The Regents of the University of California

HEALTH SERVICES COMMITTEE
August 18, 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 Blum, Lansing, Park, Pérez, Sherman, and Sures; Ex officio member Drake; Executive Vice President Byington; Chancellors Block, Hawgood, and Khosla; Advisory members Hernandez, Marks, and Ramamoorthy

In attendance: Regents Leib, Lott, Makarechian, Torres, and Zaragoza, Regents-designate Blas Pedral and Timmons, Faculty Representatives Gauvain and Horwitz, Secretary and Chief of Staff Shaw, Deputy General Counsel Nosowsky, Executive Vice President and Chief Financial Officer Brostrom, Executive Vice President and Chief Operating Officer Nava, Vice President Nation, and Recording Secretary Johns

The meeting convened at 10:05 a.m. with Committee Chair Pérez presiding.

1. **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 person addressed the Committee concerning the item noted.

Robert Byrd, representative of Pro-Life San Francisco, expressed opposition to what he described as unethical research projects taking place at UCSF, and he alleged a lack of transparency regarding compliance with State and federal laws. He stated that project leaders in UCSF laboratories were creating a demand for aborted remains for fetal tissue research and that viable fetuses were being dismembered in utero. He described this practice as barbaric and asked the University to retool these studies and to use tissues from ethical sources.

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

Upon motion duly made and seconded, the minutes of the meeting of June 23, 2021 were approved, Regents Drake, Lansing, Park, Pérez, and Sherman voting "aye."[1]

President Drake recalled that hard work and collaboration had culminated earlier that summer in an important decision by the Regents about UC Health affiliations. This was a complex, sensitive issue. President Drake was pleased that the University, with the

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

Regents' guidance, was able to engage productively and find its way to positive solutions and a hopeful future for the health of all Californians.

There was a tremendous need for greater and more equitable access to health care. UC had a critical part to play in fulfilling this need. UC Health workers had been on the frontlines of the global COVID-19 pandemic for more than 18 months. After hopeful signs earlier this year, the U.S. was in the midst of another surge. President Drake thanked the frontline workers—doctors, nurses, food service workers, and all those in all aspects of UC's health services enterprise—for their work. They were continuing this work in an environment of new risks, where vaccinated people were experiencing "breakthrough" infections.

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

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

Executive Vice President Byington welcomed a new Advisory member to the Committee, Lilly Marks, who served from 2010 to 2020 as Vice President for Health Affairs for the University of Colorado and the Anschutz Medical Campus. She also served as Chair of the Board of Directors of the University of Colorado Hospital. She was a nationally recognized leader in academic healthcare administration and finance. Ms. Marks had served as the Chair of the Board of Directors of the Association of American Medical Colleges and currently served on the Board of Directors of the Federal Reserve Bank in Kansas City, Missouri.

Dr. Byington recognized the positive outcome on UC Health affiliations. She thanked Committee Chair Pérez, President Drake, and all who worked to ensure that patients across California had access to UC Health, and that UC Health would always uphold its values. UC Health was actively involved in implementation of the new policy on affiliations. There were several areas of focus: contract language and approvals, training and communication, complaint resolution, or developing processes to receive, evaluate, and resolve complaints from patients, trainees, faculty, and staff, and reporting and accountability. UC Health had identified a point-person from each location responsible for local implementation and participation in the UC Health Systemwide Affiliations Work Group.

Dr. Byington then addressed the current and fourth surge of the COVID-19 pandemic. This was day 595 in the University's work to address the pandemic. The fourth surge had surpassed the first and second surges, and could reach the height of the third surge. The prior day, the seven-day average of cases in the U.S. was higher than 141,000, and new cases reported were higher than 252,000, nearly a record high. The number in the past winter, at its highest point, had reached about 300,000 in the month of January. Reaching a level of 252,000 cases in August was a matter of great concern, especially when compared with statistics of less than a month prior. On July 23, the seven-day average case number was 30,000. Currently, about 51 percent of the U.S. population was fully vaccinated, but this was not sufficient. This caused frustration and strain for the healthcare workforce.

There had been dramatic change in the COVID-19 landscape across the U.S. in the past month. Almost all states had increased risk, including California. This was reflected in the UC Health system as well. At this time, UC was reporting more than 280 inpatients with COVID-19, surpassing both the first spring surge and the summer surge of 2020, when there were no vaccines.

Dr. Byington presented data from the Kaiser Family Foundation for the end of July 2021, which indicated that the vast majority of COVID-19 cases, hospitalizations, and deaths in California were associated with unvaccinated individuals—98.6 percent of cases, 99.2 percent of hospitalizations, and 99.8 percent of deaths. There was no more important public health measure today than vaccination.

COVID-19 variants in California and the U.S. accounted for the increase in the number of cases and breakthrough infections. The Delta variant had now overtaken all other variants; it was more transmissible and was now driving the pandemic. Dr. Byington presented a chart which plotted the fatality rate of various infectious diseases on the vertical y-axis, and the R nought, or how contagious the disease is and how fast it spreads, on the horizontal x-axis. The original version of the coronavirus was perhaps as contagious as the common cold, more contagious than influenza, and slightly more lethal than influenza. The Delta variant was as contagious as chickenpox. Fortunately, there was not a great increase in fatality, but there was evidence indicating that the Delta variant was deadlier than the original version of the coronavirus.

Data from a study that compared unvaccinated people and vaccinated people with breakthrough infections indicated that, at the beginning of the illness, both categories had high viral loads, but the viral loads for vaccinated people fell quickly thereafter, which meant that they would be less likely to transmit the virus.

The Centers for Disease Control and Prevention (CDC) indicated that it would publish two new papers that day, and one the following week, with further evidence regarding booster shots in the U.S. Data from the United Kingdom, Canada, Israel, and Qatar showed that the mRNA vaccines were less effective against infection and symptomatic disease from the Delta variant. These vaccines remained very effective against the most severe effects of COVID-19, including hospitalization and death, with between 90 percent and 100 percent effectiveness for both the Pfizer and Moderna vaccines.

Dr. Byington then presented a chart showing test positivity in the UC system. The highest test positivity was among younger cohorts of people. The highest rate was among those 20 to 29 years old, with over seven percent positivity; people aged 30 to 39 had a 6.47 percent rate, and those aged ten to 19 years, about five percent. These were important data for UC to consider as students returned to campus, given that they were in the ten to 19 and 20 to 29 age ranges.

The UC Health Coordinating Committee had issued recommendations to the campuses for the fall, including the requirement for vaccination, reentry testing, sequestration, and for required face coverings indoors. There were also recommendations for symptom screening,

testing, contact tracing, and asymptomatic testing in coordination with local health departments. All the campuses were working to make the campuses as safe as possible.

The CDC and the U.S. Food and Drug Administration (FDA) had recently provided new information. Pregnant women were now recognized as having significant adverse outcomes from COVID-19 infection, such as premature birth. The CDC now recommended that all people age 12 and older be vaccinated against COVID-19, including people who are pregnant, lactating, trying to become pregnant, or might become pregnant in the future. There was no evidence that COVID-19 vaccines cause infection in pregnant individuals and there had been no safety signals in animal studies.

The prior week, the FDA and the CDC recommended an additional vaccine dose for immunocompromised individuals. Dr. Byington emphasized that this was not a booster dose; this was a statement to the effect that those with severe compromise of the immune system did not respond sufficiently to two doses of vaccine and needed three doses for their primary series.

Recommendations for true booster shots for most Americans were now being issued. At a press conference that day, the CDC and the White House indicated that they would advise most Americans to receive booster shots beginning at eight months after the completion of the primary vaccine series. This would not initially be stratified by risk, because this had already been accomplished. Healthcare workers and workers in nursing homes were the first to receive the vaccine in December 2020 and January 2021, and they would be the first to qualify. The expectation was that these vaccines would begin to be delivered in September. In order for this to occur, the FDA and the CDC would have to meet and agree to set these recommendations. These meetings were expected to take place later in the current month.

Dr. Byington briefly presented a new public-facing UC Health website and then recalled the key quality indicators, for which information was regularly presented to the Committee: length of stay, mortality, 30-day readmission rates, hospital-acquired infections, patient satisfaction. She reported on work she had been doing on leveraging data to improve health equity with the Health Evolution Forum, an organization of healthcare chief executive officers. The Health Evolution Forum had developed many action items for health systems, including a pledge to collect, stratify, and review data on race, ethnicity, language, and sex across top quality and access metrics. UC Health had signed this pledge and would stratify key quality indicators by race, ethnicity, language, and sex to identify opportunities for further improvement across these important domains. More information about these efforts would be presented in the future.

