The Regents of the University of California

HEALTH SERVICES COMMITTEE
August 17, 2022

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

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

In attendance: Regents Batchlor, Blas Pedral, Chu, Hernandez, Robinson, and Timmons, Faculty Representatives Cochran and Horwitz, Interim Secretary and Chief of Staff Lyall, General Counsel Robinson, Senior Vice President Colburn, Vice President Brown, Chancellor Christ, and Recording Secretary Johns

The meeting convened at 9:25 a.m. with Committee Chair Pérez presiding.

1. APPROVAL OF MINUTES OF PREVIOUS MEETING

Upon motion duly made and seconded, the minutes of the meeting of June 15, 2022 were approved, Regents Drake, Leib, Makarechian, Park, Pérez, Reilly, Sherman, and Sures voting "aye."[1]

President Drake remarked on the persistent nature of the COVID-19 pandemic. The degree of focus on COVID-19 in the U.S. had dropped, even though 450 or more Americans were currently dying from COVID-19 every day. One must not be complacent and must do all that one can to protect one's fellow citizens. UC must continue to recognize and support the tremendous work of its healthcare personnel.

The federal government had declared monkeypox a public health emergency, and the pressures on UC Health would continue to be significant. Through its research, teaching, and public service, UC is a source of hope in the effort to create a healthier future for all. President Drake thanked everyone in UC Health who works toward this goal.

2. 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.]

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

Executive Vice President Byington began her remarks by echoing President Drake's concern about complacency in the U.S. about COVID-19, even as the country was facing another public health emergency. She underscored the need for investments in public health.

At this moment, the U.S. had reached a high plateau of COVID-19 cases, higher than prior to the winter of 2020 or the winter of 2021. This was a serious concern as one entered the fall and winter season. She anticipated that significant disease transmission in the U.S. would continue. The percentage of individuals who were fully vaccinated in the U.S. remained relatively flat, and, as time passed, their vaccine-derived immunity was waning. There was a small decrease in hospitalizations, but persistent mortality due to COVID-19, between 400 and 500 daily; this would amount to 150,000 to 200,000 deaths in a year and far surpassed any influenza season.

COVID-19 was affecting life expectancy in the U.S. Recent data indicated decreases in life expectancy in California, with an overall decrease of two years, but with disparate effects across different populations. Hispanic people experienced the greatest loss, 5.74 years. Non-Hispanic Blacks had a decrease of 3.84 years, and non-Hispanic Asians slightly over three years.

The Centers for Disease Control and Prevention (CDC) had issued new guidance regarding protection against COVID-19 the prior week. The new guidance was more focused on individual risk assessment and decisions on protection, and less focused on public health. Dr. Byington approved of some of this guidance but felt that other parts of the guidance undermined the ability to decrease transmission. One valuable element in this guidance was its recommendation for vaccination and booster shots. Three-quarters of Americans were not up to date on COVID-19 vaccination. In California, 32 percent of the population was up to date on vaccinations, which was better than in many other states, but this still represented less than one-third of the population. The percentages in many states were in the teens; in Dr. Byington's view, this meant that the U.S. was not prepared to enter another winter season with COVID-19 and influenza.

Dr. Byington then discussed booster vaccination eligibility. The youngest children were the least up to date in booster vaccination, but they had also had the least amount of time for vaccination. Among people aged 50 to 64 years, only about eight percent were up to date, and among those aged 65 and older, with the highest risk for serious outcomes, only 22 percent were up to date. Dr. Byington emphasized the importance of booster vaccinations and being up to date with vaccinations before the winter months.

Increasing vaccination coverage would reduce mortality. Dr. Byington presented a model of vaccine-preventable deaths which outlined expected baseline mortality levels if one continued with the current level of booster vaccinations, if one was able to increase booster vaccinations to the level of annual flu vaccinations, and in the best-case scenario, if one was able to reach 80 percent vaccination coverage. Booster vaccinations could prevent 100,000 to 150,000 deaths this coming winter.

Dr. Byington then presented information on monkeypox. Unlike COVID-19, this was not a new virus; it had been known since 1958. Not many resources had been invested in containing monkeypox in countries where it is endemic. In the last five years, it was recognized in Africa that monkeypox had acquired a new method of transmission. This was observed in men who have sex with men in Nigeria. Warnings about this went unheeded. Monkeypox appeared to have entered Europe in May 2022 and was now spread widely across the world, with more than 38,000 cases in 86 non-endemic countries, including the U.S. Each of these countries was at risk of having a new endemic virus. The U.S. now accounted for about one-third of cases reported in non-endemic countries, or about 13,000 cases to date. Dr. Byington believed that the real number was significantly higher, since testing remained difficult. California was one epicenter of monkeypox in the U.S. San Francisco and Los Angeles had the highest case numbers and case rates compared to many cities in the U.S.

