

The Regents of the University of California

HEALTH SERVICES COMMITTEE

February 15, 2023

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, and Sherman; Ex officio members Drake and Leib; Chancellors Block, Gillman, and Hawgood; Advisory members Marks and Ramamoorthy

In attendance: Regent Batchlor, Regents-designate Ellis, Raznick, and Tesfai, Faculty Representatives Cochran and Steintrager, Secretary and Chief of Staff Lyall, Deputy General Counsel Nosowsky, and Recording Secretary Johns

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

1. **PUBLIC COMMENT**

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

- A. Georgia Lavery Van Parijs, UCLA student, asked the University to expand student access to rape test kits, which include tools to help identify and investigate perpetrators of rape and provide the most important or often only piece of evidence in rape investigations. UC students traveled 17.92 miles on average in the immediate aftermath of sexual assault for access to a rape test kit, or as much as 44 miles in rural areas. Individuals from low-income and marginalized populations are less likely to report sexual assault. Rape test kits must be available to assault victims on all UC campuses.
- B. Julianne Lempert, UCLA student, reported that the nearest designated rape treatment center for UC Merced students was the Family Healing Center in Fresno, 63 miles away. The closest general hospital that provides sexual assault forensic examinations was Memorial Hospital Los Banos, 44 miles away. Neither of these resources was listed on the medical care page of the UC Merced website; only the hotline of the Valley Crisis Center, a location that did not provide examinations. The UC website must list the locations and telephone numbers where students can receive these services in order to ensure the smoothest possible coordination of care.
- C. Sara Gibson, UCLA student, noted that UCLA students were instructed to call the rape crisis center telephone on the back of their student identification card. One

phone call to this number revealed that it leads students to the UCLA Santa Monica Medical Center general phone line, rather than to the UCLA Santa Monica Rape Treatment Center. UCLA administrators had not yet taken action to correct the information on UCLA student cards. Students should not have to navigate barriers to find adequate support following an extremely traumatic experience.

- D. Filza Vaid, UCLA student, described the difficulty of accessing resources for student survivors of sexual assault. When she and others called the telephone numbers provided to students, they found that, at UC Berkeley, one was transferred six times before receiving the correct contact information; at UC San Diego, the rape crisis center hotline did not answer the line the first two times they called; and at UC Santa Cruz, the Campus Advocacy Resources and Education (CARE) office transferred them to a resource which sent the callers directly to voicemail. Ms. Vaid asked the Committee to consider how exasperating and exhausting these calls would be in the aftermath of an assault. She asked the Committee to promote survivor justice, so that survivors do not feel alone in the aftermath of an assault.
- E. David Warren, UCLA alumnus, recounted that he and his wife, octogenarians, used the UC Davis Medical Center, where patients were waiting long hours in the emergency room. The challenge was in the high volume of patient demand. UC Health was the physician of last resort for too many people. The buildings were overused. UC Health must address the issues of the mentally ill, senior citizens, and substance abuse patients, who need medical care in the emergency room, and ensure that they have access by diverting those patients who have minor illnesses into UC outpatient facilities.
- F. Tasha Braden, UCLA Health employee in the Financial Clearance Unit, reported excessive micromanagement in her workplace. As a result, she spent more time explaining why she was spending time on a patient account than she spent clearing a patient's account or appointment. This created a stressful work environment, and Ms. Braden asked that management be held accountable.
- G. Candice Zomalt, UCLA Health employee in the Financial Clearance Unit, described a stressful work environment, especially in dealing with her supervisor.
- H. Stephanie Watts, Teamsters Local 2010 representative, expressed concern about an unhealthy, hostile work environment for union members working in the UCLA Health Financial Clearance Unit under the direction of Theresa Kyles. The dedicated workers in this unit were committed to patient care and took pride in working for UCLA Health but were suffering from the managerial style of Ms. Kyles. Ms. Watts related that the union had presented its grievance to the Office of the President (UCOP), and that UCOP agreed to investigate. Ms. Watts asked the Committee to look into this matter and to support the UCOP investigation.

- I. Jason Perez, UCLA Health employee in the Financial Clearance Unit, stated that his department had been a good place to work until recently, when managers began micromanaging. This was causing undue stress and anxiety. When employees have brought this issue up with management there has been retaliation. Mr. Perez asked that Financial Clearance Unit management be held accountable.
- J. Gabriel Mughadam, UCLA Health employee in the Financial Clearance Unit, reported that in the last several months, employees had been subjected to arduous, overbearing, and unnecessary micromanagement. For example, employees were unfairly charged with not starting an assignment on time. The hostile work environment had caused some employees to take leaves. He hoped that the UCOP investigation would bring about a resolution that would be beneficial to all.
- K. Cynthia Garcia, UCLA Health employee, disclosed that harassment, retaliation, micromanagement, and bullying were occurring in the Financial Clearance Unit. This was demoralizing and unfortunate for an organization that prides itself on providing excellent patient care. Her department had experienced changes in managers five times over the past year. Ms. Garcia asked the Committee to support the UCOP investigation.
- L. Khalia Williams, UCLA Health employee in the Financial Clearance Unit, stated that she was not being fairly compensated based on her years of experience. Supervisors were not providing adequate help to employees. The work environment was stressful and having a negative effect on employees' health.

President Drake commended the important systemwide work on understanding and addressing long COVID. There might be as many as two million long COVID patients in California alone. With these challenges in mind, UC Health had launched a vital educational program to share with providers the lessons learned from health professionals across UC. This coordinated effort would help more community and primary care providers screen patients for long COVID, manage symptoms, and make specialty referrals when necessary. President Drake noted that the discussion later in this meeting on the Global Health Institute, which addresses emerging health needs, would showcase another outstanding example of collaboration across the ten UC campuses and beyond. It had been nearly three years since the beginning of the COVID-19 pandemic, and President Drake expressed his gratitude to the frontline workers at the UC medical centers for all they have done and continue to do to care for patients with excellence and compassion.

