

The Regents of the University of California

HEALTH SERVICES COMMITTEE

June 15, 2022

The Health Services Committee met on the above date at Carnesale Commons, Los Angeles campus.

Members present: Regents Park, Pérez, Sherman, and Sures; Ex officio members Drake and Leib; Executive Vice President Byington; Chancellor Hawgood; Advisory members Marks and Ramamoorthy

In attendance: Regents Makarechian and Torres, Regent-designate Timmons, Faculty Representatives Cochran and Horwitz, Secretary and Chief of Staff Shaw, Deputy General Counsel Nosowsky, Vice President Nation, and Recording Secretary Johns

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

1. APPROVAL OF MINUTES OF PREVIOUS MEETING

Upon motion duly made and seconded, the minutes of the meetings of February 16 and March 16, 2022 were approved, Regents Leib, Park, Pérez, Sherman, and Sures voting “aye.”¹

2. PUBLIC COMMENT

Committee Chair Pérez explained that the public comment period permitted members of the public an opportunity to address University-related matters. The following persons addressed the Committee concerning the items noted.

- A. Lori Friedman, Associate Professor in the Department of Obstetrics, Gynecology and Reproductive Sciences at UCSF, noted that she had conducted research on restrictions on reproductive care in Catholic hospitals in the U.S. She referenced cases in which care was denied to patients for whom pregnancy was dangerous and to transgender patients, and miscarriages that were poorly managed because there were restrictions on doctors. Ms. Friedman expressed appreciation for the University’s efforts in revising its contracts with affiliates that restrict reproductive care. Nevertheless, it appeared that UC’s policy as written would require UC clinicians to deny care. Catholic directives would still restrict care in Catholic healthcare facilities. Ms. Friedman stated that Regents Policy 4405, Policy on Affiliations with Healthcare Organizations that Have Adopted Policy-Based Restrictions on Care, only allowed clinicians to perform restricted procedures if not doing so risked “material deterioration to the patient’s condition.” It appeared that,

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

as written, the policy for covered affiliations still did not allow UC doctors to function fully in their role, including the ability to perform the full range of standard procedures for reproductive health. Ms. Friedman suggested amending the policy and adding language asserting that clinicians have the right to make clinical decisions and perform procedures consistent with the standard of care.

- B. Jessica Gipson, Associate Professor at the UCLA Fielding School of Public Health stated that, as a researcher on reproductive health, she had worked globally and domestically, including in studies and cases where access to contraception and abortion was restricted by law that was based on religion rather than on evidence. These restrictions not only limit provider and patient autonomy but can also result in adverse health and social outcomes. These adverse outcomes are often particularly pronounced among low-income, medically underserved populations, communities in which non-Catholic-affiliated healthcare options may be particularly limited. Ms. Gipson expressed concern about UC policy, which appeared to be in direct contradiction to efforts to expand and enhance sexual and reproductive healthcare in California with the anticipated dismantling of *Roe v. Wade*. The California Future of Abortion Council was working hard to prepare California and its workforce for the critical role California would have in continuing to provide abortion services to Californians as well as caring for abortion refugees from states where these services were restricted. UC policy would require providers to deny basic and necessary healthcare services and would impede learning by and training of UC trainees and providers in the provision of comprehensive and critically needed sexual and reproductive health services. Section 3 (iii) of Regents Policy 4405 stated that UC providers in non-UC facilities can inform patients of options and transfer or refer patients for care. However, with time-sensitive care such as abortion, unnecessary referrals and delays in care result in suboptimal patient experiences, fewer options for care, as well as an increase in the cost, time, and complexity of the process. Ms. Gipson asked that the Regents include language in the policy which would allow UC providers to provide evidence-based, medically indicated care that allows for physician discretion and prioritization of the patient above and beyond religious mandates.
- C. Jody Steinauer, Professor in the Department of Obstetrics, Gynecology and Reproductive Sciences at UCSF, expressed her opposition to Regents Policy 4405. As it was currently written, it betrayed UC values by requiring UC providers to limit the care they provide to patients and by harming trainees and their future patients. As currently written in policy, the allowable tasks of informing patients of options and transferring or referring patients were insufficient to appropriately care for UC patients. UC providers must also be allowed to perform procedures. UC trainees must learn patient-centered, evidence-based care. People trained in restrictive hospitals do not learn the basic skills they should. Many obstetrics and gynecology (OB/GYN) residents trained in hospitals that restrict their practice graduate not feeling comfortable in important contraceptive and abortion skills. They are not prepared to place an intrauterine device (IUD), provide postpartum sterilization, offer comprehensive early pregnancy loss care, or perform an abortion

to save someone's life. With the U.S. Supreme Court about to overturn *Roe v. Wade*, one was heading into a crisis for patients and providers. Almost half of OB/GYN residency programs were in states that were certain or likely to ban abortion in the near future. This was the time for UC to be a leader in providing and training people in evidence-based care. Section 3 (iii) in Policy 4405 must be amended to indicate that UC providers can perform procedures. Without this change, UC's care for California patients was compromised, and the care UC learners would provide to future patients would also be compromised. Dr. Steinauer also recommended that the policy language exempt the U.S. Department of Veterans Affairs (VA), because the VA was subject to federal regulations, not regulations based on religion. She asked that the Regents amend Policy 4405.

- D. Amy Autry, Professor at the UCSF School of Medicine and at UCSF-Fresno, expressed concern about Regents Policy 4405. If a patient is having a cesarean section and wants a sterilization, to deny this and make her go elsewhere for a second procedure is detrimental to patient care and exposes her to additional risks in surgery. Current UC policy expected that a patient would be transferred out for certain kinds of care unless transfer would result in a material deterioration in the patient's condition. Material deterioration refers to physical harm on the order of malpractice. Denying a tubal ligation during a cesarean section or allowing a woman to cramp and bleed indefinitely during miscarriage does not necessarily lead to material deterioration, but it may lead to complications in later tubal ligation or to trauma from the delay in treatment. Dr. Autry described this as bad and unethical care. She was concerned about patients in the Central Valley, who have poor access to care and who would not receive evidence-based, standardized care. She was also concerned about UC trainees, especially those in the Central Valley, who might learn subpar care and apply this in their future practice, most likely in the Central Valley. Dr. Autry asked that the Regents amend policy so that it allows providers to perform procedures to protect UC patients and trainees in California, particularly in the Central Valley.

President Drake then presented remarks. At the close of another academic year, he reflected on how much had been accomplished at campuses and medical centers despite the continuing pandemic. New COVID-19 variants were continuing to emerge. Numbers of infections were increasing, and real numbers of infections were higher than the number of those reported. In spite of these developments, the campuses were able to complete the year with in-person classes and to continue with critical research and operations. The University continued to follow the guidance of public health officials and to encourage vaccination, mask wearing, and other protective measures. It was these measures that had allowed UC to maintain some form of normalcy over the past months. President Drake thanked all at UC who had worked diligently over the last two years and longer to keep the institution moving forward.

About a year prior, in the midst of the pandemic, the Regents discussed the University's affiliations with healthcare providers that have policy-based restrictions on care. With the leadership of Committee Chair Pérez and others, and with the advice and guidance of many

experts and stakeholders from within and outside the University, UC had arrived at a solid policy that creates clear expectations, more transparency, and greater accountability. Since then, many people across UC have worked to implement this policy and to ensure that the University's affiliation agreements reflect UC values.

President Drake recognized Vice President Cathryn Nation, who was retiring after more than 30 years of service to the University, and much of that service to UC Health. Throughout her career, Dr. Nation has been focused on access, equity, diversity and inclusion in the health sciences and in the health professional workforce. This included the development and expansion of the highly effective Programs in Medical Education (PRIME), working with UCSF to expand medical education and programs in the San Joaquin Valley, and to support the expansion of the UC Riverside School of Medicine. Dr. Nation had also represented UC in State and national settings. She began her career at UC, earning her bachelor's degree at UC Davis, and then received her medical degree at the UCSF School of Medicine. President Drake expressed gratitude for Dr. Nation's years of distinguished service. Her expertise and commitment to UC's mission had been valuable assets that resulted in better education, better medical care, and improved the lives of many.

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

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

Executive Vice President Byington began the discussion by thanking Advisory member Hernandez, whose term on the Committee was ending, and UC San Diego Health Sciences Vice Chancellor David Brenner, who was retiring.

Dr. Byington reported on new developments and data regarding COVID-19. Recent data indicated that COVID-19 vaccines during pregnancy not only protect the pregnant woman but also her infant. Vaccination during pregnancy protects an infant for the first four months after birth.