Some of the same public health issues arose with monkeypox as with COVID-19. There had been a failure to launch diagnostic testing early on, difficulties in communication about who is at risk, and significant vaccine shortages. The U.S. had declared monkeypox a public health emergency on August 4. COVID-19 had been declared a public health emergency due to its pandemic potential and the likelihood that all people could be at risk. One did not anticipate such a degree of transmission for monkeypox. Nevertheless, this was an emergency because there was exponential spread and spread in vulnerable populations, including those living with HIV. There was the potential for spread to domestic animals. This would make monkeypox almost impossible to eliminate as an endemic disease in the U.S. The declaration of a public health emergency increased support for vaccines, diagnostics, and treatment. While more vaccine doses had become available, Dr. Byington anticipated that the current vaccine supply in the U.S. would not be augmented until October. There had been improvement in diagnostic capability; all UC Health locations were able to test for monkeypox.

The first case of monkeypox had been confirmed in the U.S. on May 18. At that time, there were only 2,400 monkeypox vaccine doses available, and testing was limited. By August 1, there had been an exponential increase in the number of cases to 5,811. On this day, August 17, there were 13,000 cases. There had been a release of 1.1 million vaccine doses. Most of these doses had been distributed, and there was a need for an estimated that six to ten million more doses. Testing capability had improved, and there was more communication about monkeypox in the community.

There were significant differences between monkeypox in countries where it is endemic and those where it is not endemic. In endemic countries in Africa, the distribution of monkeypox cases between men and women was fairly normal, and fairly even across age groups. The numbers of cases were also very small. As an infectious disease specialist, Dr. Byington had been taught to think of monkeypox as a disease affecting children, usually acquired from interaction with animals. Currently, in non-endemic countries, monkeypox was occurring almost exclusively in men, in more than 90 percent of cases in reporting countries. Most of these individuals, where data are captured, are men who have sex with men. There were few cases in women and children. Dr. Byington was concerned

as a pediatrician, because of diseases that are related to monkeypox. One of the best-known "relatives" of monkeypox is molluscum contagiosum, commonly spread in daycare centers and schools. She did not wish to see monkeypox enter the child population. One must do everything possible to contain this virus.

UC Health was using the infrastructure it had developed in response to the COVID-19 pandemic to respond to monkeypox and to keep the UC community informed about monkeypox. Systemwide guidance had been drafted by the UC Health Coordinating Committee. As in the case of COVID-19, UC was helping to meet the needs of the state and was involved in public health activities to contain monkeypox. UC San Diego was including monkeypox in wastewater surveillance. UCSF had vaccination clinics for monkeypox. UC Davis Professor Nam Tran had advocated to allow UC clinical laboratories to test for monkeypox. This involved a great deal of work because monkeypox is considered an agent of bioterrorism. Dr. Tran was also leading the effort at UC Davis on animal surveillance for monkeypox.

The previous week, UC Health received notice from the California Department of Public Health (CDPH) that it has been awarded a planning grant to work with CDPH on public health security. Dr. Byington hoped that this would lead to the development of a better framework for health security.

Dr. Byington announced the appointment of Deena Shin McRae as Interim Associate Vice President for Academic Health Sciences. She was succeeding Dr. Cathryn Nation, who had retired. Dr. McRae was an Associate Professor at UC Irvine in psychiatry and human behavior and Associate Dean of graduate medical education. She had a strong connection to the Department of Veterans Affairs.

In academic nursing, the highest honor a nurse can receive is to be elected to the American Academy of Nursing. This year there were 12 nursing fellows elected from the State of California, and eight came from UC.

Dr. Byington welcomed the fact that UC and the California Nurses Association had reached a new multi-year agreement. This was a milestone in UC Health-labor relations. In addition to compensation, the agreement also contained a commitment to establish systemwide committees between labor and management, recognizing the need to increase inclusion in the health workforce and to increase health and safety of workers. These were areas where UC and labor can work together and are well aligned to improve the environment for nurses and patients.

Dr. Byington then presented third-quarter statistics from Vizient. One of the most important benchmarks is mortality rate. This quarter, all UC hospitals were in the top ten in the nation for lowest severity-adjusted inpatient mortality. This was a desirable position and where UC Health wished to remain. In all the Vizient quality domains—mortality, efficiency, safety, effectiveness, patient-centeredness, and equity—all UC hospitals were in the top 25 in the nation, among 107 academic medical centers. While there was currently

much bad news, UC Health continued its work as one of the safest and highest-quality health systems in the U.S.

