

The Regents of the University of California

HEALTH SERVICES COMMITTEE

October 19, 2022

The Health Services Committee met on the above date at Carnesale Commons, Los Angeles campus and by teleconference meeting conducted in accordance with California Government Code §§ 11133.

Members present: Regents Makarechian, Park, Pérez, Reilly, Sherman, and Sures; Ex officio member Leib; Executive Vice President Byington; Chancellors Block, Gillman, and Hawgood; Advisory member Ramamoorthy

In attendance: Regents Batchlor, Blas Pedral, Regents-designate Raznick and Tesfai, Faculty Representatives Cochran and Steintrager, Interim Secretary and Chief of Staff Lyall, Deputy General Counsel Nosowsky, Vice President Lloyd, and Recording Secretary Johns

The meeting convened at 10:20 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 persons addressed the Committee concerning the items noted.

- A. Kiran Clair, M.D., UC Irvine assistant clinical professor in obstetrics and gynecology, related that as a gynecologic oncology fellow, she spent over a year rotating at a faith-based hospital affiliate location. This was an invaluable opportunity to learn from patients with diverse pathologies, including complex benign or precancerous conditions, as well as patients with cervical, ovarian, and uterine cancers. The presence of the fellows enabled this site to deliver a gynecologic cancer service line. Fellows evaluate and triage patients with gynecologic cancers who present to the emergency department. Orange County lacks a traditional county hospital. For this reason, many emergency department patients are homeless, undocumented, uninsured, or enrolled in Medi-Cal. Fellows are involved in screening and enrolling gynecologic cancer patients for clinical trials, which, for many patients, provides a pathway to new trials and therapeutics that could improve the likelihood of cure or prolonged survival. Fellows work closely with social workers and other service lines, including general gynecology, internal medicine, obstetrics, radiation oncology, intensive care unit care, palliative care, medical oncology, and general surgery as consultants for complex cancer cases, both in the operating room and for hospital admissions. Fellows present and moderate gynecologic cancer tumor boards monthly, where cases are presented from community physicians and discussed by a multidisciplinary panel, which allows access to specialty consultation. Fellows are involved in end of life

discussions, often as part of a team, to provide prognostic and therapeutic information. Without the fellowships, hundreds of women each year with complex pelvic pathologies or gynecologic cancers would be forced to seek care outside their communities or to do without appropriate specialty care, which can lead to worse outcomes.

- B. Robert Bristow, M.D., professor and Chair of the Department of Obstetrics and Gynecology at UC Irvine, spoke in support of continuing affiliations with Providence St. Joseph and Providence St. Jude medical centers in Orange County across four service lines: maternal fetal medicine, gynecologic oncology, urogynecology, and obstetrical hospitalists. As a leader in women's health, UC Irvine recognized that this was a complex and nuanced issue which required protections for the rights of patients and providers. Dr. Bristow strongly believed that these affiliations embodied the role that UC plays as an instrumental component and steward of health care for the citizens of California and specifically for the patient population that UC cares for at St. Joseph and St. Jude, many of whom have safety net insurance. These patients greatly benefit from the expertise of UC clinicians, and, as a result of UC's presence, these hospitals are able to increase access to a much broader range of services and subspecialty care. There were countless examples of how UC's presence at these institutions has saved women from life-threatening gynecologic cancer, rescued mothers and babies from critical obstetrical emergencies and conditions, and improved the quality of life for local citizens. Due to the complexities of contracting with healthcare management organizations in Southern California, most of these patients did not have the option of being seen by UC Irvine physicians at the UC Irvine Medical Center. Retreating from these affiliations would deprive a large number of Californians of access to state-of-the-art health care. With the necessary and appropriate protections for patients, faculty, and trainees, UC's continued affiliations were in alignment with UC's mission to strive toward health equity for the vulnerable and underserved citizens of California and to ensure that they have access to the highest-quality health care, science, and medical education available in the state.
- C. Satyan Lakshminrusimha, M.D., Pediatrician-in-Chief and neonatologist at UC Davis Children's Hospital, explained that he and his colleagues provide telemedicine and in-person consultations for several organizations in California in the northern region of the state and in the San Joaquin Valley. Infant mortality was 51 percent higher in the rural San Joaquin Valley than in the San Francisco Bay Area and approximately 31 percent higher in the state's northern region than in the Bay Area. Access to healthcare services in these areas was limited, especially for pediatrics. Faith-based organizations such as Mercy Medical Center Redding, St. Joseph's Medical Center in Stockton, and Adventist Health in Sonora, Marysville, and Lodi were the only providers of care in their regions, where most parents must travel three to five hours for any kind of specialty care for their children. UC Davis' affiliations with these organizations improve access to care for pediatric kidney failures, cystic fibrosis, and many other chronic conditions. Dr. Lakshminrusimha asked the University to retain UC Health's ability to serve

these children in underserved areas of the state by allowing UC Davis to affiliate with these organizations. For patients living in these rural, low-income areas, there was simply no other choice.

- D. Joseph Liesner stated that, while Make UC a Good Neighbor and the People's Park Historic District Advocacy Group awaited the California Court of Appeal's decision on the adequacy of the California Environmental Quality Act Long Range Development Plan Environment Impact Report for UC Berkeley's planned housing project at People's Park, they urged the Regents to rescind their approval of housing to be built on the site. He asserted that, on August 3, 2022, UC opportunistically took advantage of a 28-hour gap in the temporary stay by the Court of Appeal enjoining UC Berkeley from all construction, further demolition, tree-cutting, and landscape alteration at People's Park, which was listed on the National Register of Historic Places. Tree crews hired by UC cut down trees in the Park. On September 16, 2022, U.S. Department of Housing and Urban Development environmental protection specialist Stanley Toal stated that the "physical actions taken at the project site prior to conducting the Historic Preservation review may jeopardize the ability to issue environmental clearance, placing the reservation of the project-based vouchers and feasibility of the project as proposed at risk." Mr. Liesner argued that UC's actions had jeopardized the supportive housing element needed by homeless people. The People's Park Historic District Advocacy Group and Make UC a Good Neighbor supported the goal of supportive housing on a feasible alternative site owned by UC, not at People's Park.
- E. Mark Servis, M.D., psychiatrist and Vice Dean for Medical Education at the UC Davis School of Medicine, expressed concern that the School's training programs could be reduced or even eliminated if UC Davis was unable to affiliate with healthcare providers. UC Davis trains students and residents who are expected to become the future healthcare providers in low-income and underserved rural and urban communities and to work to address health disparities; this was a key structural component of the School's workforce program. UC Health workforce programs used affiliates with policy-based restrictions on care because they were the only healthcare facilities in underserved regions. Over the last dozen years, the UC Davis School of Medicine had a track record of success in diversity, in a high percentage of graduates choosing primary care, and in a high percentage of graduates choosing to practice in California. Dr. Servis asked the University to allow UC Davis to continue to affiliate with these facilities so the School could train students, residents, and fellows to help care for patients in underserved communities.
- F. Tamera Hatfield, M.D., maternal fetal medicine specialist at UC Irvine, emphasized her passion for and commitment to equity in health care. Her group began its affiliation with Providence St. Joseph Hospital in Orange in 2011. They had had the privilege to serve tens of thousands of patients, elevating the level of maternal care and ensuring access to reproductive care. Their work had fundamentally changed the way obstetric patients are cared for in the community. Patient health

and well-being was the central principle of this affiliation. Partnering with faith-based institutions which are dedicated to serving vulnerable populations affords opportunity for patients who are least able to navigate complex health systems. UC must find balance in its competing priorities in order to optimize health outcomes for communities at large; non-affiliation would be a significant barrier to achieving UC's community and statewide health goals. Dr. Hatfield confirmed that her ability to practice had been without restrictions and that UC's values had not once been compromised. She attested that, in 11 years of providing care, she had never been asked to modify recommendations for pregnancy management based on ethical and religious directives; indeed, she had been encouraged to ensure the full scope of care and options counseling, and, as such, she had regularly facilitated access to services such as abortion at UC Irvine. It was imperative that one continued to work together for the greater good of women's health care and patient rights.

2. APPROVAL OF MINUTES OF PREVIOUS MEETING

Upon motion duly made and seconded, the minutes of the meetings of July 21 and August 17, 2022 were approved, Regents Makarechian, Pérez, Reilly, Sherman, and Sures voting "aye."¹

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

The Committee recommended approval of the Clinical Enterprise Management Recognition Plan (CEMRP) incentive award for Dr. Carrie Byington as Executive Vice President – UC Health, Office of the President, in the amount of \$308,635, which is comprised of a Short Term Incentive award of \$268,768 for the 2021-22 CEMRP plan year and a Long Term Incentive award of \$39,867 for the performance period of July 1, 2019 through June 30, 2022.

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

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

Vice President Lloyd introduced this item for the approval of a Clinical Enterprise Management Recognition Plan (CEMRP) incentive award of \$308,635 for Carrie

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

Byington, M.D., as Executive Vice President – UC Health, Office of the President. The award was comprised of both short-term and long-term incentive awards. The award was approved by the Administrative Oversight Committee. This would be Dr. Byington's first CEMRP long term incentive award, covering the three-year period from July 1, 2019 through June 30, 2022. The long-term incentive award had been prorated by 89 percent, based on Dr. Byington's start date of October 31, 2019 through the end of the three-year performance period, reflecting 32 out of 36 months. The total of both the short and long term incentive awards being recommended was 34.45 percent of Dr. Byington's base salary.

Upon motion duly made and seconded, the Committee approved the President's recommendation and voted to present it to the Board, Regents Leib, Makarechian, Pérez, Reilly, Sherman, and Sures voting "aye."

4. COMMUNITY HEALTH NEEDS ASSESSMENTS AND IMPLEMENTATION PLANS, UC HEALTH

The President recommended that the Regents approve the implementation strategy developed by each of the University of California hospitals to address the significant health needs identified in their respective Community Health Needs Assessments for the taxable year ending June 30, 2022.

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

Executive Vice President Byington explained that the Affordable Care Act added requirements to Section 501(r) of the Internal Revenue Code for all tax-exempt hospital organizations, including governmental hospital organizations. In addition to meeting the requirements for tax exemption under Section 501(c)(3) and regulations and other rulings published by the Internal Revenue Service (IRS), hospital organizations had several new requirements, one of which was to conduct, at least once every three taxable years, a Community Health Needs Assessment, which takes into account input from persons who represent the broad interests of the community served by the hospital, to make the Assessment widely available to the public, and to adopt an implementation strategy to address the needs identified through the Assessment. The UC hospitals have all completed Community Health Needs Assessments for 2022, and each has developed an implementation strategy to address the significant health needs identified, either by themselves, or in collaboration with other healthcare or community organizations.

Upon motion duly made and seconded, the Committee approved the President's recommendation and voted to present it to the Board, Regents Leib, Makarechian, Pérez, Reilly, Sherman, and Sures voting "aye."

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

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

Executive Vice President Byington reported that most of the U.S. remained in a period of high transmission of COVID-19. There was a large number of cases, but most were not resulting in serious disease or hospitalization. One hundred percent of the COVID-19 disease in the U.S. was now caused by one or another Omicron subvariant. For all the subvariants, the booster vaccine was expected to remain effective. An issue of concern for the coming winter was the fact that the new subvariants BQ 1 and BQ 1.1 were expected to be resistant to all monoclonal antibody treatments for COVID-19 and to the long-term antibody treatment given to immunocompromised people. These variants appeared to be increasing in Europe. These subvariants now made up about 11 percent of the subvariants in the U.S. There was a low level of COVID-19 hospitalizations at UC hospitals. The downward trend of these hospitalizations was due to good population immunity and an effective vaccination campaign in California. One could expect an increase in winter. There were decreasing mortality rates for hospitalized patients and the rates at UC hospitals were lower than in the U.S. in general. Booster vaccinations improve outcomes for patients by decreasing the severity of illness, number of days that an individual is ill, viral load, and need for hospitalization.

Vaccine interventions also resulted in significant financial savings. A recent study projected the direct medical cost savings, by payer, for vaccination programs. If one could achieve booster vaccination rates like the rates for flu, or about 50 percent of the population vaccinated, this might save more than \$40 billion this winter in medical costs. If one could achieve 80 percent vaccination, this might save about \$60 billion. The booster vaccinations would save 75,000 to 90,000 lives. The health of the nation and the economy were directly connected.