New vaccines were forthcoming. The U.S. Food and Drug Administration (FDA) advisory group had recommended authorization of the Novavax vaccine, a protein-based vaccine that some might find preferable to an mRNA vaccine. On the prior day and today, the FDA was meeting to discuss vaccination for children. The prior day, the FDA had approved use of the Moderna vaccine for children aged six to 17 years, and today, the FDA was considering vaccination for the youngest children, younger than five years.

A new study on mask wearing in community settings, the largest such study to date, covered 55 countries and 37 U.S. states including California. The study found that the mean observed level of mask wearing corresponded to an approximately 19 percent decrease in the R nought or reproduction number of the virus.

More data were emerging about the outcomes of COVID-19 infection. A recent study of neurodevelopmental outcomes of infants born to mothers who tested positive for SARS-

CoV-2 during pregnancy showed that, unfortunately, these infants have increasing neurodevelopmental sequelae if they are exposed to the virus during the pregnancy. Third-trimester infection was associated with effects of larger magnitude.

Another study indicated that child mortality from COVID-19, especially during the prevalence of the Omicron variant, was significantly higher than from influenza. A study by the UCSF Gladstone Institutes showed that natural immunity from infection with the Omicron variant is weak and limited; without vaccination, it fails to confer robust immunity against other COVID-19 variants. Data published the prior month by the Centers for Disease Control and Prevention indicated that one in five adults age 18 or older have a health condition that might be related to previous infection by COVID-19.

The U.S. was currently in a COVID-19 surge that was similar to the Delta variant surge. The reporting of cases was lower than real numbers because much testing was occurring in the home setting, without reporting to public health agencies. California was also experiencing an increase in the number of cases, with about 34 to 35 cases per 100,000 population. An important public health goal has been to keep case counts below ten per 100,000. In UC hospitals, there was an upward trajectory of hospitalizations, with 174 this week. This number was similar to the number during the Delta variant wave but lower than that for the Omicron variant wave. It was believed that the combination of vaccinations and past infections was modifying acute infections and lowering the risk of and need for hospitalization.

Dr. Byington presented a chart with COVID-19 variants prevalent in the U.S. over a number of months and drew attention to Omicron variants four and five, which were starting to be recognized. These variants were more infectious than those that had come before and might prolong the current wave of COVID-19.

Dr. Byington then discussed activities and aspects of UC Health not related to the COVID-19 pandemic. UC Health schools had been recognized as national leaders in graduate school rankings for 2023 by *U.S. News and World Report*, with top rankings in the areas of research, primary care, and diversity.

The California Medicine Scholars Program was a new program that would help prepare a pipeline for a diverse physician workforce, encouraging students from groups underrepresented in medicine to enter medical school. All UC medical schools were participating in this program, and four had been named anchor institutions: UCSF, UCSF-Fresno, UC San Diego, and UC Riverside.

In the past month, the UC Davis Medical Center was recognized with an accreditation for geriatrics in the emergency department. The UCLA Health System was recognized as one of the best employers in the U.S., as a large employer, as an employer for diversity, and as an employer of recent graduates. UC Irvine Health had also received recognition as a community health center: as a health center quality leader, as an access enhancer, as a health disparities reducer, and as a leader in COVID-19 vaccinations.

UC Health was also active in important areas related to health, including violence prevention. Dr. Byington drew attention to an activity of UC Davis Health's Trauma Prevention and Outreach Program, a Wraparound Violence Intervention Program for patients who present to the Medical Center injured through violence, including gun violence. Firearms were now the leading cause of death in the U.S. for children and teenagers.

UC had launched its Center for Climate, Health and Equity on May 25, 2022. The Center was housed at UCSF and included systemwide membership. UC Health was also making contributions at the national level. The White House had convened a group of academic health centers to address the monkeypox issue, in particular in the area of diagnosis. UC Davis Professor Nam Tran was serving as UC Health's representative to this group. UC Health Chief Data Scientist Atul Butte had been named an advisor to the Director of the National Institutes of Health (NIH).

Dr. Byington concluded by thanking Vice President Cathryn Nation for her 32 years of service to the University, recognizing in particular her contributions to workforce development, to diversity, equity, and inclusion, and to important programs like the Programs in Medical Education (PRIME) and establishment of the UC Riverside School of Medicine. Committee Chair Pérez thanked Dr. Nation for her work and congratulated her on her outstanding career on behalf of the University and the State of California.

4. **COMMUNITY BENEFIT AND COMMUNITY IMPACT ANNUAL REPORT**

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

Executive Vice President Byington introduced this report on community benefit and community impact, noting that it was a voluntary report.

Committee Chair Pérez requested clarification of how this report was voluntary rather than mandatory. Dr. Byington responded that not-for-profit hospitals have a mandatory reporting requirement to the Internal Revenue Service (IRS). As a State entity, the University did not have this requirement, but UC performed this review so that it could be knowledgeable about what it is contributing.

UC Health Director of Finance Todd Hjorth commented that UC compiles this report in accordance with regulations and guidelines required by IRS Form 990 even though the University does not submit the report to the IRS. The University wishes to report this community benefit in order to highlight the significant resources devoted to improving access to health care, to demonstrate ongoing commitment to UC Health's tripartite mission of patient care, education, and research, and to document UC Health's efforts to improve public health. This was the third year that UC Health had compiled this report.

In 2019, 180 not-for-profit hospitals in California that submit Form 990 to the IRS documented \$6 billion in community benefit. If the UC system were included in this

number, UC medical centers would add another \$1.4 billion, which demonstrated UC Health's impact.

In the current fiscal year 2021 report, UC Health documented \$1.6 billion in community benefit, \$1.7 billion in unreimbursed costs for care of Medicare patients, and \$700 million in faculty practice group charity care and uncompensated care. The report showed increases in almost all categories except uncompensated care for Medi-Cal and Medicare patients. This was a reflection of the cost structure rather than effort or the work done by UC Health. During the COVID-19 pandemic, volumes plummeted but costs remained the same. There were fewer uncompensated care patients in the current year compared to the prior year.

Committee Chair Pérez asked if UC Health expected this to continue into the future. Mr. Hjorth responded in the negative.

UC Health's community benefit as a percentage of operating costs was approximately 10.2 percent. For this benchmark of community benefit as a percentage of operating expenses, compared to California not-for-profit hospitals with 230 patient beds or more, UC was in the 75th percentile, ahead of Kaiser Permanente, Providence, Sutter Health, Dignity Health, and Adventist Health.

Committee Chair Pérez asked which not-for-profit hospitals were above the 75th percentile in this comparison. Dr. Byington responded that these were smaller regional hospitals, such as Community Regional Medical Center in Fresno and Community Hospital of San Bernardino. These were smaller facilities, and perhaps not part of a larger system.

Committee Chair Pérez commented that there were multiple variables accounting for UC Health's score of 10.2 percent. He asked if there was a pattern among the hospitals above the 75th percentile that accounted for their position, and if UC could learn from that pattern. Mr. Hjorth responded that cost structure was an important factor in this benchmark. He did not know if there was a pattern among these other hospitals.

Committee Chair Pérez requested further analysis of this. Mr. Hjorth responded that UC Health could examine this in more detail.

President Drake asked about the nature of these individual facilities above the 75th percentile; a detailed review would reveal how and why there were in this position.

Committee Chair Pérez referred to information in the background materials showing figures for community benefit as a percentage of operating expenses for Dignity Health as 7.17 percent and Adventist Health as 7.2 percent. These figures did not seem accurate, based on past presentations to the Regents. He requested further information on these figures. Mr. Hjorth responded that he could provide detail behind these numbers.

Regent Reilly asked about pricing at UC Health compared to other hospitals and health systems. The price for services such as a blood draw or an MRI might be different at a UC hospital than at Providence or Dignity Health. She asked about the amount of

uncompensated care in dollar terms. Mr. Hjorth responded that pricing was not related to reimbursement. The University was reimbursed based on its contracts, not based on the charge. UC Health was making its pricing more public, but the reimbursement was based on contracts.

Committee Chair Pérez asked if there was still a price basis for calculating the value of an uncompensated procedure. He asked if this amount would be the rate that UC charges insurance companies, or another rate. Mr. Hjorth responded that this would be the reimbursement amount versus the cost of care.

Committee Chair Pérez asked if the cost of care was a constant, regardless of compensation. Mr. Hjorth responded in the affirmative.

