

The Regents of the University of California

HEALTH SERVICES COMMITTEE

April 12, 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, Sherman, and Sures; Ex officio member Leib; Executive Vice President Byington; 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, Vice President Lloyd, and Recording Secretary Johns

The meeting convened at 11:00 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 February 15, 2023 were approved, Regents Guber, Leib, Makarechian, Park, Pérez, Reilly, Sherman, and Sures voting “aye.”¹

2. PUBLIC COMMENT

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

- A. Frank Granda, UC Irvine student, urged the University to allocate sufficient funding for additional support for students with disabilities. Currently, each disability specialist had an average caseload of 400 to 500 students. These caseloads cause long delays for students seeking accommodations and can derail academic progress for entire quarters or semesters. There were more students with disabilities seeking accommodations than ever before, but no increase in funding.
- B. Aaron Sotzen asserted that policies approved by the Regents are not executed as intended. There was a libel issue at UC. There were problems and some solutions.

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

- C. Seema Burke, parent of a UC Berkeley student, urged the Regents to work on improving safety at the Berkeley campus. Despite the high academic status of UC Berkeley, the City of Berkeley was unsafe for students and residents. In March alone, there were allegedly over 700 crimes committed around Berkeley. She stated that the City of Berkeley would not address this problem. Ms. Burke suggested that the Regents call on the Governor's office for assistance.
- D. Noah Dunning, UC Berkeley student, asked the University to provide sufficient funding for additional support for students with disabilities. He related his own experience of requesting text-to-speech software but not receiving this accommodation. There were more students with disabilities than ever before, but no equivalent increase in funding.
- E. Carlyn Leavitt, a disabled freshman student at UC Berkeley, reported that she could not receive accommodations due to a lack of resources. Disability center staff are often busy and unable to meet with students. She urged the University to provide more resources and staff to keep up with accommodations and other needs of disabled students. These issues affect students' lives and futures.
- F. Kathryn Lybarger, President of the American Federation of State, County and Municipal Employees (AFSCME) Local 3299, reported that one-third of the 30,000 UC workers represented by AFSCME earned less than \$25 per hour and most could not afford housing near the campus or medical center where they work. She criticized the University for investing pension funds in Blackstone, a private equity firm whose actions, she asserted, contributed to the housing crisis. The prior week, the Regents had approved a \$500,000 salary increase to a chancellor and extended housing assistance to chancellors to purchase second homes. Ms. Lybarger called on the University to establish a \$25 per hour minimum wage, divest from Blackstone, and invest in affordable housing.
- G. Stephen Fujimoto, UC Davis student, referred to mass shooting events in the U.S. and urged the Regents to divest from gun manufacturers. Mass shooting events highlighted the perverse profit model of gun manufacturers, and it was important that the Regents demonstrate that they would no longer invest in these companies. Gun manufacturers should be added to the list of restricted investments.
- H. Monica Cisneros, AFSCME member and UCLA employee in housekeeping, addressed the Committee in Spanish. She stated that she had been working at UCLA for 12 years. Her earnings did not cover housing, food, and basic needs. Ms. Cisneros believed that her wages demonstrated that UC did not value frontline workers like her. Every worker at UC deserved at a minimum \$25 per hour. UC should pay a salary that allows employees to survive in a better manner. There should be affordable housing for employees and students. She and her co-workers deserved to have a respectable salary.

