original strain first reported in Wuhan, China than against three common variants. Nevertheless, a chart indicated that the titers for vaccine-induced immunity were higher than the titers for naturally occurring immunity from infection. This was a cause for hope that the vaccine-induced immunity, even if less effective for the COVID-19 variants, was still highly effective in eliminating severe disease. A study by the Centers for Disease Control and Prevention (CDC) of mRNA vaccine effectiveness, including the Pfizer and Moderna vaccines, tested nearly 4,000 healthcare personnel, first responders, and essential workers weekly. This test of real world vaccine effectiveness showed that those who were fully vaccinated were 90 percent less likely to be infected. These data were important in showing that vaccination prevented not only severe disease, but infection. As of February 9, 2021, 14,990 healthcare workers at UC San Diego and UCLA had received the second dose of vaccine, and two weeks or more before they were tested. Only seven individuals tested positive for SARS-CoV-2, which corresponded to a positivity rate of 0.05 percent.

There was now a need to ensure that everyone was vaccinated and to reach out to all communities, so that everyone would be motivated and would know where and how to receive the vaccine. UC Health was providing vaccine information in multiple languages and making efforts to provide vaccinations in California communities.

The CDC had issued new guidance on travel, with fewer restrictions, but was discouraging non-essential travel. Any movement of people had a small but real risk of spreading variants. The B.1.1.7 variant, first identified in the U.K., now accounted for a large percentage of positive cases in California. The South African variant was more transmissible than the original strain, but the Pfizer vaccine was effective against it, and Dr. Byington hoped that the Moderna vaccine, which used similar technology, would also be effective against the South African variant. One was still waiting for more information on the Brazilian variant and on two California variants. As a reliable source of information, she drew attention to an online coronavirus variant tracker provided by Axios.

Dr. Byington then discussed the financial impact of COVID-19 on UC Health, which had been significant. All U.S. hospitals had experienced revenue losses from forced shutdowns

and the slow resurgence of non-emergent care. There were increased costs associated with preparing for the pandemic and treating COVID-19 patients. In 2020, U.S. hospitals were projected to lose \$323 billion, and nearly half of U.S. hospitals had negative operating margins at the end of 2020. So far, these losses had been offset by federal relief monies amounting to about \$70 billion.

With regard to increased hospital expenses, Dr. Byington noted that drug expenses increased by 17 percent in 2020. These expenses had been increasing before the pandemic, and this was exacerbated by the pandemic. This circumstance was an important reason for establishing a Pharmacy Benefits Manager for the UC system. The cost of purchased services also increased. Labor expenses were high. California nurses' salaries were the highest in the nation.

Dr. Byington presented a chart which ranked U.S. hospitals by their days' cash on hand. At the beginning of the pandemic, UC hospitals were fortunate in being among the top range of hospitals with 61 to 90 days' cash on hand. UC Health was continuing to experience losses, but the losses had slowed since the first wave of the pandemic.

Dr. Byington drew attention to the UC Medical Centers Report for the Six Months Ended December 31, 2020. It would be appropriate to compare this financial report, for a period when UC Health was dealing with COVID-19 patients, with the same period in the prior year, before the beginning of the pandemic in California.

There had been a year-over-year impact of COVID-19 on the case mix index across UC Health. In all the medical centers, the case mix index increased, which meant that there were more seriously ill patients. The average daily census did not change, but the number of discharges declined by seven percent, or almost 6,000 fewer patients during the pandemic. This was because patients were more ill and stayed more days in the hospital. Emergency room visits had decreased by 26 percent compared to 2019, and this decline had not been reversed. Patients were also coming to hospitals with more severe illness because they had stayed home longer. Ambulatory visits increased by six percent, and much of this was due to virtual care. The number of paid full-time equivalent employees also increased by six percent. UC Health's cost per discharge had increased by 13 percent during the pandemic year.

With regard to payer mix, Dr. Byington noted a one percent increase in UC Health's Medi-Cal patient population; the privately insured population decreased by one percent. She believed that this trend would continue in the next year, until California returned to full employment.

Compared to the prior year, UC Health had experienced an increase in net patient service revenue of about six percent. Dr. Byington attributed this to the increase in the case mix index, the fact that patient volumes were steady, and to the increase in outpatient volume. Total operating revenue increased by about seven percent. UC Health expenses exceeded these increases, however. Total operating expenses increased by nine percent, primarily due to staffing for COVID-19 protocols, COVID-19-related supplies, and other operating

expenses. There was also an increase in the pension and Other Post-Employment Benefits (OPEB) allocation in this fiscal year. In addition to these expenses, UC Health was responsible for transferring support from the Health System to the medical schools and faculty practice groups. These expenses had increased by 26 percent in 2020. UC Health's net position had changed. The operating margin had decreased from -1.8 percent to -4.2 percent, a decline of about 2.4 percent. This decline was real, but also reflected work done across UC Health to control expenses and costs.

Non-cash accruals were continuing to grow. Modified earnings before interest, depreciation and amortization (EBIDA) margins remained strong. Modified EBIDA had decreased by five percent compared to the prior year, but was nevertheless \$840 million in the six months through December 31, 2020. Days' cash on hand appeared to have increased by 30 percent. This was in part due to improvements in revenue cycle and decreasing days in accounts receivable by almost ten percent, but most of this was due to advance payments from Medicare, which would need to be paid back over the next 14 to 15 months.

From March 2020 to February 2021, the combined revenue loss for the schools of medicine and the medical centers was \$1.6 billion. UC Health had received government grants through Coronavirus Aid, Relief, and Economic Security (CARES) Act provider relief funding, Department of Health and Human Services stimulus funding, Hot Spot COVID activity funding, Health Resources and Services Administration funding, and County allocations, and this totaled \$864 million, covering approximately 53 percent of UC Health losses.

Dr. Byington drew attention to a positive statistic from *U.S. News and World Report* recent rankings of best graduate schools, which included diversity in medical school enrollment for the first time. Four of UC's medical schools were ranked in the top ten for diversity. This was an accomplishment on which UC Health would continue to build.

Student observer Medha Vallurupalli recalled that, as of the prior day, about 33 percent of Californians had received at least one dose of COVID-19 vaccine. On January 1, there had been about 38,000 new cases of COVID-19 in California per day; as of April 1, this number fell to about 2,600. These numbers gave one hope for a return to a new normal, yet one should not forget the individual struggles of many members of the UC community during this pandemic. In this context, mental health was very important, and UC should expand the scope and reach of its mental health services. Rates of anxiety and depression had increased dramatically during the pandemic. The University could not effectively look after the health and well-being of its community without further investment in mental health resources, including preventative services and clinical professionals. Even as students looked forward to returning to in-person instruction on campus, one should not forget the difficulties and trauma experienced as a result of the pandemic, and, as Dr. Byington had mentioned earlier, the impact of the pandemic and its legacy of loss would be felt for years to come. In returning to on-campus instruction in the fall, UC should establish protocols and contingencies that took into account the fact that some UC students resided in countries without access to COVID-19 vaccines.