Dr. Byington then continued the presentation, referring to background materials with examples of community involvement by each medical center. One example was the UC Health Milk Bank, which opened in September 2020. This was the first milk bank owned by a hospital system, the first in California to be led by a physician, and was accredited by multiple agencies. In the last 12 months, the milk bank had distributed 213,000 ounces of donated breast milk to 17 hospitals in California and to one in a U.S. territory. The focus this year for the bank would be to bring milk to all safety net hospitals in California.

Another example was a systemwide effort to provide health care and support to unaccompanied children at two emergency intake sites, one at the San Diego Convention Center, which was anchored by UC San Diego and Rady Children's Hospital, and another at the Long Beach Convention Center, which was anchored by UCLA, Mattel Children's Hospital, UC Irvine, and Children's Health of Orange County. These two sites served 4,915 unaccompanied children ages three to 17 from March to July 2021. Sixteen percent of the children had COVID-19. All the children were kept safe, and further outbreaks of COVID-19 were prevented. The children had opportunities for education, art, and health care. Over 1,000 UC healthcare workers participated, including 260 M.D.s and 42 trainees.

Committee Chair Pérez stated that he and others visited the Long Beach emergency intake site. He emphasized that the statistics shown in this presentation did not entirely convey how outstanding this work was, and the great humanity of this effort, which provided exceptional care and addressed the trauma of these young people, who had been separated from their families and faced great uncertainty. Representatives of the U.S. Department of Health and Human Services were at the Long Beach facility. They had seen facilities in other parts of the country and were impressed by the approach taken here in California compared to other places.

Regent Park asked about the medical education component of the community benefit calculation, the cost of educating medical students, interns, and residents. Mr. Hjorth responded that these were the expenses borne by the hospitals for the interns and residents, as specified by Form 990.

Regent Park requested more detailed data on these costs, and the cost per individual in these categories of interns, residents, and others. Mr. Hjorth responded that this information could be provided. Dr. Byington observed that hospital costs probably did not reflect the total cost.

Regent Park asked what else would need to be incorporated to arrive at the total cost. Dr. Byington responded that one would have to take into account costs at the schools of medicine as well as the costs at hospitals.

Regent Park summarized that the calculation of this cost would include the costs at the health professional school, at the hospital, and the tuition being charged. She asked if UC Health could provide these numbers. Dr. Byington responded in the affirmative.

Advisory member Marks referred to materials included for the UCLA Health Sciences strategy item, to be discussed later in the meeting. UCLA Health declared its commitment to serve as an anchor institution. Most hospital systems tend to emphasize the level of uncompensated care that they provide as the primary measure of community benefit, but it was important to recognize that the social determinants of health are probably the root cause of the U.S.'s declining health status and soaring healthcare costs. Clinical care alone could not solve these problems. Clinical care is important, but community health is directly related to community wealth and well-being. With respect to the concept of an anchor institution, a number of academic medical centers have made a commitment to do more than just provide clinical care, but to leverage the talent, expertise, and resources of these large institutions to help raise up the status of disadvantaged communities, whether through job opportunities, learning opportunities, or supporting small businesses. There were extraordinary examples around the country of institutions, such as the Cleveland Clinic and Case Western Reserve University, which were attacking the root causes of population health disparities in American communities.

Regent Makarechian referred to a chart in the background materials showing total community benefit of approximately \$4 billion. He requested clarification of this figure and the 10.2 percent of operating expenses. Mr. Hjorth responded that the ten percent was calculated from \$1.6 billion, the number that would be reported to the IRS. The \$4 billion total included other community benefit expenses that would not usually be reported to the IRS.

Regent Makarechian asked if UC Health's total expenses were roughly \$20 billion. Mr. Hjorth responded in the affirmative.

Regent Makarechian requested clarification of the "community benefits with Medicare" shown in the same chart, totaling approximately \$3.3 billion. Mr. Hjorth responded that this was the difference between the reimbursement the University receives for its Medicare patients and the cost of caring for them.

Regent Makarechian asked if the reimbursement was a matter of contracting. Mr. Hjorth responded in the affirmative.

Committee Chair Pérez observed that the reimbursement rate and the difference between reimbursement and the cost of care varied by location because the Centers for Medicare and Medicaid Services (CMS) reimbursement rates varied by geographic area. There was greater variation in reimbursement rates than there was in the actual cost of care. Mr. Hjorth confirmed that there was variation in reimbursement by location as well as by acuity. Hospitals were reimbursed more for higher-acuity patients.

In response to another question by Regent Makarechian, Mr. Hjorth explained that there were regional rates for every hospital.

5. **UPDATE ON UC HEALTH SYSTEMWIDE WORKING GROUP ON POST-ACUTE SEQUELAE OF SARS-COV-2 INFECTION (PASC)/LONG-COVID, AND ENGAGEMENT WITH #MEACTION ON MYALIC ENCEPHALOMYELITIS / CHRONIC FATIGUE SYNDROME (ME/CFS)**

[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.]

UC Health Chief Clinical Officer Anne Foster began the discussion by remarking that the COVID-19 pandemic has been described as a mass disabling event. Soon after the pandemic began, it was noted that some patients experienced various symptoms after their acute infection. This has become known as long COVID. Earlier studies showed that ten to 30 percent of people might develop post-acute sequelae of SARS-CoV-2 infection (PASC) after a COVID-19 infection. A recent study found that one in five adults have a health condition that might be related to a previous COVID-19 illness. It was estimated that up to two million Californians might have PASC. COVID-19 had revealed pervasive health disparities in society, with a disproportionate effect on communities of color and disadvantaged populations. There was concern about the persistence of this health impact to these communities after COVID-19 as well. The Centers for Disease Control and Prevention (CDC) recently predicted that, without mitigation efforts, up to 30 percent of the U.S. population might be infected with COVID-19 in the coming winter. This meant that PASC cases could potentially double by summer 2023. While COVID-19 vaccines significantly reduce instances of death, severe disease, and hospitalization, there was emerging evidence showing that vaccines reduce the risk of acquiring PASC by only 15 percent. It was still recommended that individuals get vaccinated, wear a mask, practice social distancing, and avoid becoming infected.

UC Health has established long COVID clinics. Given the high case numbers, demand exceeded capacity, and this was true across the U.S. UC researchers were actively engaged in a variety of PASC-related studies. UC Health has formed a PASC Working Group, with UC experts and State public health representatives, to discuss aspects of clinical care, research efforts, and education. As part of its educational mission, UC Health had developed and was filming a series of PASC or long COVID training modules, which would be widely distributed at no cost to community healthcare providers. This was aimed at expanding the number of providers who would care for these patients and address the large number of cases across California. UC Health had also engaged with #MEAction.

There were clinical symptoms common to myalgic encephalomyelitis/chronic fatigue syndrome (ME/CFS) and long COVID, with opportunities for learning.

Lucy Horton, Associate Professor of Medicine in the Division of Infectious Diseases and Global Public Health at UC San Diego Health, explained that many patients continue to experience COVID-19 symptoms for weeks, months, or even years after their initial infection. There was still no universal definition of this condition, but the commonly used terms included “long COVID” and “PASC,” the term recommended by the National Institutes of Health (NIH). COVID-19 can be seen as a clinical spectrum from the time of acute infection to post-acute phases, when there was no longer viral replication or detectable virus, but when patients could continue to have symptoms. Long COVID or PASC referred to a condition 12 weeks or longer from the onset of symptoms and could overlap with many of the other complications of acute COVID-19 illness, including complications related to hospitalization and the exacerbation of pre-existing conditions. There can also be mental health impacts.

PASC symptoms are very diverse. Over 200 symptoms have been described, and for almost every organ system. The UCSD clinic has observed that patients tend to present with a constellation of symptoms that do not correspond to the severity of their initial COVID-19 infection. The majority of patients with long COVID had mild to moderate COVID-19, and some were even asymptomatic. Patients can present with persistence of acute COVID-19 symptoms as well as new symptoms, which can begin weeks or months after recovery from the initial acute illness. This delay makes it challenging to connect these symptoms with a diagnosis of long COVID. In general, diagnostic testing produces a result of “normal,” and patients are told that there is nothing wrong, even though they may have symptoms. Dr. Horton referred to another phenomenon as the “unmasking of other conditions” such as asthma by COVID-19. It was unclear if COVID-19 triggered the development of these other conditions, or if patients previously had very mild symptoms which were then exacerbated by COVID-19.