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

Upon motion duly made and seconded, the minutes of the meeting of December 14, 2022 were approved, Regents Drake, Guber, Leib, Makarechian, Pérez, Reilly, and Sherman voting "aye."¹

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

3. **PROPOSED REQUEST FOR APPROVAL OF HILLCREST MEDICAL CENTER, SAN DIEGO CAMPUS**

The President of the University recommended that the Health Services Committee approve the San Diego campus' proposal to request recommendation by the Finance and Capital Strategies Committee to the Board of Regents at its future meetings for (1) approval of preliminary plans funding for the Hillcrest Medical Center; (2) approval of the budget and external financing; and (3) approval of design and action pursuant to the California Environmental Quality Act (CEQA), and any amendment or modification to the foregoing.

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

Chancellor Khosla began the discussion by describing the Hillcrest Medical Center project. This project would serve three significant purposes. It would address the seismic safety requirements of Senate Bill (SB) 1953; it would bring state-of-the-art facilities to the Hillcrest campus, which serves underserved populations; and it would reimagine Hillcrest as a location, with the potential for 1,000 residential units. This was a \$3 billion project with much support from the community.

Chancellor Khosla thanked Vice Chancellor for Health Sciences David Brenner for his 15 years of service. Under his leadership the UC San Diego health enterprise grew significantly. Chancellor Khosla welcomed incoming Vice Chancellor John Carethers. Dr. Carethers briefly introduced himself. He now came from the University of Michigan but had earlier served in the UC San Diego School of Medicine. He had worked at the Hillcrest facility and observed that this campus absolutely needed a renewal, even without consideration of seismic safety requirements.

UC San Diego Health Chief Executive Officer Patricia Maysent observed that much had been accomplished on the Hillcrest campus but much of the infrastructure had outlived its useful life. There was now an opportunity to improve this outstanding location in the heart of San Diego to better serve the community and advance the mission of the University. The reimagining of Hillcrest began with a partnership between the UCSD campus and UCSD Health, working together on a plan that would be transformational.

Ms. Maysent presented a rendering of the Hillcrest campus as it would appear in 2036. This was a six-phase project. UCSD was in the beginning of Phase One, which was the Outpatient Pavilion and a parking structure, to be completed in 2025. UCSD began with the Outpatient Pavilion in order to be able to bring cancer services, integrative services, surgery, and other high-end services to this campus, providing access for the community and a financial engine for the project.

This was a difficult project involving replacement of a facility, without the natural growth of a revenue stream that would be associated with a new facility. When this phase was accomplished, UCSD would then begin the first phase of housing, which would produce about 500 units; ultimately this would increase to 1,000. These would be available for staff,

residents, fellows, and community members. There would be high demand for these units, and UCSD would focus first on the UCSD community.

UCSD would then replace the hospital, and the housing component would be finished following the hospital replacement. The seismic safety requirement for the hospital was the main motivation for the project, but the infrastructure itself was built in the early 1960s. There were 36 buildings that had outlived their useful life and needed to be replaced. The hospital supports a diverse local community, and almost half the inpatients at Hillcrest were Medi-Cal patients.

The Hillcrest facility was opened in 1963 as the county hospital. UCSD assumed management in 1966 and purchased the hospital in 1980 for \$17 million; this purchase included the commitment to serve indigent patients. Hillcrest includes a trauma center, burn unit, emergency services, comprehensive stroke center, hyperbaric medicine, and HIV clinic.

The vision for the Hillcrest campus is to be an academic medical center in the heart of San Diego, providing a comprehensive environment for faculty with dry laboratories and administrative spaces along with clinical space; a location with anchor programs that would draw from across the region; to expand critical care and interventional platforms; to provide an excellent training experience and promote translational research.

As UCSD was developing the program for the hospital, it was guided by a number of principles: Hillcrest will always remain an academic medical center with destination anchor programs; the medical center must be able to generate enough free cash flow to cover the debt service for the project; Hillcrest will be positioned within UC San Diego Health as an inpatient center of excellence for trauma and indigent care and emergent care for the region, even as the outpatient and other Hillcrest facilities support the growth of elective patient care; the project will complement outpatient investments that UCSD makes across the region; the UCSD clinical program does not need to have a presence at both UCSD Health campuses, but certain programs will have a presence at both locations; any redistribution of clinical programs between Hillcrest and La Jolla would be carried out in a manner that helps advance the University's mission of teaching, research, and public service.

Ms. Maysent then discussed the scale of the Hillcrest medical center. At the time UCSD carried out the Long Range Development Plan for this project, it imagined replacing the hospital with up to 300 patient beds. The effective occupancy today was 323 beds, and the hospital was licensed for more, but many of the beds were not useable. Currently, on any given day at UCSD Health, there were over 100 patients waiting for beds in the hallways. The emergency department was the largest inpatient unit. Even without considering population growth, market share, and program growth, UCSD Health had about 140 beds fewer than it needed. UCSD was not taking in transfer patients and curtailing some surgeries in order to address the patient volume in the emergency department. UCSD was considering every possible space to add patient beds.