The progress that had been made in achieving better control of COVID-19 was clear, and one entered the third winter since the beginning of the pandemic with less fear than in the previous two winters. There would be a surge, but treatment for COVID-19 had improved and there were ways to protect the population. As UC Health moved forward and no longer had to focus constantly on treating COVID-19, the organization could pause and consider how it had been reshaped by the pandemic and how it would proceed.

Dr. Byington then reported on other UC Health matters. The UC Davis School of Medicine has been ranked as one of the top schools for diversity in the U.S. and had just been ranked in the top one percent for graduating Hispanic or Latino/a physicians, who were significantly underrepresented in the U.S. The UC system was working to close this gap.

Dr. Byington mentioned two UC Health programs which promoted more inclusive leadership and more inclusive research. UC Health was working to strengthen its partnerships with the State of California. In September, Dr. Byington had become a member of the Department of Health Care Access and Information (HCAI) workforce

development group. The prior month, HCAI had awarded \$40.8 million for students in California to pursue careers in health care, with about \$13 million to UC Health campuses. UC Irvine, UC San Diego, UCSF, and UC Riverside were all recipients of these inaugural awards.

The past week, UC Health had launched its first systemwide grand rounds, and this would occur quarterly. The topics for systemwide grand rounds in 2023 would be reproductive health care and legislative updates, evidence-based programs to achieve health equity with a focus on mental health and COVID, and health professional workforce strategies for California. The topic of the first systemwide grand rounds had been long COVID and rheumatological, autoimmune, and myalgic encephalomyelitis/chronic fatigue syndrome (ME/CFS) conditions. The Centers for Disease Control and Prevention (CDC) estimated that 24 million people in U.S. had long COVID and that one million people were out of the workforce due to long COVID. This would become the chronic disease of the next decade. UC Health had developed long COVID training modules to educate providers in partnership with the California Department of Public Health. There were not enough specialists at UC Health to address the needs of long COVID patients. The training modules covered many important issues in cardiology, lifestyle, neurology, psychiatry, pulmonary medicine, and rheumatology.

UC Health was working to create new curricula for women's reproductive health care. As was the case with long COVID, there would not be enough practitioners to address reproductive health needs in California and the U.S. The new curricula would be presented at state and national professional conferences. UC was collecting data on the impact of the U.S. Supreme Court decision in *Dobbs v. Jackson Women's Health Organization* on residency training program applications.

The UC Health COVID Research Data Set (UC CORDS), developed from the UC Health data warehouse, was now being used by over 200 investigators across the UC system at medical centers and at campuses without medical centers. UC CORDS data have been used as a source for research and new publications which result in actionable treatments and guidance. This was a model for sharing of data across campuses and for allowing all UC investigators to have access to clinical resources to conduct research.

UC medical centers had recently been recognized again as leaders in quality and patient safety. The Bernard A. Birnbaum Quality Leadership Award is an annual award from Vizient that compares clinical performance of peer institutions with respect to safety, mortality, efficiency, effectiveness, patient-centeredness, and equity. UC San Diego, UCLA, and UCSF were in the top ten for this award. For the Vizient Ambulatory Quality and Accountability Award, UC Irvine was ranked fourth in the nation. Dr. Byington expressed pride in this recognition by Vizient.

UC Health works with the Association of American Medical Colleges (AAMC) as this organization advocates at the federal level to increase funding for academic health centers. The AAMC requested data on the reach of UC Health. Dr. Byington presented a map showing the reach of UC Health, not only in California and the Western U.S., but with UC

Health patients in every state of the U.S. UC Health was a national system and its work affected the health of the nation.

Dr. Byington announced a new hire who would join UC Health in December to help UC Health focus on legislative advocacy in Sacramento. Tam Ma would be the new Associate Vice President for UC Health Policy and Regulatory Affairs. Ms. Ma was currently serving as the Deputy Legislative Secretary for health in the office of Governor Newsom.

Dr. Byington concluded her presentation with a poem by Uruguayan writer Eduardo Galeano (1940–2015). In the poem “We,” Galeano observes that “In the face of disillusionment, when disillusionment has become an article of massive and universal consumption, We continue to believe in the startling powers of the human embrace...” Many people have experienced disillusionment in the response to the COVID-19 pandemic and in the polarization that has occurred in the United States, but Dr. Byington continued to believe in the startling power of the human embrace one saw every day in the UC Health system.

Committee Chair Pérez referred to the recognition for diversity at the UC Davis School of Medicine mentioned earlier and to terms shown on a slide: “Hispanic, Latino, or Spanish origin.” He asked if “Spanish origin” meant an immigrant from Europe. Dr. Byington responded that this term from the AAMC was an attempt to be as inclusive as possible. An entire subsection of the AAMC was working on determining the right way to identify people in this category.

Committee Chair Pérez asked if this term was in alignment with characterization as an underrepresented minority. Dr. Byington responded that all the individuals in these categories would be characterized as underrepresented in medicine. In response to another question by Committee Chair Pérez, Dr. Byington confirmed that this was not a UC term or definition.

Committee Chair Pérez referred to the grand rounds presentation scheduled for spring 2023 on evidence-based programs to achieve health equity with a focus on mental health and COVID. He asked if this would focus on mental health as it relates to COVID, or broadly on mental health and COVID. Dr. Byington responded that the emphasis would be on inequities in the area of mental health which had been brought forward by COVID-19. Topics would include COVID-19 and its aftermath, as well as other topics such as substance use disorder.

Committee Chair Pérez referred to the CDC estimate that 24 million people in U.S. had long COVID and that one million people were out of the workforce due to long COVID. He asked if there were disparities in the statistics across different demographic groups, as one had observed for excess deaths and shorter life expectancy. Dr. Byington responded that this was a critical issue. There were disparities in patients who come for evaluation of long COVID. Patients who came for evaluation were largely an insured and white population. Latino(a), Black, and Native American patients were missing from long COVID clinics. Dr. Byington did not believe they were missing because they had not been

affected by long COVID, but more likely because they lacked access to services. This was an area of intensive evaluation.

Committee Chair Pérez asked if the estimates of 24 million and one million were likely undercounts. Dr. Byington responded that these were no doubt underestimates.

Committee Chair Pérez requested an update on monkeypox in California. Dr. Byington reported that monkeypox was in a downward trajectory. There had been excellent vaccination rates in high-risk populations. There had not been vaccine hesitancy or refusal to take the vaccine, even in a more complicated two-step vaccination process. The supply of the vaccine was in excess of need. There had been important behavioral interventions, with individuals modifying their behavior in order to reduce the risk of being exposed to or transmitting monkeypox. Monkeypox was a relative of a common pox virus, molluscum contagiosum, which spreads easily in school settings. One had not seen a spread of monkeypox into settings with children, either in daycare centers or schools. Whether or not one could eliminate monkeypox from the U.S. was still an open question. One would have to remain alert to monkeypox. Regional containment and control would be possible.

Regent-designate Raznick referred to the new Omicron subvariants BQ 1 and BQ 1.1 and asked if the booster vaccines were keeping ahead of the mutations. Dr. Byington responded that there had not been enough booster vaccination in the U.S. The U.S. had access to as much vaccine as it needed, but only about 30 percent of people eligible for booster vaccinations have received the booster vaccine. The question of whether one could keep ahead of COVID variants was important. The mRNA vaccines allow one to change the vaccination composition quickly. The current booster vaccine was related to the original vaccine, but there was a change in the genetic code that was accomplished quickly. Dr. Byington expressed confidence that one could keep up with variants that could become damaging or problematic but noted that there would be six- to eight-week turnaround time to create a novel vaccine if needed. It was challenging to predict what the next troublesome variant would look like. The longer the Omicron variant remained the dominant variant, the more one could learn about it and the better chance one had to build up immunity.

Regent-designate Raznick asked Dr. Byington about her level of concern regarding monoclonal antibody resistance and the increase in the subvariants BQ 1 and BQ 1.1. Dr. Byington responded that she was very concerned. These subvariants were resistant to all monoclonal antibody treatments for COVID-19. In Europe, the BQ subvariants were accelerating past the B4 and B5 mutations. BQ 1 and BQ 1.1 would increase, and there would be a period without functioning monoclonal antibodies. Drug companies were working on new generations of the monoclonal antibodies. Hospitals and providers have relied on monoclonal antibodies for treatment in many parts of the country, especially the South, where there had been low vaccination rates.

6. **EMPLOYEE ENGAGEMENT, 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 introduced the discussion by recalling that healthcare workers had been on the frontlines of the COVID-19 pandemic for more than two years. This made employee engagement efforts more critical than ever. Gauging employee morale and satisfaction was already an important function within UC Health, and this work has continued with a greater sense of urgency.

UCLA Health President Johnese Spisso presented a slide with a list of examples of tools used to collection information at each of the UC medical centers. These tools allow human resources departments to measure trends of interest to the employee population. Each location uses formal and informal tools to collect information, all locations survey their employee populations, and relevant decision-making is informed by these collected data. UC Health locations rely on the participation of their employees to get a sense of current concerns, priorities, and opportunities.

Certain trends were being observed in California and across the nation which were challenging for employee engagement. Occupancy at UC hospitals was high, often exceeding 100 percent, and resulting in patient boarding in emergency departments, satellite areas, and hallways. This was taxing for patients and staff. UC had worked with the California Department of Public Health to set up additional satellite boarding areas. Under waivers during the pandemic, UC medical centers were able to create additional and critically needed capacity for patients. During the pandemic, UC Health locations also experienced clinical and non-clinical workforce shortages. There had been increased workloads for clinical and non-clinical employees as a result of increases in patient acuity, pandemic protocols, and regulatory requirements. The medical centers faced recruitment and retention challenges due to salary and cost of living concerns.

While there was not a single, “one size fits all” approach to responding to the needs of employees, observable trends appeared that applied to more than one location. The locations were continuously sharing best practices. UC Health pays ongoing attention to diversity, equity, and inclusion, increasing communication across the health organization, and empowering employees to create organizational change. UCSF Health’s Employee Coping and Resilience Program had been launched during the pandemic to empower employees to use their voices to make a difference in the organization. The measurable results of this work were shown in the fact that the locations reported internal improvements for employee survey results. UC Health locations also compare themselves against peer groups in the nation, using information from Vizient and Press Ganey. The UC medical centers are generally well regarded as employers of high quality.

UC Irvine Health Chief Executive Officer Chad Lefteris described employee engagement approaches at UCI, envisioned as a feedback loop system. UCI Health carries out a variety of surveys, some broadly within the organization and some more focused and targeted. UCI makes efforts to communicate with employees about the importance of participating in surveys and about what UCI has done with the information and feedback it has received in these surveys. Formal and informal approaches are used. UCI Health’s co-worker engagement survey had a 70 percent response rate. UCI had developed an ideation/innovation platform called “Bright People Brilliant Solutions,” in which people

can propose innovative ideas, and UCI leaders and employees vote on the proposed solutions. Recently, this program produced new ideas about how UCI Health can improve wayfinding.

All UC Health locations had programs dedicated to the well-being and wellness of their employees. The UCI Susan Samueli Integrative Health Institute provides free access to evidence-based theories and practices through a Wellbeing Initiative for UCI and UCI Health employees. In fiscal year 2022, about 4,600 UCI Health employees participated in these programs. Mr. Lefteris noted that, contrary to his expectation, virtual programs on mindfulness and yoga for stress reduction were oversubscribed. UC San Diego had received recognition for its Healer Education Assessment and Referral (HEAR) Program, an anonymous web-based tool for screening and referral for trainees and providers.

Ms. Spisso commented that a similar model was used at each location. UC Health locations listen to their employees, develop interventions, measure results, and use this information to become employers of choice. There were good results in employees sharing information through surveys if the employees saw that UC Health was using this information to guide organizational change. UCLA Health carries out several different types of surveys, including an extensive culture of safety survey. Employees can communicate anything that leads to a “near miss” or a “good catch” in patient safety. The executive leadership team participates in rounds, and there are regular “safety huddles.”