While the risk factors for acute COVID-19 were well described, the risk factors for developing PASC were still somewhat unclear. Some of the factors identified so far were older age, female gender, having had severe infection, specific antibody profiles, and other comorbid conditions including diabetes and chronic respiratory diseases such as asthma. The underlying causes of PASC were still unknown. There were likely multiple disease processes that might account for the different subtypes of the condition. Some possible causes were viral persistence, perturbation of inflammatory responses, viral infection triggering autoimmune responses, viral-induced tissue damage or fibrosis in organs such as the lungs, and gut dysbiosis or disruption in the microbiome within the colon. Many of the symptoms resemble dysautonomia, a disorder due to the dysfunction of the nerves that regulate involuntary body functions such as heart rate, blood pressure, and sweating. A strong psychological component might be present as well.

Emerging data suggested that vaccination only offers partial protection against PASC. A recent study of patients in the Department of Veterans Affairs (VA) health system found that vaccination reduced risk by about 15 percent. This contrasted with prior, smaller

studies, which found much higher rates of protection. Dr. Horton noted that all these studies were carried out before the prevalence of the Omicron variant, and it was not yet known if these results would hold true with Omicron.

PASC is a challenging condition for clinicians. Not all post-COVID-19 symptoms are a sign of PASC. PASC is often a diagnosis of exclusion, after other concerning diseases have been ruled out. The causes of PASC were not known, and it was not known why the condition manifests itself so differently in different patients. Unlike acute COVID-19, for which there were excellent testing and treatment guidelines, there were few uniform guidelines for PASC. This was a resource-intensive condition and had the potential to be a significant strain on health systems. Dr. Horton anticipated that, ultimately, most care for PASC would be delivered in the community by primary care providers, with only the most medically complex patients referred to specialty centers.

E. R. Chulie Ulloa, Assistant Professor of Pediatrics in the UC Irvine School of Medicine, discussed PASC and its effect on children. Based on CDC data, as of February 2022, approximately 75 percent of children and adolescents in the U.S. had evidence of previous infection with COVID-19. Despite the large number of cases, serious illness in children due to COVID-19 has been much less frequent than in adults. Among states reporting this information, 1.5 percent of infected children have been hospitalized, with an increase seen in January 2022 due to the Omicron variant. There have also been far fewer pediatric deaths than the over one million deaths of adults. Children have not been the face of this pandemic, but children of all ages across the globe have been affected in profound ways. Many children have lost family members. More than 140,000 children in the U.S. alone have experienced the death of a primary caregiver from COVID-19. This, together with school closures and social isolation, has had a devastating impact on children's physical, mental, and socio-emotional development. Families and children have also experienced economic hardships and food insecurity. COVID-19 has had serious repercussions, many of which would have long-term consequences for children. Studies showed that 13 to 35 percent of children infected with SARS-CoV-2 can go on to develop serious and often debilitating conditions such as long COVID, estimated to affect hundreds of thousands of children.

The causes of long COVID were not yet known, but it was known that anyone could get long COVID, regardless of the severity of the initial infection. Many children with long COVID were asymptomatic when first diagnosed with COVID-19. Symptoms can be similar to those seen in adults and can vary from child to child, but fatigue appeared to be the most common symptom in children. The symptoms of long COVID can be very disruptive, interfering with normal activities in school and sports, causing disordered sleep and depression, and can lead to long-term health consequences affecting the rest of a child's life.

It is important to increase awareness of long COVID. Throughout the pandemic, UCI Health has worked tirelessly to establish strong relationships with the broader community, including low-income, minority neighborhoods, where COVID-19 disease, morbidity, and mortality have been devastating. In partnership with these communities, UCI has recruited medical volunteers to help run COVID-19 vaccine clinics and has run monthly town hall

meetings in English and Spanish to educate the community about COVID-19–related topics including long COVID in order to increase understanding, aid early diagnosis, and improve responses and intervention. UCI Health was also engaging with children and their parents through community engagement studios and was working to set up multidisciplinary post-COVID-19 clinics to care for these children. Funding and research were needed to improve the lived experience of children and to enable their recovery. Toward that end, the NIH created the RECOVER Initiative to learn more about the long-term effects of COVID-19. UCI Health was studying the mechanisms of health and disease in pediatric long COVID as well. Dr. Ulloa concluded that there was still much work to be done.

Elyse Singer, Professor of Neurology at UCLA, discussed long COVID and its effects on the nervous system. There were many COVID-19 neurology symptoms. The most common symptoms of acute infection were loss of smell and taste, and headache. There was an ICU or sepsis syndrome which occurs in people who are severely ill with COVID-19. The most common symptoms were cerebrovascular diseases, stroke, and hypoxic brain damage due to lack of oxygen caused by COVID-19-related pneumonia. In the post-acute infectious period, there was a host of symptoms including cognitive dysfunction, fatigue which did not respond to any type of rest, foul smell and taste due to regeneration of the olfactory nerve with the sending of abnormal signals to the brain, and loss of control of basic autonomic functions such as pulse, blood pressure, temperature, sweating, digestion, and balance. Understandably, under these circumstances, many patients suffer post-traumatic stress disorder and depression. This was due in part to the frightening experience, but probably also caused by abnormalities in neurotransmitters in the patient's brain due to inflammation.

Long COVID shares some features with other post-infectious disorders, including ME/CFS. The most important shared features were fatigue and post exertional malaise, when a patient, after a trivial activity, must spend a day or two in bed; cognitive dysfunction; chronic pain, often in muscles or joints; poor sleep; autonomic dysfunction; and small fiber neuropathy. As a result, the patient's normal bodily functions can be disrupted at any time, and the patient experiences loss of control over his or her life. There was some evidence of biomarkers that were consistent and persistent in PASC patients with neuropsychiatric symptoms. This had been published by UCSF in a small, preliminary study carried out with institutional funds, not NIH funds. Dr. Singer noted that there was not yet adequate funding for studies of long COVID, although there were more than enough patients who would like to join studies.

Long COVID can be very complex. Dr. Singer described a typical patient as a 42-year-old female, working in a career, who complains of “brain fog,” dizziness, and painful red feet. This person usually has more than one neurologic problem at any one time. She needs cognitive testing, which might show minor neurocognitive disorder, although this is not minor if one has to work in an environment with computers and telephones. An MRI of this patient's brain might reveal micro-clots, and a tilt-table test might show that she has autonomic insufficiency, with the involuntary nervous system not functioning correctly. Many patients have red toes and swelling in their feet, an indication of small fiber

neuropathy, which had not been much included in neurology education until recently. A skin biopsy is needed most often in order to verify this condition, which would not appear in routine neurologic tests. The patient might need intravenous immunoglobulin (IVIG) therapy or steroids, and it was difficult to convince insurance companies to pay for this. The needed treatment needed to be carefully documented.

A more common problem is cognitive dysfunction. In most patients, this affects the frontal and prefrontal areas of the brain. In most but not all patients, there is dysexecutive syndrome, which affects the ability to sequence, to plan, and to engage in goal-directed activities. These patients have difficulties with planning, problem-solving, attention and focus, working memory, and goal-directed behavior. There were psychological aspects to this condition as well. People around the patients would describe them as apathetic, easily distracted, or disorganized. A person with this condition, no matter how intelligent, might not be able to perform a job. Dr. Singer noted that she had had many patients with this condition who were no longer able to perform their jobs.

The study of PASC and neurology was a work in progress. One had learned that these problems are real and evolve over time. One was beginning to see patients who had recovered from COVID-19 three, four, or six months earlier, experiencing strokes. The mechanisms causing this were not known. The cause might be a persistent virus or autoimmunity. Dr. Singer emphasized the importance of genetics. A large number of her patients had a history, themselves or family members, of autoimmune disease. Because the mechanisms were not yet understood, one was treating symptoms rather than causes. Long-term outcomes were not known. One suspected that the inflammatory barrage the brain is under during COVID-19 might increase the risk of degenerative neurologic diseases like Parkinson's or Alzheimer's in the future. Dr. Singer concluded with a plea. There was a need for more COVID-19-trained specialists in the community. There needed to be certainty about reimbursement for tests, transport, and treatment. There needed to be more research on the mechanisms of symptoms, and treatment trials, which UC Health could begin now, without waiting for the NIH. There was a tremendous need to educate the public and to challenge misinformation.

Arthur Mirin, leader of the California chapter of #MEAction, recalled that his organization's engagement with UC began in 2019, with public comment to this Committee. #MEAction's original outreach was in the area of ME/CFS, but when the connection between ME/CFS and long COVID became clear, this engagement took on a new dimension. ME/CFS is a debilitating disease. Its hallmark symptom is post-exertion malaise. Approximately 25 percent of ME/CFS sufferers were bedbound or homebound and 75 percent were unemployed. There was a five percent recovery rate for the illness. Before the COVID-19 pandemic, the disease affected an estimated 180,000 Californians. ME/CFS most often begins with an infection, often a viral infection. As a result of other viral infections, ME/CFS onset rates ranged from five to 27 percent. Experts estimated that ten percent of COVID-19 survivors would develop ME/CFS. If this estimate comes true, there would be one million additional cases of ME/CFS in California. Most PASC sufferers had symptoms reflective of ME/CFS, such as post-exertion malaise, fatigue, "brain fog,"

and autonomic dysfunction. A few small studies indicated that 45 percent of PASC patients developed ME/CFS.