The Hillcrest campus could sustain a patient population of at least 460 beds, but there were restrictions on achieving this growth. The California Environmental Quality Act (CEQA) process had established a limit on the number of patient beds, there were site restrictions, and funding availability was a concern. The cost of the hospital replacement alone would be from \$1.8 billion to \$2 billion. Capital equipment costs might be in the range of \$300 million to \$400 million. The project would be funded through philanthropy and debt. UCSD was now planning for 350 to 400 beds. If UCSD constructed 375 beds, it would be able to accommodate growth in neurosurgery, neurosciences, vascular, cancer, and women's and infants' programs, but would not be able to accommodate growth in general surgery, urology, abdominal transplants, and some cancer programs. In an ideal scenario, UCSD would like to build more beds. UCSD hoped to secure preliminary plans funding in fall this year, would break ground, and would complete the new hospital sometime between fall 2031 and 2032. The existing hospital would remain operational during this entire time.

Regent Sherman asked what the absolute limit would be for the number of beds that could be built in this hospital. UCSD Health Chief Strategy Officer Douglas Cates responded that UCSD would not know the exact number until the design work was under way. There were constraints related to footprint and height. He anticipated that the campus might be able to build as many as 425 beds in the long term, based on physical constraints and CEQA considerations. Regent Sherman observed that UC hospitals were always overcrowded and running out of space. UCSD should push for the maximum number of beds and deal with CEQA and administrative questions as the project proceeds.

Regent Makarechian asked how many beds the hospital was licensed for. Ms. Maysent responded that the hospital was licensed for 381 beds, but some rooms were no longer useable due to the age of the facility.

Regent Makarechian stated that CEQA should not be a major concern. UCSD Health had 100 patients waiting for beds on any given day. As suggested by Regent Sherman, UCSD should strive to build a much higher number of beds, given that this hospital opened in 1963. The building height should not present difficulties because the site was not in the flight path of airplanes. Compared to 1963, there was now a need for a much larger hospital. Ms. Maysent responded that UCSD Health would need to add more patient beds at the La Jolla hospital as well, and this would be a ten-year project. UCSD would need to find some short-term relief for the need for patient beds. UCSD Health was considering how all these pieces might fit together. There was general agreement among UCSD Health faculty and understanding among administrators that this project would need to be as large as possible.

Regent Makarechian asked about the funding concerns for the project. Ms. Maysent responded that about 50 percent of the patients at this hospital were Medi-Cal patients. This was a replacement facility project, adding \$1.8 billion of debt. UCSD Health Chief Financial Officer Lori Donaldson commented that the campus had been working with the Office of the President on various funding scenarios. This work was still in the preliminary programming phases. The questions of what services the hospital would provide, the size of the hospital, and the revenues the hospital might produce would determine if UCSD could cover the debt service on \$1.8 billion or more.

Regent Makarechian asked about the status of the project within UCSD Health and if it would be a standalone project. Ms. Maysent explained that UCSD Health had a single license for both the Hillcrest and La Jolla hospitals. The hospital would continue to be on that license as part of UCSD's integrated health system.

Regent Makarechian observed that, because a large percentage of patients were Medi-Cal patients, there might not be sufficient revenue to support the project. He asked if the project would require standalone financing or be financed as part of UCSD Health. Ms. Donaldson responded that, as part of its business planning, UCSD Health was hoping that, by building a larger project at Hillcrest, some services from other sites could be moved there. UCSD was considering its entire system and both hospitals in determining if there would be enough incremental revenue to cover the debt service.

Committee Chair Pérez asked if changing and expanding the range of services to be provided at Hillcrest would change the payer mix. Ms. Maysent responded in the negative. She did not believe that this would occur.

Regent Leib expressed the general view of the Committee that a larger number of patient beds at Hillcrest would be desirable, given the growth of the population in San Diego County. He emphasized the transformational nature of this project, which the local community valued and appreciated.

Regent Reilly asked if UCSD was currently developing any plans to address the current daily patient overflow. Ms. Maysent responded that UCSD Health was working to address this.

Advisory member Ramamoorthy conveyed the faculty's support for the Hillcrest project. Faculty and staff had been included in the planning process. She emphasized the importance of this hospital for the community and region.

Dr. Carethers commented that the hospital had been built as a county hospital; the University would now be remaking the facility with its vision of a community academic health system. He noted that the number of licensed beds did not include the hospital's use of short-stay beds. Short-stay beds did not require licensing, and one could use them as a way to address the volume of short-stay patients who do not stay more than 24 hours.

President Drake expressed agreement with the remarks made earlier about the hospital's capacity. The new hospital would be full on the first day of operations, and UCSD needed to maximize the space. Seismic safety considerations were another reason to proceed with this project as quickly as possible.

Committee Chair Pérez expressed appreciation for UCSD's engagement with the broader community regarding this project, including civic and philanthropic leaders and patients.

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

4. **UC HEALTH SYSTEMWIDE WORKING GROUP ON POST-ACUTE SEQUELAE OF SARS-COV-2 INFECTION (PASC)/LONG-COVID ACCOMPLISHMENTS AND FUTURE WORK**

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

Chief Clinical Strategy Officer Anne Foster began the discussion by recalling that UC Health responded to long COVID as it first emerged as a post-COVID-19 chronic illness in a number of ways. UC Health campuses have formed long COVID clinics and were actively caring for many patients across the state. A number of research studies were taking place at UC. Executive Vice President Byington formed the UC Health Working Group on Long COVID in 2020. This group brings together experts from across UC, representing many medical specialties, along with representation by the California Department of Public Health. The group focuses on clinical issues, organizes educational sessions, and considers research issues related to long COVID.

As part of its educational mission, UC Health produced a 12-part long COVID provider training module in English and Spanish that seeks to expand the knowledge base of providers, so that more providers are willing to screen and treat long COVID patients in the greater community. The training module is offered free of charge and had been distributed in California, across the U.S., and to other countries.