In spite of the challenge of COVID-19, UC Health had maintained excellence across the health system. This was recognized by *U.S. News and World Report* in its recent hospital rankings. UCLA was ranked best in California and number three in the nation. UCSF Health was ranked as number one in Northern California, number three in California, and number nine in the nation. All the UC medical centers ranked first or among the highest in

their regions. Dr. Byington congratulated all the UC healthcare workers who had made this possible in such a challenging year.

Regent Lansing asked about the recommendation for a third shot eight months following first completed vaccination. She asked if this booster shot would be adapted for the Delta variant. Dr. Byington responded that the CDC and the FDA had already recommended three doses of mRNA vaccine for immunocompromised people; this was not a booster shot, but part of the primary series, and could occur 28 days after the second shot. The recommendation for a booster shot of the same vaccine received previously, eight months later, had been announced that day by the CDC. Pfizer and Moderna were working on vaccines for the Delta variant, and these were in clinical trials. A recommendation might be received in the future regarding a Delta variant vaccine. This vaccine would be considered a new vaccine, not a booster vaccine.

Regent Sherman asked about the practical effect of moving from emergency use authorization to full approval. Dr. Byington explained that this meant that practitioners could use the product in any way that they believed would benefit the patient. Currently, under emergency use authorization, practitioners were restricted in how to use the product.

Regent Sherman referred to the process of getting the third shot and asked if people receiving the booster shot would be checked against the central database for California. Dr. Byington responded in the affirmative. The dates of vaccinations were known to pharmacies, and, in clinical practice, this information was contained in patients' electronic health records. Individuals would be able to seek out this vaccination on their own at a pharmacy, eight months following their initial vaccination. She hoped that, in UC hospitals and clinics, there would be an alert if a patient had not yet received the booster shot at a point eight months or more following the initial vaccination, so that the location could offer the vaccine to that patient.

Regent Sherman asked about outreach by UC to encourage unvaccinated people be get vaccinated. Dr. Byington responded that the University had been engaged in extensive outreach since the beginning to increase vaccination rates.

Regent Sherman asked what method had been most effective in getting people to take the vaccine. Dr. Byington responded that this was to answer questions and address concerns. There was a great deal of misinformation in circulation about the vaccine, such as the assertion that the vaccine rendered people infertile. UC employees had expressed concerns about side effects and missing work due to side effects.

Committee Chair Pérez asked how UC Health could address these concerns about side effects and the risk of losing one's job for patients who were not UC employees, and how UC Health could increase the vaccination rate within its own patient population. Dr. Byington responded that UC Health was working to address these concerns. Using the central database, the California Immunization Registry, UC Health chief medical officer groups had developed ways to identify patients and to ensure that UC Health could use the time when a patient is in the hospital or clinic to vaccinate. UC Health outreach efforts in

the community were directed at UC patients and at people who were not UC patients, the public at large.

UC Davis Human Health Sciences Vice Chancellor David Lubarsky reported that UC Davis Health was working to address vaccine hesitancy in the community, cooperating with community organizations and holding events throughout Sacramento. Vaccination rates had stalled in some underserved communities, not due to lack of access, but due to misinformation. UC Davis was developing messaging that it hoped would address this vaccine hesitancy.

Committee Chair Pérez observed that UC Health was not the only player in this field; others must also make efforts to encourage vaccination.

UCLA Health President Johnese Spisso related that UCLA had partnered with the Los Angeles Dodgers Foundation and the Los Angeles Lakers to share information and encourage people to get vaccinated.

UC San Diego Health Chief Executive Officer Patricia Maysent noted that, since the UC vaccination mandate was in place, the percentage of staff who were vaccinated increased from 85 percent to 89 percent. Many of the staff who were hesitant about vaccination were women who were pregnant or wished to become pregnant.

Committee Chair Pérez referred to the hospital rankings mentioned earlier and emphasized the outstanding performance of UC medical centers. Dr. Byington commented that the evaluation criteria change every year; maintaining these high rankings year over year was challenging, and she congratulated the leadership of the medical centers. Dr. Drake concurred with Dr. Byington; to be ranked highly year after year, in spite of changing criteria, reflected the quality, breadth, and depth of UC Health and was a testament to the hard work of UC Health employees.

UCSF Health Chief Executive Officer Mark Laret remarked that there were numerous surveys with different benchmarks. Generally, UC Health ranked highly in all these surveys. UC Health needed to examine its own benchmarks for excellence. The high rankings achieved by UC Health were very positive news, but the system must also hold itself accountable to benchmarks unique to UC Health. There was still much work to be done to meet the various needs in UC Health's communities.

Committee Chair Pérez referred to information presented earlier regarding test positivity rates in the UC system and the fact that UC students fell into the age ranges with higher rates. He asked if these data been broken down by vaccinated and unvaccinated individuals. Dr. Byington responded that UC Health was analyzing these data. As in the rest of California, the majority of these positive cases were among unvaccinated people. Campuses were reporting high rates of vaccination.

Committee Chair Pérez asked if UC students were vaccinated at higher rates than their age groups in general. Dr. Byington responded in the affirmative; UC students would have

more protection, but she noted that students would interact with their age groups off campus, and these included unvaccinated people. This presented a certain risk and needed to be monitored.

Committee Chair Pérez referred to implementation of the new policy on UC Health affiliations. He asked about transition and succession planning, in case UC Health did not have the outcome it wished with an affiliate after a two-and-a-half-year period. Dr. Byington responded that this issue was addressed within contract language and approval. UC Health was working with its affiliates, helping them to understand this language and UC expectations.

Regent Zaragoza asked about campus plans in case of a major COVID-19 outbreak. Dr. Byington responded that one had learned the prior year, before the vaccine was available, that the greatest risk would be in the beginning of the academic year, when students come to campus from different parts of the country. UC Health recommended that students be tested on arrival, go through a seven-day sequester period, and be tested again. This double testing would allow UC to identify cases, especially asymptomatic cases, with isolation and quarantining of contacts, if that student had contacts. This would prevent an outbreak from occurring. UC Health had made it clear to the campuses that there must be supported isolation and quarantine space. If an outbreak were to occur, UC Health would carry out testing, isolation, and quarantine measures, and it was working with public health departments at each location. She believed that the campuses had the expertise and resources to manage an outbreak.

Regent Zaragoza asked how the campuses were handling the case of immunocompromised students, who were not able to get the vaccine. Dr. Byington responded that the vaccine was recommended for immunocompromised people and they should be vaccinated. Committee Chair Pérez suggested that the question of how campuses would handle students who could not be vaccinated should be directed to Provost Brown and his office.

Ms. Maysent commented that the medical centers were now in full operation and experiencing breakthrough infections, exposures, and quarantining, and were managing this. She reflected that the medical centers and campuses should take into account not just the infections that were forecast, but the peripheral damage that might occur. Faculty, students, and staff might become exposed and small departments might have to close temporarily. There were many potential situations one had to think through.

4. **CALIFORNIA'S HEALTHCARE SAFETY NET AND THE ROLE OF UC HEALTH**

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

Advisory member Hernandez provided a high-level overview of the Medi-Cal program in California. Californians understand that this program is critically important to the state, and 91 percent of Californians surveyed stated that Medi-Cal is either "very important" or

"somewhat important" to the state. Medi-Cal covered slightly more than 13 million people in California: nearly one in five workers under age 65, more than one million seniors over 65, about half of all California children, half of Californians with disabilities, and one in three Californians seeking help for a mental health or substance use problem. More than half of California births were covered by the Medi-Cal program.

Medi-Cal was the backbone of California's healthcare system; it was the number one purchaser of healthcare services in California. After Medicare and the Department of Veterans Affairs (VA), it was probably the largest public purchaser of healthcare services in the U.S. This was an enormous and complex program. Medi-Cal represented two-thirds of patient revenues in City and County hospitals and primary care clinics. California was fortunate in having a robust network of Federally Qualified Health Centers. A significant amount of primary care for people on Medi-Cal was provided in these clinics, which had a unique funding stream from the federal government that compensated for primary care in ways not available to other fee-for-service physicians. Were it not for this network, Dr. Hernandez believed that there would be significant problems in meeting many of the primary care needs of this population.