- I. Douglas Gil, senior custodian at UCLA and AFSCME member, reported that he and many of his colleagues were struggling to make ends meet. He was only able to rent a room with his UC salary. In order to afford a one-bedroom apartment, he would have to move much further away than the 45 minutes he currently spent in traffic getting to work at UCLA. He called on the University to raise the minimum wage for UC workers to \$25 per hour and to invest in affordable housing for employees and students.
- J. Monica Martinez spoke for Nora Alvarez, a UCLA Medical Center employee and AFSCME member. She and her colleagues worked long hours, but too many were struggling to survive on their UC earnings. She earned about \$3,500 per month. Her mortgage was \$2,000, which left less than \$1,500 for everything else, including the nearly \$100 monthly cost for the privilege of parking near work. It was disheartening for UC workers to learn of a chancellor receiving a \$500,000 pay raise. She demanded that the University raise the minimum wage for all UC workers to \$25 per hour.
- K. Michael Foster, UCLA Health Patient Communication Center employee and Teamsters 2010 member, reported that 500 of his co-workers were subject to unhealthy and hostile management practices. He had worked for two years in his position and had observed a decline in the quality of the work environment in the last six to eight months. Management had made it a policy to include work-related activities such as meetings, training, evaluations, and calls with a supervisor in employees' limited break time.
- L. Amber Martinez, UCLA Health employee in the Patient Communication Center and Teamsters 2010 member, expressed concern about an unhealthy and hostile work environment. She and her co-workers could not appropriately support patients when they were pressured to rush patients off a call. Management was emphasizing quantity over quality and had been giving unfavorable performance evaluations without supporting evidence to employees with many years of experience and who had never received negative reviews in the past. Employees were being micromanaged, bullied, harassed, and accused of not performing their duties.
- M. Annette Becerra, UCLA Health Patient Communication Center employee and Teamsters 2010 member, voiced concern about an unhealthy and hostile work environment. She had never felt as unsupported in her work as now. The focus had shifted from patient care to quotas and metrics. Management had set quotas that were not practical or achievable, and care for patients was being disregarded. Ms. Becerra asked the Regents to address this situation.
- N. Diana Hernandez, UCLA Health Patient Communication Center employee and Teamsters 2010 member, stated her concern about a hostile work environment created by management. She reported that she sometimes must keep patients on a call longer than necessary, even when she could handle the request after the call is ended. Employees cannot use the restroom comfortably because they are being

timed and pressured to hurry back. The quality of the work environment had deteriorated, and Ms. Hernandez asked the Regents to intervene.

- O. Rebekah Groom, UCLA Health Patient Communication Center employee and Teamsters 2010 member, reiterated comments made by Ms. Becerra. Employees are compelled to keep patients on a call longer than necessary; if they do not do this, their break time increases, and they are punished. Patients are forced to wait on hold much longer than necessary. Ms. Groom complained of micromanagement by supervisors and asked the Regents to investigate this situation so that employees can focus on patient care rather than quotas.

3. **APPROVAL OF APPOINTMENT OF AND COMPENSATION FOR TIM COLLINS AS CHIEF EXECUTIVE OFFICER, UC RIVERSIDE HEALTH, RIVERSIDE CAMPUS AS DISCUSSED IN CLOSED SESSION**

The President of the University recommended that the Health Services Committee approve the following items in connection with the appointment of and compensation for Tim Collins as Chief Executive Officer, UC Riverside Health, Riverside campus:

- A. Per policy, appointment of Tim Collins as Chief Executive Officer, UC Riverside Health, Riverside campus, at 100 percent time.
- B. Per policy, an annual base salary of \$550,000.
- C. Per policy, a hiring bonus of 13.6 percent (\$75,000) of base salary, which is intended to make the hiring offer market-competitive and assist in securing acceptance of the offer. The hiring bonus will be paid in two equal lump sums of \$37,500 each. The first will be paid within 30 days of the initial hire date, and the second will be paid after completion of one year of service. The hiring bonus will be subject to the following repayment schedule if Mr. Collins separates from the University or accepts an appointment at another University of California location within two years of his appointment: \$37,500 if separation occurs within the first year of employment and \$37,500 if separation occurs within the second year of employment, subject to the limitations under policy. Any unpaid hiring bonus amounts will be forfeited at the time of separation if separation occurs for any reason.
- D. Per policy and starting in the 2023-24 plan year, eligibility to participate in the Clinical Enterprise Management Recognition Plan's (CEMRP) Short Term Incentive (STI) component, with a target award of 20 percent of base salary (\$110,000) and maximum potential award of 30 percent of base salary (\$165,000), subject to all applicable plan requirements and Administrative Oversight Committee approval. The 2023-24 plan year starts on July 1, 2023 and ends on June 30, 2024, and the first possible short term incentive award will be determined following the close of the 2023-24 plan year. Any actual award will be determined based on performance against pre-established objectives and may be prorated in the

first year of participation.