Regent Sures referred to testing statistics mentioned earlier by Dr. Byington regarding almost 15,000 vaccinated healthcare workers at UC San Diego and UCLA, of whom seven tested positive for COVID-19, a positivity rate of 0.05 percent. He asked if any of the seven individuals had significant symptoms or became ill. Dr. Byington responded that these individuals displayed very few symptoms. Regent Sures stated his understanding that the vaccines were very effective, and that people who had been fully vaccinated, even if they did become infected, would not have substantial symptoms. Dr. Byington confirmed that this was the case.

Regent Sherman asked about the difference between emergency use authorization and full licensure of a vaccine. Dr. Byington explained that emergency use authorization was for drugs that were no longer experimental, since they had passed clinical trials, but which were not yet considered part of normal practice. An individual receiving a vaccine under emergency use authorization must do so voluntarily. This was an important difference. Most medications that patients receive are under full FDA licensure.

Regent Sherman asked if full licensure would make a difference for an employer's ability to mandate vaccination for employees, or for UC to require vaccination for the UC population. Deputy General Counsel Rachel Nosowsky responded that this question was currently being litigated. Many people believed that it was permissible to institute a mandate, even under emergency use authorization, in order to protect the workplace, people opposed to vaccination had sued the Los Angeles Unified School District and were suing other entities over this question. This part of the law was unclear. Dr. Byington added that she expected full licensure of the mRNA vaccines to occur in the next few months. Once they were licensed, this question might be easier to answer. There was precedent for employers or universities to require licensed immunizations.

Regent Sherman noted that UC had given about five percent of the total number of vaccinations given in California. This number seemed small, given the scope of the UC Health enterprise. He asked if this was due to federal allocations. Dr. Byington responded that this number would increase as more vaccine supplies came to California. The University's vaccine allocation had increased significantly in the past week, to about four times what it had been two weeks prior. UC Health was accelerating its vaccination efforts.

Regent Sherman referred to UC Health financial figures. There appeared to be a big increase in salary expenses across the board, but UC Irvine and UC Davis were exceptional, with about double the systemwide average, and he asked about the reasons for this. UC Davis Human Health Sciences Vice Chancellor David Lubarsky responded that UC Davis Health had been growing at a rapid pace. There were also significant additional expenses related to COVID-19. UC Irvine Health Chief Executive Officer Chad Lefteris responded that UC Irvine Health had opened new sites and programs. The costs at UC Irvine were due to growth and the experience of COVID-19.

Regent Sherman asked if UC Irvine was hiring significantly more personnel during this period. Mr. Lefteris responded that UCI hired personnel for new programs and to open new sites. Dr. Lubarsky noted that UCD added headcount, opened 23 patient beds, added a new

unit, and expanded into shell space to accommodate overflow intensive care unit patients. UCD also added new ambulatory clinics in the region in the past three months.

Regent Sherman asked about projections for the second half of the current fiscal year. Dr. Byington responded that UC Health was experiencing a steady increase in its ambulatory services, among other things; UC Health would have to pay back the advance payments from Medicare and was planning for this.

Regent Stegura commended the UC medical schools' high rankings for diversity. She asked about the representation of women among medical students. Dr. Byington responded that changes were taking place in the U.S. This year, more than 50 percent of medical students were women. UC Davis School of Medicine Dean Allison Brashear reported that, in recent years, more than 50 percent of the medical school classes at UC Davis were women. UC Irvine School of Medicine Dean Michael Stamos noted that enrollments at his School were about 53 percent women.

Regent Leib asked what the campuses were doing to prepare for reopening in the fall with regard to student mental health. Dr. Byington responded that the following day, at the meeting of the Council of Chancellors, UC Health would present recommendations for reopening. In addition to campus services, UC Health would provide mental health services through the Virtual Care Network. Chancellor Khosla reported that, in preparation for reopening, UC San Diego was taking a fresh look at all classroom spaces to ensure there was proper ventilation and pursuing an aggressive vaccination strategy for all faculty and staff. UC San Diego Health Chief Executive Officer Patricia Maysent related that UCSD was using its recreation center to deliver 5,000 vaccines a day. UCSD was currently vaccinating employees, including student employees; it would begin vaccinating students after April 15.

Committee Chair Lansing drew attention to Governor Newsom's announcement that the state would reopen on June 15, assuming sufficient vaccine supplies.

Regent Park requested that the full Board receive a briefing on preparation plans for the fall return to campuses. She recalled that, at an earlier meeting, she had asked the chancellors for a commitment to meet recommended ratios for counselors and psychiatrists to students. She asked about the status of this request. Chancellor Hawgood reported that UCSF met the recommended ratios for counselors and psychiatrists. Chancellor Khosla stated that his campus was committed to adequate access to mental health services. The student health program at UCSD was operated in coordination with the UCSD Medical Center. Ms. Maysent added that UCSD was developing a mental health strategic plan for students, to be implemented this fall.

Regent Park asked if the ratios in the fall would be different. Ms. Maysent responded that the number of providers was not the only relevant statistic. UCSD had a dashboard with other criteria in addition to ratios of providers to students, such as time to triage, time to first appointment, and time to referral to a subspecialist.



Regent Park reiterated her question about the ratios. Ms. Maysent responded that the challenges in meeting staffing numbers were due to a wage issue and staff turnover, but she anticipated that the campus would meet the recommended ratios by the fall. Chancellor Block believed that the ratios at UCLA were favorable. UCLA had been working on telehealth capacity and was mindful of this challenge.

Regent Park asked about follow-up from campuses not represented at this meeting about their commitment to meeting the ratios. Dr. Byington responded that the campuses would provide a written response by April 19.

Dr. Lubarsky briefly reported on the demonstrated effectiveness of vaccines, based on the experience of UC Davis Health.

Committee Chair Lansing noted that the Pfizer vaccine was stated to be effective for six months. She asked if this was because the data were currently limited to six months. Dr. Byington responded in the affirmative. The effectiveness was expected to last longer. The vaccine manufacturers would monitor trial participants for a period of 24 months, and the results of this monitoring would determine the timing of booster shots.

Regent Guber asked how the University would approach re-vaccination when this became necessary after a year or other period of time. Dr. Byington responded that discussions about this were now ongoing. Many infectious disease physicians believed that this virus might become endemic, recurring every year. It was not yet known how often people might need to be vaccinated.