Dr. Hernandez presented charts showing Medi-Cal enrollment by race/ethnicity, language, gender, and age. About half the Medi-Cal population was Latino(a), and the primary language of one-third of the Medi-Cal population was Spanish. With regard to gender, there was a slightly higher enrollment of women than men. About 40 percent of enrollees were aged 20 and younger; about 50 percent were aged 21 to 64.

In fiscal year 2019–20, $99 billion were spent in the Medi-Cal program. Dr. Hernandez presented a chart illustrating the funding sources for Medi-Cal, which included 65 percent in federal funds and 23 percent in State General Funds. Sixteen percent of all State General Funds went to support this program. The remaining 12 percent of funding, through other State and local funds, involved a complex set of intergovernmental transfers from Counties to the State to draw down federal funds. From an economic point of view, the Medi-Cal program was counter-cyclical. At times of significant unemployment or downturns in the economy, the demand for this program increases. In early 2020, when the State's economy shut down and people sheltered in place due to the COVID-19 pandemic, Medi-Cal enrollment grew substantially.

A decade prior, about half of the Medi-Cal population was in managed care; in 2020, this figure had increased to 85 percent. The use of the fee for service model was declining. In 2012, the State moved most of the Medi-Cal population into managed care. This was an important point, because the State was about to re-procure managed care plans in the commercial market in the coming year. This would be a moment when the State had the opportunity to address care coordination, whole person care, and bring more attention to health equity and the accountability of managed care plans.

The expansion of Medi-Cal occurred during the implementation of the Affordable Care Act (ACA), and Medi-Cal benefits aligned with ACA benefits. These included preventive and wellness services, specialty and acute care services, rehabilitative services, and

pediatric and adult dental services. Medi-Cal also covered mental health and substance use disorder treatment, but, in Dr. Hernandez's view, the program did not cover this area well. There were also "restricted scope" benefits; someone who was not eligible or not yet enrolled in Medi-Cal could receive pregnancy-related services, for example.

The funding streams within Medi-Cal were fragmented. There were different funding streams for physical health, specialty mental health, and treatment for substance use disorder. No single system or provider was responsible for coordinating a person's care across all needs. The Medi-Cal program was disorganized from the point of view of a consumer trying to navigate the system. In many ways, the State was asking patients with complex conditions to navigate a fragmented system.

The Medi-Cal program was expanded with ACA. The State, with its own General Fund, had also expanded coverage to undocumented persons in California up to age 26. In the most recent State budget, Governor Newsom had committed to expanding the program for undocumented individuals over age 50. This would take effect in 2023. The expansion of Medi-Cal led to a significant decrease in the number of uninsured individuals in California. Before the ACA, uninsured people in California were more than 15 percent of the population; currently, around six to seven percent of Californians were uninsured. This was due in large part to Medi-Cal. There was a greater focus now in the program on achieving health equity, in part because it was such a large purchaser of healthcare services. There was more interest in and more work being done on accountability for outcomes. Dr. Hernandez drew attention to the work of the California Advancing and Innovating Medi-Cal (CalAIM) initiative and underscored that there was now a unique opportunity to enhance the Medi-Cal program.

UCLA Health Chief Strategy Officer Santiago Muñoz discussed UC's role as a safety net provider. He noted that UC Health was a critical regional-level provider of Medi-Cal services in major metropolitan areas. By most measures, UC Health was the number two provider in California of Medi-Cal hospital services, and the concentration of Medi-Cal utilization within UC Health was at an all-time high. UC Health systemwide efforts, local interventions, and leadership had helped manage the growth of unreimbursed costs, allowing the University to expand its commitment to Medi-Cal.

The Institute of Medicine/National Academy of Medicine defined safety net providers as "providers that organize and deliver a significant level of health care and other needed services to uninsured, Medicaid and other vulnerable patients." Characteristics of safety net patients were that they were Medi-Cal eligible, low-income, uninsured, medically vulnerable, had special needs and limited access, and faced various barriers. Safety net providers typically provided a higher volume of services to Medi-Cal and uninsured patients and offered services that were unique, costly, associated with the teaching mission, and relied on government funding. Safety net providers were involved in coordinating the delivery of special care and made local investments.

Core safety net providers were a diverse group. The California Welfare and Institutions Code referred to "designated public hospitals," and the State Department of Health Care

Services applied this term to County healthcare systems and to UC Health. UC Health was paid specially as a safety net provider under Medicaid demonstration. Important components of the safety net were Federally Qualified Health Centers, local health departments, and special service providers, such as private physicians who care predominantly for low-income people and ambulatory care sites with a demonstrated commitment to serving poor and uninsured patients.

Safety net providers operating as business entities must cover their operating expenses. Services provided yielded different levels of Medi-Cal payments and, therefore, abilities to cover costs. Certain elements in California public policy were designed to ensure access to health care. With regard to routine community care, public policy had special provisions that allowed the State to pay for routine ambulatory community care, such as Federally Qualified Health Centers, at a better level. The same was true of routine hospital care. Special supplemental payments ensured that non-complex hospitalizations concentrated at local safety net hospitals would be paid for. Examples of this type of provider were the Venice Family Clinic, closely bound to UCLA Health, and the Valley Presbyterian Hospital in Van Nuys, a high-volume Medicaid provider in the San Fernando Valley.

Designated public hospitals were the least likely to cover their Medi-Cal expenses because of the unique services they provided. County hospitals relied on County government subsidies. Welfare and Institutions Code Section 17000 legally required Counties to serve in the safety net role, and this had been critical to maintaining the healthcare safety net for many decades. UC Health relied on a growing list of federal supplements and cost shifting. UC Health received no explicit subsidies from the State, but had partnered with the State to reduce the unreimbursed expenses through increased federal funding. This had allowed UC Health to increase the amount of Medicaid services it provided, and, as a result, UC Health was increasingly reliant on federally funded supplemental payments. The history of UC Health was consistent with the safety net mission. The UC Davis, UC Irvine, and UC San Diego medical centers had taken over former County hospitals. There was a competitor expectation that UCD, UCI, and UCSD would continue to play the County hospital role in those markets, particularly on the part of large suburban health systems such as Kaiser Permanente. As UC Health relied on federal subsidies and cost shifting, it was important to balance its services to government payers with its ability to maintain revenue from commercial payers.

Mr. Muñoz reiterated that, by most measures, UC Health was the number two provider of Medi-Cal hospital services in California; it accounted for slightly more than 5.5 percent of total Medi-Cal inpatient days, over 8.5 percent of total Medi-Cal outpatient visits, and over nine percent of total Medi-Cal costs. Dignity Health was the largest provider of Medi-Cal services in the state, but it had a significantly higher number of hospitals.

The concentration of Medi-Cal utilization within UC Health was at an all-time high. Medi-Cal inpatient utilization had grown from ten percent in 2010 to 38 percent in 2020, varying by quarter and year. Public program utilization, including Medi-Cal and Medicare, accounted for more than 50 percent of total inpatient utilization. The ability to cost shift to commercial payers and recover expenses was more critical than ever.

UC Health had a unique role in providing safety net care and provided clinical care different from that provided by other hospitals in the same markets. UC Health provided tertiary and quaternary care for adults and pediatric patients, highly specialized surgeries and programs, specialty ambulatory care and diagnostics, designated cancer centers, solid organ transplant centers, psychiatric hospitals, children's hospitals, and services otherwise not available in these markets. UC Health filled gaps in community care in working with other entities. These activities were highly reliant on specialized physicians and staff and required significant capital investments. UC Health was unique in its academic teaching mission and in the community service it provided, providing care not available elsewhere, partnering with counties and community providers, and doing what competitors failed to do—in the University's view, some of UC Health's larger competitors were failing to provide their fair share of Medi-Cal services, given their size. UC Health's public investment was demonstrated by its manifold activities and leadership in response to the COVID-19 pandemic.

Mr. Muñoz illustrated UC Health's commitment to Medi-Cal with statistics on the growth of Medi-Cal patient care at UC from 2015 to 2020. There had been a 24 percent increase in hospital inpatient days, a 67 percent increase in managed care inpatient days, and a 33 percent increase in intensive care days. While volumes were increasing, complex cases were increasing at a faster rate. UC Health had made significant efforts to secure a renewed commitment from the State and the federal government to help mitigate the growth of unreimbursed expenses.