UCLA Health had many employee recognition programs. Ms. Spisso emphasized the importance, in the area of quality of patient care and satisfaction, of acts of kindness that staff perform for patients and families. Some employee recognition programs were focused on this. During the pandemic, UCLA volunteers have provided “kindness carts,” with healthy treats and inspirational messages delivered to employees in patient care units. Small efforts can be meaningful. UCLA developed approaches for staff safety during the pandemic when it observed that patients and visitors became fatigued by rules and protocols imposed due to the pandemic and there were more incidents of aggressive behavior directed at staff. Medical and security staff worked together on ways to deescalate these kinds of situations and to provide support for staff. UCLA Health participates in a number of national surveys to which employees can contribute feedback. Survey results have shown UCLA and UC Health as an employer of choice.

Mr. Lefteris concluded the presentation with comments on staff turnover, an issue of concern for all UC Health locations. He presented a chart with turnover rates for fiscal year 2021–22 for each UC Health location, along with regional turnover rates for health care and regional turnover rates overall. Turnover rates at UC Health locations were lower than regional turnover, although they had increased in the last few years. UC Health was closely monitoring these rates, which served as a proxy for employee engagement. UC must focus on the causes of turnover, the details of employees’ reasons for leaving, and use these data in its retention efforts.

Committee Chair Pérez noted that the staff turnover rate at UC Irvine was 12.4 percent, while the rate for healthcare employees in this region was 19.9 percent, and regional

turnover overall was 21.3 percent. He asked what the baseline rate was before the COVID-19 pandemic. Mr. Lefteris responded that turnover at UCI Health had increased by about two percent. Ms. Spisso added that the staff turnover rate at UCLA Health was ten percent in 2019. In 2020, when the pandemic began, few employees wanted to leave their jobs, and the rate decreased to eight percent. The rate increased to 11 percent in 2021.

Committee Chair Pérez asked if UC Health was experiencing a significant increase in turnover based on a rolling three-year average, or if there had been one year with low turnover followed by years with greater turnover. He also asked about the reasons for employees leaving UC Health and if they were leaving the healthcare field altogether. Employees might be satisfied with the University but not want to work in this field, given their experiences of the last two years. This was an important area to examine.

Regent Makarechian commented that three factors mentioned in this discussion were especially troubling: high hospital occupancy, the workload for employees, and the challenges of employee retention given the cost of living. He related that he had attended a UCSF discussion a few days prior on automation and robotics in health care as a means to address employee stress and burnout; he suggested that the report from that discussion be shared with the Board or the Health Services Committee, or that there be a presentation at a future meeting. Many nurses had retired in the last few years. From his own experience as a patient, Regent Makarechian knew how hard and how many hours nurses, residents, and other hospital employees work. Employee engagement efforts at UC medical centers were very important. He expressed concern about how the current economic environment of high inflation affected lower-paid employees at UC Health. UC had signed contracts and given raises in the last few years on the basis of lower rates of inflation. Along with the high stress of working in a hospital environment one also had to consider the stress caused for these employees by the high cost of living. Many UC Health employees could not afford to live near the UC medical center where they work. Regent Makarechian asked if the University was taking action to address UC Health employees' financial needs in a difficult economic environment. Ms. Spisso responded that, through its human resources departments, UC Health endeavored to offer competitive salary and benefit packages. UC also made efforts through its employee assistance programs at each location. During the pandemic, there had been a tremendous response from businesses and donors which allowed UC Health to provide resources for employees. Mr. Lefteris noted that the Clinical Enterprise Management Recognition Plan (CEMRP) program extended to frontline hospital workers. He acknowledged that keeping up with inflation was challenging.

Committee Chair Pérez recalled that a new contract had been negotiated for nurses in the last six months. He asked about other healthcare workers; it was his understanding that a number of new contracts had been signed in the last six to eight months which took into account changes in economic conditions. Ms. Spisso confirmed that this was the case. This would continue to be a guiding principle in all discussions as contracts opened up.

Regent Leib asked why the staff turnover rate was higher at UC Riverside than at the other locations. UC Riverside Health Chief Executive Officer Donald Larsen recalled that UCR Health was a much smaller organization than the other UC Health locations, with a smaller

number of employees overall, so that losing even a small number of employees can make a difference in the turnover percentage. This was the main reason for the difference in rates. In 2020, the turnover rate at UCR Health was 16 percent; this decreased to 11 percent in 2021. The rate of 14.6 percent in 2022 was due to pandemic stress, among other factors. UCR did not have a hospital but had six clinics and struggled to recruit and retain medical assistants. UCR partnered with medical assistant schools in the community to offer externships, which provided UCR with a pipeline.

Regent Leib asked about the reasons for the low turnover rate of 8.2 percent at UCSF. UCSF Health Chief Executive Officer Suresh Gunasekaran responded that there had been variation in turnover over a three-year period, as suggested by Committee Chair Pérez. UCSF Health had been successful in retention of key workforce populations, with nursing and service worker populations remaining relatively stable. There were some trends that were cause for concern. UCSF had trouble recruiting and retaining some specialized populations. UCSF had good relationships with local educational institutions, and many new graduates would choose UCSF as a place to start their careers. Chancellor Hawgood added that in its surveys, UCSF also asks hospital staff and physicians if they plan to remain in the healthcare field. The number of those who state that they are considering leaving health care had increased. Chancellor Hawgood was concerned that some employees had remained on the job because they knew they were desperately needed during the pandemic, and that there might be losses in the next few years. This would depend on macroeconomic forces and a person's confidence about securing another job.

Regent Sures stated that it was undeniable that the quality of care at all UC Health institutions was excellent, as was patient safety. There were issues of concern in the areas of hospital occupancy, shortage of staff, increased workload, and recruitment and retention. He suggested that the Committee study each of these four topics in greater depth and form working groups to develop solutions. UC Health had received waivers during the pandemic to allow certain practices and procedures, and Regent Sures did not understand why UC could not extend these waivers. UCLA Health used tents to add capacity and was able to see a much larger number of patients. Regent Sures asked how the Regents could help in seeking extension of these waivers for the medical centers. These waivers helped the patient population. Ms. Spisso responded that, during the pandemic, because Governor Newsom had declared a state of emergency, UCLA was able to receive regulatory relief to allow it to be more creative in how it used its facilities and to accommodate more patient beds. Many UC hospitals opened so-called "shadow beds," putting two patients in larger rooms generally only used for one patient. UCLA Health was able to add 50 more beds in this manner. With the end of the state of emergency, the medical centers would again face these regulatory challenges. Over the past month, there had been four regulatory surveys at the Ronald Reagan UCLA Medical Center. Ms. Spisso believed that the individuals carrying out the surveys were aware of the challenges UCLA was dealing with. UCLA would continue to work with local entities and the California Hospital Association, which was examining how hospitals could receive ongoing waivers as needed. UC San Diego Health Chief Executive Officer Patricia Maysent, who was UC Health's representative to the California Hospital Association, commented that one could not overstate the volume of patients at UC Health at this time. While patient volume seemed excessive during the

pandemic, it had now increased. Demand for services was enormous. Patient diversion was not allowed for the emergency department. This situation put a great deal of stress on staff. UC medical centers did many things to support the emergency department and patients in hallways who need services and for whom medical centers cannot provide beds for 24 to 48 hours. This was a very challenging time for UC medical centers.

Committee Chair Pérez commented that there were different types of waivers. Some waivers were intended to increase access, while other waivers were intended to increase access but change staffing ratios. The University must make a clear distinction between these two. If UC failed to do so, it would undermine UC's ability to secure waivers. The California Hospital Association might not have been as clear as it should be in differentiating these two types of waivers. UC Health had had the ability to waive certain staffing ratios but did not take advantage of these waivers. While UC did not act on these waivers, the fact that it could do so caused tension. UC must be clear about which waivers it would seek to extend after the end of the public health emergency.

Regent Sures remarked that securing certain waivers would allow UC hospitals to expand in areas where this was necessary, perhaps on a temporary basis; for example, being able to expand during patient surges. Regent Sures asked about nurses who complained about not being able to get break time. He asked if this type of complaint was common and how UC Health dealt with these complaints. Ms. Spisso responded that break relief was part of staffing requirements and agreements. Instances when break time is not available are reported through the chief nursing executive. At all UC medical centers, nursing managers and directors are registered nurses and are on the floor as well to assist and troubleshoot. Compliance with break requirements was important.

Regent Sures asked if there were many such complaints. Ms. Spisso responded that there had not been many complaints during the last several months at UCLA. There had been more complaints at various times during the pandemic. Mr. Leteris added that the same was true for UC Irvine.

Regent Sures asked if UC medical centers were conducting exit interviews with employees in order to find out their reasons for leaving and to be able to mitigate this loss. Mr. Leteris and Ms. Spisso responded in the affirmative. Ms. Spisso added that UCLA had earlier had an informal process; UCLA now had a standardized tool which allowed for tracking of these data.

Regent Sures asked about safety measures for employees and patients. Metal detectors were being used in the UCLA emergency department. He asked if there had been more incidents of violence in the emergency department. Ms. Spisso responded that there had been an increase in violent incidents in community hospitals in Los Angeles. UCLA was using a metal detection system and had added a security system which allows one to identify immediately where an individual is. Mr. Leteris added that a similar system was in place at UC Irvine and confirmed that the frequency of violent events at hospitals in the U.S. had increased.

Regent Sures asked if there was a similar level of security at all UC emergency rooms. Mr. Lefteris and Ms. Spisso responded in the affirmative. Ms. Maysent commented that UC did not have the same security measures in other clinics and settings, where there could also be violent patients, families, and visitors. Potential problems, such as individuals carrying a gun, are caught in advance in emergency departments, but people with guns walk into rehabilitation centers and outpatient clinics. Dr. Byington stated that there would be a report on workplace violence at UC Health at a future meeting.

Advisory member Ramamoorthy asked if the data on staff turnover were broken down by healthcare worker type. This would allow for a focused intervention. She asked about the economic impact of turnover. It is difficult to replace an employee with 15 to 20 years of experience and expertise in a medical specialty. UC Health must consider this carefully. The information presented earlier compared turnover at UC Health locations to regional benchmarks. Dr. Ramamoorthy asked about benchmarks for top ten institutions, because these were the institutions with which UC Health should be comparing itself. The regional benchmarks used for this presentation likely included all institutions, such as community hospitals. Dr. Ramamoorthy asked how UC Health compared to its peer group. She described the physician workforce as the anchor of patient care delivery. Physicians were the revenue generators and provided the expert care that patients sought at UC medical centers. They were not unionized and did not have established break times. Some physicians were leaving and walking away from high salaries. UC must focus on physician loss and make more efforts in mitigating this. Mr. Lefteris responded that the data sources on staff turnover were detailed enough to allow for analysis by job type, department, or division. It was also important to consider the factor of longevity. Currently, the national average cost of nurse turnover was in the range of \$46,000 to \$58,000 per turnover. This cost would be higher at UC. Ms. Spisso added that, based on Vizient benchmarks, which encompassed 105 academic medical centers, UC Health institutions were in the top percentage with the lowest turnover. UCLA shares physician survey data with clinical chiefs and department chairs. UCLA has also endeavored to instill the idea for these chiefs and chairs that they are also chief retention officers and must understand what is causing turnover in key areas.

Regent Park asked what collective action UC Health needed to take to respond to staff turnover rates currently and projected for the coming years. Dr. Byington responded that one must increase the pool of people entering the healthcare workforce. Collective action can be taken in California to reduce barriers and to ensure that all qualified people feel that they can pursue a career as a physician. In the long run, this would lead to greater retention. One also had to increase the number of residency training slots. It was necessary to increase and diversify the pipeline. Mr. Lefteris commented that these efforts must begin with middle school students, making them aware of the many ways that they could join the healthcare profession.

Regent Park asked about more specific goals for increasing workforce numbers. Ms. Spisso responded that, three years prior, UCLA Health partnered with UCLA Extension to develop a medical assistant training program. UCLA provides scholarships for participants. Many participants work during the day, so the courses are scheduled from 6 p.m. to 9 p.m.

Participants can receive a credential in a year and be employed in UCLA clinics. This program had been very successful and addressed a need for positions that UCLA had struggled to fill.

Regent Sherman asked if UC had data for why employees leave, by category, so that UC can address the reasons for leaving. Mr. Lefteris responded that UC Health collects these data and tries to get this information even before an employee decides to leave. Retention of employees was essential.