Regent Guber asked about the percentage of the population that needed to be vaccinated to effectively end the pandemic, and about reasons why some people were not getting vaccinated. Dr. Byington responded that data were regularly published on vaccine hesitancy, and this hesitancy was declining. Confidence in the vaccine was growing as people saw family, friends, and neighbors getting vaccinated and being well. As much as 30 percent of the population might still be hesitant to receive the vaccine. There could be many reasons for vaccine hesitancy, and one should listen to and be able to address concerns.

Committee Chair Lansing asked if the U.S. would achieve herd immunity, even if 30 percent of the population were not vaccinated. Dr. Byington responded that this was possible because there was some immunity from natural infection, but it was important to persuade people to get vaccinated. Children were about 20 percent of the population. Vaccine trials for children were occurring, and 95 to 97 percent of parents wanted their children to be immunized. Immunizing children would also help the U.S. reach herd immunity.

Regent Muwwakkil commented that it was difficult to find vaccination appointments and that it might become more difficult as more people became eligible for vaccination. He wondered if the effects of vaccine hesitancy had in fact been felt yet. Dr. Byington responded that one had been working in a situation of scarcity, with people clamoring for

the small available supply of vaccine. She anticipated that there might be a doubling of the vaccine supply in the U.S. by May 1. At that point, it was important to ensure that people were ready to receive the vaccine. One was moving into a different phase of the vaccination strategy. The next 100 million vaccinations would be more difficult to achieve than the first 100 million.

4. **SPEAKER SERIES – COMMUNITY PARTNERSHIPS: HEALTHY DAVIS TOGETHER, DAVIS CAMPUS AND VACCINATION SUPER STATION AT PETCO PARK, SAN DIEGO 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.]

Chancellor Khosla observed that part of the State of California's success in emerging from the COVID-19 pandemic was due to the UC system. UC San Diego Health played an essential and strategic role in its region; it led the region in setting up testing and was the first hospital in the region to receive COVID-19 patients. Chancellor Khosla briefly mentioned UCSD activities in testing, contact tracing, preparing the campus for a safe return of students, and vaccination.

UC San Diego Health Chief Executive Officer Patricia Maysent reported on the work of the COVID-19 Vaccination Super Station at Petco Park, which was an outstanding regional team effort among UC San Diego Health, the City and County of San Diego, and the San Diego Padres. She first presented a video in which organizers, medical professionals, and volunteers described their experiences in this unique project, including feelings of awe, inspiration, and hope. The Super Station opened on January 11, 2021 and operated seven days a week with approximately 3,500 volunteers. This type of effort has been replicated across the U.S. The virus had demonstrated that collaboration and teamwork were the only way to beat the pandemic.

Ms. Maysent stated that providing vaccines was the most life-affirming work that UCSD Health had done in the past year. In December 2020, UCSD Health developed a plan to vaccinate its healthcare workers. About 75 percent of UCSD healthcare workers were vaccinated, and Ms. Maysent discussed reasons for vaccine hesitancy among these employees, which included pregnancy. In early January 2021, the County of San Diego expressed its concerns to UCSD about the ability to vaccinate the community. Ms. Maysent posed the question to her team of what it would take to vaccinate 5,000 people in five days. In this partnership, the County provided vaccines and funding for vaccination, the San Diego Padres provided space and information technology support, and the City provided traffic and fire safety. The Super Station had the capacity to vaccinate more than 5,000 people a day and provided options for both cars and pedestrians.

UCSD Health Chief Information Officer Christopher Longhurst observed that part of the role of an academic medical center was not only to innovate, but to share knowledge. UCSD Health published the lessons learned in implementing the Super Station in an article in the *Journal of the American Medical Association* in late January. This led to dozens of

calls from the U.S. and other countries requesting information, and similar drive-through vaccination stations were set up in many other cities. He underscored the importance of volunteers in this effort. It took about 300 people to staff the Super Station for 12 hours, with 150 in each overlapping eight-hour shift. Some of the lessons learned concerned information technology. UCSD integrated its electronic health record system with the State's mandated My Turn website in order to make the Super Station and other UCSD vaccination sites accessible to everyone using the My Turn website. One had learned that electronic health records could sometimes delay the process of vaccination. Within the first week, the site shifted to a scribe-based workflow with tasks divided between vaccinators who were just vaccinating and employees transcribing. The work of transcribing was moved to the registration site, and this increased efficiency and allowed the project to reduce its overall staffing needs. UCSD had a patient safety team on site and worked to ensure that all records created were accurate. Inclement weather and vaccine supply chain issues caused unplanned, temporary delays and closures. Dr. Longhurst underscored the positive impact that the work of the Super Station had on morale for UCSD Health faculty and staff, the large number of vaccinations accomplished, almost a quarter of a million, and the national and international impact of this example of an effective approach to mass vaccination.

Ms. Maysent noted that, after the Super Station closed down in mid-March, UCSD Health continued its vaccinations on campus for patients, students, campus employees, and the community at large. UCSD Health began to see that it was still not reaching areas with significant need for vaccinations. In order to reach these populations, UCSD Health set up a mobile vaccine clinic and had delivered 8,000 vaccinations to date in this manner, and this effort was increasing in scale.

Dr. Longhurst noted that UCSD Health had mapped all its patient addresses in its electronic health records to the California Healthy Places Index. Through a purposeful outreach to its patient population, UCSD had vaccinated both affluent and less affluent people at the Super Station. More than 50 percent of the patients vaccinated by the mobile vaccine clinic were in the two lowest quartiles of the Healthy Places Index quartiles. The mobile clinic was reaching the hardest-hit areas in San Diego County. UCSD Health was evolving its vaccine efforts. Providing vaccines in the community and making access as easy as possible would be essential for success.

Chancellor May reflected that a silver lining of the pandemic for UC Davis had been learning how to partner even more strategically with the local community. He introduced Professor of Epidemiology and Associate Dean for Public Health Sciences at the UC Davis School of Medicine Brad Pollock. Dr. Pollock directed the Healthy Davis Together initiative, in which UC Davis worked with City of Davis partners to prevent the spread of COVID-19 on campus and in the surrounding community. Healthy Davis Together was a model for other university communities and was featured in the *New York Times*, NBC News, and local news media. This initiative was a demonstration of the fact that public service is a paramount value for UC Davis.

Dr. Pollock recalled that, in June 2020, actions were already under way to prepare for the return of students in the fall. The campus then began the Healthy Davis Together initiative, with the goal of stopping the spread of the virus in the community in a comprehensive way. The virus would not stop at the campus boundaries. In August and September 2020, there were many reports in the news media about COVID-19 outbreaks on college campuses. People living in communities near college campuses were worried about students arriving from other parts of the country and bringing contagion with them.