UC Health operating expenses related to Medi-Cal had grown from $1.9 billion in 2015 to just below $3.6 billion in 2020, an 81 percent increase over five years. Through its partnerships with the State Department of Health Care Services and the Centers for Medicare and Medicaid Services (CMS), UC Health had been able to double its commitment to Medi-Cal and keep unreimbursed expenses in check; these expenses had grown at a rate of 45 percent. UC Health's ability to provide this care had grown at about twice the rate of unreimbursed expenses. The ability to manage the unreimbursed expenses was critical to increasing the commitment to Medi-Cal. The University had worked with the State to develop new methods of drawing down federal funds.

In conclusion, Mr. Muñoz enumerated some remaining challenges: increasing demand for care by vulnerable populations; uncertainty regarding federal, State, and local support; the changing structure and environment of the broader healthcare system and the resulting disequilibrium caused by changes in the payer mix. There was also a challenge related to changes in services provided. An example of this would be when private hospitals shut down behavioral healthcare programs; this places pressure on UC Health. There were ongoing cost pressures related to labor, capital, pension, and supplies.

Committee Chair Pérez underscored the role of the Legislature in effectuating the ACA and Medicaid expansion in California, and in legislation changing the hospital tax rate. State policy changes had created funding opportunities. Dr. Hernandez acknowledged that the Legislature enabled the ACA expansion. California led the nation in reducing the number of uninsured individuals and expanding eligibility and benefits, and efforts to

reduce the number of uninsured to zero were continuing. Mr. Muñoz stated that California was fortunate in having the Medi-Cal expansion. Dr. Hernandez noted that patients who were previously uninsured were now not crowding hospital emergency departments with ambulatory-sensitive conditions. Primary care had been expanded, and medical services were being provided to patients whose only option in the past had been to go to an emergency department.

Regent Park asked about the history and implications of the fact that UCD, UCSD, and UCI had absorbed the County hospitals in their regions and about the responsibility of caring for the indigent. UCSD Vice Chancellor David Brenner responded that the Hillcrest hospital had been the County hospital in San Diego. When UCSD founded its medical school, this became the first hospital of the medical school. At that time, there was an understanding that the UCSD hospital would continue to receive County support, but this support did not continue. This was a disappointing development. UCSF Health Chief Executive Officer Mark Laret related his understanding that, under former Governor Brown, as medical schools were being started at these three campuses, with the need for teaching and training sites, the State worked with the Counties to transfer these hospitals to the University, with the understanding that County support would continue. There were not any other County hospitals in those counties, as there were in Los Angeles and San Francisco. UCD Human Health Sciences Vice Chancellor David Lubarsky confirmed that UC Davis purchased the Sacramento County hospital and took over its operations. A large population of uninsured patients should have been within the purview of the County but were not considered so by the County. This led to a contentious lawsuit which was settled prior to Dr. Lubarsky's tenure. Since institution of the ACA, the vast majority of these patients were eligible for Medicaid. UC Davis found that between 93 percent and 97 percent of homeless patients seen in its emergency department were covered by Medicaid. In Dr. Lubarsky's view, the most significant problem now was not the amount of care that the County should assume, but the lack of continuity in care. When patients from underserved populations, especially those needing mental and behavioral health services, left the UCD medical center, there was little support from the County for mental health and non-emergency healthcare services that could be provided in another setting. This was a problem that remained to be addressed, and it affected UCD Health capacity and ability to serve acute care patients.

Regent Park observed that it was important to reflect on this history. This was a huge assumption of responsibility by the University that had only grown over time. She asked about UC's Medi-Cal hospitalizations, specifically what percentage they were of the total Medi-Cal expenditure types, excluding long-term care. Mr. Muñoz responded that this information could be provided. He estimated this percentage to be in the range of 35 percent. It was a high percentage of the total Medicaid spending.

Regent Park asked about the volume of Medi-Cal outpatient services. UCLA Health President Johnese Spisso responded that UCLA Health was expanding its service in this area through its Federally Qualified Health Centers, such as the Venice Family Clinic. UCLA Health was also working at its existing sites with L.A. Care to reach additional Medi-Cal members, particularly at UCLA's new downtown clinic and at a site in Santa

Clarita. L.A. Care's greatest need for its Medi-Cal patients was in specialty outpatient services rather than primary care.

Advisory member Marks observed that, as a Coloradan, she felt envious of the commitment made by the State of California and the Legislature to funding and supporting the Medi-Cal program. Nevertheless, according to the information presented, there was still an approximately $1 billion deficit in the UC system, based on the costs of serving this population. The practice of shifting costs to commercial payers, through commercially insured patients, was common to academic medical centers across the U.S. Most public universities were major safety net providers. She noted that the commercial insurance market was becoming more resistant to these cost transfers. Reimbursement on commercial contracts had become flat and was beginning to shrink, and margins were also shrinking. She asked if UC Health was experiencing this problem in its commercial reimbursement, and, if so, how this affected UC's ability to sustain services to meet patient needs at the current and rising levels. The other missions of UC Health, research and teaching, also relied on these shrinking margins. Mr. Muñoz responded that UC Health was always thinking about maintaining this balance and covering its operating expenses. The same pressure on commercial reimbursement was also being experienced in California. UC Health wished to increase its commitment to Medi-Cal but would need help from the State and from CMS to manage the unreimbursed expenses. UC Health had enjoyed some measure of success, such as new hospital-based supplemental payments in the last few years, but would need more such assistance. UC Health had engaged a high-profile, national consultant to help develop this message and clarify the technical aspects of this supplemental funding.

Committee Chair Pérez asked about UC interventions with CMS and at the federal level regarding reimbursement rates across geographic areas, because the rates varied. Executive Vice President Byington commented that this was a reason for the importance of the Leveraging Scale for Value initiative, which helped to maintain costs at the lowest possible level. Working with Federal Governmental Relations, UC Health made it clear that the foremost issue concerned CMS and reimbursement. Dr. Lubarsky reported that UC Davis was working to understand how to scale its care of the underserved so that it would not be limited by the need for full reimbursement by Medi-Cal. UC Davis Health provided almost all the psychiatric care for the entire Sacramento County jail system, all the staff for the County mental health crisis unit, all faculty for the Federally Qualified Health Center run by Sacramento County and had grown this faculty from two to 12. UC Davis Health had also expanded its presence at the Sacramento Native American Health Center, had provided physician help at La Familia Counseling Center, and would soon be providing care to homeless people in shelters. None of these activities were credited. UC Health carried out a significant amount of work under the aegis of other community organizations. The organizations pay UC the cost and recover these costs through their Federally Qualified Health Center role.

Regent Park observed that these were important facts that should be communicated to the public. UC should highlight these important contributions and services.

Mr. Laret commented that the University was sometimes paid as a high-cost provider. He asked that the Regents consider two policy issues. The first concerned UC offering commercial insurance to its employees. For one dollar of the cost of providing care to any patient, the University received 80 cents for Medi-Cal patients, 75 cents for Medicare patients, and $1.25 for commercially insured patients. This was the fundamental economic basis of cost shifting. UC provided commercial insurance to a large number of individuals. When UC considered purchasing health insurance, its own plans were sometimes costlier than plans such as those offered by Kaiser Permanente (Kaiser). The University carried a $1 billion tax on its cost structure because it served the underserved in California, a highly important function. Kaiser provided a limited amount of care to Medi-Cal patients and had a lower cost structure as a result. Mr. Laret hoped that UC would consider how to encourage more of its employees to enroll in health plans including UC and safety net hospitals, rather than Kaiser. The second policy issue was a broader issue for the State and concerned the nonprofit status in health care. Some organizations provided only a limited amount of care for underserved, while other organizations did nothing other than serve the underserved and struggled financially. There was unfairness in who was doing the most work; the burden was not being shared equally. This was a policy issue that must be addressed at the State level.

Advisory member Ramamoorthy observed that, while Dignity Health cared for a large number of underserved patients, the University cared for more patients with complex conditions, and the cost to the UC system was significant. She asked about the amount of Kaiser's contribution to Medi-Cal care. Mr. Muñoz responded that this information could be gathered. He estimated that about three to five percent of Kaiser care was for Medicaid patients.

Committee Chair Pérez remarked that Kaiser had not stepped up as UC had to serve more underserved patients following the expansion of Medicaid. Kaiser had benefited disproportionately from Covered California, the State's health insurance exchange. A newly insured population was now able to afford Kaiser. UC should consider how much Kaiser was benefiting from policy shifts versus how much care different entities were providing to Medi-Cal and uninsured patients.