UCLA Assistant Professor of Medicine Nisha Viswanathan, Director of UCLA's Long-COVID Program, explained that the program had been created about 18 months prior. Its goals included ensuring that physicians make correct diagnoses, and that UCLA can provide care to patients for this complex emerging medical condition. The program was organized around a care of long COVID primary care physicians who further rely on subspecialists who are able to amplify patient care. The group meets frequently to discuss the most complex cases in order to be able to create integrated comprehensive care plans.

Feedback on the program from patients has been positive, and demand has been high, with high numbers of referrals. This has led to long wait times. About one-third of referrals were from outside the UCLA Health system. There were out-of-state and international patients.

Caring for long COVID patients is time- and resource-intensive. One was caring for a younger population, patients who do not usually suffer from chronic illnesses. Patients may suffer from brain fog, which makes it difficult for them to navigate the healthcare system. They might need assistance with care coordination, more frequent contacts with the clinic, and have to deal with disability issues that extend beyond the scope of the clinic. Because patients were younger and not usually well-equipped for dealing with chronic illnesses, they might require more social work involvement. In addition, physicians were in a

situation of limited information; this was an evolving subject matter, with new papers being published daily. It had been difficult for the traditional primary care doctor to provide the level of care needed for long COVID patients because of the amount of research needed to keep abreast of topics related to long COVID.

UCLA Professor of Psychiatry Helen Lavretsky, Director of the UCLA Psychiatry Post-COVID Clinic, related that her work included assisting primary care physicians with diagnosing and managing the neuropsychiatric symptoms of long COVID. Mental health problems emerged in most patients with long COVID; there was also stress caused by the pandemic and pandemic restrictions, which resulted in about 50 percent of patients experiencing symptoms of anxiety and depression, as well as resulting in increases in substance abuse and suicides, including among healthcare workers.

The symptoms of fatigue, brain fog, chronic malaise, anxiety, and depression occur in the majority of patients with long COVID. Some have severe symptoms of post-traumatic stress disorder, increased suicidality, and a small proportion develop psychosis and delirium. A review of electronic health records showed that the estimated percentage of patients with neuropsychiatric symptoms among patients diagnosed with COVID-19 was about 33 percent, with about 13 percent receiving the first such diagnosis. For patients who had been admitted to an intensive care unit, the estimated incidence of a diagnosis was about 46 percent, and for a first diagnosis was about 26 percent. The level of neuropsychiatric morbidity was much higher for patients with COVID-19 than for patients with influenza or other respiratory tract infections.

There currently were no guidelines for treatment. The medical profession was developing knowledge as its work proceeded and physicians and researchers learned from each other. Dr. Lavretsky emphasized the importance of integrative, whole-person care. With respect to mental healthcare needs, information services about long COVID were inadequate, although the general public was learning more about the illness. Access to mental health services that provide counseling about and management of neuropsychiatric symptoms of long COVID was inadequate, as was the number of mental health practitioners trained in the management of long COVID. There were few support groups for patients and a lack of neuropsychologists and psychometrists who could assist in assessing cognitive impairments, which was imperative for disability claims. There were few cognitive, physical, and speech rehabilitation services. Disability management teams lacked information in handling claims. The UCLA Post-COVID Clinic spent much time processing and working on disability claims.

Regent Reilly asked if similar long-term effects were caused by other viral infections and what made COVID-19 unique. Dr. Viswanathan responded that there was post-viral fatigue syndrome associated with other conditions, but long COVID was distinct in having a variety of symptoms. As research proceeded, there appeared to be different mechanisms at work in long COVID causing the symptoms; these mechanisms had not been identified in other post-viral conditions. Medical professionals were using the knowledge base gained from the study of other viral conditions, but there was more to be learned that was specific to long COVID.

Committee Chair Pérez asked what UC was learning about long COVID from the experience of medical professionals in other parts of the world; for example, about symptoms that might present like other neurodegenerative diseases such as neuropathy. Dr. Viswanathan responded that it was imperative to learn from colleagues in other places. Findings and many case reports were being published. One has learned that COVID-19 can attack nerve endings and cause neuropathy.

Committee Chair Pérez asked what could be learned from work on myalgic encephalomyelitis/ chronic fatigue syndrome (ME/CFS), and how this experience might inform the approach to ME/CFS. The presentation had mentioned a lack of knowledge regarding the effects of long COVID for disability claims; this was also the case for ME/CFS. Dr. Lavretsky reported that she and colleagues were engaged in a study of the relationship of ME/CFS and long COVID, and their corresponding and overlapping symptoms. She believed that, in research on the two diseases, each would inform the other about disease management, symptoms, and progression. This work was in progress, with help from the Centers for Disease Control and Prevention (CDC). The ME/CFS community was active in advocating for research funding for both ME/CFS and COVID-19, due to the similarities between the two conditions.

Regent Leib asked how people enrolled in UCLA's program and who was eligible. Dr. Viswanathan responded that UCLA would see any patient with commercial insurance. There was an outside referral process. UCLA has treated Kaiser Permanente, workers' compensation, and Department of Veterans Affairs (VA) patients. Due to the limited number of long COVID treatment programs around the state, insurance companies have been willing to cooperate with the University. Dr. Lavretsky added that she consulted with other UC campuses on psychiatry and long COVID.

Regent Leib asked about Medicare patients. Dr. Viswanathan affirmed that UCLA would see Medicare patients for long COVID. Dr. Foster commented that the goal of the long COVID provider training module mentioned earlier was to increase the knowledge base and providers' ability to appropriately screen and begin the treatment and management of long COVID, and to refer more complex cases to an academic medical center. This was a common condition. She cited a current estimate that one in five patients who had experienced acute COVID might develop long COVID. The skills to deal with long COVID needed to be assimilated by primary care physicians.