Regent Sherman asked where these employees go, and if they remain in the medical field or leave the field. Mr. Lefteris responded that about 50 percent of healthcare employees in the U.S. who were leaving their jobs at this time were also leaving the healthcare field. Ms. Spisso described UCLA's efforts to hire graduates from its own School of Nursing. This last year, UCLA succeeded in hiring more than 400 nurses. For a new graduate or a new employee, UCLA must spend at least six weeks training that individual. UCLA monitored this process closely because it represented a significant investment. The retention rate for new graduates was 95 percent. UCLA interviews individuals who leave UCLA to find out their reasons for leaving. If UCLA can retain an individual longer than the first year, this person is likely to become a career employee.

Regent Reilly asked about the retention and recruitment of mental health providers at UC. Ms. Spisso responded that this was challenging. UCLA operates a large psychiatric hospital and has a large outpatient psychiatric population. Behavioral health was integrated into many primary care clinics. UCLA worked with all the training programs in the region to try to increase this pipeline. UCLA was considering how it would staff its mid-Wilshire campus and creative ways to provide scholarships. Mr. Lefteris reported that UC Irvine was giving family medicine physicians training in behavioral health in an effort to extend this expertise beyond the traditional providers and psychiatrists. More programs like this one would help address the need.

Committee Chair Pérez recalled previous discussions about the mental health needs of UC Health employees. At that time, the usage rate of the services that UC provided was not as high as one might have expected. He asked if there had been a shift in the number of employees taking advantage of mental health support services within UC Health. Ms. Spisso responded that there had been an increase at UCLA. Over the last two years, UCLA has continued to add resources to its employee wellness programs. People were reaching out and making use of these program more quickly now. In the first year of the pandemic, employees had not had the time to do so. Mr. Lefteris agreed with this assessment.

Regent Park asked if UC Health was measuring employee engagement accurately, or if there might be something missing in these surveys and data tracking. Ms. Spisso responded that UC Health was paying continuous attention to this question; this was the reason for the many different survey tools in use. In the last two years, UC Health had increased tracking of equity, diversity, and inclusion. UC Health consulted with Vizient, Press Ganey, and other national organizations about which survey tools were being used.

Recently, UCLA deployed a “pulse survey” of only five questions because many people were not taking the time to complete longer surveys. UCLA issues many pulse surveys and changes the survey questions each time, based on the results of the last survey. Mr. Lefteris observed that no doubt something was being missed; this was inherent in this kind of work. The culture of safety survey, in use at all the medical centers, was a proxy for engagement. UC Health wished to receive feedback and was providing as many options as possible for feedback. Ms. Spisso observed that routine surveys provided information on trends, but that rounding in the various clinical areas and dialogue and interface with staff was invaluable. UC Davis Human Health Sciences Vice Chancellor David Lubarsky reported that his location had initiated a model for distributed psychological support, a peer support program. UC Davis Health had trained about five to six percent of its entire workforce for psychological triage. These employees were distributed across every unit in the medical center and had been trained to serve as a sounding board, a colleague most familiar with the troubles that someone might be experiencing, and to refer individuals to the care needed. These individuals were identified across the organization, and this gave UC Davis the ability to get information at the ground level on issues that the institution might be missing. This had been a successful program.

Committee Chair Pérez commented that, while this discussion had focused on nurses and physicians, the data UC Health was collecting was broader in scope. It was important to continue to take this approach. Employees in every different part of the UC health delivery system were essential, and it was important to value and support them.

7. **AFFILIATIONS WITH HEALTHCARE ORGANIZATIONS THAT HAVE ADOPTED POLICY-BASED RESTRICTIONS ON CARE: UC FACULTY PHYSICIAN PANEL – WOMEN’S REPRODUCTIVE HEALTH AND TRANSGENDER CARE AT THE AFFILIATED HOSPITALS, AND UC HEALTH UPDATE ON IMPLEMENTATION OF POLICIES GOVERNING COVERED AFFILIATIONS**

[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 thanked the Committee for its guidance over the last several years on the issue of affiliations with healthcare organizations that have adopted policy-based restrictions on care. This engagement had resulted in a Regents policy (Regents Policy 4405, Policy on Affiliations with Healthcare Organizations that Have Adopted Policy-Based Restrictions on Care) and an interim Presidential policy which provided UC with a framework for current and future affiliations. UC Health was currently in year one of a two-year implementation process for these policies and had already seen positive results. From the vantage point of practitioners and educators, the policies ensure that tens of thousands of people who rely on UC services each year while receiving care at affiliate locations continue to have access to the care and expertise of UC clinicians. The policies also keep approximately 700 training positions open each year for future physicians, nurses, pharmacists, and other health professionals who will serve the people of California.

As the University entered the second year of policy implementation, it found itself facing significant political changes and pressures in the U.S. which added complexity to the discussion and increased the impact and urgency of UC affiliations with entities with policy-based restrictions on care. The Regents and Presidential policies offered a framework to navigate these complexities and positioned UC Health as a national leader, as many academic health centers grappled with these issues. Dr. Byington stressed that UC Health remained committed to engaging in the deep work and dialogue required to meet the imperative of upholding UC values and ensuring that UC clinicians can continue to provide high-quality care for as many people as possible.

Faculty Representative Cochran then introduced five UC faculty members, four practicing physicians from UC clinical settings and a professor from the UC Davis School of Law, to provide testimony on reproductive and gender-affirming healthcare practices at UC and in affiliated healthcare settings with ethical and religious directives. Since the U.S. Supreme Court decision in *Dobbs v. Jackson Women's Health Organization*, many Americans had come to learn more about the intricacies of obstetrics and gynecological care in hospitals as well as the complexity of healthcare decision-making for physicians, patients, and patients' families. Since the Regents approved Regents Policy 4405: Policy on Affiliations with Healthcare Organizations that Have Adopted Policy-Based Restrictions on Care, the Academic Senate has been concerned about what, concretely, the policy and the contracts subject to it permit. The speakers would share their expertise in these matters. They were Jennifer Kerns, Associate Professor of Obstetrics and Gynecology at UCSF, and Director of the Complex Family Planning Fellowship at San Francisco General Hospital; Tabettha Harken, Professor of Obstetrics and Gynecology at the UC Irvine School of Medicine, also Division Director of Complex Family Planning, Obstetrics and Gynecology, and Director of the Ryan Residency Abortion and Contraception Training Program; Mya Zapata, Assistant Clinical Professor of Obstetrics and Gynecology at the UCLA School of Medicine; Mark Litwin, Professor and Chair of the Department of Urology at UCLA School of Medicine, who directed clinical faculty practices in affiliated settings where urologic procedures were provided within the guidelines of those settings; and Lisa Ikemoto, Professor at the UC Davis School of Law and expert in areas of reproductive health law and healthcare disparities.

Dr. Kerns shared that she had been practicing as an obstetrician-gynecologist at UCSF for 14 years. She explained that complex family planning was specialized training in contraception and abortion following a residency in obstetrics and gynecology. Dr. Kerns was also a generalist, working on labor and delivery, gynecologic surgeries, and in outpatient clinics. She traveled to Wichita, Kansas once a month to provide abortion services and was able to observe firsthand the effects of limiting access to abortion and contraception. The current time was unique and sobering, following the U.S. Supreme Court's decision to overturn *Roe v. Wade* and allowing states to outlaw abortion. People with sufficient financial resources and social support were traveling on average over 500 miles to access abortion, while some were forced to continue a pregnancy against their wishes. Dr. Kerns felt deeply honored to work at a University of California campus where the commitment to non-discrimination and evidence-based medicine has always been of the utmost importance.

UC's commitment to these principles helped her to carry out the job that she was trained to do. As a UC faculty member, she worked at San Francisco General Hospital, a public safety net hospital serving the most vulnerable people in the healthcare system. As a physician, Dr. Kerns had been trained to support her patients' health. Fortunately, responding to emergencies accounted for only a small percentage of her patient care. The mission and mandate for healthcare providers is to work upstream from the emergency: to identify and treat high blood pressure before it leads to stroke; to screen for cervical cancer with pap smears before cancer develops; and to prescribe contraception for someone who wishes to avoid pregnancy before she becomes pregnant. The scope of the work that physicians do necessarily includes all the work done upstream from emergencies, to keep patients healthy and thriving in their families and communities. It is this upstream, non-emergent care that allows patients to avoid emergencies.

Dr. Kerns provided examples from her practice pertaining to contraception. As a UCSF physician at SFGH, she was not restricted from offering the full scope of reproductive services to patients. The prior month, she took care of a 38-year-old woman who was having her third cesarean section. She had a condition called placenta previa, in which the placenta sits over the cervix, a condition that can lead to catastrophic bleeding for the mother and the baby as the cervix changes during pregnancy. This patient had to be admitted to the hospital for several weeks during her pregnancy because of this complication, keeping her from her work and away from her children. During her pregnancy, she requested permanent sterilization at the time of her cesarean section, as it was clear for her that she was done with childbearing. She wanted to focus her time and energy on her existing children. In addition to being clear on this point, she also knew that any future pregnancy would be a high-risk pregnancy, with the potential for the same or even worse complications with the placenta. Dr. Kerns performed the cesarean section and delivered a healthy baby. Consistent with best practices, endorsed by national guidelines and professional societies, including the American College of Obstetricians and Gynecologists, the Society of Family Planning, the Centers for Disease Control and Prevention, and the World Health Organization, Dr. Kerns also performed a permanent sterilization for this patient by removing her fallopian tubes, a step in the procedure that took an additional five minutes.

Dr. Kerns' understanding was that if she, as a UC physician, had been working in a hospital with restrictions on abortion and contraception, she would not have been allowed to fulfill her patient's request. She would have been allowed to do so if this had been an emergency, but permanent sterilization is never an emergency. Emergency situations that can arise in this context are uterine rupture during pregnancy, a life-threatening event when someone has closely spaced pregnancies, or a morbidly adherent placenta, when the placenta invades into the uterus. This patient of Dr. Kerns would have been more likely to have an unintended pregnancy soon after the birth of her last child, and that closely spaced pregnancy would have increased her chance of having life-threatening events like uterine rupture or abnormal invasion of the placenta into the cesarean section scar, with hemorrhage. Performing a sterilization when the patient requests it prevents these emergencies.

The physician's job is to intervene upstream when a patient requests care that will keep her healthy and safe in the future. According to best estimates, over 50 percent of permanent sterilization procedures, also known as tubal ligations, occur immediately postpartum, within the same hospitalization, because access to the fallopian tubes is much easier right after a patient gives birth. If the patient has a cesarean section, the fallopian tubes are accessible, and no additional procedure or additional risk is needed. For a patient with a vaginal delivery, the procedure requires little more than a small incision, as the postpartum uterus is still enlarged and close to the level of the belly button, where the incision is made. This procedure can be done with low-risk anesthesia, an epidural, and takes about 20 minutes. When a patient is denied sterilization at the time of giving birth, she must return six or more weeks later for a separate surgery. This adds obstacles and risks to her care. Nearly half of all patients do not appear for postpartum visits, and the number was even higher for vulnerable populations. Physicians have a window of opportunity to provide services, to work upstream for the health of birthing patients, and that window often closes with discharge from the hospital.

Approximately 50 percent of patients who request a postpartum permanent sterilization and are denied the procedure become pregnant within a year. Denying a patient permanent sterilization at the time of her delivery can put her at risk, risk which is real and documented. For those who are able to follow up after six weeks, a permanent sterilization procedure then becomes an additional surgery, with risks of general anesthesia and risks of laparoscopic surgery, surgery done with a camera, which include bleeding and damage to other organs.

Dr. Kerns' patient was a high-risk surgical patient. In addition to her prior cesarean sections, she had had two other surgeries, for her appendix and her gall bladder, making an additional surgery riskier, especially regarding damage to other organs. It was not an emergency that prompted performing this patient's permanent sterilization, but there were many compelling reasons to do so, and each reason was sufficient in and of itself. Delaying care for permanent sterilization is not consistent with the principles of medicine, that of taking action to avoid increased risk and harm in the future.