5. **UC SAN DIEGO HEALTH SCIENCES STRATEGY, 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.]

Executive Vice President Byington stressed the need for UC Health to strengthen its strategic planning efforts. How UC Health addressed its challenges was of the utmost importance, and its approach must reflect UC values. At a leadership retreat meeting in December 2019, UC Health identified three overall goals for UC Health: to improve the health of all people living in California, to promote health equity through the elimination of health disparities, and to reduce barriers to access to UC Health's clinical, education, and research programs by creating more inclusive opportunities for employees, students,

and trainees. At this and upcoming meetings, the Committee would hear presentations from the six academic health centers on their strategic planning.

Chancellor Khosla drew attention to the strong integration between UC San Diego Health and UCSD Student Health Services, and between the School of Medicine and the rest of the campus in research and research funding.

UCSD Vice Chancellor David Brenner explained that UCSD Health Sciences had three Schools—Medicine, Pharmacy, and Public Health; it also included the Health System and the clinical Physician Group. He stated that the structure of other organizations was often much more fragmented, with faculty practice, hospital, and medical school separate from one another. UC had a unique opportunity for synergies. All academic health systems had four basic missions: education, research, clinical care, and community outreach. Dr. Brenner emphasized the efficiencies and synergies across the three health sciences schools at UCSD. The schools had a common administration and UCSD had tried to eliminate redundancies. The environment was collaborative and collegial, both within UCSD and with other institutions. The goal of recruiting and retaining outstanding physicians and scientists was not left to individual departments; UCSD viewed this as an institutional commitment, and the chancellor, vice chancellors, deans, and department chairs worked together to recruit exceptional individuals. UCSD was also committed at the institutional level to providing state-of-the-art facilities and equipment. UCSD had made a new, reinvigorated commitment to diversity and inclusion. As had been mentioned in the preceding discussion, UCSD had taken over the County hospital and provided important health services to the underserved. The idea of developing a learning health system, of continuous education modification, was also important at UCSD. This had not been the norm for health systems, which tended to be rigid and slow to change. Large data sets, informatics, and artificial intelligence were changing the health system environment.

The School of Medicine was the oldest of the three schools and was based on the idea of providing personalized medical education with independent study projects and advanced technologies to prepare physicians for continual learning and working as part of healthcare teams. The School had made significant changes to the first two years of the curriculum, from traditional teaching to organ-based and problem-based teaching in small groups. The School still needed to develop the second two years to take advantage of new technologies and approaches. With regard to increasing diversity, over the past ten years, the School had increased its percentage of students from groups underrepresented in medicine from 19 percent to 28 percent. The percentage of Latino(a) students had increased from ten percent to 16 percent during this period. The School had developed new threads within general medical education; one was focused on health equity, and one was an American Indian and Alaskan Native health academic concentration. The School was in the process of developing a new physician assistant training program. Research at the School had benefited from the strengths of UC San Diego and the San Diego community in general. This year, the campus received about $1.6 billion in research funding, of which roughly half was for the health sciences. There had been an emphasis on team science and large center grants, in addition to the traditional individual principal investigator grants. The School was interested in providing a better infrastructure to facilitate large grants and in

better collaboration with industry. There were 600 biotechnology companies in the nearby Sorrento Valley neighborhood, one-third of which had been founded by UCSD faculty. The rankings of UCSD Health had improved dramatically. UCSD Health wished to leverage the academic strengths of the School of Medicine and other schools at UCSD to improve patient care, to apply lessons learned from the COVID-19 pandemic, and to develop digital health and a health information system in order to follow large numbers of patients more efficiently.

The School of Pharmacy was 15 years old. Its goal was to prepare pharmacists and pharmacy leaders for careers in California in a research-intensive environment. The role of pharmacists had expanded, and the School trained pharmacists to be primary healthcare providers and members of a clinical team. Pharmacy students and medical students shared classes, so that they would acquire an ethos of team science and team health care, the interaction of a team to provide the best patient care. Areas of research interest for the School included drug discovery and development for neglected diseases. The rationale was that a public school of pharmacy, in particular, should be interested in research on neglected diseases. Other research interests were structure-based drug design and microbiome analysis. Further areas to be developed in the future were pharmacogenomics, pharmacoeconomics, and pandemic preparedness. The School had made a commitment to increase diversity among its students and faculty.

The School of Public Health was a new school that offered the bachelor of science, master's, and doctoral degrees. It was characterized by inclusion and diversity, continuous evaluation and improvement, and community outreach. Areas of focus for the School were environmental health, health on the U.S.-Mexico border, mental health and addictions, healthy aging and longevity, and the concept of a learning healthcare system.

Dr. Brenner outlined how two key events of the last year-and-a-half had influenced UCSD Health Sciences: the Black Lives Matter movement for racial justice and the COVID-19 pandemic. UCSD Health Sciences had committed to addressing racial and gender biases in the health sciences. An Excellence in Diversity faculty initiative had allowed UCSD to increase the numbers of faculty from underrepresented groups and to receive funding for the career development of these faculty members. There were four ongoing work streams at UCSD Health to address equity and inclusion in both the academic and research arena and in clinical operations and patient care.

UCSD Health's response to the COVID-19 pandemic had shown UCSD at its best. UCSD Health conducted significant research related to the pandemic and vaccines and continued its educational activities. In clinical capacities, there was an enormous shift in people, research, and infrastructure to address COVID-19 in virus testing, screening, vaccines, contact tracing, and patient care. UCSD used wastewater testing on campus, which enabled early detection of COVID-19 cases. UCSD produced a significant amount of published research on COVID-19, including research on the development of COVID-19 variants. Dr. Brenner concluded his remarks by underscoring that UCSD Health goals were in line with the goals of the overall campus and drawing attention to UCSD Health's need to

expand infrastructure, with new clinical facilities, a home for the new School of Public Health, and new research laboratories.

UCSD Health Chief Executive Officer Patricia Maysent noted UCSD Health's work on the U.S.-Mexico border during the pandemic. Critical care teams were working in Tijuana and Mexicali. About 120,000 people crossed the border every day, and about 500,000 American expatriates lived in Tijuana; UCSD Health considered these people part of its region and market.

The clinical growth of UCSD Health over the past eight years had been impressive, from just over $1 billion in revenue to a number approaching $2.8 billion in fiscal year 2021. Much of this was enabled through the development of the Jacobs Medical Center. The integration of the campus and UCSD Health was reflected in the fact that Student Health Services reported to UCSD Health. Student Health Services used Epic, an electronic health records system, which allowed UCSD to conduct tracking, contact tracing, and vaccination tracking.

UCSD Health operated in a challenging local reimbursement market, different than elsewhere in the state. San Diego, in spite of its cost of living, was at the lower end of reimbursement scale of the Centers for Medicare and Medicaid Services (CMS). There was no County hospital; the Hillcrest facility was the anchor hospital for the underserved population. Ms. Maysent emphasized that the CMS reimbursement to UCSD was materially lower than to other UC medical centers for the same types of patients. This was due to legacy issues concerning the wage rate and CMS reimbursement index. This lower rate affected UCSD's commercial contracts, funding for fellows and residents, and payment for COVID-19–related services. This was an issue not only for UCSD Health but for the San Diego region. The commercial market was competitive, with Scripps Health, Sharp HealthCare, and Kaiser Permanente. This consolidated market drove down commercial reimbursement rates. This forced UCSD Health to operate with a low cost structure, and there was sometimes pressure on days' cash on hand.

Ms. Maysent briefly outlined UCSD Health's strategic framework and goals, with a basis in accountability, engagement, and dismantling structural racism. UCSD Health was always working on a foundation of financial sustainability and pursuing the development of its network. UCSD Health set specific goals for itself, such as maintaining 80 days' cash on hand and receiving a Top Ten designation in quality and accountability by Vizient.

Ms. Maysent presented a map showing the UCSD Health network. In 2012, UCSD Health was very much oriented toward tertiary and quaternary care. With the passing of the Affordable Care Act and the narrowing of networks, UCSD understood that it needed to provide more primary care but did not have sufficient cash to acquire practices. UCSD established a clinically integrated network and Medicare Accountable Care Organization with more than 550 physicians. These affiliated physicians were not employed by UCSD but used the UCSD Epic electronic health records system and were part of UCSD contracting and quality efforts. This was the approach UCSD used to cover its region, including affiliations with hospitals.