Healthy Davis Together aimed to take the best available COVID-19 interventions and apply them all at once to an entire community. The project was launched in September. It had two major components, one of which was epidemiology: testing, contact tracing, isolation and quarantine, wastewater epidemiology, and vaccination. The other component was health behavior. Testing is an important tool in a pandemic, but must be combined with changes in behavior and isolation of people who might spread the virus. Dr. Pollock also identified five “cores” which supported the project: informatics, innovation and technology, which examined new testing modalities, special populations, enabling environment, and knowledge sharing.

The project used a polymerase chain reaction (PCR) testing platform which is used for genomic analysis of plant pathogens and has a high throughput. This was a saliva test at a cost of less than \$10 per test. This test was also able to identify virus variants as they emerged, such as the B.1.1.7 variant. Genomic testing was being carried out for everyone tested. Dr. Pollock presented charts showing the test positivity rates for Davis and Yolo County, and for California overall. The positive rate in Davis was currently 99 percent lower compared to the beginning of the year. The campus and the City of Davis had low rates compared to the rest of Yolo County and the rest of the state.

Wastewater monitoring was another key strategy. In Davis, there was one treatment plant for the entire city, so if the virus was detected at the treatment plant, this indicated that someone somewhere in the city was shedding the virus into the sewer system. Healthy Davis Together had placed hundreds of sampling stations throughout the city. This allowed the project to discriminate signals by neighborhood and allowed for more precision in developing actionable information for increased testing by neighborhood. Wastewater testing could give one an early warning, two or three days, of potential outbreaks. Dr. Pollock noted that, in order for wastewater testing to be effective, one had to have a statistically reliable means of distinguishing “noise” from a real signal of the virus, and this was not easy to do. UC Davis was developing temporal modeling for this, similar to that used for tracking influenza seasons.

Health behavior change was an equally important dimension of this project. Healthy Davis Together ran communication campaigns to increase testing. At least 60 percent of the Davis population had been tested at least once. UC Davis had established an Aggie Public Health Ambassadors program, which involved 275 undergraduates, who were paid and received course credit for their work. They were deployed on the campus and into the city to provide information and distribute personal protective equipment. The program was preparing to deploy these Ambassadors to K-12 schools. Healthy Davis Together encouraged students

to develop incentives to stay in place rather than travel during the spring break, and was working with local businesses to make their environments safer with information on how to use plexiglass barriers and channel customers in stores.

Healthy Davis Together had been actively engaged with the Davis Joint Unified School District for several months to help plan a safe return of students to in-person instruction and would be offering PCR testing at schools. The Davis School District had over 1,500 educators and staff and 8,200 students across 19 sites. It was a diverse district where one out of five students was receiving a free or reduced price meal program. Dr. Pollock hoped that the Aggie Public Health Ambassadors, when they were deployed in the school system, would serve as role models for high school students.

Vaccination in California had been a complicated process. After a slow start, this process now appeared to be moving in the right direction, and vaccination rates were increasing. Healthy Davis Together, working with the Federally Qualified Health Center of Yolo County, had set up two vaccine clinics: one in West Sacramento and one in Woodland. The project had also launched a mobile van service to reach migrant farm workers with testing and vaccinations. Healthy Davis Together coordinated its outreach efforts with Yolo County Public Health, major health provider organizations, and retail pharmacy chain stores in the county.

Dr. Pollock shared some of the preliminary impacts of the project. UC Davis had been carrying out surveys and tracking awareness of the pandemic and health-related behaviors; positive changes had been observed over time in mask wearing, physical distancing, use of outdoor spaces, and limiting travel. The rate of testing had more than doubled from September 2020 to January 2021. Individuals had elected to be tested more frequently and regularly. Healthy Davis Together was innovative in combining epidemiologic infectious disease control with health behavior change; in recognizing that viruses do not stop at campus borders and working in partnership with the City, Yolo County, and private industry; and in using and analyzing its own data to refine its approach in order to target affected populations and to determine next steps. This project was still a work in progress. Healthy Davis Together was also developing technical reports and scholarly publications to disseminate the knowledge it had gained. The project had been developed to address the COVID-19 pandemic, but it would leave behind an infrastructure to sustain community health beyond the end of the pandemic. Dr. Pollock stressed that this project was a team effort with many partners.

Committee Chair Lansing remarked on the difficulties experienced by underserved communities in accessing vaccinations. She asked if mobile clinics were being used in Los Angeles. UCLA Health President Johnese Spisso responded in the affirmative; this work was being done by the Venice Family Clinic, which was staffed by UCLA employees. Committee Chair Lansing asked if there was enough coverage for underserved communities in Los Angeles. Ms. Spisso responded that there was a need for more vaccine supply. She believed that this program was able to reach the underserved, but it needed more vaccines. UCLA Health had performed 150,000 vaccinations so far. These were distributed based on the Social Vulnerability Index, but Ms. Spisso noted that there were

more vulnerable patients in Los Angeles than in other cities. She looked forward to an increased supply of vaccine.

Regent Park asked if the logistics expertise for these UCSD and UCD projects came from within UC or from external partners. Ms. Maysent responded that logistical and process improvement expertise was provided by both UC and external partners.

Regent Park asked if the mobile clinics provided an opportunity for offering other health care, in addition to vaccines, and if these programs might be expanded. Dr. Pollock responded that UC Davis Health began its mobile clinic for testing, in particular for congregate living facilities in Yolo County and migrant farm worker camps. Vaccination was then added as a component to this program. UC Davis also had a medical surveillance program with contracts for occupational testing in the field for the California Department of Forestry and Fire Protection (Cal Fire) and the California Highway Patrol. Mobile health services could be expanded. UCSF Health Chief Executive Officer Mark Laret recalled that UCSF offered free testing for public health departments in California. This was welcomed by many departments, which were not well equipped to handle an issue of the magnitude of this pandemic. As UC Health considered how it would expand its footprint, serving areas such as the Central Valley, he hoped that UC Health would further strengthen its relationships with public health departments in all counties and examine how it might provide more meaningful services and help prepare for the next pandemic, should one occur.

President Drake stated that he was impressed by how quickly UC Health made use of an equity lens in considering the distribution of the vaccine. Mobile clinics had been used for years to reach isolated patient populations. The use of telemedicine had increased since the last year, and this might be particularly important for mental health and for reaching broad numbers of people quickly and effectively.

Regent Reilly congratulated UC San Diego and UC Davis on these projects, which demonstrated that UC was not a university on the hill, separate from the community. She asked where mobile clinics were being dispatched, and if UC was working with local nonprofit organizations. Dr. Pollock responded that UC Davis relied heavily on its partnerships with community organizations and with county health departments. This allowed UC Davis to target mobile clinic interventions. Scheduling might depend on the types of tests and vaccines being used. Ms. Spisso added that UCLA had been providing specialty care with mobile clinics for some time, such as eye care. The Johnson and Johnson vaccine had the advantage of requiring only one dose, and this was especially helpful for vaccinating the homeless population.