- E. Per policy and starting in the 2023-26 performance period, eligibility to participate in the CEMRP Long Term Incentive (LTI) component, with a target award of ten percent of base salary and a maximum potential award of 15 percent of base salary, subject to all applicable plan requirements and Administrative Oversight Committee approval. The 2023-26 performance period starts on July 1, 2023 and ends on June 30, 2026, and the first possible long term incentive award will be determined following the close of the 2023-26 performance period. The LTI uses rolling three-year performance periods, and any actual award will be determined based on performance against pre-established objectives over each three-year LTI performance period and may be prorated in the first three-year performance period by dividing the number of complete months employed during that three-year period by the number of months in the full performance period (36 months).
- F. Per policy, standard pension and health and welfare benefits and standard senior management benefits, including eligibility for senior management life insurance and, after five consecutive years of Senior Management Group service, eligibility for executive salary continuation for disability.
- G. Per policy, eligibility to participate in the UC Employee Housing Assistance Program, subject to all program requirements.
- H. Per policy, reimbursement of actual and reasonable moving and relocation expenses associated with relocating his primary residence, subject to the limitations under Regents Policy 7710, Senior Management Group Moving Reimbursement.
- I. For any outside professional activities, Mr. Collins will comply with applicable Outside Professional Activity (OPA) policies and reporting requirements.
- J. This action will be effective on Mr. Collins's hire date which is estimated to be on or about May 1, 2023.

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

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

Associate Vice President Jay Henderson outlined the proposed appointment and compensation terms for Tim Collins as Chief Executive Officer, UC Riverside Health. The proposed base salary of \$550,000 was 3.7 percent above the 60th percentile and

13.3 percent below the 75th percentile of the Market Reference Zone for the position and 6.8 percent above the current career incumbent's base salary.

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

4. **UCLA HEALTH PEDIATRIC AND CONGENITAL CARDIAC AFFILIATION WITH CHILDREN'S HOSPITAL OF ORANGE COUNTY, LOS ANGELES CAMPUS**

The President of the University recommended that the Health Services Committee recommend that the Regents:

- A. Authorize UCLA Health to enter into an affiliation with Children's Hospital of Orange County (CHOC) to develop, support, and grow a premier, shared pediatric and congenital cardiac program (the "Cardiac Program"), as follows:
 - (1) UCLA Health and CHOC each shall commit the operations of their existing Cardiac Program Services at their existing Cardiac Program Facilities (as defined in the Affiliation Agreement) to be operated as a collaborative endeavor of CHOC and UCLA Health under the Cardiac Program Affiliation Agreement and governed by the Cardiac Program Oversight Committee, including approval of the operating and capital budgets of the Cardiac Program.
 - (2) The definitive agreements will contain provisions that require approval by UCLA Health for any agreements with third parties directly relating to the provision of Cardiac Program Services (except payor agreements) that have a material and adverse economic impact on the Cardiac Program; incurring capital expenditures that are not included in the annual budget; the addition of any third parties to the Cardiac Program Affiliation; any changes to the Cardiac Program Facilities; the branding and marketing of the Cardiac Program including the use of the University's name; and the removal of any medical director of the Cardiac Program.
 - (3) The Regents, through UCLA Health, may commit up to an additional \$25 million in connection with the Cardiac Program.
- B. Authorize the Chancellor of UCLA and the Vice Chancellor, Health Sciences of UCLA, or their designee, upon satisfactory completion of appropriate business, regulatory, and compliance due diligence and after consultation with the Office of the General Counsel, to approve and execute any agreements and documents reasonably required to implement the foregoing, including any subsequent agreements, modifications, or amendments thereto, provided that such agreements,

modifications, amendments or related documents do not materially increase the obligations of the Regents.