Committee Chair Pérez referred to information provided about reduction in life expectancy in California due to COVID-19, with disparities among different population groups. This was a population health issue that the University should be studying. He expressed concern about the recent CDC guidance and requested that there be further discussion at a future meeting on COVID-19 and population health. Dr. Byington stated that she shared the concerns about the CDC guidance. For example, the CDC indicated that people may leave isolation after five days without testing; however, people with the Omicron variant were positive for eight days on average. The reason given for not requiring testing or longer time in isolation was that there is uneven access to testing and sick leave in the U.S. Dr. Byington expressed frustration with the fact that, instead of making testing more available in a wealthy nation, the U.S. had moved to the lowest common denominator.

Committee Chair Pérez commented that these changes in guidance reflected a desire to get people back to work more quickly, but this might create new clusters of exposure. Dr. Byington provided a local example of a coffee shop that was closed when employees contracted COVID-19 after the shop removed all COVID-19 precautions.

Committee Chair Pérez remarked that UC had an opportunity and an obligation to take part in this conversation about guidance and policy. He referred to the fact mentioned earlier that the youngest children in the U.S. were the least up to date in booster vaccination. There appeared to be apprehension among parents about vaccinating children in this age group. He asked if there were any additional information that would be helpful to give parents comfort in seeking vaccination. Dr. Byington responded that vaccine hesitancy was one of the most life-threatening factors in the U.S. at this time. Misinformation on COVID-19 had been hard to combat. Large and well-financed groups promoted misinformation. There were declines in other childhood vaccinations. The first case of polio in the U.S. since 1979 had recently been reported. Dr. Byington anticipated measles and whooping cough outbreaks. One must address vaccine hesitancy as a life-threatening problem.

Committee Chair Pérez noted that the second largest school district in the U.S. had just reduced its COVID-19 protocols. He raised the question about UC's role in informing the public discussion of these policies. With regard to monkeypox, he referred to the information presented about the differences in affected populations in endemic countries and in countries where monkeypox was a new illness. He asked about how long it might take for such a shift in the affected populations to occur in non-endemic countries. The public discourse in the U.S. about monkeypox had been about this disease affecting men who have sex with men. This might not be the case in endemic countries, and in some recent cases in Europe and the U.S., it was clear that transmission was not caused by intimate sexual encounters. He expressed concern that the public discussion of monkeypox would result in an inadequate response, with an underestimation of the numbers of vaccine doses that might be needed in the future. Dr. Byington responded that more vaccines were needed, and that vaccine hesitancy could be a problem, especially if stigma were attached

to this disease. Monkeypox has not been classified as a sexually transmitted disease, but it is a sexually transmissible infection.

Committee Chair Pérez again stressed that the public health discourse had stressed this mode of transmission, rather than transmission through non-sexual intimate contact. Dr. Byington commented that, considering the small numbers of cases in endemic countries, monkeypox has not been thought of as a contagious disease. COVID-19 had begun with an R naught of between two and three. At this time, with the Omicron variant, the R naught was at about ten. The R naught of monkeypox has generally been about one or 0.8, not very contagious. But with a potentially new mechanism of sexual transmissibility, there had been an explosive increase in the number of cases.

Committee Chair Pérez asked if UC Health was engaged in sufficient outreach to UC Health patients to help them identify their risk profile and determine whether they should seek vaccination. Dr. Byington responded that UC Health works to educate its providers, including student health center providers. There would be cases of monkeypox on campuses and UC Health must be prepared to identify them quickly and to provide vaccinations promptly. This called for discussions with local public health departments, and UC had developed strong relationships with these departments during the last two years of the COVID-19 pandemic.

Committee Chair Pérez reiterated his question about outreach and asked if UC Health was pursuing a similar strategy as it had with COVID-19. Dr. Byington responded that infection prevention teams at UC Health had created many resources for providers across the UC system.

President Drake referred to the large numbers stated earlier of deaths that could be prevented by booster vaccinations. It was perplexing that people were choosing to ignore information or not availing themselves of resources that could save their lives. This was a significant current challenge for the U.S. The University has developed guidelines for monkeypox prevention and control on the campuses. Dr. Byington related that the chancellors had asked UC Health to develop systemwide guidance for monkeypox. UC Health has created this guidance, and Dr. Byington believed that it would be issued that day. This guidance would allow for a uniform response across UC and ensure that every campus is prepared for cases or outbreaks of monkeypox.

Regent Reilly referred to the relatively low percentages of people in the U.S. who were fully vaccinated. She asked if the University was doubling down on its efforts to provide information and about the reasons for these low percentages. Dr. Byington responded that vaccine hesitancy had been a problem during her entire career as a pediatrician. At this time, there were active and well-financed misinformation campaigns. Much of this misinformation could be traced to unfriendly states, including Russia. Misinformation disseminated through social media was difficult to combat. Research on communications and messaging was necessary in order to understand which messages resonate with people to lead them to make life-enhancing choices rather than the opposite. Dr. Byington believed that people should have choices, but it was shocking when people actively refuse a vaccine.