Committee Chair Lansing expressed pride in what UC Health had been able to achieve to ensure the health and safety of the population of California and thanked the presenters and their colleagues for their work.

## 5. **EXISTING STATE OF HEALTH BENEFIT PLANS**

[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 recalled that UC Health had been engaged in a joint effort with systemwide Human Resources for several years to improve and refine health benefit plan offerings for UC employees, retirees, and their families. There was a significant opportunity yet to be realized as an employer/provider/payer partnership for the mutual benefit of the University and its employees.

Executive Director of UC Self-Funded Health Plans Laura Tauber provided an overview of the health plans that are offered to UC employees and their families, discussed why it makes sense for UC to self-fund its health plans, how to leverage the unique situation of being an employer, provider of healthcare services, and payer in a way that benefits UC and its employees, and a five-year roadmap.

The University has three self-funded Preferred Provider Organization (PPO) plans. The largest was UC Care, with a tiered design that encouraged members to go to UC providers on the campuses that have them. All campuses had Tier One providers in the network for reasons of equity. The UC Health Savings Plan (HSP) and CORE were high-deductible plans. HSP had a UC-funded Health Savings Account in the amount of \$500 for the employee and \$1,000 for a family. CORE was free to employees. UC Blue and Gold was a Health Maintenance Organization (HMO) that the University flex-funded with its UC providers, taking risk on their assigned membership through an Accountable Care Organization (ACO) arrangement. Kaiser Permanente (Kaiser) coverage was also offered to employees under a fully insured contract with the University.

The Kaiser plan was a medium-cost plan for the University, but one of the lowest-cost plans for employees. UC Care was a very expensive plan for the University because of plan design and because it attracts older and higher-utilizing members. It was also the most expensive plan for an employee. While some of the plans are PPOs and some are HMOs, and the deductibles and out-of-pocket maximums vary, they look very much alike in the member copays and out-of-pocket expenses. This can make choosing a plan harder to understand for employees because they see less differentiation among the plans.

UC Care's design and the fact that it had by far the highest risk score, with older, sicker members made it the most expensive plan for the University and members. Relative risk scores measure the differences among the plans. UC Blue and Gold, with about 120,000 members in 2021, was the plan in the middle and was the most representative of the University's average membership in its health plans. Kaiser's enrollment was significantly younger than that of UC Care and was comparable in risk profile to the high-deductible HSP. CORE was not included in the University's risk adjustment process and did not have its own risk score.

Employee contributions were determined by base salary, not including overtime or bonuses. There were four pay bands. The lowest pay band was for employees earning less than \$58,000 per year and the highest was for those earning more than \$171,000 per year. Proportionately, UC Care had the highest-paid employees, with 52 percent of those enrolled earning over \$114,000, but almost half were still in the two lowest-paid pay bands. The situation of Kaiser was the opposite, with 83 percent of enrollees from the lowest two pay bands, in part because their contribution to the premiums were among the lowest.

Ms. Tauber presented a chart showing enrollment in the various plans by campus. Each campus told its own story in enrollment. UC Santa Barbara and UC Merced did not have Kaiser facilities in their areas, so enrollment in Kaiser was low; employees enrolled in Kaiser likely lived in an area where Kaiser was present or might have been long-term Kaiser members, liked the experience, and chose to travel to a Kaiser facility. Kaiser had entered Santa Cruz only a few years prior, so enrollment was still relatively low but growing. A majority of UC Berkeley employees chose Kaiser for a variety of reasons, including cost, proximity of many Kaiser services, and because they liked what Kaiser offers. In Santa Cruz, the Palo Alto Medical Foundation (PAMF), a Sutter Health affiliate, was preferred by some faculty. PAMF was only available in the PPO plans and this accounted, in part, for the large enrollment in UC Care at UC Santa Cruz. Among campuses with a UC Health presence, enrollment in Kaiser was highest in Irvine at 50 percent and Riverside at 63 percent. UC San Diego had the lowest Kaiser penetration of the UC Health campuses at 30 percent. UC Davis had a large enrollment in the UC Blue and Gold plan. This resulted mostly from the discontinuation of the Western Health Advantage plan in 2020. Western Health Advantage allowed UC Davis employees to see UC providers at an employee contribution cost equal to the cost of Kaiser. UC Davis was subsidizing employee costs for all its Blue and Gold enrollees to make this cost equal to Kaiser and had succeeded in moving almost all employees who had been enrolled in Western Health Advantage into the Blue and Gold plan, and in attracting some employees from Kaiser to the Blue and Gold plan, presumably because of increased provider choice and access to UC providers.

UC Care had been self-funded since 2014. HSP and CORE became part of the self-funded portfolio in 2017. UC Blue and Gold was flex-funded beginning in 2019; this was the closest UC could come to self-funding for this plan, because the State of California did not allow absolute self-funding for an HMO. Health Net was required to retain a small amount of risk. The self-funded plans were intended only to break even, and UC had largely been achieving this.

One of the original goals when UC Care was created in 2014 was to encourage use of UC providers. In 2010, as a fully insured PPO plan, 28 percent of spending on medical services in UC Care went to UC providers. By 2020, with a tier structure and other member incentives, this had increased to 53 percent of the spending. In a similar manner, 27 percent of the medical spending in the Blue and Gold plan in 2010 went to UC providers. By 2020, with changes in the plan design and narrowing of the network, this had increased to 51 percent.



Ms. Tauber then discussed the rationale for moving to self-funded plans. There were five key reasons. Self-funding reduces the amount spent on health plan administration and allows for more to be spent on healthcare services. UC can customize its offerings to best meet the needs of its community. Since the University determines the plan design, coverage, and cost, it is easier to keep these costs within budget for UC and affordable for employees. UC can encourage its employees to see UC providers, keeping the dollars paid for services within the University, and can draw on UC Health programs of excellence, including data-driven care management. UC's large employee base allows it to test models of care that can be applied to all UC patients and potentially offered to other employers.

Self-funding has saved UC money, realizing the goal of having the ability to predict costs for UC budgeting purposes and providing more affordable health plan offerings. After factoring out the differences in the risk profile of the people enrolling in the plans each year, self-funding cut the average increase in premiums in half. A governance structure was put in place in 2017 with the establishment of the Executive Steering Committee on Health Benefits, currently chaired by Dr. Byington. Other voting members of the Executive Steering Committee were the Executive Vice President and Chief Operating Officer, the Executive Vice President and Chief Financial Officer, the Chief of Staff to the President, and a representative of the Academic Senate. The Executive Steering Committee was the fiduciary and plan administrator for systemwide health benefits and met monthly.

The total health benefits portfolio currently consisted of self-funded and insured plans. UC Health provided administrative functions for the self-funded portfolio. Systemwide Human Resources oversaw group insurance regulations and other human resources components for the self-funded plans and administered the fully insured portion of the portfolio. Financial accounting was managed by the Systemwide Controller.