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

Executive Vice President Byington introduced the item. UCLA Health sought to enter an affiliation with Children's Hospital of Orange County (CHOC) to develop, support, and grow a premier shared pediatric and congenital cardiac program.

UCLA Health President Johnese Spisso reported that UCLA had been working on this contractual affiliation for a year and a half. This would be an exclusive contractual affiliation between UCLA Health and CHOC for a specific service line of pediatric congenital cardiac surgeries. The affiliation would be one UCLA program with two sites. There would be no amalgamation of assets or staff. Future contribution margin would be shared. UCLA would provide its surgeon expertise. All four UCLA hospitals were operating at well over 100 percent capacity. The UCLA Mattel Children's Hospital had only 135 beds and was full. This arrangement would help UCLA address its inpatient capacity constraints, improve access to care, and allow procedures to be performed closer to where patients' families live.

Ms. Spisso related that, some years prior, UCLA Health had been fortunate in being able to recruit Glen Van Arsdell, a leading pediatric congenital cardiac surgeon. The complex surgeries in question are performed on children with significant anomalies such as transposition of the great arteries, atrial septal defects, ventricular septal defects, and coarctation of the aorta. From the time UCLA recruited Dr. Van Arsdell, there has been a great increase in the numbers of referred patients to a point beyond UCLA's capacity. These cases require a long stay in the pediatric intensive care unit, which has a limited number of beds. UCLA began working with CHOC on a possible affiliation. Nationwide, there were fewer than 20,000 such cases per year, so it was desirable to concentrate these services in centers of excellence with surgeons and specialized teams of pediatric cardiologists, nurses, and infusionists. These services were concentrated in a limited number of hospitals in the U.S., and UCLA Health was pleased to be able to offer this program. Higher-volume programs tend to demonstrate better patient outcomes. A high percentage of these patients are Medicaid patients.

The affiliation with CHOC would allow UCLA to grow quaternary patient volumes in a small market segment, increase patient access without having to add inpatient pediatric beds, leverage capacity at CHOC including neonatal intensive care beds, and make use of UCLA Health talent and strengths. The affiliation would allow inpatient surgical growth that would otherwise not be possible at UCLA Health and would protect and advance UCLA's teaching mission.

UCLA Health Chief Strategy Officer Santiago Muñoz outlined the risks of the affiliation. UCLA had identified its current spending and earnings on this service line. These baseline expenses and revenues would continue and would not be shared. UCLA would

meticulously track all the growth above this baseline, including revenues and expenses, and would share this with CHOC. Mr. Muñoz acknowledged that it was possible that this transaction would not produce the anticipated growth, but this appeared to be a low risk, given the current demand for these services. UCLA had included provisions in the agreement that would allow UCLA to exit the transaction if it did not grow as anticipated. There were also risks in the status quo. UCLA wished to grow beyond its current constraints. There was a need to expand services to retain talented faculty. There were limitations on UCLA's ability to train residents and fellows and on UCLA research. This affiliation would address these limitations.

Regarding the financial elements of the affiliation, Mr. Muñoz noted that there would be a 13-year initial period, which had been negotiated and reflected CHOC's wish for stability in the deal and UCLA's wish for the ability to generate growth, and, if this did not take place, to use its talent and resources elsewhere. UCLA and CHOC predetermined the division of the future growth and created protections that would allow UCLA to exit the arrangement if growth targets were not met. The affiliation would protect UC Health systemwide Medicaid supplemental payments. UCLA believed that the current financial structure would enable UCLA to secure \$45 million of additional margin over 13 years, which UCLA would be unlikely to achieve in the absence of this affiliation. The affiliation involved no separate legal entity and no amalgamation of assets and liabilities. The agreement included detailed termination provisions that would allow UCLA to exit the arrangement through mutual agreement or due to various changes that might occur at CHOC, or if performance quality targets were not met after certain cure periods.