With regard to payer strategies, UCSD was working to further its relationships with brokers. UCSD Health was viewed as an expensive provider that cared for patients with complex conditions. UCSD was trying to rebrand itself with these brokers and change its position in the payer market. It was building out its network, offering lower-cost care, building services around the patient, and developing population health approaches.

Ms. Maysent briefly described the plans for the redevelopment of the Hillcrest campus, where 36 aging buildings would be replaced. In a synergistic partnership of UCSD Health and the UCSD general campus, UCSD would be using ground lease revenue to build multi-family housing on the west side of the Hillcrest campus; this was projected to generate sufficient funding to build the infrastructure at Hillcrest, such as roadways and parking. The financial requirements of building clinical facilities rested with UCSD Health. The development of the new outpatient pavilion, a site for cancer services, surgery, imaging, and radiation oncology, would provide financial growth and help with the replacement of the Hillcrest hospital. UCSD projected that the new hospital would need 375 patient beds and would cost between $1.2 billion and $1.6 billion. Currently, UCSD Health did not have the necessary cash or debt capacity and was working to find ways to sustain this magnitude of debt.

Another significant undertaking now under way was a behavioral health collaboration between UCSD Health and San Diego County Behavioral Health Services. The County had made a $115 million commitment to build a new inpatient psychiatric hospital on Third Avenue, two blocks from the Hillcrest campus. The hospital would be on the UCSD license, with the rationale that, currently, the County was not able to bill for Medi-Cal; under the UCSD license, the hospital would be able to bill for Medi-Cal. The new facility would provide inpatient and other services with an emphasis on coordination of care, so that patients have a full continuum of services and do not have to go back and forth between different psychiatric healthcare sites. This collaboration would represent a tremendous gain for the San Diego region. Ms. Maysent concluded by noting that UCSD Health was carrying out a funds flow update. An area of challenge for the institution was physician engagement and alignment. Faculty were experiencing burnout from the COVID-19 pandemic and the ongoing challenge of balancing all missions within the context of the funds flow model and growth.

Regent Leib praised the work of UCSD Health and its role in the community. The dedicated vision of UCSD leadership had been made clear during the COVID-19 pandemic.

Regent Park asked why the San Diego region was reimbursed at a lower rate by CMS. Ms. Maysent responded that this was based on a complicated, legacy formula involving many factors such as consideration of wage rates. In her understanding, this was something like a zero-sum game. If there was a rebalancing of CMS reimbursement across the country, California and Florida would lose, although the San Diego region might gain. It was not the case that other parts of the state were reimbursed too much; it was that the San Diego region was not reimbursed enough. Regent Park asked that the campus provide updates, as UC San Diego gained further understanding of and worked on this CMS reimbursement issue.

Regent Park asked about updates to the medical school curriculum. UCSD School of Medicine Interim Dean Steven Garfin responded that the School had updated its first- and second-year curriculum to be more organ-based and patient-centered, with an earlier introduction to patients in the first year, as opposed to the third year. Dr. Garfin observed that the world around medical schools was changing, but medical schools were not changing. There was a standard core curriculum in the third and fourth years. UCSD was working on changing the curriculum to make it more fluid and student-oriented. This presented challenges with regard to accreditation by the Association of American Medical Colleges and the Medical Board of California. Dr. Brenner added that there was failure in continuity of care for patients in the third year of medical school. One model proposed that students follow a panel of patients for several years. This would be labor-intensive, and was the kind of paradigm shift being considered by UCSD.

Regent Park requested that there be a discussion item at a future meeting on changes and updates to medical school curricula. Committee Chair Pérez observed that this topic was also of interest to the Academic and Student Affairs Committee.

Advisory member Ramamoorthy seconded Ms. Maysent's comments on physician alignment and engagement. She praised UCSD Health leadership for its efforts to address the hardships experienced by physicians and for listening to faculty concerns. There was communication and transparency, and this had enabled UCSD to respond as a team to the COVID-19 pandemic.

6. **SPEAKER SERIES – HOMELESS HEALTHCARE COLLABORATIVE, LOS ANGELES CAMPUS**

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

UCLA Health President Johnese Spisso began the discussion by noting that there were more than 66,000 people experiencing homelessness in Los Angeles County, including both sheltered and unsheltered populations. Numbers of homeless people had increased during the COVID-19 pandemic, in particular due to economic hardships. UCLA Health's initiative to provide health care to homeless people was a collaboration among the UCLA Hospital and Clinic System, the School of Medicine, the Venice Family Clinic, the UCLA schools of social and health sciences, community organizations, philanthropic partners, and the County and the City of Los Angeles.

UCLA Health reviewed information from its Emergency Department to identify gaps in care and areas of greatest need. From January 2016 to May 2021, UCLA cared for 15,000 unique patients experiencing homelessness. Ninety-five percent of these patients received care through the Emergency Department, for a total of 38,000 encounters, and, in 85 percent of the Emergency Department visits, the patients were discharged without being admitted. In spite of having clinics in the community, UCLA noticed that this population was still using the Emergency Department. UCLA needed to reach out to this population in a more effective way.

UCLA Health reviewed the medical needs of this population, which were not only complex medical needs, but also social needs and psychiatric and behavioral health needs. UCLA Health operates one of the few inpatient psychiatric facilities in the region. UCLA identified multiple opportunities to better serve this patient population in acute outpatient care, psychiatric and behavioral health, and intermediate medical and behavioral health. UCLA wished to develop a comprehensive care delivery strategy. This type of initiative requires close coordination with community agencies, and community partnerships were essential elements in UCLA's initiative. UCLA Health was able to build on its many years of experience with its Stein Eye Institute. For the past 40 years, UCLA had been providing eye care and screening free of charge to vulnerable communities in Los Angeles with mobile vans. The mobile eye clinic provided basic screenings and prescriptive lenses to over 20,000 under-resourced adults and children annually. This was an excellent model to build on. UCLA also operated mobile outreach vans through the Venice Family Clinic, which was a Federally Qualified Health Center, and had an experienced street medicine program, which provided basic primary care and was able to refer patients for laboratory tests, medication, and other services.

Medell Briggs-Malonson, M.D. and Chief, Health Equity, Diversity and Inclusion for the UCLA Hospital and Clinic System, reiterated the idea that, although UCLA had a long history of providing care to this vulnerable population, it realized that it needed to do more and so conceptualized the UCLA mobile healthcare unit. UCLA found that, when homeless people had acute care needs, they were not going to Federally Qualified Health Center clinics. The patients themselves explained that they did not go there because these clinics often closed at 5 p.m. or were far from where the patients were staying. There was often a long wait for care at these clinics and there was no continuity of care. These patients often came to the Emergency Department because they knew they would receive comprehensive care, a warm place to stay, and that they would be seen immediately. UCLA wished to ensure appropriate continuity of care and comprehensive services. With a mobile healthcare unit, UCLA could directly deploy primary and urgent care services and social services referrals, and refer patients to a nearby clinic for follow-up or to an emergency department if necessary.

UCLA Health reviewed the primary Emergency Department discharge diagnoses for this population. Common reasons for coming to the Emergency Department were limb, muscular, or back pain; these people were walking for long periods during the day and resting in uncomfortable environments. Other common diagnoses were headaches and urinary tract infections. All these conditions can be managed by a mobile team. UCLA wished to extend its street medicine program, or "direct community care." This approach removed traditional barriers to care and emphasized the provision of high-quality, compassionate care and specialty care. For this population in particular, it was important to build trusting relationships and rapport.

Dr. Briggs-Malonson presented a map of Los Angeles which indicated the density of homelessness in different areas. UCLA's service strategy for providing care to this population was multifaceted. UCLA would increase van service to streets and encampments within four areas in Los Angeles County: the West Side, Downtown, South

Los Angeles, and the Sepulveda Basin and San Fernando Valley. UCLA would deploy vans and go into shelters and hotels. There were also tiny home developments and safe parking sites where people did not have access to high-quality medical care. UCLA teams would provide follow-up care to patients after discharge, and UCLA would fulfill community and County agency referrals for care.

UCLA would deploy two sets of vans, blue vans and gold vans. The primary focus for the blue vans would be street and encampment outreach, with a secondary focus on hotels, shelters, and following up on community and County referrals. The blue vans would be deployed at least five days a week, during times when there would be the greatest engagement, on the weekends and in the evening. The primary focus for the gold vans would be on post-discharge follow-up. The gold vans would also follow up on community and County referrals, hotels, shelters, tiny home developments, and safe parking sites, and operate similar hours.