Dr. Kerns also routinely provided other contraception to patients upon their request immediately after delivery, including intrauterine devices (IUDs) and contraceptive implants in the arm. These were both highly effective methods of contraception and have been endorsed and promoted by the professional societies mentioned earlier. These were methods that could otherwise only be started with an additional visit, which did not occur for about half of patients, leaving them either with contraception they did not want or, often, no contraception at all. Dr. Kerns' understanding was that, if working in a hospital with restrictions on contraception, she would not be allowed to perform these contraception procedures. In order to help patients prevent unplanned and undesired pregnancies, the most important thing she could do was to give them the contraception they want when they request it. Denying contraception postpartum has a significant impact on their health and livelihood. Dr. Kerns had seen this in Kansas with many patients and had heard stories of women from Texas, Arkansas, and Oklahoma who were denied postpartum sterilization and were now shouldering significant burdens to access abortion. California and the UC

system had an opportunity to support broad access to an evidence-based standard of care for women's reproductive health.

Dr. Harken noted that she had taught medical students and residents for more than 16 years and continued to do generalist work, delivering babies and caring for patients in the emergency department. The UC Irvine Medical Center was the only hospital in Orange and San Bernardino Counties providing hospital-based abortion services for patients too sick to receive services in the outpatient clinical setting. Dr. Harken was very familiar with high-risk pregnancies, emergency obstetrical situations, and the intricacies of referrals and transports.

She drew attention to two areas in the current UC policy. For people who did not work in health care, it might not be immediately clear why these areas could be problematic. The policy stated that UC personnel and trainees may "provide any item or service they deem in their professional judgment to be necessary and appropriate in the event of an emergency..." While this seemed like common sense, this was the federal minimal requirement of care, what is minimally allowable under the Emergency Medical Treatment and Labor Act (EMTALA) of 1986. This raised the questions: what is the definition of an emergency? How sick must a patient be before Dr. Harken would be allowed to intervene to help her? How long would a physician have to willfully endanger the patient by withholding evidence-based care before providing such care, which, at a UC facility, would have been started immediately upon diagnosis?

The policy recognized that there are policy-based restrictions on care and protected the rights of UC personnel and trainees "to make clinical decisions, counsel, prescribe, and refer or transfer... without limitation..." Again, this seemed appropriate, but it only allowed UC physicians to make decisions, counsel, and prescribe. The policy did not allow UC physicians to perform procedures and interventions, or to treat outside the ethical and religious directives, unless in case of emergency.

Dr. Harken presented an example demonstrating why this was problematic and why the current option of transferring or referring patients was not an acceptable solution, as it appeared to be on paper. One common situation was that of a patient who comes to the hospital early in pregnancy with cramping and bleeding. The hospital diagnoses that her water has already broken at five months. This is a devastating situation, not only because the baby needs the bag of water, the amniotic sac, intact to allow for lung development, but also because the intact bag of water protects the mother from the onset of infection and bleeding. The longer she remains with the bag of water broken, the higher the risk. Eventually, she can develop sepsis, hemorrhage, require transfusion, and suffer kidney damage, as well as possibly lose her uterus. There was currently no treatment to address this situation. The best that Dr. Harken could do would be to counsel the patient and offer her and her family options of how to proceed and to honor their wishes. Given the high risk of death to the fetus and the risks to the mother, UC Irvine always offers to induce delivery, which must be carried out in a hospital. The mother will deliver a five-month-old fetus that cannot survive outside the uterus. This is called an induction termination of pregnancy. Some parents choose this option because they want to see and hold their baby, have a

religious ceremony, bless their baby, or bury their baby. UCI nurses prepare special memory boxes for families which include photographs and mementos. UCI also always offers a surgical termination of pregnancy in which the patient is under anesthesia for the procedure. Some patients choose this option because they cannot face leaving labor and delivery without a baby or because it is too painful to wait, knowing that eventually they will go into labor at an unpredicted time, or due to the need to continue working at their jobs, as their family relies on their wages, or to care for other children they have. Dr. Harken's understanding was that, as a UC physician, if she were working in a hospital that operated under the ethical and religious directives, she would not be allowed to provide the induction or the surgery. Instead, she would have to offer the patient to wait and see if she developed an infection or refer her to another clinic to have her surgery. She would not have the option of delivering and of seeing and holding her baby. Dr. Harken would have to hope that, when she sent the patient away, the patient would receive care before she developed a serious infection.

The option of transferring patients might look good on paper but can be very problematic in practice. The most critical issue is the ability to determine if a patient is stable enough for transfer. In general, pregnant patients are healthy, but when they get sick, this happens quickly. Patients are not predictable in this respect. A physician must decide how stable a patient is and consider how far away the other facility is. Will the patient remain stable during the whole time of transport? Even in a city like Los Angeles, with many hospitals, would families want their loved one to leave a hospital and be put in an ambulance that has to navigate Los Angeles traffic? Outside a large city, the question is: how close is the nearest hospital? Making this determination can be one of the most challenging decisions for a physician. The physician must then deal with the bureaucracy of transfer, which can worsen outcomes for patients due to significant delays in care. Even with affiliation agreements between a non-UC facility and UC Irvine, UCI often cannot accept patients for three to four days because its hospital is at maximum bed capacity. With the COVID-19 crisis, hospitals have been overloaded and understaffed for months. Even now, the UCI hospital was still over capacity. Dr. Harken noted that she was on call for labor and delivery the past Friday night. She had to decline all maternal transports due to lack of beds and nursing staff. A patient whose bag of water broke at five months, in a hospital that restricts abortion, might have to wait for several days to transfer to UCI for abortion care while her risk of a serious infection and sepsis increased. All this time, a physician could provide her with the care that she needs at the affiliated hospital site if the physician were not prohibited from doing so by religious directives or other hospital policy. Hospital resources and beds should be prioritized for patients who require a higher level of care, not for a similar level of care that could be provided but is not allowed.

Another point to consider about transfers is the social and emotional impact on patients and their families. In Dr. Harken's experience, patients with severe pregnancy complications that require pregnancy termination during a hospital stay are extremely sad and distressed. The physician can provide some comfort and stability by offering the care the patient needs when she needs it. In a hospital where Dr. Harken would have to tell a patient that she could not provide care because abortion was prohibited in the hospital, this would add extra trauma to the patient's experience. This patient did not want to terminate

the pregnancy; she wanted to have a baby but has just learned from providers that this is no longer an option. But in addition to this devastating news, a physician would tell her that she will not receive this care at the affiliated site. This would imply that a UC physician did not support the patient's choice to have an abortion and that UC did not believe that the patient had made an appropriate choice. As a UC doctor, Dr. Harken would be very upset to have to turn her patient away to another site, despite her knowledge and training to respect the patient's informed choice for pregnancy termination. She emphasized that patient transfers are problematic and not the solution they might appear to be on paper.

Dr. Harken stated her view that patients at affiliate locations with restrictions on care do not benefit from having UC physicians when their water breaks or they experience an inevitable loss of pregnancy, given current UC policy. The UC physician's presence in that facility conveys the message that the University supports the spread of institutions which restrict the standard of care and evidence-based health care, and that UC finds it acceptable to ignore a woman's autonomy, to determine that a woman cannot make important health decisions for herself, and instead to impose upon her the values of a religious doctrine that might or might not be in line with her faith. Especially because many of the facilities that operate under the ethical and religious directives are safety net hospitals and because they receive State Medicaid and Medicare funds, UC would be endorsing a substandard model of health care for patients who already have poor access to contraception and abortion services. UC policy as it currently stood was very problematic for reproductive rights. If the University altered its policy to allow UC physicians to practice evidence-based medicine and specifically perform procedures that are considered the standard of care and in line with best current practices and if the University could embed protection for UC values and UC physicians into its affiliation agreements, this would go a long way to ensure that the policy did not have the effect of discriminating against the underserved, the disenfranchised, and people of color.

Mya Zapata stated that she was the Medical Director of the Labor and Delivery Unit at the UCLA Medical Center and described her patient care and teaching activities. In her own practice, she cared for patients ranging from five and six years of age to patients in their 90s, delivering babies, carrying out gynecologic surgery, and caring for patients over their reproductive lifetime. A common reason for a woman of reproductive age to come to an emergency department with UC personnel for obstetric/gynecological care is early pregnancy complications. When a patient presents to the emergency department with bleeding or cramping very early in pregnancy, an ultrasound is usually performed to evaluate whether the pregnancy is viable and to understand which treatment the patient needs. If the patient is bleeding, physicians want to know whether the patient has had a miscarriage and has already passed the pregnancy tissue out of her body, if the pregnancy has ended and the pregnancy tissue is still retained inside the uterus, or if the pregnancy is still ongoing.

In some cases, the pregnancy is still ongoing but is abnormal and has no chance of continuing and to result in a birth later. Commonly, in these situations, physicians are certain that there is going to be a miscarriage, which is called a spontaneous abortion, and physicians would know that it is inevitable. An example of an inevitable abortion would

occur when a patient in the first trimester is bleeding heavily, so much that the bleeding could cause her to have anemia, or lower her blood count significantly, and put her at risk over time. Sometimes, while bleeding is occurring, the ultrasound shows that an embryo might still have cardiac activity. Physicians have clear guidelines about what constitutes normal cardiac activity in an early pregnancy, and this helps define what is abnormal. Often, in these clinical settings, the heart rate is slow and abnormal because the pregnancy is ending, but it has not yet stopped. In this scenario, the uterus could continue to bleed heavily while it is trying to expel the pregnancy tissue, but the pregnancy has not yet detached and sometimes might not detach. The patient could continue to bleed, and there would be no way to predict when the pregnancy tissue would detach, or if it would detach on its own. This process can lead to life-threatening bleeding for the patient. If Dr. Zapata were evaluating a patient in this scenario, which was a common one at the UCLA Medical Center, she would counsel the patient that this was an inevitable abortion; there was no chance of an ongoing normal pregnancy. According to the standard of care and national guidelines, she would recommend immediate removal of the pregnancy tissue using a manual uterine aspirator device. Dr. Zapata would offer this service immediately and can offer this service at UCLA without any limitation.

It would be considered unsafe to delay this care in the setting of bleeding, although the patient might not be considered to be in a life-threatening situation at that moment. It was Dr. Zapata's understanding that, if she were caring for this patient in a hospital that had prohibitions on abortion, she would not be able to perform the manual uterine aspiration at that time, if the pregnancy still had cardiac activity, unless the patient was considered to be in a life-threatening emergency. Although Dr. Zapata, as a clinician, would know with certainty that this pregnancy was ending, she would not be able to proceed, even if the patient had chosen or wanted this procedure. Dr. Zapata's goal was to avoid life-threatening emergencies, and the standard of care would be to proceed immediately, in that moment. If she were unable to proceed, she would have to administer substandard care, which would mean prolonging the patient's bleeding. She would perform actions to support the patient, such as giving her blood transfusions to help keep up with the bleeding and to prevent a life-threatening emergency, but this was not the standard of care. One might wonder if physicians could wait until the cardiac activity stopped and then proceed with the appropriate procedure, but the bodies of women who are birthing can be unpredictable. The cardiac activity, although abnormal, and even though it will inevitably stop, can continue for hours. Waiting longer to provide the care only puts the patient's life at risk and would make her incur other procedures and measures. Emptying her uterus at that moment, the standard of care, would stop her bleeding.

Current UC policy stated that transferring a patient at that moment would be an option, but a patient who is actively bleeding would not typically be considered for transfer. Even if this patient were a candidate for transfer, she would likely be waiting for days, given the current state of hospitals. A physician would be required to continue giving the patient blood transfusions to keep her safe until the cardiac activity stopped. This was not the standard of care. UC policy stated that the physician could proceed in the event of an emergency, but "emergency" was not clearly defined, and it was not clear in the case when the patient's situation would be emergent enough for the physician to proceed with care

otherwise prohibited at an affiliate hospital. If UC policy stated that a UC provider can perform procedures without limitation, the physician would be able to provide care in line with the standard of care. In general, miscarriages are emotionally and physically traumatic for patients. Deferring and delaying a patient's care only adds to the trauma the patient already experiences.

Dr. Zapata outlined another clinical scenario, that of performing gender-affirming surgery for transgender male patients, which was part of her clinical practice. Under current UC policy, a UC physician could not perform gender-affirming surgery, meaning removal of the uterus, cervix, and fallopian tubes, in locations with restrictions on such care. Dr. Zapata presented two hypothetical examples. "Chris" is a 35-year-old transgender male, assigned as female at birth, but who identifies as a transgender male. He has followed international guidelines set forth by the World Professional Association for Transgender Health (WPATH), has been evaluated and referred by qualified mental health professionals, has provided documentation of his personal history, progress, treatment course, and eligibility for gender-affirming surgery. He has an official DSM diagnosis of gender dysphoria, a recognized medical indication for his chosen surgical treatment. According to WPATH criteria for gender-affirming surgery, he has undergone the appropriate 12 months of hormone therapy and proceeding with the surgery is considered a medically necessary component of gender-affirming surgical therapy.