Regent Makarechian asked about exclusivity in the affiliation, and if this affected the other UC medical centers. Mr. Muñoz responded that the affiliation would not affect the other medical centers. He explained that exclusivity meant that UCLA Health would perform these surgeries only at the identified sites. This pertained to UCLA Health; faculty would have the autonomy to provide surgeries at other locations. Nothing in the transaction would eliminate opportunities or flexibility for any other UC Health campus.

Regent Makarechian referred to the fact that CHOC was located in Orange County and close to the UC Irvine Medical Center. He recalled that the UC medical centers had agreed to maintain their activities within certain geographical boundaries. He asked if there was any concern about UCLA Health being active in a region served by UCI Health. UCLA Health Sciences Vice Chancellor John Mazziotta responded that, in years past, there was an informal agreement about how far in each direction each medical center would pursue its activities. Any decision to go beyond one of these boundaries into an area served by another medical center would be discussed with the other campus. In this case, there were discussions with UC Irvine. Chancellor Gillman confirmed that this was the case. Discussions about this affiliation were positive, with transparency and the support of UCI leadership to extend this unique opportunity to a close partner of UCI. Chancellor Gillman expressed satisfaction with how the discussions had evolved; this affiliation would be a benefit to the people of Orange County.

Regent Makarechian asked about the new hospital facility that UCI was building, which would house cardiac care services. Dr. Mazziotta responded that this type of surgery was specialized to such a degree that few physicians could provide it. This situation might change in 13 years, and should it change, the University could reevaluate the affiliation.

Regent Makarechian asked about keeping malpractice and other liabilities of UCLA and CHOC separate. Mr. Muñoz responded that all current parameters, protections, and coverage for surgeries performed at UCLA Health would remain in place. In the same way, all of CHOC's liability protections would remain applicable. UCLA and CHOC were not merging a business. The clinical staffing for the surgeries would be arranged through a reciprocal physician services agreement, complementary to the affiliation agreement, and which was no different from any other physician services agreement UCLA would have at any other hospital. The agreement delineates the protections necessary for a UC provider to practice at that hospital.

Regent Sures asked if Children's Hospital Los Angeles performed this type of surgery. Ms. Spisso responded in the affirmative.

Regent Sures asked if UCLA Health would be in competition with Children's Hospital Los Angeles as a result of the proposed affiliation. Ms. Spisso responded that, given the numbers of cases in the state, there was a need for both programs. UCLA had been experiencing higher numbers of referrals since Dr. Van Arsdell joined UCLA. UCLA collaborated with Children's Hospital Los Angeles.

Regent-designate Raznick asked about operations with affiliates and patient experience and if UC Health had the opportunity to implement what UC believed to be best practices, processes, procedures, communications, and strategy with an affiliate. Ms. Spisso responded that, for the past year, Dr. Van Arsdell and members of his team had been working at CHOC two days per week. They had an opportunity to assess CHOC operations and found them to be outstanding. One of the benefits of the affiliation was a joint oversight committee that would work to maintain high quality and standards. Currently, many children received initial care at CHOC and were transferred to UCLA for complex surgeries.

Regent-designate Raznick observed that procedures and patient engagement at UCLA Health were well defined, and he hoped that UCLA could bring this to its partner in the affiliation. Ms. Spisso responded that the CHOC team was engaged and receptive. UCLA believed that CHOC would be a good partner in this relationship.