People state many reasons for refusing a vaccine, but most of those reasons are based on misinformation. Vaccine hesitancy was a significant threat to public health.

Regent Reilly asked if UC was conducting research on effective arguments for vaccination. Dr. Byington recalled that there had been a peak in vaccine hesitancy in the late 1990s; this seemed to come under control in the 2000s, when child immunization rates were good, better than today. The COVID-19 pandemic brought with it misinformation and people forgoing medical care, including routine childhood medical examinations. Overall vaccination rates in some communities were lower now than they had been before the pandemic.

Regent Reilly suggested that public service announcements by the University of California, encouraging people to get vaccinated, might be effective in various news media outlets, such as Spanish language radio stations, to reach populations that are under-vaccinated.

Regent Reilly asked how many doses of the monkeypox vaccine UC had received. Dr. Byington responded that she did not know the precise number; it was in the thousands, and less than the University would like. There had been a large allocation the previous week.

Regent Reilly asked if UC expected an increase in available doses. Dr. Byington responded that more doses had not yet been produced. She anticipated that more doses would not be available until October.

Regent Reilly asked if there was only one company manufacturing the monkeypox vaccine at this time. Dr. Byington responded in the affirmative. There was also a smallpox vaccine which might be effective, and which might be used if the current monkeypox outbreak was not brought under control. Because the smallpox vaccine is a live virus vaccine, it is not appropriate for people with immune deficiency, pregnant women, and people with skin conditions such as eczema.

Regent Leib asked if a third booster shot would be required. Dr. Byington responded that she believed there would be annual booster shots for everyone, as there were for influenza. That would be a logical outcome. It would take time to reach a pattern in which one booster shot per year would be adequate, and the U.S. was not yet at that point. The antibody immunity from infection or vaccination wanes over time. A pattern of annual vaccination was likely in the future.

Regent Leib stated that currently, it seemed that people who had received a second booster shot were not eligible for a third. Dr. Byington confirmed that this was the case. The question was now before the CDC. One expected a new type of vaccine that would respond to both the original strain of COVID-19 and the Omicron variant to be submitted for approval in the fall. It would be interesting to see if the CDC recommended that everyone receive this vaccine, or if the recommendation would be limited to certain populations. Dr. Byington hoped that everyone in the U.S. would receive this vaccine before the winter.

Regent Leib asked about the vaccination requirement for UC students returning to classes this fall. Dr. Byington responded that the University was continuing to implement its vaccine policy, which required all vaccinations and booster shots, if individuals are within the age group for eligibility.

3. PROPOSED REQUEST FOR APPROVAL OF THE PARNASSUS RESEARCH AND ACADEMIC BUILDING AND WEST CAMPUS SITE IMPROVEMENTS, SAN FRANCISCO CAMPUS

The President of the University recommended that the Health Services Committee approve the San Francisco campus' proposal to request recommendation by the Finance and Capital Strategies Committee to the Board of Regents, at its future meetings, of (1) additional preliminary plans funding for the entire Parnassus Research and Academic Building and West Campus Site Improvements project, working drawings and construction funding for the Site and Make-Ready Work Portion of the project, the scope of the Site and Make-Ready Work portion of the project, design of the Site and Make-Ready Work portion of the project following action pursuant to the California Environmental Quality Act (CEQA), and external financing, and (2) for the total project budget, additional external funding, and design pursuant to CEQA for the Parnassus Research and Academic Building.

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

Chancellor Hawgood introduced this item for the Parnassus Research and Academic Building, which would have no patient care activity. The project budget would exceed $300 million, requiring review and discussion by this Committee before further presentation to the Finance and Capital Strategies Committee.

The Parnassus campus had first been populated in 1900. The oldest still existing building, UC Hall, was opened in 1917. It was currently empty, with a seismic safety rating of V. UCSF was proposing to replace this building with a modern, state-of-the-art research building. UCSF had produced a major master plan for the Parnassus campus, the Comprehensive Parnassus Heights Plan (master plan), which had been approved by the Regents. This plan would extend over approximately 30 years. Several projects had been designated for Phase One, the first decade of the master plan through 2030. The two major capital projects were the New Hospital on the eastern end of the campus, and this new research building on the western end of the campus.

The existing UC Hall building had 147,000 gross square feet. Built as a hospital, it was subsequently used as a mixed academic and research building until UCSF began to move people and programs out about five years prior due to seismic safety concerns. UCSF planned to replace this with an approximately 270,000-gross-square-foot building, although the exact size had yet to be determined. The design architects were in place. This was a critical project because all UCSF research buildings on this campus were built prior to 1970, with the exception of the relatively small Regeneration Medicine Building, added in 2011. The Parnassus Research and Academic Building would provide 174,000 gross

square feet of wet and dry laboratory space supporting approximately 53 principal investigators. These would be a combination of existing investigators, who would move into this building from locations that need to be renovated, and new recruits. UCSF planned to demolish the existing School of Nursing Building for reasons of seismic safety. There would be an exorbitant cost to retrofit this building. The School of Nursing program would be moved into the new building. In addition, there would be some retail, education, and building support services.