Regent Leib asked how many patients had enrolled in UCLA's program. Dr. Viswanathan responded that UCLA had about 1,600 patients.

Regent Leib asked about the enrollment procedure for patients. Dr. Viswanathan responded that patients needed to meet certain criteria: a positive COVID test, and symptoms must persist for longer than 12 weeks after the initial infection. It can take 12 weeks to resolve an acute COVID infection. Patients who meet these criteria receive a comprehensive evaluation to understand the symptoms and the timeline of symptoms. Long COVID was a diagnosis of exclusion, excluding other medical issues that might be occurring. It takes

time after seeing a patient to make a definitive diagnosis of long COVID in a patient rather than another medical condition.

Regent-designate Raznick asked about anticipated long-term healthcare needs and how UC would address them. He asked if the symptoms of long COVID diminished over time, and about the medical community's expectations about COVID overall in the future, such as future mutations. Dr. Viswanathan responded that COVID was expected to become a chronic, endemic virus. As people continue to become infected, and because recurrent infections put one at increased risk of long COVID, there was a high probability that the number of people with long COVID would increase over time. There would be an ongoing need for care and treatment. Long COVID itself appeared to be a relapsing-remitting illness. One suspected that this is a chronic illness that goes into remission rather than one that is truly cured. Many of Dr. Viswanathan's patients who had recovered had returned a year later with recurring symptoms. The healthcare system in the U.S. might have to reimagine how it delivers care for patients needing chronic care. This might require greater investment in social services and changes at the political level in how one views and addresses disability. There were many unanswered questions.

Regent-designate Raznick asked about the impact of long COVID on different communities and if the University was serving all, including low-income communities. Dr. Viswanathan responded that a UCLA study found that patients across all demographic groups had equal incidence of long COVID. Incidence was greater in women than in men, but there were no differences in incidence by ethnicity. When one considers which people seek care, the situation is very different. Patients who had sought care in the long COVID program at UCLA were disproportionately white and people with higher income. Dr. Viswanathan referred to these patients as "healthcare-empowered," people who are comfortable navigating the healthcare system and contacting their insurance company. Some patient populations might need additional assistance to access care. Some Medicaid patients had informed Dr. Viswanathan that their provider in the community took a very long time to identify the illness before referring the patient to UCLA. UCLA Health Sciences Vice Chancellor John Mazziotta observed that the unfortunate consequences of this viral infection presented an opportunity for academic study of the interplay of this immune response to a viral protein and the proteins in the nervous system. For decades there had been controversy about ME/CFS and questions about whether it was a psychiatric or pathophysiological condition. Conducting clinical trials and research in a setting like UCLA was an outstanding opportunity to gain insight into the immune system, nervous system, and all other systems adversely affected by these types of viral illnesses.

Committee Chair Pérez commented that ME/CFS patients were still facing hurdles. It was to be hoped that, when large numbers of people were affected by long COVID, this might change presumptions about the very real challenges faced by patients with ME/CFS. An important question was that of providing a broader educational experience for the medical community so that patients treated by primary care physicians in the community have a better ability to navigate care, whether for ME/CFS or long COVID.

Advisory member Marks reflected that the long-term impact of COVID on society would take years to understand. Academic medical centers were experiencing their own form of institutional long COVID, with impacts on finances, capacity, and the health of the workforce. She raised the question of how one was caring for the caregivers. Physicians, nurses, and other essential workers might or might not have had COVID-19 but were dealing with the consequences of having been on the frontlines of COVID, and this manifested itself in mental health issues such as anxiety. One should think about this as well as about the primary duty to patients. Dr. Lavretsky responded that institutions like UCLA were barely dealing with the existing flow of patients and were not addressing the wellness of their workforce. Some UCLA nurses suffered from long COVID and became disabled, and many were forced to come back to work before they were ready. UC San Diego Health Chief Executive Officer Patricia Maysent emphasized the importance of developing appropriate support systems, such as opportunities for psychological therapy, and removing the stigma of mental health challenges. UCLA Health President Johnese Spisso reported that many UCLA faculty and staff were affected by COVID-19. Fatigue was an issue of concern when the UCLA Medical Center in Westwood was operating at 118 percent capacity, and the Medical Center in Santa Monica at 110 percent capacity. With respect to getting information out to Medicaid patients, she noted that UCLA was working with the L.A. Care Health Plan, the largest provider of Medicaid in Los Angeles, to make it possible for L.A. Care patients to access UCLA, the only provider of long COVID care in the area. It was also necessary to educate the provider community about the need to refer patients.

Committee Chair Pérez expressed appreciation for UCLA's establishment of a meaningful partnership with L.A. Care. He suggested that the University should also communicate with Federally Qualified Health Centers in the state to see what services UC could provide there.

Advisory member Ramamoorthy raised the issues of long COVID among healthcare workers, workplace exposure, UC Health's long-term commitment to the wellness of its workforce, and patient safety.

UCSF Health Chief Executive Officer Suresh Gunasekaran remarked that, besides frontline clinicians, UC Health campuses had thousands of staff including food service workers, housekeepers, patient transport staff, and social workers. In the first half of the fiscal year, UCSF Health had tried to grant as much leave time as possible and to bring in temporary staff in order to give employees time off. This came at a significant financial cost. There was a difficult balancing act of addressing both staff needs and the needs for patient care. Mr. Gunasekaran anticipated that this challenging situation would continue for another 12 to 18 months.

Committee Chair Pérez observed that there were significant disproportionate rates of excess mortality among certain populations in California, and one could assume similar patterns in long COVID. Some people were not able to access the care they needed, and this had long-term societal implications, including for upward mobility and access to education.