#MEAAction had been meeting with Dr. Foster since September 2021 and has provided resources and information to UC regarding PASC and ME/CFS, including suggested systemwide continuing medical education curriculum material. Mr. Mirin and Lisa McCorkell of the Patient-Led Research Collaborative on long COVID have proposed a statewide centers of excellence program, to be administered by UC. This led to a sponsored \$120 million budget request in the State Assembly.

Mr. Mirin stressed that UC needs to play a leadership role in educating physicians and healthcare workers about PASC and ME/CFS. In addition to providing training, UC should serve as a continuing state resource, including tele-mentoring. The University of California, with the largest academic healthcare system in the nation, was in the best position to take on this public service. UC medical centers need to treat ME/CFS along with PASC. This would benefit patients with either of these overlapping diseases, and it was an appropriate role for UC Health to take on diseases for which there was a desperate need for research. With appropriate financial support, UC should establish centers of excellence that would engage in clinical care, research, education, and public outreach. These centers should promote health equity and serve rural and underserved populations through a statewide network of satellite clinics. With an estimated two million Californians having acquired long COVID, there was no time to waste. Mr. Mirin hoped that UC would embrace the opportunity to perform this very important public service.

Committee Chair Pérez stated that he would like to have a longer discussion of this topic at a future meeting. He asked about the \$120 million State budget request. Mr. Mirin responded that Assemblymember Bill Quirk requested \$120 million over four years in the most recent session of the Assembly.

Committee Chair Pérez asked if this item was included in the budget when the Legislature passed its version of the budget that week. Mr. Mirin responded in the negative.

Committee Chair Pérez noted that Stanford Medicine has an ME/CFS Initiative. He asked about efforts to establish similar centers of excellence at UC, commenting that there were issues of funding, stigma, and frustration experienced by patients with ME/CFS who are trying to access the right complement of services but are told that they have some other, unrelated condition. Mr. Mirin responded that the proposal by #MEAAction and the Patient-Led Research Collaborative suggested that UC be allocated the funds to administer the statewide program, but the intent was to take advantage of the best public and private entities in the state, including Stanford University, and to support a network of satellite clinics throughout the state. Funds would pass through UC to these other entities. The intention of the program was to make use of the best that California has to offer, with UC in a central administrative role.

Dr. Foster explained that every campus had a clinic that receives patients with ME/CFS and provides evaluation and management. Patients with this condition are seen throughout UC Health.

Committee Chair Pérez commented that case management and care for these patients could be improved at UC. He suggested that there be further discussion of the #MEAAction and Patient-Led Research Collaborative proposal. He noted that Dr. Singer had presented clear, actionable suggestions as well.

6. UC LOS ANGELES HEALTH SCIENCES STRATEGY, LOS ANGELES CAMPUS

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

UCLA Health Sciences Vice Chancellor John Mazziotta began the discussion by emphasizing UCLA Health Sciences' identity as part of the UCLA campus, contributing to the campus' finances, reputation, and programs. UCLA Health shares many programs with the general campus, such as the Depression Grand Challenge. Dr. Mazziotta noted that three health schools were not part of UCLA Health: the Schools of Nursing, Dentistry, and Public Health, which reported separately to the Executive Vice Chancellor and Provost. This had been the case since the inception of these schools.

UCLA Health comprised two large entities, different from one another but highly interdependent. One was the UCLA Health System, with four hospitals, 250 clinics, and the Faculty Practice Group; the other was the School of Medicine, with its research and academic mission. UCLA Health's goal was that both of these interdependent components should thrive. It was important to dispel a false dichotomy, an idea that one would fail if the other succeeded. The two need to thrive and succeed together. UCLA Health's academic mission differentiated it from community and for-profit health systems. There was a history in the U.S. of academic medical schools being dependent on the profit margins generated by their health systems. In the first half of the 20th century, medical schools were small and trained their students and residents in affiliated hospitals. In the 1960s, with the expansion of the National Institutes of Health (NIH) and the signing into law of the Medicare and Medicaid Act, there was significant growth in health sciences research infrastructure and recruitment of faculty into U.S. medical schools. Ultimately, this process outpaced the revenue from tuition and, for public institutions, State funding. Medical schools developed their own hospitals and owned their hospitals and health systems. Over time, the academic mission came to depend on the margin of these health systems, a situation that continued today. This situation had also been affected by the Balanced Budget Act of the 1990s.

The UCLA Health System relies on the School of Medicine for research, clinical trials, and trainees; the School of Medicine relies on the Health System as a place to train people, gain new insights into research opportunities, and as a source of sufficient funds to cover the academic mission. Running a health system was a challenging business. The margins were low and had become lower since the COVID-19 pandemic. Health systems must grow to

survive, be relevant, and support the academic mission of their institutions. This was a difficult balance to achieve.

UCLA Health President Johnese Spisso recalled that UCLA Health had begun a renewal of its strategic plan in 2017. The strategic plan confirmed that UCLA has an extreme shortage of inpatient beds, given the size of the network that UCLA has been able to build and given the market demand. Continued success would require UCLA to not only expand and maximize its ambulatory care footprint but to add new patient beds. The strategic plan also confirmed that UCLA is well positioned for success in this market. UCLA's competitors were rapidly pursuing the same goals, and Los Angeles is a competitive market in health care.

The UCLA Health System has four hospitals, a joint venture rehabilitation hospital, and over 200 sites in the community that provide primary care, secondary specialty care, oncology, imaging, and ambulatory surgery. For a system of this size, UCLA Health should be operating with 1,500 inpatient beds, but currently had 801 beds. Given waivers and flexibility during the COVID-19 pandemic, UCLA was able to open some "shadow beds," putting two patients in one room. On a daily basis, UCLA operates about 900 beds by using space in the emergency department and other satellite spaces to accommodate patients. The joint venture rehabilitation hospital, with Cedars-Sinai and Select Medical, allowed UCLA to bring 138 state-of-the-art rehabilitation beds to Century City. This in turn allowed UCLA and Cedars-Sinai to convert rehabilitation beds to acute care beds. UCLA was able to acquire the mid-Wilshire campus in the past year and was proceeding with opening a state-of-the-art behavioral health facility that would add 125 inpatient behavioral health beds. Nevertheless, UCLA still had a gap of about 500 beds and for this reason had engaged with community partners while it awaited more capacity.

The mid-Wilshire campus was a \$400 million investment in mental health patients. The campus would undergo a full renovation to bring it to UCLA Health standards. UCLA expected construction to begin in early 2024 and for the hospital to be operational in early 2026. This would allow UCLA to repurpose 74 inpatient psychiatric beds at the Ronald Reagan UCLA Medical Center for adult and pediatric care.

Ms. Spisso presented a map showing UCLA Health ambulatory care sites in the Greater Los Angeles area. These included sites owned and operated by UCLA and sites where UCLA works in partnership with other entities. UCLA Health's annual reports reflected only the business volume in UCLA-owned clinics. UCLA's partnership work was reflected in the financial statements and annual reports of the other organizations. One example was the Orthopaedic Institute for Children in Los Angeles, near the University of Southern California campus. The UCLA Department of Orthopaedic Surgery has approximately 90,000 outpatient visits annually; of these, 42,000 take place at the Orthopaedic Institute for Children. About 85 percent of this population was covered by Medi-Cal. These numbers were not included in UCLA Health annual reports. The same was true for the Venice Family Clinic, a Federally Qualified Health Center, where all the employees were UCLA Health employees. The Venice Family Clinic has about 150,000 visits annually, or about

50,000 unique patients. A high percentage of these patients were insured through Medi-Cal or uninsured.

UCLA Health was acquiring software that would allow it to identify where there are gaps in care in the community and would use this tool to guide the expansion of its care network. UCLA's work in partnerships allows for increased access and capacity. UCLA hospitalists were working at 20 other hospitals throughout Los Angeles. When UCLA's hospitals are at capacity, it can admit patients from the broader community to receive care from a UCLA hospitalist. UCLA needs this more dispersed geographic network of hospitals because many patients live in distant neighborhoods, and the commute to UCLA for secondary care would be burdensome for them. The network also allows UCLA to bring specialty care to communities. As one example, hospitals in Downtown Los Angeles were staffed with specialists in cardiology, neurology, and stroke.