UCSF currently planned to demolish UC Hall after exterior abatement, and for this to be completed by the end of the next calendar year. UCSF would immediately begin construction of the new building at the end of 2023, continuing through 2026, with the goal of completing most of the external construction of this building before beginning the major construction of the New Hospital on the other end of the campus. The Regents had approved preliminary plans funding for the Parnassus Research and Academic Building in May 2021. Chancellor Hawgood anticipated that further items regarding this project would be presented in September and in spring 2023.

Regent Park asked about the number of principal investigators. Chancellor Hawgood responded that this was 53, but that this number could perhaps be enhanced; this would be determined by budget and design considerations. This number did not include the School of Nursing personnel in the building. The project also assumed about eight graduate students, postdoctoral scholars, and technicians for each principal investigator. There would be about 250 research-focused personnel in the building.

Regent Park asked if there would be office space. Chancellor Hawgood responded that there would be office space for the principal investigators and for the School of Nursing. He anticipated that the offices would be of relatively small size, perhaps 75 square feet.

Regent Park asked if other UCSF faculty would have the ability to use space in this building. Chancellor Hawgood responded that UCSF had engaged hundreds of faculty and staff in the master planning process, which examined not just plans for facilities but questions of how UCSF carries out its work. One of the exciting programs in this building would be the "CoLabs" initiative, a new way of thinking about core facilities that provides opportunities for rotation. Faculty in other buildings or at the Mission Bay campus could come and access equipment in this building that is too expensive to replicate in other laboratories. Students would be able to gain expertise in certain technologies. This was one example of innovation in how work would be done in this building.

Regent Park referred to the space program, which included 12,000 gross square feet of education space. She asked if this would be an increase. Chancellor Hawgood responded in the negative, explaining that some education space would be lost in the demolition of the current School of Nursing building. There was an education master plan for the site. UCSF had recently renovated the adjacent Clinical Sciences Building, which had a significant amount of net new education space. The 12,000 gross square feet of education space in the Parnassus Research and Academic Building were relatively modest compared

to the total size of the building, but this plan was integrated within the entire UCSF master plan.

Regent Park asked if UCSF was increasing education space in other buildings on campus. Chancellor Hawgood responded in the affirmative. There would be additional increases in future phases of the master plan.

Committee Chair Pérez asked about the size of the School of Nursing. Chancellor Hawgood responded that the current School of Nursing building was about 80,000 square feet in size. The building had other functions not specific to the School of Nursing, such lecture halls and a large cafeteria. The exact same functions of the existing School would fit into the new space.

Committee Chair Pérez noted that the new building would have a total of 271,000 gross square feet. Of this total, about 147,000 would replace UC Hall and 80,000 would offset the loss of the current School of Nursing space; this left a net difference of 44,000 gross square feet. He asked if this net difference was in alignment with the master plan. Chancellor Hawgood responded in the affirmative.

Committee Chair Pérez asked if the campus anticipated any California Environmental Quality Act concerns in connection with this project. Chancellor Hawgood responded in the negative. If UCSF were to include additional square footage in this building, this would decrease future expansions, consistent with the campus master plan and space ceiling. UCSF did not intend to modify the master plan or space ceiling.

Chancellor Block asked about parking for the building. Chancellor Hawgood explained that parking was addressed in the master plan. Parking was not being constructed in this building. UCSF had engaged multiple parking and transportation consultants due to the complexity of parking issues at UCSF and the question of what future parking needs would be, ten and 20 years into the future.

Upon motion duly made and seconded, the Committee approved the President's recommendation, Regents Guber, Park, Pérez, Reilly, and Sherman voting "aye."

4. **APPROVAL OF ADDITION OF QUALITY PERFORMANCE METRICS RECOMMENDED BY THE UNIVERSITY OF CALIFORNIA HEALTH CLINICAL QUALITY COMMITTEE TO THE CLINICAL QUALITY DASHBOARD**

The President of the University recommended that the Health Services Committee recommend that the Regents approve the addition of four categories of performance measures to the University of California Health Clinical Quality Dashboard: (1) quality and patient safety issues reported to the California Department of Public Health and the Joint Commission (including patient complaints); (2) risk management early identification of potential claims; (3) healthcare provider behaviors that undermine a safe, respectful, and

reliable environment of patient care; and (4) population health, including efforts to reduce health disparities.

[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 item, which represented a milestone in the advancement of quality benchmarks at UC Health and a step forward in the ability to improve quality and care for all UC patients.