5. **OVERVIEW OF THE UNIVERSITY OF CALIFORNIA GLOBAL HEALTH INSTITUTE'S PROGRAMS**

[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 introduced the item. The UC Global Health Institute (UCGHI or Institute) worked across the ten UC campuses and equipped students and faculty from across various disciplines with the skills to be leaders in global health. The Institute was helping to make global health a career path.

Interim Associate Vice President of Academic Health Sciences Deena McRae noted that, while the Institute had joined UC Health the prior year, it had been at work since 2009 to develop a strong network of global health specialists, scholars, and community partners. At the beginning of this academic year, the Institute formally joined UC Health's Academic Health Sciences unit to further advance this work systemwide. The Institute leveraged the expertise and power of the UC system through education, advocacy, and research. The mission of the Institute is to train the next generation of diverse global health leaders.

Madhavi Dandu, M.D., Director of UCGHI, related that the Institute was trying to address issues that were too complex to be solved by any individual discipline or university. It had pioneered a new model to innovate structural solutions to the causes of poor health. The Institute's network was made up of local and global multidisciplinary collaborators—students, faculty, postdoctoral fellows, community partners, healthcare providers, lawyers, and policy makers—working on cutting-edge issues including those related to gender and health and planetary health.

The Institute was able to carry on its work thanks to early visionaries such as the Institute's founder, UCSF Professor Emeritus Haile Debas, philanthropic investment, and support by the UC campuses. For every dollar invested, the Institute has been able to raise more than \$20 in additional funding.

Dr. Dandu remarked on the needs for a diverse, intersectional workforce, for UC to be deeply connected to its community, and to challenge existing power structures that have become barriers to health. The University must ask itself questions about its role in the U.S. health system. How is UC helping public health, or how might it be harming health? The Institute had created an environment that fosters experimentation. Dr. Dandu stressed the connection between the health of Californians and the health of the world. Concerns in California, including COVID-19 and natural disasters, reflected concerns in the wider world.

A major area of activity for the Institute was providing educational and training opportunities for students interested in global health. While these programs were embedded in UC, most had necessary and important involvement by international and local partners. Learners ranged from high school students to UC faculty and staff. Over a decade, the Institute had reached more than 6,200 undergraduate learners, generated more than 600 in-

depth student opportunities, and supported more than 20,000 fellows globally. These trainees have spanned all ten UC campuses, Charles R. Drew University, and 36 different countries.

In recent years, the Institute has focused on offering courses for undergraduates, especially on campuses without global health opportunities. Besides providing course content, these online courses have allowed students to meet role models and mentors. In the next few years, the Institute hoped to consolidate courses for graduate students as well as develop a certificate program potentially for international partners and community members.

A subset of learners interested in global health would want to continue and to earn degrees, receive formal fellowship training, and pursue careers in global health. The Institute supported UC Santa Cruz in the development of its new Bachelor of Arts and Bachelor of Science degree programs in Global and Community Health, established in 2022. As of January 2023, UCSC already had more than 85 students who had proposed or declared their majors in Global and Community Health, and the campus expected a significant increase in the spring when majors are typically declared.

Degree programs were one way to provide deeper training; the Institute had also enjoyed success in creating and implementing a plethora of fellowships and short-course programs which allowed for mentored, hands-on experiences. These programs had various content areas, but all had diverse sets of learners and trainees, mostly from underserved communities. Training opportunities provided close to the time when an individual embarks on a career increased the chances of success in work and that trainees would remain and work in underserved communities.

One of the Institute's programs was the GloCal Health Fellowship program, a 12-month mentored research program and fellowship for investigators who are interested in studying diseases affecting developing countries. Participants included U.S. doctoral students, professional students, and U.S. and international postdoctoral fellows. Dr. Dandu highlighted two fellows. Victoria Ojeda was a 2012–13 GloCal fellow. She had an undergraduate degree in Psychology and Spanish and she obtained her MPH and Ph.D. in Community Health Sciences from the School of Public Health at UCLA. Her GloCal project focused on deportation of Mexican migrants from the U.S. She credited her training in the GloCal program with helping to set up her current work, which focused on health disparities among immigrant women and incarcerated individuals, and she worked between San Diego and Tijuana, Mexico. Moses Obimbo Madadi was a 2016–17 GloCal fellow. He was a clinician-scientist focused on obstetrics translational research and was a faculty member at the University of Nairobi, Kenya. He had been a research fellow at UCSF and received training in epidemiological methods and stem cell technologies. He would use next-generation sequencing to analyze microbial communities and metabolomic profiling to identify predictive and diagnostic signatures of adverse pregnancy outcomes. These data would be used to develop artificial intelligence-assisted prediction models that could be used as valuable screening tools in low-resource settings to identify at-risk pregnancies for early interventions.

In addition to education and training, the Institute was also engaged in research. Faculty and staff associated with the Institute had procured and initiated more than \$5 million in research. The Institute broke down barriers within and between UC campuses to allow for interdisciplinary collaboration. Faculty had conducted research on many topics including farmworker health in the Central Valley, disparities in drinking water access in California, and local and global campus violence prevention. One project was the California Home Abortion by Telehealth study, a three-year, patient-centered study with over 6,000 patients enrolled from 22 states in the United States. The study aimed to assess the safety, effectiveness, and acceptability of medication abortions provided by telehealth. This \$1.1 million project was housed in the Institute's Center for Gender and Health Justice and guided by UCSF Professor Ushma Upadhyay. Preliminary findings suggested that telehealth for abortion is safe, effective, and acceptable and could be a powerful tool in addressing the surge in demand for abortion in protected access states, especially following the recent *Dobbs vs. Jackson Women's Health Organization* decision by the U.S. Supreme Court. Professor Upadhyay's involvement with the Institute was an example of the multiple ways this involvement could take place. She first learned about the Institute when she was a research assistant. Later she was awarded a fellowship as a junior faculty member to support her work measuring reproductive autonomy. As her work expanded, so did her role in the Center for Gender and Health Justice, where she now served as Co-Director.