Expanding access through clinic locations was not enough to serve the most vulnerable populations. UCLA Health's Homeless Healthcare Collaborative currently had two mobile vans and hoped to have ten vans by the end of the current year. The vans serve patients experiencing homelessness throughout Los Angeles. UCLA had about 65,000 homeless patients. Currently, the vans served West Los Angeles, the Convention Center, South Los Angeles, and North Hollywood. With a full complement of ten vans, the program would be able to expand these services further.

Two years prior, UCLA Health had hired its first Chief of Health Equity, Diversity and Inclusion for the hospital system, and this has allowed UCLA to study health equity within its patient population. UCLA Health had launched several pilot programs with the L.A. Care Health Plan to facilitate specialty access for patients in the community, and UCLA was working to become an anchor network, partnering with the community in the areas of purchasing, employment, housing, and food insecurity.

Given current challenges with recruitment and retention, UCLA Health was pleased to have been recognized by *Forbes* in 2021–22 as a best large employer, a best employer for diversity, and a best employer for new graduates. *Newsweek* recognized UCLA Health as a most loved workplace in 2022. Ms. Spisso concluded her remarks by noting that UCLA Health provides broad education for faculty, staff, students, and trainees on respecting patients and their families to provide an optimal patient experience.

UCLA School of Medicine Interim Dean Steven Dubinett presented the School's highest priorities: to foster research and education in the service of patients; to promote and sustain an inclusive environment; and to lead in innovation for training scientists and physicians. Among the highlights of the curriculum is a new third-year program called the "Discovery Year," which allows third-year medical students time for creative and scholarly experiences in an area of their interest. The program encourages acquisition of skills for self-directed learning and scholarship. Students have the opportunity to engage in any one of eight topic areas such as basic, clinical and translational research, global health, and health delivery improvement science.

The School's research has community impact. UCLA led an NIH initiative in California, the "Share, Trust, Organize, Partner: STOP COVID-19 California" partnership, which included 11 academic institutions and more than 75 community partners and provided COVID-19 training and information. UCLA faculty developed SwabSeq, a unique saliva-based COVID-19 test that is accurate and inexpensive. More than one million tests have been provided with this technology.

In precision health, UCLA faculty have led the ATLAS Community Health Initiative, an opportunity to use universal consent, centralized biobanking, genomic testing, and high-performance computing to deliver genomic information for clinical care and research. Some drugs can cause profound toxicities for a certain percentage of patients. Physicians can prevent toxicities by knowing this genetic information before prescribing.

In the past year, the School of Medicine was awarded more than \$940 million in research funding, including \$559 million from NIH. In order to facilitate grants for faculty through an administrative structure, the School formed a Grant Submission Unit, which had expanded over the past ten years. The Grant Submission Unit provides project management and content expertise, editing and proofreading, and administrative and infrastructure support, particularly for large grants. Over ten years, this had led to almost \$600 million in funding and a higher-than-average success rate.

An important aspect of the School's work is moving discoveries to clinical benefit. UCLA faculty have participated in the development of 14 U.S. Food and Drug Administration (FDA)-approved drugs for cancer.

UCLA faculty have been involved in the development of therapeutics that have a meaningful impact. Two examples of this were Herceptin, developed by Professor Dennis Slamon, and XTandi, developed by Professors Charles Sawyers and Michael Jung. UCLA faculty continue to be recognized for their work by the National Academy of Medicine, the National Academy of Sciences, and the Lasker Awards program.

Dr. Dubinett concluded by noting that the School of Medicine has established an infrastructure for justice, equity, diversity, and inclusion (JEDI) in close collaboration with the UCLA Health System. These efforts included an anti-racism roadmap, a new mentorship program, and a JEDI Plan in each department. Emerging initiatives included professional development and education for faculty, staff, and students.

Regent Park asked about UCLA Health's plans for growth, particularly in partnerships. She asked if there was a specific goal for partnerships. Ms. Spisso responded that UCLA Health was taking a multi-faceted approach. Partnerships with physicians and specialists in Los Angeles hospitals addressed an immediate need for capacity and to bring expert care to the community. In the future, UCLA would need to own and operate more of its own patient beds. UCLA Health envisioned another hospital tower on the Westwood campus in its long-range plan. This would require replacing the existing cogeneration plant on the campus because there was not enough power to support a new hospital tower. The hospital tower project might be ten years in the future and the cost would be high. One reason for

the acquisition of the mid-Wilshire facility was the ability to add 125 beds. In the short term, UCLA was considering a variety of options. Dr. Mazziotta commented that UCLA Health could not expand or increase revenue from inpatients because inpatient beds were full every day. This was the case for every hospital in the UC system. At this time, growth and new revenue could only come through two vehicles. One was increased ambulatory care, which was essentially a pass-through, with professional fees going to doctors and providers; the other was making adjustments for inpatients, with shorter length of stay and changes in payer mix. These were the only tools left. There was a relentless escalation of costs for labor and supplies. This was a significant challenge and growth was a key factor. The net margin that UCLA Health can use for strategic investments is the gross margin minus depreciation costs and growth costs. UCLA must continue to invest in growth in order not to stagnate and in order to remain relevant. The budgets of Kaiser Permanente and other large competitor health systems were many times larger than the budget of UC Health systemwide. Growth should not occur too quickly and should not be excessive, but it must proceed at a pace that allows UCLA Health to maintain its balance.

Regent Park asked if the preferred growth was in bed capacity. Ms. Spisso responded that this was the most significant need right now. Patients come to UCLA from other counties, outside Los Angeles, and are willing to wait in the UCLA emergency department even though there is capacity at other hospitals. Dr. Mazziotta recalled that, when the Ronald Reagan UCLA Medical Center was planned, after the 1994 Northridge Earthquake, there was a general view that inpatient activity would decline, with more care moving to the outpatient setting. These predictions were wrong. Ms. Spisso remarked that UCLA had expanded the services it can offer to outpatients. Five years prior, all bone marrow transplants were performed as inpatient procedures; currently, more than 50 percent were performed as outpatient procedures, with monitoring. UCLA was increasing the complexity of outpatient services.

Regent Park asked about plans for the Faculty Practice Group. Ms. Spisso responded that UCLA's practice over the last several years has been to bring on individuals as UCLA physicians, rather than having another group do this. UCLA had brought on an orthopedic surgery group about four years earlier.

Regent Park asked if the Faculty Practice Group was shrinking. Dr. Mazziotta explained that the term "provider practice group" would be more accurate than "faculty practice group." This entity carries out billing and collecting for all UCLA providers, whether they are faculty physicians or staff physicians. As UCLA continued to grow and increase the number of providers, faculty titles would not be appropriate for many of them. A faculty title requires teaching and other responsibilities as a condition of employment and advancement. Many providers, often far from the UCLA teaching centers, did not have the ability or interest to serve in a faculty position. If an individual wishes to teach, he or she should be a faculty member, but faculty titles did not make sense for medical staff.

Regent Park asked about UCLA's efforts to help produce the healthcare workforce needed in California and how increasing the workforce might contribute to diversification of the workforce. Ms. Spisso responded that this had been a special focus for UCLA in the last

three to four years. Faced with difficulties in staffing clinics with medical assistants, UCLA Health partnered with UCLA Extension and developed a core curriculum for a medical assistant training program. This year-long program trains medical assistants and offers scholarships. Trainees who complete the program and pass an examination get a job working in a UCLA clinic. This has allowed entry-level staff to receive education and prepare for a job in health care. Some applicants from the program come from other departments at UCLA Health such as nutrition services, environmental services, and clerical positions. Ms. Spisso described the program as a great success. It had been fully accredited in the first year. UCLA was considering the development of more such pipeline programs. Dr. Mazziotta added that UCLA was proposing to expand the medical assistant program significantly, with a teaching location in Downtown Los Angeles. Ms. Spisso noted that tuition for the program was about \$20,000. UCLA provided scholarships because many people did not have resources to pay the tuition. In addition, courses are taught in the evening from 6 p.m. to 9 p.m. so that people who work full-time can participate.

Regent Park suggested that there be further discussion at a future meeting about UCLA Health efforts to diversify leadership, both clinical and faculty. She referred to an article that had appeared in *CalMatters* that spring which reported that Californians with special needs experience difficulties in accessing dental care, with long wait times. She asked how the UCLA School of Dentistry could address this. Dr. Mazziotta responded that the School of Dentistry was committed to the care of these populations. The School was in need of renovation and expansion. Dr. Mazziotta had discussed with Chancellor Block the possibility of the School of Dentistry coming under the umbrella of UCLA Health. UCLA Health was building its network across the City and County of Los Angeles, and this could include both medical and dental care. Dental care for disadvantaged populations was a matter that did not receive enough attention.