UC Health was working on a five-year plan to realize the true power of the University as an employer, a provider, and a payer for healthcare services for its employees. UC Health wishes to offer the best experience for its members through innovative health benefit offerings. After learning how to offer the best health care in the most cost-effective way, UC Health would like to share this with other employers.

Ms. Tauber outlined some key UC Health goals. UC Health supports the clinical, teaching, and research mission of the University by training the next generation of healthcare professionals while supporting innovative basic science and clinical research. UC Health is motivated to do the right thing for the University system as a whole and for UC employees; it understands the importance of living within budgets and providing high-value care. UC Health is focused on improving access to UC providers at all the campuses, using all modalities available, including virtual care. UC Health recognizes the importance of health benefits in recruiting top talent and wants to support this through creating an outstanding patient experience.

UC Health principles included improving the overall health and well-being of UC employees; measuring and demonstrating the value of seeking care from UC providers; making UC primary care more accessible to all employees; recognizing that it would take

time to reach a desired end point; commitment to the UC mission of teaching, research, and public service, while remaining competitive on cost; and conducting pilot projects to find innovative ways to enhance patient care.

A real benefit of the employer/provider/payer partnership is the opportunity to innovate for better patient outcomes, provide improved access to care, and enhance the member experience. UC Health has established a population health function with representatives across the health enterprise to better manage the care of employee members, improve outcomes, and reduce cost, with efforts focused particularly on the UC Care and Blue and Gold plans, guided by data from the UC Health data warehouse. UC entered into an ACO risk-sharing relationship with Health Net in 2016 that has helped control the cost of the Blue and Gold plan. Now that this plan was flex-funded, UC had the opportunity to pursue even more innovative and strategic initiatives to manage care and provide better value. The UC Care plan was tiered to encourage selection of UC providers. A number of initiatives have taken place across all the campuses to improve access. Examples included expanding the Canopy health network into Santa Cruz, locating two UCLA sites in Santa Barbara, the development of a clinically integrated network in San Diego, and the UC Davis program for oncology located in Merced.

UC Health provides a high quality of care. Cancer was one of the most costly conditions to treat. According to a 2015 study published in the journal *Cancer*, National Cancer Institute–designated Comprehensive Cancer Centers provided better outcomes for newly diagnosed cancer patients. There were only eight such Centers in California, and five were at UC. UC was leading the fight against cancer by sponsoring more than 1,000 clinical trials.

According to a report by Beacon Economics commissioned by University and released in January UC Health’s total economic impact on labor income in the state is over \$37 billion annually. Supporting the University’s health enterprise is good for California. Like the state, the University benefits from all the activities of the health enterprises, accounting for 62 percent of revenues this year overall, including services provided at the health centers and clinics, government grants and programs, and other sources. The health centers and clinics alone provide over half the revenues at UC. Ms. Tauber presented a graph showing the growth in importance of the health centers to the overall UC budget over the last 40 years. In 1980–81, UC Health accounted for \$465 million in UC revenue; today, this amount had grown to \$16 billion.

Dr. Byington commented that health benefits were among the most important benefits offered by the University, and among the most costly. There was therefore concern about the ability to maintain these benefits in the future. UC had the advantage of having academic medical centers. Although its self-funded medical plans were fairly young, they had experienced remarkable growth over the past decade. She believed that there were still opportunities for innovation that would make these UC health plans the plans of choice for UC employees. UC Health had defined six key priorities on which it would concentrate in the coming five years: improve access to UC Health care for UC employees and their dependents at all campuses; manage employee contributions and risk in an optimal way;

efficiently deliver quality; promote UC Health plan value to members and encourage members to choose UC providers; promote accountability through benchmarked criteria, data demonstrating the quality and value of UC Health; and actively manage and optimize the relationship with Kaiser, since Kaiser is an important provider in California and for UC employees. With regard to the last point, Dr. Byington hoped that Kaiser would refer UC employees who need tertiary or quaternary care to UC providers. Managing UC's health benefit plans would be an important part of the UC system's recovery from and rebuilding after the COVID-19 pandemic.

Regent Park referred to information provided on a slide showing that 50 percent of spending in the Blue and Gold HMO plan was on non-UC providers and requested clarification. Ms. Tauber responded that five locations did not have medical centers, so that many plan members there had no easy access to UC providers. Some Blue and Gold members chose other providers. UC San Diego Health Chief Executive Officer Patricia Maysent reported that, at UCSD, half of Blue and Gold members received care from UC providers, while half received care in the Sharp HealthCare system. When the Blue and Gold plan was initiated, UCSD did not have the same primary care access and had since built up that access. She described this as legacy involvement in the Sharp system by UCSD employees.

Regent Park observed that, not counting the UC Health Savings Plan and CORE, about 40 percent of UC members were enrolled in Kaiser. Kaiser had a lower cost and a slightly younger population than the Blue and Gold plan. She asked about the University's ability to offer a lower-priced product that would be popular with a younger age group. Ms. Tauber responded in the affirmative. UC Health was involved in a request for information/request for proposal for a PPO plan. She believed that this was possible through an effective combination of plan design, network, and managing contributions.

Regent Park remarked that the University would not subcontract out education to other entities; the University was also a healthcare provider, and was nevertheless subcontracting out a very large portion of these healthcare services to another entity, and this was somewhat surprising. She assumed that UC Health was actively examining this area, especially since UC's goal was to deliver the highest quality of health care to all the populations of the state. Dr. Byington responded that UC Health's future would be to serve as the healthcare provider for UC employees.

UCSF Health Chief Executive Officer Mark Laret stated that UC Health should be the first option provider for UC employees, although this was not possible in every circumstance. There were many cross-subsidies in the U.S. healthcare system. Medi-Cal, the Medicaid program in California, did not pay the full cost of care. Medicare fee-for-service, about 35 percent of UCSF business, did not cover the cost of care. Medicare paid about 75 cents per dollar of care, and UCSF made up the difference with commercial insurance. This was an essential feature of the economics of UC Health and the entire U.S. healthcare system: cross-subsidizing from commercial payers to support government payers. One reason why Kaiser was less expensive was that Kaiser performed a relatively very small amount of Medi-Cal service in the state. UC had and would likely always have a large number of

commercially insured patients. UC should provide an incentive for UC employees to enroll in plans with UC Health providers. This was a small topic with enormous ramifications.

Faculty Representative Gauvain reported that, based on discussions of the Academic Senate's Health Care Task Force, many employees have an interest in having a benefit option outside the employer's resources. One reason for this was privacy. Many employees would like to have their health concerns managed by someone other than an entity connected to their employer. It was in fact irrelevant whether this concern was real or perceived. Ms. Gauvain cautioned against having a "company town" mentality. UC Health should be mindful of these concerns. She expressed concern that the price of the PPO plan UC Health was considering, mentioned earlier by Ms. Tauber, might fall outside the reach of UC employees with lower salaries. Dr. Byington responded that UC Health was working to make health plan options affordable for all UC pay bands.