The scope of services would range from primary and preventative care to urgent care. Medical screenings would include checking for aches and pains. Primary care would include chronic disease identification and management and vaccinations. Urgent care would focus on wound care, skin infections, and lacerations. Basic psychiatric care and referrals would be provided, as well as social service assessments and referrals. An important factor in the overall health and wellness of this population is housing. UCLA would communicate with housing agencies in the hope of finding permanent housing for those who request this.

There would be a physician and a nurse in each of the blue and gold vans. The nurses and physicians would be paid. This would be part of their jobs. They would be trained in street medicine and trauma-informed strategies. The standard for these vans would be the same as for any UCLA Health clinic. The program had hired a medical director and an operations director and would have a team of social workers. The vans would also be staffed with resident physicians, medical students, nursing students, and public health students. These students, and future physicians, would learn about the social determinants of health. UCLA Health projected that, when it launches these vans, it would be able to reach 400 to 500 patients per month. Vans had been purchased and would be launched in the first week of October. Dr. Briggs-Malonson concluded by stating that the ultimate goal of the Homeless Healthcare Collaborative was to broaden and strengthen UCLA Health's partnerships with stakeholders throughout Los Angeles County so that the Collaborative can provide comprehensive and coordinated care to this vulnerable population in order to advance health equity and to improve the social conditions and opportunities for this population as well.

Regent Sherman noted that there was a large homeless encampment in West Los Angeles, on the grounds of and outside the Department of Veterans Affairs facilities (VA). He asked if UCLA Health would be providing services at this location, or if there were a jurisdictional issue with the VA. Dr. Briggs-Malonson responded that UCLA would service this area. UCLA Health had meetings scheduled with the VA in order to coordinate services.

Regent Park asked about the cost structure of these services and the growth potential of mobile clinics. Ms. Spisso responded that the University hoped that there would be legislation to support reimbursement. Currently, the program would be funded by UCLA funds and philanthropic partners. Once a patient is established in a Federally Qualified Health Center, visits to the Center are reimbursed; however, as discussed earlier, these patients were reluctant to use those facilities. UCLA Health wished to demonstrate that this program could improve health in a cost-effective way. Much of the work is a demonstration project. Dr. Briggs-Malonson added that UCLA would monitor this program closely for health outcomes, social outcomes, and cost-effectiveness; UCLA hoped that this model could be expanded in Los Angeles and elsewhere. Chancellor Block praised the program, which would keep people as healthy as possible under difficult circumstances, and thanked UCLA Health employees who were putting the program together. UCLA Vice Chancellor John Mazziotta commented that projects like this one have been attractive to philanthropists.

Regent Lansing underscored that homelessness was a great tragedy. She asked about the cost of each van. Dr. Briggs-Malonson responded that these were specialized vans outfitted with medical-grade refrigeration and other features. Each van cost approximately $125,000. There were also costs of licensing and staff. Ms. Spisso added that the vans would be licensed under UCLA's hospital license.

Regent Lansing asked how many vans the program needed to serve this population. Dr. Briggs-Malonson responded that the program would begin with two vans and planned to expand to up to eight vans to cover the Los Angeles region. As the program further observed and identified existing needs, the number of vans might be increased to 12. The program planned to have at least four deployed before the end of the current fiscal year, increasing to eight in the following year.

Executive Vice President Byington emphasized that the inclusion of medical students and trainees was a vital part of this program. In her view, UC medical students were an underutilized capacity for meeting the needs of patient populations who were difficult to reach. She hoped that the evaluation of this program would be published and shared with other health professional schools. This program could be a model for others, and the State should be interested in the program as it considered funding for health professional schools and the services that would be linked to that funding.

Committee Chair Pérez asked about criteria the program would use for determining deployment to different areas. Dr. Briggs-Malonson responded that the program considered 20 different criteria, such as individual healthcare outcomes, healthcare utilization, social impact, and financial factors. The program would track patient satisfaction and the experience of students and residents who took part in the program. As the program was deployed throughout Los Angeles, it would seek to identify gaps in service and geography and to fill those gaps.

Committee Chair Pérez asked if the program would also take into consideration calls for service made to the Los Angeles Fire Department. There might be very different levels of

calls in different places depending on subpopulations of homeless people. This information might be of interest to UCLA's program. Dr. Briggs-Malonson responded that UCLA would consider this.

Committee Chair Pérez asked if the program would consider different types of staffing over time, based on need. Ms. Spisso responded that this was discussed in planning for the program. A major portion of the cost was the cost of staff. At first, the program had considered deploying only nurses or nurse practitioners. Based on conditions treated in the Emergency Department, the program would first deploy with physicians and nurses. As the program expanded to eight or ten vans, there might varying levels of expertise and models of service.

Committee Chair Pérez observed that, while there was a need for an M.D., some interventions could be handled by people with other skill sets, not requiring an M.D. Ms. Spisso noted that UCLA's street medicine program through the Venice Family Clinic included teams of volunteers, who were not nurses, doctors, or paramedics, but who have received training at the level of medical assistant.

7. **UPDATE FROM THE UNIVERSITY OF CALIFORNIA CANCER CONSORTIUM**

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

Chief Clinical Officer Anne Foster reported on the work of the University of California Cancer Consortium. Cancer was the second leading cause of death in California after heart disease. More than 1.4 million California residents were living with a history of cancer, and nearly one out of every two Californians would develop cancer over their lifetime. The five National Cancer Institute (NCI)-designated comprehensive cancer centers in the UC system were at the frontlines of the fight against cancer and were among the 51 comprehensive cancer centers in the nation. Each of UC's cancer centers held the highest designation from the NCI and conducted cancer research across the continuum of basic, translational, clinical, and population sciences. Individually, each UC cancer center was a leader in cancer care in its region, conducting clinical trials and translational research. Each cancer center also had a strong focus on serving the surrounding communities. Collectively, the UC cancer centers served the entire population of the state. The cancer centers were embedded in their respective academic medical centers and treated all kinds of cancer in adults and children. Year after year, there was growth in the number of cancer patients seen at UC. UC was on pace in 2021 to exceed the number of patients seen in previous years. As of June of the current year, UC had already seen a number of patients equal to 80 percent of patients the prior year. During the COVID-19 pandemic, UC hospitals continued to provide the best care available to cancer patients. In *U.S. News and World Report* hospital rankings, all UC cancer centers ranked in the top 15 hospitals for cancer in California, out of 94 hospitals. UC cancer centers also ranked well in the nation for adult cancer care.

The UC Cancer Consortium was formed in 2017, launched by then President Napolitano to leverage the combined expertise and strengths of the five cancer centers. The Consortium was a collaboration across the centers, who have joined forces to address California's most pressing cancer-related problems and opportunities. Dr. Foster presented a chart illustrating the leadership structure of the Consortium. Under the leadership of Founding Chair Alan Ashworth, the Consortium had launched joint initiatives in a number of priority areas. The Consortium sought to leverage the impressive scale of the UC system, strengthen operational excellence in patient care, expand research operations and oncology training, drive cancer policy for the State of California, advance health equity and cancer prevention, and advance "systemness" through fostering collaborative research. The Consortium was also exploring ways to expand its influence in cancer research at the national level, such as increasing its involvement in National Institutes of Health (NIH) opportunities and other federal initiatives.

Many UC cancer patients were enrolled in clinical trials, important for learning which treatments or interventions are effective for cancer patients. Collectively, the UC cancer centers were carrying out almost 1,000 clinical trials at any given time. The cancer centers continued to enroll patients in therapeutic clinical trials during the COVID-19 pandemic through increasing telehealth visits.

The Consortium had a Quality Council, bringing together experts on quality from all five cancer centers to improve cancer patient care through sharing best practices and collaborating on quality improvement projects. The Quality Council was chaired by Pelin Cinar, M.D., Medical Director of Quality and Safety at UCSF. The Quality Council was partnering with UC Health population health and data warehouse teams to develop a common cancer population definition and various dashboards. The Consortium was also building capacity in cancer care quality expertise through an American Society of Clinical Oncology training program.