Chief Clinical (Strategy) Officer Anne Foster explained that this item would present the work of the Clinical Quality Committee (CQC) and propose systemwide quality and patient safety measures.

UCLA Health Chief Medical and Quality Officer Robert Cherry recalled the Regents' involvement in the establishment of the CQC, whose major goals are to ensure that there is performance improvement activity throughout UC Health and to provide the Health Services Committee with prioritized and timely information to support its oversight function for clinical quality and safety across UC Health. The Regents' oversight function was greatly appreciated. Board oversight in healthcare quality is a recognized best practice for health system quality improvement, and this includes setting aims, soliciting data, developing actionable measurement sets, optimizing the environment, culture, policies, and procedures, and establishing an appropriate accountability structure for quality and safety.

The CQC collaborates with UC clinical leaders to make recommendations on actionable measures for population health, quality, and safety. The CQC reviews the performance improvement plans of the medical centers and UC quality and safety data, comparing UC data with institutional and external benchmarks. The CQC also reviews serious adverse events and would develop corrective and preventive action plans, communicating with the Health Services Committee and the Compliance and Audit Committee as appropriate. The CQC would also coordinate with the Finance and Capital Strategies Committee to review items of shared interest.

The CQC aligns and reports systemwide statistics and data. The CQC seeks input on the metrics from the clinical and administrative leadership groups, recommends measurements and benchmarks to senior management and HSC, utilizes the UC Health Data Warehouse to expand upon existing dashboards and support performance improvement, and utilizes Vizient as the academic health system collaborative for measurement and benchmarking. Vizient provides meaningful benchmarks that anchor UC Health in comparison with like institutions.

Vizient helps UC Health become a high reliability organization, with a focus on zero harm to the patient. The Vizient quality domains mirror the Institute of Medicine (National Academy of Medicine) domain areas for best practices—mortality, efficiency, safety, effectiveness, patient-centeredness, and equity. Each of the domains has associated

measurement sets and weights which allow for rankings and sharing of best practices. UC Health's aspiration was to have all the UC medical centers in the top ten of Vizient rankings.

Dr. Cherry presented a chart showing improved Vizient rankings for the UC medical centers from 2017 to 2022, which had been the result of a coordinated effort across UC Health. All the UC medical centers were in the top quartile; three were in the top ten.

UC Health has a specific focus on equitable care. UC Health campuses have health equity leaders who are meeting regularly, coordinating, and sharing best practices. They would seek to identify how one can optimize UC Health structures and policies to deliver the best care, standardize collection of patient demographic data, and work to advance UC Health's goal of becoming an anchor institution for the promotion of racial equity, social well-being, and community health. Partnerships with UC Health population health and other affinity groups would be important in closing gaps in care.

Population health focuses on the goal of providing optimal care to all demographic groups. Dr. Cherry presented a chart representing blood pressure control by race and ethnicity. Analysis of data allows for customized interventions for different demographic groups. Population health considers a number of measures, including optimizing diabetes care—ensuring that blood pressure and glucose are under control, providing eye and kidney assessments, and ensuring the full delivery of services. The same was true for a new class of cardioprotective drugs which reduce heart attacks, strokes, and congestive heart failure.

Regulatory opportunities were another area of focus for the CQC. UC Health reported to a number of regulatory agencies and entities. UC Health found particular value in its conversations and dialogue with the Joint Commission and the California Department of Public Health. The clinical regulatory affairs group within UC Health had identified certain areas of opportunity for improvement. One was hospital-acquired pressure ulcers, which included not just bed sores but device-related pressure ulcers. Another area was the retention of foreign objects related to procedures and surgeries.

The California Department of Public Health had a backlog of cases of complaints and reported events, sometimes back to 2012. UC Health works with the Department to ensure that it is implementing best practices. For example, in the case of pressure ulcers, this would include appropriate skin assessments, evidence-based care plans, and patient awareness to improve outcomes.

The CQC also considered risk management opportunities. Precautionary Incident Notifications (PINs) are recorded by UC Health's risk management teams. PINs are categorized as adverse event reports, patient experience reports, or other issues such as equipment malfunction. PINs are collected in real time so that opportunities for improvement can be realized and shared. The root causes of incidents are categorized as well. Some examples of these categories are clinical judgment, communication with patient, and supervision failure.

The CQC was also focused on the Patient Advocacy Reporting System (PARS). All UC medical centers participated in PARS. PARS collects and surveys patient complaints. For UC Health and other health systems in the U.S., the statistical analysis provided by PARS can identify exceptionally serious patient complaints about areas where malpractice might occur in the future. Dr. Cherry noted that PARS can identify a subgroup of physicians whose behavior might compromise and undermine a safe, respectful, and reliable environment. PARS data have enabled UC to engage in evidence-based interventions to help regulate behavior and provide a better patient care environment.