UC Davis Human Health Sciences Vice Chancellor David Lubarsky recalled that, when he began working at UC, he realized that the custodians working in doctors' offices could not see UC doctors; the economic model was prohibitive, and this had motivated him to work on evening out these costs for employees. Forty-one percent of UC Davis patients were Medicaid patients, and UC Davis needed some commercial patients to support this cost. The easiest and simplest way to do this was for UC Health to take care of its own employees. Dr. Lubarsky noted that the Kaiser, Sutter, and Dignity healthcare systems did not allow their employees to sign up for care with another entity. He suggested that UC Health should be the default plan for UC Health employees, which would be like the situation of all other healthcare workers in California. UC Health must lower its plan costs for lower-salaried employees and become the default choice for employees.

Faculty Representative Horwitz asked if the expansion of UC Health risked turning the University into primarily a medical enterprise rather than an educational institution and crowding out the undergraduate and graduate educational mission of UC.

Mr. Laret recalled that he began his career at UC in 1980, when the University's medical centers were truly an auxiliary enterprise. Over the decades, the University quite specifically has wanted to take on the job of providing healthcare services, not just as a means to educate medical students and residents or have a laboratory for clinical research, but as a value in and of itself. UC's health system had become integral to healthcare delivery in the state, especially for the underserved. This reflected a failure of the competitive healthcare market, which did not encourage systems like Kaiser to serve underserved parts of the state. UC Health's services for the underserved resulted in growth of the enterprise. The public service mission of what was once an auxiliary enterprise had become large. In this business, one had to achieve and maintain scale in order to be successful. Clinical income was able to cross-subsidize education and research at UC. The size of UC Health, and its status as the largest public healthcare system serving the underserved, had resulted from decisions made over the years by the Regents and UC leadership.

Regent Park did not see a conflict among these entities of the University and saw UC Health as a point of tremendous pride.

Committee Chair Lansing stressed that UC Health did not diminish the academic mission of the University but enhanced it. An important mission of the University is to serve the underserved, and the medical centers did so in an extraordinary way. Income from UC's health enterprise provided financial support for the academic mission and allowed UC to grow and thrive. She was grateful for the synergies provided by the medical centers.

UC Irvine Health Affairs Vice Chancellor Steven Goldstein stated that UC Health trained undergraduates, graduates, and professional students. UC was able to provide this training as others could not, because UC had a professional environment. UC offered undergraduates the perspective of careers across the spectrum of the health field. This was a great benefit, especially for first-generation students looking to enter the science, technology, engineering, and mathematics fields. UC Health collaborated with science and engineering faculty, but also with the arts, humanities, and social sciences. This breadth was possible at UC but not at a typical liberal arts college. It was a privilege to be able to present these opportunities for students at UC.

UCLA Health Sciences Vice Chancellor John Mazziotta stated his view that the work of UC Health was not in any way in competition with the educational mission of UC. UC Health had a synergistic and complementary relationship with the other missions of the University.

Regent Muwwakkil asked how the growth of UC Health could benefit the University's academic enterprise in a direct, financial way. Dr. Byington responded that there were large, direct contributions from the medical centers to the campuses to support education and research, as well as other tax funding and indirect costs recovery to the research portfolio that benefit the UC system as a whole. The contributions were large and both direct and indirect.

6. **STRATEGIC PLAN AND FISCAL YEAR 2021–22 BUDGET FOR UC HEALTH DIVISION, OFFICE OF THE PRESIDENT**

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

Executive Vice President Byington began the discussion by briefly summarizing UC Health's mission, vision, and core values. A number of factors contributed to the 2017–22 strategic plan for the UC Health Division at the Office of the President (UCOP). In 2020, the COVID-19 pandemic required a redirection of strategic focus. The UC Health Coordinating Committee was formed, and multiple working groups reporting to this Committee produced guidance, policies, operational analyses, plans, and crisis standards of care. The Center for Data-driven Insights and Innovation published a daily COVID-19 tracker and other critical analyses. UC Health advocated at the State and federal levels,

regularly updated the Regents and many UCOP and systemwide groups. Student Health and Counseling coordinated many critical activities in response to COVID-19.

The UC Health Division followed the UCOP framework in identifying strategic objectives and goals. Strategic objectives concerned people, financial stability, operational excellence, policy and advocacy, and executing the mission. The UC Health Division had 12 goals in these five objective areas. Dr. Byington and members of her leadership team presented the 12 goals.

**Goal One—Advance Progress in Promoting Diversity and Inclusion—**Support each UC health professional school in its efforts to improve diversity and campus climate by advancing innovative initiatives that increase accountability, promote best practices, and improve equity and inclusion for all UC health professional students, residents/fellows, faculty, staff, and administrative leaders.

The work on this goal had focused on best practices, model programs, and recommendations for improving equity, diversity, and inclusion. There were a number of accomplishments in 2020.

**Goal Two—Develop Health Benefits Portfolio Strategy—**By end of 2022, under the leadership of the Executive Steering Committee on Health Benefits (ESC), develop and implement a future strategy to offer innovative, differentiated, compelling, affordable, and comprehensive health plans with outstanding member experience while containing annual percentage growth to four percent or below.

In 2021, the focus was on creating a five-year roadmap. The Division was proceeding with a Request for Proposals for a pharmacy benefits manager, to be effective in 2022, as well as a Request for Information/Proposals for a Preferred Provider Organization (PPO) plan that would be effective in 2023.

**Goal Three—Improve Systemwide Financial Analysis—**Develop the expertise and standardized infrastructure necessary to make accurate financial decisions and enhance regional and systemwide financial analysis of the health systems to optimize revenue, control expenditures, and conserve assets.

The Division had updated its ability to record key metrics used to analyze operational and financial performance; developed a systemwide data warehouse, to be launched in the next few months, to standardize and automate the monthly collection of financial data from the medical centers; initiated the development of a UC Health-wide capital plan and debt strategy; and was preparing a community benefits report.

**Goal Four—Drive Savings and Efficiencies Through Leveraging Scale for Value (LSfV)—**Achieve at least \$500 million per year in value through cost reduction and revenue generation starting in FY 2021–22 through improved system operational effectiveness by implementing new Leveraging Scale for Value initiatives and a new organization/governance.

The Leveraging Scale for Value program was continuing to pursue improvements across UC Health to increase revenue and decrease costs. The prior year, the program had an impact of over \$500 million, evenly divided between revenue improvement and cost reduction. This year, the program was focusing on areas such as pharmacy, supply chain, and information technology systems for radiology.