"Jane" is a 35-year-old woman who has never had a pregnancy and does not plan a pregnancy in the future. She is a cisgender female, meaning that she was assigned as female at birth and identifies with the female gender. She has a common condition, uterine fibroids, which are benign tumors of the uterus. This condition can often be managed with hormonal treatments and does not usually require surgery but can require surgery. Jane's fibroids are not life-threatening or cancerous, and this is not an emergency. She is experiencing side effects from the hormonal treatments, is bothered by symptoms of pressure in her pelvis from the fibroids and is requesting a hysterectomy—removal of her uterus, cervix, and fallopian tubes to treat this benign medical condition. As a cisgender female, she would be able to proceed with a hysterectomy for this benign, non-life-threatening condition at a hospital which prohibits gender-affirming surgery. Chris and Jane are of the same age, have not had children, do not use to wish their uterus for childbearing in the future, do not have cancer or life-threatening emergencies, and both have confirmed medical conditions, are making well-informed, autonomous choices to proceed with appropriate surgical treatment. At a hospital which prohibits gender-affirming surgery, Jane will be able to proceed with the surgical treatment; Chris will not.

Dr. Zapata stressed that she practiced patient-centered care and aimed to not discriminate against any group of patients. Current UC policy discriminated against transgender patients. Transgender patients already experienced discrimination in many areas of their lives, and denying care is another form of discrimination, increasing the risk of poor health outcomes which have been documented for transgender patients, such as mental health disorders, depression, suicide, and delays in care when it has been denied. Dr. Zapata hoped that UC Health would help her and her colleagues provide the standard of care and best practices for patients.

Mark Litwin, Professor of Urology, Public Health, and Nursing and Chair of the Department of Urology at UCLA noted that his Department had about 45 surgeons, 24 residents, and 20 fellows. A few years prior, Dr. Litwin and his colleagues established UCLA's Gender Health Program, which has been acknowledged as one of the best programs providing transgender care in the U.S. He noted that most transgender patients come to the hospital for common medical reasons, not major surgeries. The Program is a multidisciplinary group with urologists, gynecologists, plastic surgeons, head and neck surgeons, craniofacial surgeons, psychiatrists, psychologists, fertility preservation experts, vocal therapists, care navigators, and other staff. The Program works with the guidance of a community advisory board, people in the transgender and gender-nonconforming community. Dr. Litwin emphasized his concern about looking out for the interests of this very marginalized group of individuals. He directly supervised UCLA urologic surgeons who performed gender-affirming surgeries at the main UCLA Medical Center location, the Santa Monica location, and at affiliated hospitals, including two hospitals run by the County of Los Angeles and some community hospitals.

It was Dr. Litwin's understanding that the focus of the current discussion was not on the wisdom of the affiliations that have been established or on how ethical and religious directives might conflict with the ethos of the University, but on the lived experience of patients in the real world. In the world of urology, the procedures relevant to transgender patients include vasectomy, or male sterilization, which was not affected by the affiliations, because it is an office-based procedure performed at multiple locations. Another procedure is vaginoplasty, the creation of female external genitalia in transgender women, which goes along with orchiectomy, the removal of male gonads in transgender women. Phalloplasty, also known as metoidioplasty, involves the creation of male genitalia in transgender male patients. Vaginoplasty and phalloplasty had not been affected by the ethical and religious directives principally because they are complex reconstructive surgeries, performed at UCLA's main hospitals and not at community affiliates.

Lisa Ikemoto, Professor at the UC Davis School of Law, explained that her research included the interaction between the legal exemptions for providers who decline to provide healthcare services based on religious or moral grounds and the use of religious restrictions by healthcare entities, including the ethical and religious directives. Comments by the other panel speakers had raised at least two concerns for her. The first concern was about implementation. Medical procedures require hospital staff assistance. In facilities with ethical and religious directives, the directives bind staff, individual providers, and even tenants of the medical office buildings who are on site. The directives prohibit "formal participation" and limit "material cooperation," or acts that contribute to but are not essential to the "immoral" service, in the language of the directives. Material cooperation is not strictly prohibited in all cases; this depends on the facts and circumstances. Ms. Ikemoto was concerned about the limits on cooperation for UC faculty, staff, and trainees. In some situations, this would mean that they might not be able to carry out the services they deem necessary, even in an emergency. Very few doctors do absolutely everything by themselves. They might need to order a drug from personnel at the hospital who are subject to the ethical and religious directives; they might need assistance in carrying out procedures, and the people who would assist them are not UC members and

are bound by the directives. This was an effect of the ethical and religious directives which, while they do not apply directly to UC faculty, staff, or trainees, affect their ability to carry out their professional duties.

Another aspect of implementation had to do with UC's policy, which stated that UC personnel and trainees have the right to provide any service they deem to be necessary and appropriate in the event of an emergency. As elucidated by the previous speakers, there is a distinction between emergency circumstances and other important circumstances when services might be needed. Per UC policy, UC personnel are to proceed without seeking approval from any non-provider, including any items or services where referral or transfer to another facility would, in their sole professional judgment, risk material deterioration to the patient's condition. The term "material deterioration" is language also used in the federal EMTALA law. UC policy is not restricted to the emergency department, which is where EMTALA applies. Ms. Ikemoto reiterated her concern about the limits on cooperation arising from ethical and religious directives that apply to non-UC faculty, staff, and trainees, which might inhibit the ability of UC personnel to carry out their duties in a medical crisis.

Ms. Ikemoto raised a second concern for the Committee's consideration. There are federal and State laws that protect or exempt providers who refuse or decline to provide services based on religious and moral belief. Most State laws, including in California, protect such providers from liability when not providing a service causes harm to a patient. Ms. Ikemoto raised the question of what happens to UC faculty, staff, and trainees who cannot carry out their duties to the standard of care because they are inhibited from doing so in an affiliate location. They are not protected by the religious exemptions under federal or State law.

Dr. Byington recalled that, in August, UC Health had issued its first annual report on covered affiliations and the status of Regents Policy 4405 and the interim Presidential policy. The report described the progress made to date in implementing these policies. UC Health is committed to continuous quality improvement. Engagement with stakeholders over the last several years had resulted in these two new policies, and UC Health and its patients had benefited from this process. UC Health has had the opportunity to scrutinize and improve how it affiliates with organizations that have policy-based restrictions on care and how it affiliates overall. This past year, UC Health standardized its processes, improved oversight and control, and ultimately worked to ensure that affiliations are aligned with UC values. This work involved hundreds of UC Health personnel, representing a broad range of administrative functions including contracting, communications, medical education, and quality improvement. These individuals had worked thousands of hours to ensure that both the letter and the spirit of the Regents and Presidential policies are respected and consistently implemented across all UC Health locations.

Discussions about the policies clearly identified concerns regarding affiliations and confirmed the importance of these affiliations to UC Health's education, research, and public service mission. It can be difficult to work in a situation where there are two competing rights, rather than a right and a wrong. In Dr. Byington's view, this was the

situation that UC Health had found itself in several years prior. UC Health had heard concerns regarding the ability of providers to advise patients, prescribe treatments and interventions, and refer or transfer. UC Health listened and adopted contractual language that ensures the rights of UC providers to engage in activities without interference. UC Health heard concerns regarding care in emergency situations which could result in discrimination. In June 2021, the Board adopted a policy that addresses these issues, and which led to the interim Presidential policy. There were a number of questions from the Academic Senate about the definition of “emergency” and who determines if an emergency is occurring. UC policy language has been clarified to define an emergency based on the EMTALA industry standard. UC Health has made it clear that the treating provider is the one with the authority to decide if an emergency exists, and to act. UC Health had changed the contractual language in a way that protects providers to ensure that they have the ability to define an emergency and to act when they see an emergent situation.

Dr. Byington believed that the policies were producing a positive momentum across UC Health. When one engages in difficult and sometimes emotional discussions with respect, all the participants benefit. In the first year of the two-year implementation process, there had been a number of developments which strengthened UC Health. First, UC Health has clarified contracting language with most of its affiliate partners. This was a major gain for a system as large and complex as UC. UC can now easily identify contracts and quickly identify language that protects UC providers; this has been standardized across the system. UC Health has also formalized the evaluation of its contracts and implemented processes on each campus for greater due diligence for the evaluation of affiliations and to determine if an affiliation benefits the University and the patients that it serves. UC Health has established new oversight and visibility regarding these issues. UC Health had just completed the first year of the policy implementation process. There would be more work in the second year to continue to refine and improve these policies, and Dr. Byington expected that the work of enhancing policy would in fact continue, beyond the second year, into the future.

UC Health has also created communication tools, using various formats, to promote increased awareness among all stakeholders. Model language and guidance have been developed for UC academic health centers and health professional schools to communicate with patients, faculty, staff, and trainees about policy requirements. There would be an ongoing process of education for UC Health trainees who arrive, graduate, and change every year. Dr. Byington anticipated that this effort would be further improved when the interim Presidential policy had been updated and finalized, following systemwide review.

UC Health has also established contacts at each location for complaints. UC Health faculty, staff, students, trainees, and patients may submit complaints or grievances related to care received or provided at covered affiliates. UC Health made use of existing complaint processes and augmented them. Complaints are scrutinized and raised to the highest level. Responsible individuals had been identified at each UC Health location. The locations completed a review of complaints received through June 30, 2022. No complaints related to care at covered affiliates or to breaches of UC Health policy were identified. This was an important finding, and this area would need to be reviewed year after year. UC Health

would continue to share the results of reporting in the second year of policy implementation and beyond.

UC Health had also established procedures for expedited patient transfers. Should one need to transfer a patient, one wishes to meet the patient's needs as quickly as possible. Updates that have resulted from the new policies included outlining patient transfer expectations in all transfer agreements with affiliates; this had not existed before the adoption of the new policies. UC Health has communicated with UC personnel and trainees on policy and procedures and was informing patients about restrictions on care and available options for care, should a transfer need to take place.

The policy process had also strengthened UC Health governance and oversight. As required by the Regents policy and the interim Presidential policy, UC Health must submit an annual report on affiliations. This requires ongoing monitoring at each location. The report had been released in August. The interim Presidential policy also called for the establishment of a joint clinical advisory committee, to be co-chaired by the Executive Vice President of UC Health and the Chair of the Academic Senate. The committee includes members appointed by the Academic Senate, UC Health, and the President. The committee advises the President on the annual report, solicits feedback from stakeholders, being especially attuned to complaints, and provides input on the policy.

UCLA Health President Johnese Spisso reported that the work done by UCLA to ensure adherence to the policies had brought forth a standardized process that ensures communication and transparency within the organization. In the past, under the legacy model, individual departments or divisions could forge relationships with other medical groups in the community; this was no longer the case. The process begins with a request by an individual department or division, which is reviewed by senior leadership. For a clinical affiliation involving a physician services agreement or clinical services agreement, the matter is brought to the President and Chief Executive Officer of the Hospital System. If the request is for a teaching affiliation, it is brought to the Dean of the respective school. The rationale for the affiliation is thoroughly discussed. The Office of Legal Affairs carries out legal and technical review for compliance with the contracting requirements specified in the interim Presidential policy and makes any revisions to the agreement that are necessary. There is discussion with the Vice Chancellor for Health Sciences, and there is documentation of the full review process by the Office of Legal Affairs of the agreement, the University of California Health Non-Discrimination Addendum, and the completion of the Covered Organization Affiliation Agreement Checklist. The non-discrimination addendum and the checklist were attachments to the Presidential policy. The responsible department completes the checklist, signs the checklist, and sends the agreement and the non-discrimination addendum to the covered affiliate for the affiliate's review. As a next step, the affiliate agrees to the non-discrimination addendum, and then the entire package is ready to submit to the Chancellor for approval. Ms. Spisso noted that, if any revisions are made during any steps of the process, the process stops, and questions are addressed. If the Chancellor approves the agreement, he or she signs the checklist, and then the underlying agreement can be signed by the parties.