Dr. Cherry presented a conceptual "Promoting Professionalism Pyramid" with escalating evidence-based interventions to promote desired behaviors and outcomes. Interventions included mentorship, self-correction, peer messengers, and, when necessary, assignment to a performance improvement program by a clinical chair or other authority. UC Health had experienced considerable success with this model, which had salvaged several careers.

Dr. Cherry concluded by outlining the proposed action. The Clinical Quality Dashboard had been standardized over the last several years. UC Health now wished to integrate new criteria into the Dashboard, such as quality and population health measures and risk management measures. This was an iterative process, and the discussion today had presented a framework and a beginning. UC Health wished to build on the Dashboard with scalable, actionable measurements to promote better performance throughout UC Health. In the future, UC Health would consider the Co-worker Observation Reporting System (CORS), which concerned staff complaints about other staff members. UC Health also wished to explore how it can learn from employee engagement surveys and present these in a meaningful way to the Health Services Committee. Dr. Cherry invited the Committee to participate in this process.

Regent Park asked if the Committee would receive an update, perhaps in six months, on the criteria that would be adopted today. Dr. Cherry responded in the affirmative.

Regent Park requested more information about CORS and how this system works. She assumed that CORS would concern healthcare provider behavior that undermines a safe, respectful, and reliable environment of patient care. When there are failures in this area, these matters routinely come to the attention of the Compliance and Audit Committee. Regent Park referred to some of the background materials provided. An April 2008 article from *The Joint Commission Journal on Quality and Patient Safety* outlined steps that hospital governing boards should take. One step was setting aims, and the article recommended the specific aim "to reduce harm this year. Make an explicit, public commitment to measurable quality improvement…" She asked about the process of achieving this, and about the University's public commitment to measurable quality improvement in focusing on goals such as health equity and on more specific goals such as blood pressure control among African American patients. UC Health did not yet appear to have made a measurable quality improvement commitment. UC Health was committed to collecting data and to optimization and collaboration. Regent Park asked about accountability and reiterated her question about how UC Health would get to measurable quality improvement.

In response to Regent Park's first question, Dr. Cherry explained that CORS, unlike PARS, was designed to deal with issues in real time. PARS provided statistical data after some period of time. CORS issues were escalated in real time and addressed. There could be further discussion of CORS at a future meeting. Dr. Cherry stressed that the CQC was not merely interested in collecting data, but wished to show clear, tangible results in equity, population health, and closing safety gaps.

UCLA Chief of Health Equity, Diversity and Inclusion Medell Briggs-Malonson reported that there were now health equity leaders at UC Davis, UCLA, UCSF, and UC San Diego. These leaders had been meeting monthly for the last three to four months to undertake the development of a strategy for the entire UC Health system with a special focus on population health and meaningful measures. One wished to avoid overgeneralization. It was important to have a good understanding of the data. UC health equity leaders were focused on a collaborative approach so that when goals are set, these goals would lead to the desired result. Health equity was based on the care UC provides to its patients, but it was also important to address the social determinants of health. UC Health wished to ensure that, when goals and measures are implemented, they would have a positive impact on the most vulnerable patient populations.

UCLA Faculty Practice Chief Medical Officer Samuel Skootsky commented that the idea of a public commitment to certain goals was excellent. For a number of years, UC Health had been working on its ability to measure such goals in a reliable manner in ambulatory care. Reliable measurement was not simple because patients can go to many sites to receive services, but this idea was excellent, and UC Health would study how it could move in this direction.

Regent Park suggested that the CQC make a presentation at a future meeting with specific goals related to some of the areas that had been identified as important in this discussion. A great deal of effort goes into goal setting and measurement. She reiterated her wish to see UC Health's public measurable quality improvement commitment.

Regent Park raised the issue of effective governance. It was not clear which matters had or had not been delegated to the CQC by the Board and the Health Services Committee. She requested an answer at a future meeting about which matters, in the view of the CQC, had been delegated to the CQC, and which matters were not the responsibility of the CQC and still within the jurisdiction of the Health Services Committee. Dr. Cherry recalled that there had been a task force that provided direction to the CQC. A major request of the task force had been the development of a number of safety-related measures that would give the Health Services Committee information in real time and an understanding of how UC Health can close safety gaps in order to be a high reliability organization. This was a fundamental guide for the CQC. Regent Park had identified a certain ambiguity in the relationship between the Health Services Committee and the CQC. For this reason, the CQC felt that some Regent members of the Committee should be involved in the development of CQC measures and criteria. While the charge to the CQC was clear, the CQC wished to ensure that there was ongoing communication.

Committee Chair Pérez asked why the Committee was only now discussing the question of Regents' engagement in this process. Dr. Cherry reflected that the conversation about the role of the CQC and how it can best serve the Health Services Committee had been ongoing for several years. This was a journey and a process of maturation.