It was important to share the results of research, and one way this occurred was through UC Global Health Day, a UC systemwide conference on global health that showcases the outstanding research, training, and outreach taking place across UC and beyond. Global Health Day is a valuable opportunity for UC students, fellows, faculty, staff, and visiting scholars to gather and share their work. While conferences are common in academia, Global Health Day has been innovative in including trainees, scientists, community members, and experts equally and is a unique opportunity for direct dialogue among communities that do not often interact with each other. With an immense effort to increase accessibility by minimizing cost to registrants and increasing digital access, UC Global Health Day had included more than 4,200 registrants from 67 countries at over nine conferences since 2010.

Workforce development and conducting research are most effective when they can change policy and advocate for historically excluded communities to improve access to healthcare for underserved populations. The Institute's programs and initiatives always worked to consider the question, "How will the Institute's work change the health system or improve the health of communities?" The Institute had various advocacy initiatives. One was the UCGHI Student Advocacy Initiative, which included 40 student advocacy interns and eight faculty mentors from ten UC campuses. This program tries to make a measurable impact on U.S. domestic and global health policy, California's legislators, the UC system, and broader communities. The UCGHI Student Advocacy Initiative had engaged more than 4,000 additional students, faculty, and community members through three letter campaigns addressed to all 53 California congressional members and both senators. Student advocacy interns held 20 in-person meetings with California legislators or their staff, published over 20 op-eds on health and advocacy topics, and engaged the community in congressional meetings, training sessions, and other community-based events.

Dr. Dandu concluded her presentation by recalling that the most vulnerable populations are disproportionately affected by any disease or disaster. One had the potential to develop innovative solutions for equity, justice, and improvement in the health of communities. UCGHI provided a way for talented, committed people to act, broke down divisions and promoted interdisciplinary creativity, and listened respectfully to the expectations of communities.

President Drake commended the Institute on its work and impact and recalled the life experience and motivation of its founder, Dr. Haile Debas, and his work to realize the Institute.

Chancellor Hawgood opined that the last decade had been a “golden decade” for global health, with tremendous funding from many foundations. He believed that there would now be a transition, and that foundations would seek to provide funding directly to the developing world rather than to U.S. universities. He asked what UC would do when the financial underpinning of its global health work changed. Dr. Dandu responded that it was more efficient and effective for people to perform work directly with the resources they need; UCGHI was in alignment with the principle of moving funding to the developing world. It was important for the Institute to consider global health as being both domestic and international, including a focus on disparities and inequities at home; this allows for a different kind of collaboration. Over the next five to ten years, UCGHI would be considering who its domestic partners are, and where the global health expertise gained over the past ten years would be effective and helpful. The Institute would expand its thinking about possible funding sources, beyond just foundations with an international focus, and work with community organizations and partners at home.

6. **UC DAVIS HEALTH STRATEGY, DAVIS 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.]

UC Davis Health Vice Chancellor for Human Health Sciences David Lubarsky presented the UC Davis Health (UCDH) strategy, underscoring the desire and vision to be an academic medical center on the cutting edge, to embrace and develop the next generation, the next innovation, and the next cure. UCDH is grounded in equity, provides unparalleled care, researches and develops trailblazing therapies and technologies, educates a future-ready workforce, and pursues excellence. UCDH has a patient-centered approach and embraces the values of kindness, trust, and inclusion.

UCDH was the second largest employer in the Sacramento region, with approximately 18,000 employees; five years prior, there had been about 13,000. UCDH takes seriously its anchor institution mission for community health, with many initiatives around the region and in local underserved communities. UCDH currently had revenues of \$4.3 billion.

The UC Davis School of Medicine currently had approximately 770 students, 1,300 faculty members, 270 principal investigators, 900 or more active clinical trials, and more than

\$400 million in annual grant funding. The School had about \$200 million in National Institutes of Health (NIH) funding; this funding was increasing each year and was at the highest level in the School's history.

The Medical Center and clinics occupy a unique place in the Northern California healthcare ecosystem, and many patients rely on UCDH for the quality and breadth of its services. UCDH serves as the Level One trauma center for 33 of California's 58 counties, which makes UCDH an ally for many small community hospitals. Beyond the 30,000 inpatient admissions in its licensed beds, UCDH has constantly grown its surge capacity and in fact cares for 46,000 inpatients each year. Inpatient service had grown by almost 50 percent in the last five years. UCDH has 25 outpatient clinics, 24 partner care locations, and many other locations where UCDH serves in a partnership healthcare plan alliance, providing pediatric subspecialty services via telehealth in 14 Northern California counties. UCDH currently had about 1.5 million outpatient clinic visits per year, not counting about 100,000 other visits under contract for psychiatric services for the county jail system and for services at Federally Qualified Health Centers (FQHCs). The Betty Irene Moore School of Nursing was ranked 23rd in the nation by *U.S. News and World Report* as a graduate school of nursing and seventh best in the U.S. for its family nurse practitioner program.

Dr. Lubarsky presented a map showing the UCDH footprint of clinics and affiliate network sites. Most formal arrangements with affiliates concerned four service areas: the trauma center, the comprehensive stroke center, the cancer center, and pediatric care. UCDH's telehealth support for pediatric emergency care in rural community hospitals had reduced the number of pediatric patient transfers by 50 percent.