Goal Five—Create a Quality/Population Health Management Function—Advance value-based care delivery, improve patient outcomes, and reduce costs by providing leadership and support on the development and implementation of a data-driven systemwide quality and population health management function.

Accomplishments in the past year included formalizing a governance structure, developing a systemwide framework to prioritize work in value-based care delivery, and launching a working group on social determinants of health. This year, the program would further refine metrics and focus on clinical interventions for diseases and conditions such as diabetes and hypertension, among others.

Goal Six— Establish a Center to Leverage Systemwide Data—Support research, inform and improve business and clinical operations, and generate efficiencies through economies of scale by establishing a new center within UC Health for system-level data-driven insights, innovation, and transformation.

The staff of the Center for Data-driven Insights and Innovation worked closely with campus leaders, physicians, pharmacists, and information technology professionals across UC. The Center had been heavily involved in efforts surrounding COVID-19, allowing thousands of clinicians and researchers to learn best treatment practices from systemwide data. The Center provided critical, real world data to the U.S. Food and Drug Administration on the use of drugs, diagnostics, and vaccines. The Center would be continuing its efforts in pharmacy, population health, and other areas to reduce the cost of care and to demonstrate the efficacy of real world clinical data, used safely and respectfully.

Goal Seven—Strengthen UC Health Operations and Sustainability—To optimize operational effectiveness and drive achievement of strategic planning goals, UC Health will improve internal delivery capabilities and explore innovative solutions to make the Division more sustainable.

The Division had undertaken several process improvement initiatives in addition to the transition to working from home. The organizational structure had been updated and streamlined. Over the next year, the Division would continue to strengthen operations by effective management of its budget, managing the return to work, recording diversity, equity, and inclusion efforts, meeting the next iteration of the strategic plan, and working across divisions to develop business cases that support systemwide UC Health efforts.

Goal Eight—Establish UC Student Health Partnerships—Establish effective, initiative-based working partnerships between UC Health Academic Health Centers and Student Health and Counseling units by December 2021.

Over the last year, a telehealth platform was established for all student health and counseling services and over 200,000 telehealth visits had taken place. The primary goal for the coming year was a joint project between the Virtual Care Collaborative and Student Health, a tele-mental health and counseling pilot program that would be launched on four campuses: UCSF, UC Santa Cruz, UC Santa Barbara, and UC Irvine. UC San Diego was taking a leading role and providing services.

Goal Nine—Strengthen UC Health Policy Function—Strengthen the health policy function within UC Health by more effectively leveraging the expertise across UC Health. This function includes legislative and regulatory activities and interfacing on policy issues that align with UC Health objectives and priorities. This should include UC Health experts, deans, health system leaders, and stakeholders to refine and advance priorities and a proactive policy portfolio, across missions, by June 2021.

Accomplishments in 2020 included the development of a policy database of key 2020 regulatory, legislative, and programmatic initiatives affecting UC Health. The database was intended to be an institutional resource and a foundation to build on in the current year. Working groups were focusing on telehealth opportunities and other topics, and UC Health was continuing to work with State Governmental Relations and Federal Governmental Relations.

Goal Ten—Develop and Launch Systemwide Strategic Initiatives—UC Health will provide leadership and support for campuses to collectively prioritize and advance targeted systemwide and regional initiatives.

In 2020 and 2021, UC Health had been focusing on the response to COVID-19. UC Health would develop initiatives such as care delivery at UC Merced, the pharmacy benefits management tool, and other initiatives to optimize performance.

Goal 11—Develop Systemwide Enrollment Plan and Strategy—Improve alignment of the future size and scope of UC health sciences programs with State workforce/emerging health needs by developing a new systemwide health professions enrollment plan and strategy by December 2021.

For the past two years, these efforts had focused on medical student enrollment, on the UC Programs in Medical Education (PRIME), the UC Riverside School of Medicine, and expansion of a branch campus in the San Joaquin Valley. In 2020, UC Health had finalized issue briefs on the current state/national educational supply and future workforce needs in seven major health professions.

Goal 12—Improved Access to UC Health Services for All Campuses—Lead systemwide improvements at all campuses for broader access to UC physical and behavioral health providers using all modalities available, including telemedicine, by December 2022.

In 2020, the first area of focus was improving access to providers at UC Merced. A working group was formed with participants from UC Merced, UCSF, UCSF-Fresno, UC Davis,



and UCOP. A decision was made to focus on expanding existing community resources to residencies and other training opportunities and to assist in recruiting one or more primary care physicians. In addition, the Canopy health network had expanded to Santa Cruz. Virtual health had been a focus.

Dr. Byington briefly presented the UC Health Division fiscal year 2020–21 budget. Unrestricted State funds had been reduced. The budget for fiscal year 2021–22 would include a gradual restoration of frozen positions and some growth in the Center for Data-driven Insights and Innovation and the Leveraging Scale for Value program. She noted that, in the coming fiscal year, each UC medical center would present its strategic plan and priorities at a meeting of the Health Services Committee.

Regent Park commented that this had been an extraordinary year. UC Health's accomplishments in the entire plan were commendable. She asked why there did not appear to be greater efforts or funding directed at Goal One, which was to advance progress in promoting diversity and inclusion. She acknowledged that UC Health's attention had understandably been focused on COVID-19 during the past year. Dr. Byington responded that this was a priority for UC Health. In the upcoming year, she hoped that there might be new funding of \$13 million that would allow for investment in these efforts, for the creation of new spots for medical students, and for funding existing spots now funded by the campuses themselves. Dr. Byington hoped that the work of the Center for Data-driven Insights and Innovation and the Leveraging Scale for Value program would result in cost savings or new revenue streams that could be devoted to these initiatives. UC Health needed to develop reliable and growing streams of income. There were opportunities in UC's health benefits plan, in expanding UC Health's footprint in the state beyond the campus locations, and in grants and philanthropy.

Regent Park acknowledged that this was a multi-faceted funding challenge. She asked UC Health to provide a more aggressive plan for achieving Goal One faster, to be presented later this year. Vice President Nation recalled that four UC medical schools had been rated in the top ten for diversity. A decade earlier there had been a decline in diversity. The efforts on PRIME had spanned a long period of time. Dr. Nation was proud to say that 37 percent of UC's entering medical students were from groups who are underrepresented in medicine. This was a tribute to PRIME, the efforts of the campuses, and student advocacy. There was also an important focus on opportunities in the Inland Empire and the San Joaquin Valley. The growing percentage of underrepresented students in medicine reflected a steady commitment of UC medical school deans and others to focus on diversity.

Committee Chair Lansing concluded the discussion by noting that for UC Health to accomplish what it had accomplished during the COVID-19 pandemic was extraordinary.

The meeting adjourned at 2:20 p.m.

Attest:

Secretary and Chief of Staff