UCSF Health Chief Executive Officer Suresh Gunasekaran described UCSF's affiliation review activities. UCSF was reviewing all its affiliations with an unprecedented scrutiny for policy compliance and to meet UCSF's goal of providing the highest level of care. UCSF has conducted a thorough review of all its affiliations to ensure that the highest leadership levels, including the deans of the various schools and UCSF Health leaders, first ask if the affiliation is needed at all, if it furthers UCSF's mission, if it will help UCSF serve unmet needs in the community, and if it is critical to UCSF's education and research mission. These questions guide UCSF in determining whether to continue with an agreement or terminate it. Subsequently, leadership works with the clinical department before the contract is extended to ensure that the department feels comfortable that UCSF is meeting the standards of UC Health-level care in these agreements and that they are consistent with UCSF goals. Only after these discussions does UCSF proceed to documentation, in a process similar to that at UCLA described by Ms. Spisso. Through this process, UCSF has been able to continue and improve the terms of partnerships that provide needed services to patients in the community who otherwise would lack access to UCSF-level care. At the same time, UCSF has been able to ensure that the same high standards are provided.

Mr. Gunasekaran outlined some of the benefits of UCSF's partnership with Santa Rosa Memorial Hospital (SRMH), a Providence entity. The affiliation has allowed UCSF to fill critical gaps in pediatric care in numerous specialties including hospital medicine, neonatology, neurology, cardiology, hematology, gastroenterology, and endocrinology. UCSF and SRMH have established a pediatric care quality infrastructure for the community through systematic case review and through development and implementation of evidence-based guidelines for pediatric care, both facilitated by UCSF leaders. SRMH has also become a key member of a UCSF consortium which aims at standardizing care across clinical practices. Through this partnership, UCSF further ensures that its trainees are able to train for family medicine in residency programs shared by SRMH, Kaiser Permanente, and Sutter Health, and sponsored through the UCSF School of Medicine. UCSF has placed its maternal/fetal medicine physicians who practice in this community into a dedicated service; they practice solely in facilities that are not subject to policy-based restrictions on care.

For those affiliations that meet UCSF policy requirements, UCSF has updated and expanded its healthcare quality policies and processes to ensure that the care provided at affiliate facilities adheres to UCSF standards. Committees that oversee credentialing and quality of care at affiliates now report up through existing UCSF channels for oversight of quality, including to the UCSF Health Executive Medical Board, which is charged with overseeing the performance and activities of medical staff and reports to the governance advisory council chaired by the Chancellor. UCSF uses the same process for quality review at affiliate locations as it does on its own campus. Data are reviewed and issues are escalated in exactly the same manner. In this first year of policy implementation, no complaints or concerns had emerged from this process. UCSF would continue to refine this scorecard and engage faculty at affiliate sites to ensure that review of clinical performance was clear, ongoing, and consistent.

Dr. Byington then outlined next steps for the second year of implementation. One step was to finalize the Presidential policy, which was proceeding through the standard UC process. Further, UC Health must define all the quality measures to be used in tracking affiliations, continue to communicate with and educate all who are affected by the policy, and begin the policy audit process. Earlier this year, as part of the Presidential policy finalization process, the Office of the President solicited online comment through a UC website and received a total of 64 comments on the interim Presidential policy. This was very different from the over 5,000 comments UC received before drafting the interim policy. The interim policy was submitted to the Academic Senate for review. The Academic Senate received 45 letters, from all the campus divisions of the Academic Senate, and from many Senate committees. In general, support was expressed for the policy and framework. The Academic Senate expressed faculty's preference that UC Health seek options for affiliations that do not involve policy-based restrictions on care whenever possible. The faculty members who had spoken earlier articulated concerns about performing procedures. Other concerns have also been identified, such as the definition of an emergency and who decides what constitutes an emergency; Dr. Byington believed that this point had been addressed and clarified by the policy, and that this must now be further communicated. Concerns were raised about restrictions on locations where UC employees can seek health care, and about possible deleterious effects of the proposed policy on UC training sites and training affiliation agreements.

Dr. Byington outlined some activities related to the updated quality metrics framework. In measuring the quality of care provided at covered affiliates, UC Health uses standard quality indicators defined by the Institute of Medicine and in use by UC Health hospitals. UC Health had maintained its reporting structure for complaints and grievances and was enhancing this wherever possible. UC Health actively searched for complaints, and none had yet been received in this area. Speakers earlier during the public comment period, practitioners at affiliate sites, had attested that they were not impeded in their ability to practice medicine. UC Health continued to look for any evidence that the judgment of its providers has been impeded or that the policy had been breached, in which case UC Health would vigorously defend its providers' rights. UC Health hoped to improve in measuring access to reproductive health care and other services through its affiliations. In the spirit of the policy, UC Health wished to ensure that it was maintaining or improving access to services, and to confirm that necessary and appropriate emergency services can be provided at all affiliate locations.

UC Health was working to improve its communications about these policies and wished to ensure that the implementation was on track. The policy required an audit of contracts to be completed after December 2023, but UC Health had also requested an interim audit by the Office of Ethics, Compliance and Audit Services.

Committee Chair Pérez shared his impression from this presentation that UC Health was testing its compliance with the letter of the policy, but that there had not been an explanation of the spirit of the policy. Dr. Byington responded that UC Health wants to ensure that it upholds UC values, especially the value of non-discrimination, and that it provides the highest quality of care, particularly to underserved areas of the state.

Committee Chair Pérez expressed agreement with Dr. Byington's characterization of the spirit of the policy. He believed that, in addition, one should state that there should not be artificial barriers to access to health care, barriers which are inconsistent with science and the best practice of medicine as one would expect it at a UC facility; that UC doctors and trainees not be limited in the ability to exercise their professional judgment, in the same way that they would not be limited in a UC facility; that non-science-based restrictions would not limit the delivery of care, the provision of training, or professional judgment. Dr. Byington confirmed that these points had been discussed.

Committee Chair Pérez remarked that there was a difference between the presentation on implementation of the policy and the panel presentation by faculty members about implementation on the ground. He expressed concern that there might be disparities in access to high-quality care based on the facilities where one receives the care. This might not be the case, but he would like assurance on this point. With respect to the reporting of complaints, patients with the greatest economic power and greatest social resources perceive an ability and a need to complain different from medically needy and indigent patients, people with limited access to health care and limited resources in general. He expressed concern about the sensitivity of testing in this matter, of determining whether complaints were not being received because there was no problem or that complaints were not being received for other reasons. Dr. Byington responded that UC Health shared these concerns. During this process, UC Health has made an effort to communicate with providers in affiliate sites, to find out about their experiences and to see if they have experienced any kind of limitation on their practice. UC Health was also examining statistical data. Were there fewer abortion procedures than one would expect in an affiliate site? Fewer instances of care for ectopic pregnancies than one would expect? Have complaints been identified by the State? UC Health was trying to identify any gaps in reporting or barriers to reporting.

Committee Chair Pérez requested clarification of the definition of what constitutes an emergency, the working definition that the University was using. Deputy General Counsel Rachel Nosowsky acknowledged that there was a need for clarification. The intention of the definition was to mirror the EMTALA law.

Committee Chair Pérez reiterated his question about the working definition. He asked if UC was still working to define this. Ms. Nosowsky responded that the term was thought to have been defined, but it was clear that it had not been adequately defined. Work remained to be done.

Committee Chair Pérez commented that EMTALA, a federal law, was in place before UC's adoption of this policy. He asked what had materially changed if the standard was that of the EMTALA law, and what difference UC policy would make if UC was simply enshrining EMTALA in its policy. Ms. Nosowsky responded that there was commentary and concern, as the policy was being drafted, that emergency care could not be provided and that non-physicians had to be consulted in order to perform emergency procedures. She believed that there were differences in understanding of what constitutes an

emergency. There had been numerous references in this discussion to life-threatening emergencies, but this was not part of the EMTALA definition.

Committee Chair Pérez asked what UC doctors could do now, based on the policy, that they could not do 15 months prior. Dr. Byington responded that the contractual language stipulated that UC providers can determine if an emergency is occurring and are expected and have a duty to act based on their best critical judgment. This might have been possible earlier in many affiliate settings, but UC has now enshrined this in contractual language that did not exist before. This should give greater confidence to UC providers. UC Health has also stated that its providers will not consult with a non-medical entity to decide if they can act; they are empowered to act.

Committee Chair Pérez referred to the situations and concerns discussed by Drs. Kerns, Harken, and Zapata. He asked if Dr. Byington believed that UC physicians could act based on their own judgment in each of those cases without restriction or retribution. Dr. Byington responded that she believed that this would be the case for all the procedures mentioned except bottom surgery, which was not provided at many locations.

Committee Chair Pérez stated that the policy required that procedures be provided without discriminatory restriction. In one of the examples provided, a certain procedure would be allowed for a cisgender female patient but not allowed for a transgender male patient. There was a discriminatory application of access. Dr. Byington responded that she believed that the affiliate might view this as, in one case, a healthy organ being removed and in the second case, a non-healthy organ being removed. This might be the basis for determining if there was discrimination or not. Ms. Nosowsky commented that an affiliate might describe the situation this way if the University disagreed with the affiliate's interpretation of discrimination. A case brought to UC's attention involving discrimination might be cause for disaffiliation. This was the point of the termination provisions in all the contracts.

Committee Chair Pérez asked if, in the case mentioned earlier, a UC provider would also be able to provide a similar procedure for a transgender male. Ms. Nosowsky clarified that if a UC physician were precluded from providing the procedure because the affiliate did not interpret its rules as allowing the procedure, the University would have to make a statement to the effect that the affiliate had violated the contract or that UC and the affiliate could not come to an agreement on how the contract was being interpreted.

Committee Chair Pérez asked how the University would establish its definition of discrimination versus the distinction between healthy or non-healthy organs. In the case discussed, a medical diagnosis affected the whole patient, not just one organ. He recalled requests he had made to have representatives of these affiliates attend a meeting to discuss these issues. He had had private meetings with two affiliates, but affiliates had not agreed to attend a Regents meeting or to provide written comment. In these private meetings, in discussing some of the issues covered in this meeting, the affiliates stated that the procedures for an IUD or implantation of other contraception would not be acceptable; they would not allow these procedures to go forward. They would not view UC's language as giving UC providers the ability to implant an IUD, to implant other contraception, or to

provide contraception or sterilization at the time of delivery. The affiliates' response had been that the patient could go to another clinic. The answers that Committee Chair Pérez had received from affiliates in private, affiliates who declined to attend a public meeting of the Regents, did not correspond to the reality that UC hopes for. Dr. Byington responded that, while she had not attended the meetings referred to by Committee Chair Pérez, she had had a number of conversations with the affiliates, as had the UC Health chief executive officers, to try to come to a common understanding of the contract language. She believed that, if there were a case in which UC felt that the judgment of its provider had been impeded, or that the physician had not been able to provide the care that he or she felt reflected the standard of care and was in the best interest of the patient, the University would defend that provider. There was written termination language in all the contracts, should such a situation occur. UC can terminate a contract if it finds that its values are not being upheld, and for that reason alone.

Committee Chair Pérez asked Mr. Gunasekaran if he had concerns about the percentage of patients who have or do not have post-discharge follow-up for contraception. Mr. Gunasekaran responded that he had concerns, and that when UC has concerns about any affiliate setting, the framework is essential. The premise of UCSF's framework has been formalized and UCSF has had decades of experience with it. UCSF trusts the medical directors at the sites who are UCSF faculty. These individuals are responsible for understanding that the service is operating at the UCSF level of care. As had emerged from this discussion, there should not be feedback mechanisms that people do not make use of. Faculty have insight into this because they are on site. The panel of faculty speakers at this meeting had shown that there was cause for concern. Questions to be asked were: Is UC receiving patient feedback? Is UC conducting reviews? Is UC examining publicly available data? UC Health was working on this. This was a work in progress, not perfect, because the system was not set up precisely for this.

Committee Chair Pérez stressed that UC should create the expectation of a standard in these matters, rather than expecting someone with less expertise and data to try to navigate the healthcare system for themselves. Feedback was important, but UC had an obligation to determine these standards itself. Mr. Gunasekaran expressed agreement with this; he asserted that this was a reason for pursuing affiliations. UC Health was trying to meet the needs of communities in those communities.