UCDH had insufficient inpatient capacity; with about 648 licensed patient beds, the system began each day with 670 to 680 patients and reached 750 by the middle of the day. No matter how many beds have been opened, more patients wish to receive care at UCDH. UCDH's motto was to "complete, and not compete" with any healthcare organization that shares its values. UCDH was not in this business for short-term gain but to provide services that no other organization could. UCDH had improved and taught additional skills to departments in partner community hospitals. There was more work to be done in decreasing the length of patient stays, and UCDH was working vigorously to understand the factors involved and to improve its processes and increase the number of patients it can serve. UCDH was developing a "care at home" strategy as well.

Dr. Lubarsky briefly described UCDH programs aimed at reducing health disparities, such as setting up COVID-19 vaccination clinics in underserved communities and providing vaccinations to 20 percent of the homeless population in the Sacramento area in the past year. Other programs and activities were the Healthy Aging Clinic and providing training for individuals caring for family members with dementia. UCDH had received recognition as an age-friendly health system, and the Human Rights Campaign Foundation granted UCDH one of the few 100 percent scores in the U.S. for LGBTQ+ care.

In the face of decreasing profit margins, UCDH was trying to find ways to work more efficiently and to identify other sources of revenue to support its mission. To address

insufficient inpatient capacity, UCDH was engaged in ambitious capital projects, the California Hospital Tower and an ambulatory surgery center, the 48X Complex, to accommodate patients for one-night or overnight admissions, which would become more common in the coming years.

In its education enterprise, UCDH strives to create a workforce that is excellent and reflects the community in which UCDH practices. The School of Medicine was in the top one percent in the U.S. for graduating Hispanic students, and 74 percent of the 2022 medical student graduates would care for the underserved. *U.S. News and World Report* ranked the School of Medicine third in the nation for the diversity of its student body, taking into account ethnicity and socioeconomic status.

Dr. Lubarsky concluded his presentation by recalled that UCDH was increasing its research funding each year, and he briefly described a number of research collaborations between UCDH and the main Davis campus.

Regent Reilly referred to the high percentage of UC Davis School of Medicine graduates who planned to work as primary care physicians. She asked about the reason for this success. Dr. Lubarsky attributed this success to the faculty, who believe in and convey this to students, and who lead by example. He recalled that UCDH had debated about which students it should take on and had settled on the idea that its purpose is to make communities healthier and that it should take on students who would have the greatest impact in their communities.

Regent Park asked how UCDH would know that it was succeeding. Some criteria were hard to define. She asked about specific goals and benchmarks UCDH was using to chart progress. Dr. Lubarsky responded that every UCDH goal and principle had an associated benchmark; there was an enterprise-wide scorecard. UC Davis Health Chief Strategy Officer Ron Amodeo explained that this scorecard had 48 metrics attached to the strategic plan. UCDH had assembled an enterprise project management team which was actively managing every project toward every goal. Results were reported quarterly, and employees are aware if they are falling behind. Dr. Lubarsky commented on another goal for UCDH, which is to employ more people from the local Sacramento area, in particular from neighborhoods with the highest rates of unemployment and the lowest levels of median income, and to increase the percentage of these employees in the non-licensed workforce.

Regent Park asked about benchmarks for eliminating health disparities in the community. Dr. Lubarsky responded that ensuring health equity requires that everyone have access to health care. In its own clinics, UCDH measures whether or not people with different insurance characteristics have the same wait times for appointments; in UCDH clinics all patients have equal access to physicians. Medi-Cal patients are not treated differently than commercially insured patients. UCDH was also seeking new ways to work with FQHCs to extend care to Medi-Cal patients in underserved areas.

Regent Park asked about telehealth. Dr. Lubarsky adumbrated the telehealth programs for stroke and pediatric care, especially for rural emergency departments. Telehealth visits for

UCDH's own physicians and patients currently accounted for 15 to 16 percent of total visits. This also contributes to equity, in that patients do not have to take time from work to travel to an appointment.

Regent Park asked about streamlining administrative processes and paperwork in order to remove barriers for patients. Dr. Lubarsky responded that UCDH had a full digital data strategy; this was a main supporting feature for all the rest of the strategy. Becoming patient-centric meant getting rid of redundant, low-value interactions such as repeatedly filling out forms, providing copies of insurance cards, and being asked the same questions. Mr. Amodeo added that UCDH would implement artificial intelligence to reduce some of the redundancies, but some of these activities were required by regulations.

Regent Batchlor noted that nearly 40 percent of patients in California were covered by Medi-Cal. She asked what percentage of UC patients were covered by Medi-Cal. If UC wishes to address health disparities, it should make UC Health services available to these populations. The Regents should be tracking this percentage, and UC medical centers should be serving at least the percentage of Californians who are enrolled in this program. Dr. Lubarsky responded that 41 percent of UCDH inpatients were enrolled in the Medi-Cal program. In UCDH's own clinics, about 22 percent of patients were covered by Medi-Cal, but this did not include about ten percent of UCDH patient visits under direct contract in prisons and FQHCs.

Regent Batchlor observed that most low-income communities were not primarily served by FQHCs. UC needed to take a broader look at the providers in the community and to know which providers were taking care of low-income populations. Dr. Lubarsky expressed agreement. It is necessary to understand where there are gaps and where there is need. UCDH had carried out a community health needs assessment in the region together with Kaiser Permanente, Sutter Health, and Dignity Health and had identified areas that are not well served, where additional expansion is needed.

The meeting adjourned at 12:40 p.m.

Attest:

Secretary and Chief of Staff