With respect to provider diversity, Committee Chair Pérez noted that, based on his experience as a patient at UCLA, UC Davis, and UCSF for 15 years, there appeared to be few Latino or African American providers.

Regent Sures asked about the possibility of UCLA Health expansion in new facilities in the San Fernando Valley. He asked about the challenges of starting a new facility from zero. Dr. Mazziotta responded that UCLA Health regularly considers such possibilities. Proposals for new hospitals are extraordinarily expensive, with a long development time frame.

Regent Sures asked about short-term solutions. Ms. Spisso responded that this geographic location was appropriate and that there might be actions UCLA could take in the near future; some promising discussions were underway.

Regent Sures asked that UCLA Health present some options to the Board for expansion of UCLA Health services into the San Fernando Valley.

Dr. Mazziotta recalled that UCLA Health had many patients in hospitals that it did not own or operate, taken care of by UCLA physicians subsidized by UCLA. The revenue from these patients goes to those hospitals.

Regent Sures remarked that patients were lining up to receive care at UCLA, but not at other hospitals. Ms. Spisso responded that UCLA Health's rankings might account for this. Patients had communicated to her that they did not mind waiting for care at UCLA because of the quality of the care. This was an ongoing challenge for UCLA Health, and the Chief Strategy Officer, Santiago Muñoz, has been focused precisely on these questions: What can UCLA Health do in the near term, and in the right location, to increase capacity?

Regent Leib asked how UCLA Health's growth and margins had been strained by the COVID-19 pandemic and about UCLA Health planning, based on the experience of the pandemic. Dr. Mazziotta emphasized that this was a national problem. Hospital margins in the U.S. had been reduced to zero or negative value after the pandemic and when federal support through the Coronavirus Aid, Relief, and Economic Security (CARES) Act ended. Many more people needed to be hired during the pandemic to run testing and vaccination centers, among other things. UCLA Health would try to make use of this additional workforce in other areas as UCLA Health activities expanded, but this was an adjustment that would take a number of years.

Regent Leib asked how UCLA Health was analyzing growth. Ms. Spisso responded that when UCLA hospitals are at maximum capacity, they are unable take in transfer patients with complex conditions. The UCLA Health System's highest margins come from inpatient services. At capacity, UCLA hospitals are not allowed to take in patients with complex conditions, receiving tertiary and quaternary care, who bring in incremental revenue. New patients coming in allow UCLA to add revenue. The limited number of patient beds caps this revenue. UCLA Health's financial modeling showed that, as one adds beds, the financial situation improves.

Regent Leib asked about a UCLA Health location in Orange County shown on a map during the presentation. He asked if UC Health was competing against itself. Ms. Spisso explained that this location was an oncology practice at Saddleback Medical Center. Many years prior, these physicians had joined UCLA Health. UCLA Health works closely with UC Irvine Health and would work to ensure that the patients of these physicians, when seeking other types of care, would receive that care at UCI Health.

Regent-designate Timmons asked about UCLA's safety net hospital partners. The Venice Family Clinic was staffed with UCLA staff. She asked if other such locations were also staffed this way, and how these staff were paid. Ms. Spisso responded that the Venice Family Clinic was a Federally Qualified Health Center. UCLA provided other services and funding to the Venice Family Clinic. Each of the arrangements with safety net partners was different, a unique relationship. These included Harbor-UCLA Medical Center and Olive View-UCLA Medical Center. UCLA provided a number of services at Martin Luther King, Jr. Community Hospital. Specialists working at that hospital bill and collect for services;

there was often shortfall associated with this, and this usually flowed through the department and back to UCLA.

Regent-designate Timmons asked if the UCLA staff at these facilities were represented by unions. Ms. Spisso responded that these employees were represented by different unions depending on the location.

Regent Makarechian asked about the status of the mid-Wilshire acquisition. He asked if there had been any surprises, if the project was on schedule, and if all 125 beds would be for mental health. Dr. Mazziotta responded that the project was schedule, with no surprises. The location would be dedicated 100 percent to mental health, with some other services to address the non-psychiatric needs of mental health patients.

Regent Makarechian asked if the UC medical centers had an agreement about boundaries between them. Dr. Mazziotta responded that the health systems had an informal agreement not to encroach on each other's territory. This issue rarely arose, and the Southern California campuses were currently developing a plan together to support UC Riverside Health with resources and activities. The relations among the health systems were collaborative, not contentious.

Regent Makarechian expressed his own and others' gratitude for the opening of the UCLA Health Montecito primary and specialty care facility in the Santa Barbara area.

President Drake commented on the plans for a new hospital tower at UCLA and the source of energy to run the new facility. It would be important to consider how clean that source of energy is. The COVID-19 pandemic had shone a light on disparities in access to health care. As UC Health considered growth, it must ensure that it addresses these disparities in access and outcomes. The UCLA Medical Center was a world-class institution, but within driving distance there were people without access to reasonable care. President Drake urged UC Health, as it grows, to break down barriers to care.

Regent Sherman asked about the current volume of telehealth services and asked if telehealth capacities were being used as part of the mobile van services. Dr. Mazziotta responded that telehealth had become a way of life during the pandemic. UCLA telehealth visits had increased from 900 to 90,000 over five months. Mobile vans used telehealth capabilities in many ways, such as to transmit patient scans from the vehicle. Ms. Spisso added that telehealth had allowed UCLA to expand capacity without physical locations. During the pandemic, UCLA patient volume had been 60 percent in person and 40 percent via telehealth. UCLA had now reached a steady state of 80 percent of patient visits in person and 20 percent via telehealth. Outpatient visits had increased by about ten percent, and telehealth had allowed for this increase. The "hospital at home" model had also become part of UCLA Health operations.

Regent Reilly asked if there were any issues of concern unique to UCLA Health of which the Regents might not be aware. Ms. Spisso responded that the UC medical centers had common concerns, experienced to varying degrees. All UC medical centers were now

dealing with overcrowding in hospitals and emergency departments. Another current concern was the increased potential threat of violence against healthcare workers. This was a national issue, and UC Health locations were working on ensuring security. Dr. Mazziotta added that he did not believe there was any significant issue of concern at UCLA that was not present at the other UC Health locations.

Regent Leib asked how the increase in telehealth volume affected profit margins, whether positively or negatively. Ms. Spisso responded that UCLA Health was able to receive funding for telehealth services during the pandemic. The cost of providing services to patients, whether in person or via telehealth, was about the same.

Executive Vice President Byington remarked that the total number of UC Health ambulatory visits had increased since the time of the pandemic. Telehealth has allowed UC Health to grow its ambulatory practice.

7. UPDATE ON AFFILIATIONS POLICY IMPLEMENTATION

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

Executive Vice President Byington recalled that the Regents adopted Regents Policy 4405, Policy on Affiliations with Healthcare Organizations that Have Adopted Policy-Based Restriction on Care, in July 2021. UC Health has been working to implement this policy systemwide as well as the Interim Policy on Affiliations with Certain Healthcare Organizations that was issued by President Drake in September 2021. Since July 2021, UC Health had placed a moratorium on new, noncompliant affiliation agreements and had created implementation groups for all segments of the process changes that were required to implement these policies. Every UC Health campus had implemented an affiliation agreement due diligence and approval process, which included an affiliation due diligence checklist and a contract review and approval process.

UC Health had reviewed a multitude of contracts, including those with private/nonprofit entities and government entities. All contracts with covered affiliates must comply with UC policy by December 31, 2023 or be terminated. To date, UC Health had signed omnibus addendum agreements with CommonSpirit Health (formerly Dignity Health), effective February 1, 2022, and with Adventist Health, effective December 10, 2021. Master template language had been approved with Providence and individual contracts were being amended location by location. UC Health was also working with Loma Linda University Health, Scripps Mercy hospitals, and other private hospitals. The Office of the General Counsel was working with the U.S. Department of Veterans Affairs and the Indian Health Service to update agreement language.

Through March 31, 2022, 97 contracts had been reviewed. The contracts were new, renewed, expired, or terminated and were primarily clinical agreements or training agreements. In addition, the UC policies require communications about policy-based restrictions on care to all stakeholders. UC Health has developed model communications

documents to provide consistent messaging for patients, faculty, staff, and trainees. All locations were sharing information through multiple channels, including websites, educational materials, targeted emails, and meetings of various kinds.