Committee Chair Pérez countered that this presumed that these were the only potential affiliates. There were providers both with and without policy-based restrictions. There were providers with policy-based restrictions who had modified these restrictions in order to align with the expectations of UC Health. One expectation was that UC would assess alternative affiliates, so that if the affiliates UC already had relationships with refused to comply with UC expectations and standards, UC would find another way to serve patients. Committee Chair Pérez would not accept the notion that only the incumbent affiliation agreements would allow UC to meet needs of underserved patients.

Committee Chair Pérez asked Ms. Spisso how effective expedited transfer agreements with other hospitals were, given that UC did not have control of both sites involved in the patient

transfer. Ms. Spisso recalled that the UCLA Health system had main hospitals in Westwood and Santa Monica and more than 250 clinics throughout the region. When UCLA patients need hospital care, they often go to the nearest facility rather than to the Westwood and Santa Monica hospitals. Over the years, UCLA has placed its hospitalists in these other facilities to take care of UCLA patients. The UCLA hospitalists can facilitate transfers. In its work with its affiliates, UCLA Health had upfront discussions about UC policy requirements. UCLA was seeking affiliations where appropriate levels of care can be provided and exiting affiliations in which UCLA was not receiving full cooperation.

Regent Sures referred to the question of how to define an emergency. He asked Dr. Harken about a situation in which a UC resident at an affiliated hospital believed that there was an emergency, but a physician disagreed with the resident. He asked what would happen. Dr. Harken responded that she did not know but believed that the authority of the physician would prevail over the views of the resident. The resident would have to defer to the attending physician. Dr. Harken agreed with Regent Sures that this would be an issue of concern.

Regent Sures asked Dr. Byington how she would address this issue. Dr. Byington responded that this issue could arise at any hospital, including a UC hospital. The attending physician is the treating physician of record and has the authority, duty, and responsibility to create a treatment plan for the patient.

Regent Sures asked if, in this type of situation, under UC's affiliate agreement, the UC physician does not have full autonomy to make a determination about what constitutes an emergency. Dr. Byington responded that this was always the case. The resident physician practices under supervision because he or she is still in training. She noted that, in these affiliations, UC faculty practice at the affiliated sites, and these faculty are the ones who supervise UC resident trainees. In medicine there is always a hierarchy of student, resident, fellow, and attending physician, no matter the location. Interim Associate Vice President Deena Shin McRae explained that Liaison Committee on Medical Education Elements 9.1 and 9.2 require that the attending physicians supervising medical students are faculty of the sponsoring institution. UC would have control over instruction, the quality of supervision, and be able to ensure that these are in alignment with UC's principles and mission. With respect to residents and fellows, Accreditation Council for Graduate Medical Education requirements dictate that the program director, who is from the sponsoring institution, has the power and authority to determine who has privilege of supervising and teaching UC residents and fellows. UC had control over quality and learning experiences at affiliate sites. In response to a question by Regent Sures, Dr. Harken confirmed that these statements about hierarchy were accurate. She did not know whether this situation could be more problematic at an affiliate site.

Regent Sures asked Dr. Harken if she had experienced specific situations in which she wished to transfer a patient, but the process took too long and was outside the norm. Dr. Harken responded that she only practiced at UC Irvine. Recently, she had often had to turn away transfers due to lack of available patient beds. She had experienced situations when she wished to bring a patient to UCI for urgent reproductive healthcare and had called

an ambulance, but the UCI emergency department was on diversion and unable to take this patient. Such a patient would end up at another hospital, where she might receive a hysterectomy that would not have been necessary, had she been treated by UC Irvine's obstetrics and gynecology team.

Regent Sures stated his understanding that the transfer situation was complicated because UC hospitals were sometimes filled beyond capacity and could not accept a transfer from an affiliate. Dr. Harken confirmed that this was the case.

Regent Sures asked if UC hospitals understood the value and importance of an expedited transfer from an affiliate. Ms. Spisso responded that medical necessity comes first, emergency medical conditions that require tertiary or quaternary care services. Requests for transfers from UCLA hospitalists practicing at affiliate locations go directly to the UCLA transfer center. She underscored that UCLA listens to its referring physicians and takes the need for transfers seriously.

Regent Leib asked how many affiliations UC Health had. Dr. Byington responded that there were thousands of affiliations. When UC Health reviewed the affiliations to identify those with policy-based restrictions on care, it found that there were 77 individual hospitals or clinic settings. For those 77 locations, there were about 500 different affiliation agreements, because there are affiliation agreements with different hospital departments.

Regent Leib asked how many specific hospitals UC was affiliated with overall, including those with policy-based restrictions. Dr. Byington responded that the overall number was in the hundreds; there were 77 with policy-based restrictions on care.

Regent Leib asked if UC had ended any of the affiliations with these 77 sites once Regents Policy 4405 was adopted. Dr. Byington responded that UC had reviewed about one-third of the affiliations that had come up for evaluation. Some affiliations had ended, for a number of reasons. Ms. Spisso described how, with the new policy process, some requests for affiliation do not get past the entry level. This year, UCLA had eight requests for affiliation renewal and was reviewing these. Ms. Maysent reported that UC San Diego had an affiliation with Father Joe's Villages, where it had a clinical and teaching program. This entity did not agree with policy changes in the contract, and that contract was terminated. Since then, Father Joe's Villages has indicated that it might wish to reengage with UCSD, but the contract was terminated.

Regent Leib stated that he was interested in the effectiveness of Regents Policy 4405. He asked if there were examples of positive effects of the policy. Mr. Gunasekaran responded that the medical centers were reviewing affiliations and asking whether they needed all these affiliations to accomplish their goals. UCSF had identified and ceased some affiliations which might have been subject to ethical and religious directives, were not mission-critical, or had been established many years prior and were now inactive. Institutional focus would be on the question of which affiliations were necessary to advance UCSF's mission. A significant number of contracts had to be modified to add language and include data reporting. There had been many changes associated with the policy, which

had raised the expectations for every affiliation. This would continue into the second year of policy implementation.

Regent Leib stated his understanding that the essential rationale for affiliations was to provide greater access to UC care in communities around the state. Dr. Byington added that education was another important reason for the affiliations.

Regent Leib asked if UC Health was aggressively pursuing affiliations in the areas of Los Angeles that were most underserved. Ms. Spisso responded in the affirmative. One of UCLA's largest affiliations was with a Dignity hospital in downtown Los Angeles. Due to the large size of the city and to traffic, UC's expert cardiologists and neurologists were needed at this and other facilities. Many of UCLA's agreements pertained to providing specialty coverage, so that hospitals could meet the "golden hour" of care delivery, the period of time immediately after a traumatic injury during which there is the highest likelihood that prompt medical and surgical treatment will prevent death. UCLA Health provides a robust regional cardiology service, much of it based in affiliate facilities.

Regent Park shared her view of this policy and the issues that led to it as a series of tradeoffs, and an effort to make the best tradeoffs possible. She suggested that the definition of "emergency" should be as broad and as flexible as possible and written in laymen's terms, if possible. The hypothetical case discussed earlier in which a hysterectomy would be performed for one patient and not another was troubling and presented discrimination masquerading as something else. The development of this policy was a productive struggle. The concern that a patient might not come back for additional care was a concern shared broadly in health care. Clarity was important in developing policy. The fact that there had not been complaints did not mean that there were no issues of concern. Regent Park urged UC Health to continuously consider what issues it might be missing.

Regent Batchlor asked if UC had considered limiting these affiliation agreements to services not affected by policy restrictions, and if doing so would undermine UC Health objectives. Dr. Byington responded that this question had been discussed at length. Many UC affiliations, on the surface, were not related to reproductive healthcare, transgender care, and end of life care, but many faculty stressed the importance of reproductive healthcare in all specialties. UC faculty and providers did not believe that simply not having a direct affiliation with obstetric and gynecologic services would address the problem, especially now, when there were so many pressures on reproductive healthcare in general. UC Health felt strongly that when it is present, there are more options for individuals. By disaffiliating in these areas, UC might be creating further harm.

Committee Chair Pérez recalled that UC's affiliation with one organization did not include these services, but this organization nevertheless did not wish to agree to UC's terms.

Regent Batchlor suggested that limiting affiliation agreements to areas without constraints would reduce the number of people negatively affected.

Committee Chair Pérez noted that a patient might come to the hospital for treatment of one kind but then need treatment of another kind.

Regent-designate Raznick referred to the lack of registered complaints. With respect to women's reproductive healthcare and emergency procedures, he asked if there were quantitative data indicating that these procedures are being performed within a standard mean. This question was focused on potential conflicts within the affiliate organization between the attending physician and medical contribution from the staff. Dr. Byington responded that UC Health sought publicly available data gathered by the State of California on complications of pregnancy, abortion procedures, and care of ectopic pregnancies. In faith-based affiliate hospitals, the proportions of these procedures appeared to be in line with the proportions for all pregnancies. There did not appear to be a smaller proportion of abortion procedures in faith-based affiliate hospitals.

Regent-designate Raznick asked if, besides abortion, this included other emergency procedures that had been discussed by Dr. Harken and the other faculty speakers. Dr. Byington responded that she believed that these procedures would be able to be performed under medical necessity at an affiliate hospital. If UC had evidence that this was not occurring, the contractual language would allow UC to raise the issue for discussion with the affiliate or even terminate the affiliation.

Committee Chair Pérez suggested that Dr. Byington review this discussion and identify those procedures that should be allowable. UC Health should consider drafting side letters presenting UC's interpretation of the policy, according to which specific procedures fall within what is allowed by the policy. The University should not wait until it finds out that a patient was not able to receive care that they deserved or that a UC practitioner was not able to practice in the way that UC expects them to; this would limit UC's options. The University would then have to state that it did not mean what it said, and continue with the affiliation, or would have to consider canceling an affiliation. UC Health could get ahead of this problem by following up on this day's discussion.

Advisory member Ramamoorthy observed that most academic medical centers have grown and expanded and had a need for more space. There was a need for more patient access and more outreach. There was a need to compete in a challenging market while fulfilling the University's mission. UC Health needed affiliations to accomplish these goals. There were compelling reasons to support the affiliations. First and foremost was the mission of education. Affiliate hospitals like the Veterans Administration/Department of Veterans Affairs provided outstanding experiences for UC trainees. Dr. Ramamoorthy underscored that UC's medical schools had high rankings because of their affiliations, not in spite of them. UC Health was a key conduit for access to specialized care for patients, care that cannot be duplicated in the community. For example, transgender surgery was complex, requiring five or six different specialties. Only a few medical centers in the U.S. can perform this well. Those patients require this pathway to UC's expert care. UC Health affiliations allow UC to expand its outreach to various areas, populations, and communities throughout California and reducing disparities can only be accomplished through strategic partnerships with community hospitals in rural areas. UC Health should be proud of its

extensive and unique effort to audit, review, and enhance its affiliate contracts. This effort would not only solve problems for patients in California, but would be an example for other academic medical centers in the U.S.

Regent Leib believed that it was possible to find a solution in these matters. He expressed concern that representatives of UC affiliates were not willing to attend and speak at a public Regents meeting. This indicated a problem. If one could get the affiliates to come and speak at a meeting, one could solve these issues.

Dr. Byington affirmed that UC Health needs partners and affiliates and needs to have productive conversations with these partners. These conversations have taken and are taking place. The question of whether these conversations must take place in a public forum was a different matter. She emphasized her commitment to having productive partnerships for the University.

Committee Chair Pérez invited the largest UC Health affiliates to attend a Regents meeting and to speak in public. It was difficult to have this discussion when the partner or affiliate was not at the table. The answer he had received from the affiliates was that they were private entities and that these were private contracts. Committee Chair Pérez emphasized that the University is a public institution and that these are public contracts. UC has obligations as a public-serving institution. The inability to have this conversation in a public setting to establish a common understanding about the meaning of the policy language made things more difficult and limited UC's options to achieve resolution. He reiterated his invitation to the affiliates to come to a Regents meeting so that UC can continue to refine and improve its policy. He looked forward to the development of common understanding within UC of the policy and what is covered by the policy, working together with the faculty and Dr. Byington, and then communicating that common understanding to UC Health's affiliates so that there would be clarity rather than opacity.

The meeting adjourned at 3:20 p.m.

Attest:

Secretary and Chief of Staff