The UC cancer centers were also leaders in precision oncology, with many foundational discoveries emerging from their leadership, clinicians, and researchers. The Consortium was building a database of cancer genomics data, which was regularly updated by the centers. Dr. Foster presented a representative dashboard; it currently reflected more than 15,000 de-identified tumor genomic test results. As the Consortium continued to build the database, it would become an important resource for systemwide precision oncology. The Consortium hoped that it would lead to important advancements and improvements in patient care. Another way that the Consortium was building precision oncology expertise was a systemwide molecular tumor board, launched in fall of the past year. This was a virtual meeting forum where clinicians and researchers from across UC discussed precision oncology cases.

The Consortium also hoped to improve the lives of California cancer patients through precision oncology policy. "Preventive Risk Evaluation for Education and Monitoring through Personalized Testing (PREEMPT)" was the first proposed sponsored legislation from the Consortium. This proposal addressed a precision oncology issue that affected many cancer patients, and especially those from populations disproportionately at risk for

cancer. Not all cancer patients were being tested for genetic mutations. Patients were not being tested for appropriate genes, and those who were tested were not being reimbursed for the cost of the tests. PREEMPT would bring precision cancer medicine into the hands of cancer patients by requiring reimbursement from insurers for genetic counseling and testing, according to national guidelines. The University planned to introduce the Consortium to the Legislature through learning sessions and would be engaging advocate partners in the coming months.

Each type of cancer presented unique challenges. Systemwide consortia had teamed up to collaborate on a variety of issues to bring about advancements in cancer prevention and treatment. Dr. Foster drew attention to two of these collaborations. One was the UC Pancreatic Cancer Consortium. Pancreatic cancer was the third leading cause of cancer-related deaths in the U.S. and one of the deadliest cancers, with less than an 11 percent five-year survival rate. The Pancreatic Cancer Consortium was focused on research to drive clinical advances and had recently received $1.5 million in funding from a private foundation, the Canopy Cancer Collective, to increase multidisciplinary care for pancreatic cancer patients. Over the past seven years, the Hematologic Malignancies Consortium had been focused on finding treatments for blood cancers such as leukemia and lymphoma, had successfully opened 11 multi-campus clinical trials, and had recently received $4.5 million in State funding to continue to build systemwide capacity in this area.

All the NCI-designated cancer centers had a robust program of community outreach and engagement, and the UC cancer centers were no exception. During the COVID-19 pandemic, the UC cancer centers made changes to their infrastructure and leveraged existing community partnerships to reach vulnerable populations and combat COVID-19 in these communities. All UC Health campuses served Hispanic and Latino(a) communities. Members of the UC San Diego Moores Cancer Center received funding from NIH to provide COVID-19 testing in community health centers and provide community health worker-led contact tracing. The UC Davis Comprehensive Cancer Center participated in providing rapid antigen testing in the Central Valley at locations convenient for workers and their families. The UC Irvine Chao Family Comprehensive Cancer Center partnered with a local task force to hold a virtual vaccine town hall meeting to address questions from the Asian American community. The UCSF Helen Diller Family Comprehensive Cancer Center leveraged its connections in the Bay Area African American community to send out COVID-19 newsletters and perform community outreach. Umoja Health was doing important testing and vaccination work in Oakland under the leadership of Kim Rhoads, M.D., of UCSF.

Dr. Foster concluded her presentation by noting that there were unique challenges for cancer care during the COVID-19 pandemic. Due to pandemic restrictions, many cancer patients, even first-time patients, were not allowed visitors. The Simms/Mann-UCLA Center for Integrative Oncology initiated a program where former chemotherapy patients wrote letters to those currently undergoing treatment. Chemotherapy can be an isolating experience. This program provided support that might have been missing during the pandemic.

Committee Chair Pérez requested clarification of the phrase "leveraging the scale of the UC system" in the context of the Consortium, and what the benefits of this were in real terms. He recalled that the same language was used to describe the UCPath project, which had not produced the systemwide savings that UC hoped to achieve. Dr. Foster responded that the UC system was the tenth largest healthcare delivery system in the U.S. This phrase referred to the sheer volume of patients and services. There were financial opportunities, such as shared savings on chemotherapy agents, which can be very expensive. This language also encompassed the areas of treatment and research: the sharing of best practices, the coordination of multi-campus trials, the tumor board mentioned earlier, and the precision oncology and genomics database.

Committee Chair Pérez asked if it was the case that, before the formation of the Consortium in 2017, the UC Health campuses were not sharing best practices and information, or were sharing them in less efficient ways. Dr. Foster responded that there were shared best practices and multi-campus trials prior to 2017. In her view, the work and power of the Consortium was in deliberately harnessing these joint efforts and having a platform of work organized around priorities. The impact of the UC cancer centers is magnified when they work together.

Committee Chair Pérez asked if there were any remarkable achievements in the last three years which would not have been possible but for the Consortium. Dr. Foster referred to the precision oncology, genomics database, and tumor board projects mentioned earlier. Other clinical best practices were being shared. Scott Lippman, M.D., Director of the UC San Diego Moores Cancer Center, commented that, while there had been collaboration among the UC cancer centers before the establishment of the Consortium, the Consortium formalized and designated resources for these efforts. The molecular tumor board provided a formal process for discussion of complex cases resistant to all known therapies and the sharing of genomic data and identification of clinical trials, which was patients' only hope for survival. This was a formal mechanism for sharing ideas and protocols for patients without other options for therapy. Michael Teitell, M.D., Director of the UCLA Jonsson Comprehensive Cancer Center, concurred that the molecular tumor board was a great opportunity for physicians to share best practices and information on complicated cases. The Consortium had also allowed UC Health to formalize shared activity on grant funding and the development of proposals for State policy and legislation to improve genetic diagnoses for patients.

Committee Chair Pérez asked if UC Health was creating a patient experience better than that at other academic medical centers, and seamless integration of services for patients from different components of UC Health. Dr. Teitell noted that, due to its size and scale, UC Health could provide services to almost 16 million of the approximately 40 million people in California. The sharing of best practices, work on legislative issues, and reaching into communities to serve underserved patients would be affected by the Consortium's efforts. Dr. Lippman added that the UC cancer centers had various signature programs. The work of the Consortium allowed patients access to targeted trials that could be held at any of the sites. Dr. Teitell remarked that there was also potential for uniform contracting among the UC sites with providers of materials and resulting cost savings.

Regent Lansing reflected that, in the past, researchers and hospitals worked in an isolated manner. The Consortium was breaking down walls between researchers, and patients at one UC hospital had access to all of UC's expertise. This effort was transformative, and Regent Lansing believed that lives had been saved due to the work of the Consortium.

UC Davis Human Health Sciences Vice Chancellor David Lubarsky noted that UC Health had a high level of NCI funding and, as a system, the largest number cancer clinical studies and patients in the world.

Committee Chair Pérez asked if this had happened since 2017. He wished to ensure that UC Health was measuring its progress, and that there be clarity about how the Consortium approach was different from UC's earlier activities. Dr. Lubarsky responded that the Pancreatic Cancer Consortium was seeing only about 1,000 of the 6,000 pancreatic cancer patients in California. The survival rate was still lower than ten percent after five years. With the Consortium, UC Health was trying to organize itself so that it would be the destination for all pancreatic cancer patients in California to receive the latest therapies. None of the UC cancer centers on its own could achieve this, but when they joined forces, they could complete studies more quickly. UC Health would become a magnet for any pharmaceuticals or experimental devices that might help treat this disease. UC Health hoped to accomplish this for every subspecialty of cancer and, incrementally, to improve the care available to patients with specific cancers.

With regard to Committee Chair Pérez's question about tracking progress over time, Executive Vice President Byington responded that UC Health was developing benchmarks for itself to demonstrate success in clinical and research outcomes. The work of the tumor board and the availability of a searchable genomics database were remarkable.

Dr. Lippman commented that the work of the molecular tumor board was tangible evidence of the effectiveness of the Consortium and its effect on patient care. Something like this had not occurred before. The tumor board facilitated the sharing of ideas concerning real patients with no other therapy available and directly influenced clinical protocols. Collaboration on pancreatic cancer research had existed before but had increased significantly since the founding of the Consortium and recent allocation of greater resources. Dr. Lippman observed that UC Health could do more to leverage its scale in negotiating with big pharmaceutical companies to secure drugs for UC patients at reduced prices.

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

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

(Discussion of this item was deferred to a future meeting.)

The meeting adjourned at 2:30 p.m.

Attest:

Secretary and Chief of Staff