UC Health has implemented a complaint resolution process. Faculty, staff, students, trainees, and patients may submit complaints or grievances through a number of channels. In medical schools and residency programs, the ability to report complaints was a condition for accreditation. UC Health locations had identified the individuals responsible for receiving, evaluate, and report concerns and had carried out an active review for complaints that might highlight a covered affiliate. As of March 31, there were no complaints identified in this category.

Patient transfer operational groups have been working on the patient transfer process, developing and finalizing plans that outline patient transfer expectations in UC's transfer agreements. UC Health was communicating with UC personnel and trainees about these agreements and informing patients about restrictions on care and available options.

UC Health was also required to produce quality benchmarks for covered affiliates and was working on a quality metrics framework. This framework would be based on UC Health's own quality framework and the major quality indicators that it reviews in the UC system. The quality domains for the framework were in alignment with quality domains of the Institute of Medicine/National Academy of Medicine.

Another requirement was to establish the Joint Clinical Advisory Committee on Covered Affiliations, an advisory committee to the President. This committee included Senate faculty and chief medical officers or designees from all locations.

Compliance with these policies would be audited by the Office of Ethics, Compliance and Audit Services (ECAS), and ECAS planned to begin an audit in December 2023. Dr. Byington concluded by noting that a report on covered affiliations would be presented at the August meeting.

Committee Chair Pérez expressed concern that the outcome of the affiliations should align with the University's expectations. The quality criteria that had been presented, and by which UC would judge its covered affiliates, were a good subset but did not test some underlying questions. He referred to a chart shown earlier which indicated that, of the 97 contracts that had been reviewed, only one had been terminated. Committee Chair Pérez wished to see if the updated agreements in fact aligned with UC policy. One should review patient mix and the types of procedures performed to determine if these numbers were consistent with what would be the case at a UC facility. One should review experience with prescriptions, formularies, whether there were implicit limitations to the formularies, and other factors that one would examine in testing for compliance with policy. He stressed that the University must test whether the updated agreements with affiliates produce outcomes in alignment with those agreements. He suggests that additional outside experts might bring valuable perspectives and insight to the Joint Clinical Advisory Committee on Covered Affiliations.

President Drake suggested that the University should take a broad look at the patient mix in its affiliates. Affiliations allowed UC Health to have access to patients in areas where it would otherwise have difficulty providing service. Dr. Byington responded that this would be reflected in health equity measures. UC Health would identify the percentage of Medi-Cal patients in each affiliate.

Committee Chair Pérez emphasized the question of whether a patient population was receiving a complement of care similar to that offered at a UC Health facility. If not, it was necessary to understand if this was due to reasons that are understandable or if this was due to inconsistency between the terms of the agreement and the implementation of the terms of the agreement. It was good to have a complaint process in place, but a lack of complaints should not satisfy the University. UC had an obligation and an opportunity to test for certain questions.

Dr. Byington responded that she understood Committee Chair Pérez's concerns. During the discussion and development of the policies, a concern was expressed that UC Health affiliates were in general of low quality and of lower quality than UC Health sites. This was one reason for measuring and documenting the quality of affiliates using the same criteria by which UC Health judges its own facilities. Dr. Byington asked if Committee Chair Pérez wanted more specific indicators of reproductive health outcomes, such as numbers of tubal ligations and ectopic pregnancies. Committee Chair Pérez responded that these numbers would be helpful. UC Health faculty with expertise in these areas could determine appropriate standards and benchmarks. Other criteria might be whether or not prescriptions of contraceptives are actionable, such as contraceptive implants. Committee Chair Pérez wished to ensure that the changes being made to agreements with affiliates were real.

Chancellor Hawgood observed that UCSF, in its affiliations, was not directly providing the kind of services mentioned. This was a complicated analysis, and raw numbers from a hospital would not reflect the actions of UC physicians in those hospitals.

Regent-designate Timmons raised the question of whether it is possible to capture numbers of people having problems accessing these services, or the lack of care.

Regent Leib asked about the next steps. Dr. Byington responded that the first report would be presented at the August meeting. Working groups would continue to meet and numbers would be finalized on June 30. Following that report, there would be annual reporting, and UC Health would go through the first audit of policy compliance in this area.

8. ***DOBBS v. JACKSON WOMEN'S HEALTH ORGANIZATION – IMPLICATIONS AND ACTIONS AT THE UNIVERSITY OF CALIFORNIA***

[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.]

Deputy General Counsel Rachel Nosowsky explained that *Dobbs v. Jackson Women's Health Organization* concerned a challenge by an abortion services provider in Mississippi to a 2018 ban by that state on abortions beginning at 15 weeks after conception. The U.S. Supreme Court accepted an appeal from a lower court decision that had struck down this ban under *Roe v. Wade* and *Planned Parenthood v. Casey*. Those cases had established that there is a fundamental right to abortion. In *Planned Parenthood v. Casey*, this right was effectively limited by allowing for restrictions on abortion. In a recently leaked draft opinion, the Supreme Court appeared to have voted down this longstanding precedent which protected to some degree a woman's right to be treated as a human being rather than as a vessel for reproduction. President Drake had charged the University with thinking through some of the potential impacts in California and to UC specifically of the expected Supreme Court decision and of so-called "trigger laws" in many states, including Arizona. While the human impact of this decision was the University's greatest concern, particularly for the most vulnerable and marginalized members of society, UC must also consider legal issues anticipated for healthcare providers and others in California who want to help abortion refugees. Members of the California Legislature were also working to address this impact.

Legal issues for the healthcare industry focused on federalism and conflict of law questions. What is the potential liability for California providers and others who assist residents of states that ban abortion in obtaining abortion services in California? What is the liability for those who facilitate access to abortion for individuals in those states via telehealth? UC was also examining potential liability for California agencies, institutions, and individuals who might advertise the availability of abortion and supportive services to individuals in states where abortion is banned. Other legal issues included privacy and security concerns. There were limitations to the privacy of records. There was a question as to the scope of UC insurance and indemnification policy, and how much these would protect providers who provide these services.

Chief Clinical (Strategy) Officer Anne Foster reported that there was great concern about the anticipated Supreme Court decision in the UC Health departments of obstetrics and gynecology (OB/GYN). In reproductive health services, UC facilities were at capacity, as they were for other services. There were issues of concern regarding staffing, use of space and regulatory flexibility, which is important when an institution seeks to expand or rethink how it provides a service, and funding. The University had a successful family planning fellowship training program, but which lacked funding in some instances. There were concerns about a potential increase in numbers of patients from out of state; it would be difficult to expand services, even if this was desired. There was a concern about the basic safety in UC clinics for patients, students, faculty, and staff. The U.S. was, unfortunately, a violent society. Resources and funding would be necessary to ensure that California remains a safe haven for abortion services. There might be restrictions on grants and awards related to reproductive health services, and this would affect the University's research mission. Dr. Foster stated her concern about ensuring consistent and uninterrupted patient care, training, and research across UC and ensuring appropriate funding and resources.

Student observer Steven Gong referred to the UC Health annual report on community benefit and impact and praised UC Health for being in the 75th percentile of California not-for-profit hospitals in terms of percentage of their operating expenses devoted to community benefit. Approximately 22 of the 100 hospitals presented in one chart had a greater percentage than UC. UC Health should learn from the example of these hospitals in which areas it could improve. Mr. Gong asked how UC could improve its community benefit through financial assistance and Medicaid-subsidized services and requested more data explaining why UC medical centers' net community benefits decreased by \$90 million compared to the prior year. If this was due to Medicaid supplemental payments, he asked if this was the case just at UC Health, or more widely. With respect to post-acute sequelae of SARS-CoV-2 infection (PASC) and long COVID, Mr. Gong commented that diagnosing PASC depended on access to adequate testing, which was harder to obtain in lower-income, historically marginalized communities. UC Health's ability to treat PASC depended on its ability to continue to provide COVID testing and make testing accessible, especially for the vulnerable populations UC Health serves. UC Health excels at providing interventional health care, but PASC and myalgic encephalomyelitis/chronic fatigue syndrome (ME/CFS) demonstrated that much more work remained to be done on the social determinants of health and preventative long-term treatments. Referring to the discussion of the implications of the *Dobbs v. Jackson Women's Health Organization* case for the University and the anticipated overturning of *Roe v. Wade* by the U.S. Supreme Court, Mr. Gong was happy to hear that work was being done to keep California as a safe haven for people seeking abortion services. UC Health had a critical role to play in this as a national leader in health care.

The meeting adjourned at 1:55 p.m.

Attest:

Secretary and Chief of Staff