Committee Chair Pérez asked if this meant that the Health Services Committee was immature. Dr. Cherry responded that all health system governance structures were in various stages of maturity.

Committee Chair Pérez asked if UC population health efforts were considering gender as well as race. Dr. Cherry responded in the affirmative.

Committee Chair Pérez asked about race and maternal mortality. National data indicated that African American women experienced two to three times the rates of maternal mortality compared to White women. He asked if there were similar statistics with respect to Latina women in California. Dr. Briggs-Malonson responded that there were significant health inequities in California, and UC medical centers, in their regions, continued to see areas for improvement across categories of race, ethnicity, gender, socioeconomic status, sexual orientation, language, and ability status. In terms of maternal mortality, Latinas performed better than African American women. The worst outcomes were among African American and indigenous women. There was much work to be done in this area. UC Health must continue its efforts to address this and other health inequities.

Committee Chair Pérez asked Dr. Briggs-Malonson how she defined UC Health. Dr. Briggs-Malonson responded that UC Health comprised the UC medical centers or health systems.

Committee Chair Pérez asked if this was limited to the operations that UC directly controls or if the definition extended to affiliate relationships. Dr. Briggs-Malonson responded that, in her view, UC Health had significant impact and influence on its affiliations as well as on other organizations with which UC did not have affiliations. UC Health was clearly a leader in California and the nation and should strive to be a leader in health equity.

Committee Chair Pérez asked if this was an equity and quality lens that UC should apply to its own and to its affiliate operations. Dr. Briggs-Malonson responded that UC had already begun integrating this focus. The need for equitable health care had been defined by the Institute of Medicine for more than 20 years.

Committee Chair Pérez asked about the intersection of these questions and patient-centeredness. Dr. Briggs-Malonson responded that it was important to integrate equity into every piece of the UC Health organization—in operations, finances, and the delivery of patient care. One also had to consider the patient experience. One could provide the best care possible, but if patients did not feel that they were given respectful and affirming care, UC Health was still not doing its job. UC Health was actively focusing on this.

Regent Park requested that there be less ambiguity and greater clarity about the interaction of the Health Services Committee with the CQC. Dr. Cherry concurred and reflected on the goals of the CQC, which included working for greater access to care for those who lack it.

Committee Chair Pérez asked how Dr. Cherry expected to answer these questions of population health and UC Health's provision of care to California populations. Dr. Cherry responded that this effort would require more than just the CQC. This involved leaders throughout UC Health in collaboration with the Health Services Committee.

Advisory member Ramamoorthy praised the work of the CQC, which was reflected in UC Health's performance on national benchmarks. She referred to risk management and adverse incident reporting. As a clinician, Dr. Ramamoorthy was familiar with the Patient Advocacy Reporting System (PARS), but Precautionary Incident Notifications (PINs) and the Co-worker Observation Reporting System (CORS) were new to her. While these tools would improve quality and the patient care environment, and it was important to identify unprofessional behavior, she cautioned that these tools and systems, in particular co-worker reporting, might do good but might also have problems. As these initiatives come forward, Dr. Ramamoorthy asked that this be discussed with the Academic Senate and faculty, so that faculty understand how these tools and systems will affect them and have an opportunity to provide feedback.

President Drake emphasized the importance of being able to monitor factors such as diabetes care, cardioprotective drug use, and blood pressure control over time. These efforts lead to patients' lives being saved. He urged UC Health to strive to remain in the top ten health systems in the U.S. in terms of low patient mortality. He praised the work of the CQC in evaluating programs, showing how UC Health meets objectives, and presenting this information to the Health Services Committee.

Regent Reilly stated that it would be helpful to hear from other boards of health systems where this functions well, and the quality control committee interacts effectively with the board of directors. It would be helpful to see how these best practices work in real time.

Committee Chair Pérez suggested that the Committee defer action on this item to allow time for Regents to become involved in this work and to address questions raised in this discussion, and that an action item would be presented at a future meeting.

Regent Reilly asked if this delay would cause a problem. Dr. Cherry responded that if a few Regents joined the CQC to refine the proposed action, this would not delay the pace of discussions and efforts to refine the plan and objectives.

Committee Chair Pérez concluded that the Committee would defer action on this item and appoint a few Regents to work with the CQC.

5. **UC HEALTH FISCAL YEAR 2021–22 REPORT ON 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 announced that UC Health had completed the first-year report on covered affiliations, covering July 1, 2021 to June 30, 2022. The report represented the work of hundreds of individuals and many working groups. There would be a full discussion of this report at the October meeting of the Health Services Committee.

The meeting adjourned at 11:10 a.m.

Attest:

Secretary and Chief of Staff