Committee Chair Pérez asked about the ongoing relationship between UC Irvine and CHOC and requested confirmation that this affiliation would not displace the UCI-CHOC relationship. UC Irvine Vice Chancellor for Health Affairs Steve Goldstein responded that this was a strong relationship that had developed over the last five years. The UC Irvine Health chair of pediatrics was CHOC's pediatrician in chief. The two institutions worked together across their organizations. The hiring of major division heads at CHOC took place

in synchrony, and these individuals became faculty members at UCI. The Chief Executive Officers of CHOC and UCI Health communicated weekly.

Committee Chair Pérez reiterated that the proposed affiliation would not displace the relationship between UCI and CHOC. Dr. Goldstein confirmed this and observed that building up a program of this quality, with the unique skills of these pediatric surgeons, was a slow process.

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

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

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

Executive Vice President Byington began her presentation by stressing that the big news of the moment was the end of the COVID-19 public health emergency. In California, the public health emergency ended on February 28, 2023. The health emergency in the U.S. had ended on April 10, and the public health emergency would end on May 11. Dr. Byington presented a chart showing rates of COVID-19 deaths during winter in the U.S. over the last three winters. There had been a dramatic reduction in the number of deaths. She attributed this significant reduction to a number of factors but most importantly to the fact that approximately 92 percent of the U.S. population had some type of immunity. Immunity came from vaccination, infection, or a combination of both.

Vaccination had been extremely effective in reducing death from COVID-19 infection across all ages. Another chart showed rates of COVID-19 deaths by vaccination status, whether unvaccinated, vaccinated without an updated Omicron booster shot, and vaccinated with an updated booster shot. There was almost an eightfold difference between the unvaccinated and the vaccinated without a booster shot. For individuals vaccinated with a booster shot, there was a further, almost twofold reduction in mortality. Unfortunately, only 16 percent of the U.S. population was up to date with the Omicron booster shot.

Another reason for the decline in mortality was that, for the last year, the principal variant was the Omicron variant, and currently this variant accounted for 100 percent of the disease in the U.S. Omicron had been shown to be less virulent and less likely to cause hospitalization or death, even though it is more transmissible. There was a large number of variants, and any one of them might become predominant in the future.

Even though public health emergency had ended in California and would end in the U.S. the following month, was ending, COVID-19 had not left the environment, the healthcare system, or daily life. Dr. Byington presented another chart showing excess mortality in the U.S. from 2018 to 2023 from pneumonia, influenza, and COVID-19. The rate was still significantly higher than the average baseline before COVID-19. The entire nation was still

a “red zone” for excess mortality. In response to a question by Regent Leib, she confirmed the rate of excess mortality was now moving closer to the baseline. One would need to monitor this.

There had been a decline in the number of COVID-19 patients at UC medical centers, and there were currently 89 of these patients in the UC system, one of the lowest numbers since the beginning of the pandemic.

Dr. Byington outlined the changes that would now occur following the end of the COVID-19 emergency declarations. The changes would affect coverage, cost, and payment for testing, treatment, and vaccines. In May payment would move to commercial coverage, although Medicaid patients would still be eligible for free COVID-19 testing and some treatment. There would be changes within Medicaid coverage and federal match rates and changes in telehealth rules. Many states enjoyed enhanced coverage for their most vulnerable patients and would like to make this coverage permanent.

Committee Chair Pérez asked if UC Health also had an interest in maintaining the new ability to use telehealth, especially for patients who were geographically isolated and far from a hospital. Dr. Byington responded in the affirmative. Before the pandemic, UC Health had about 1,500 virtual visits per month; the number of virtual visits was now in the range of 250,000 per month. This had improved access to care.

At the request of chancellors and President Drake, UC Health convened its COVID working group in February to make plans for the end of the public health emergency. UC Health had provided recommendations to the campuses. The campuses understood the steps needed to protect students and employees. UC Health had emphasized that some steps should continue now and in the future, such as the promotion of public health literacy on every campus, which would include education of the entire campus community, a sustainable level of preparedness, and outreach using student health ambassadors. The student health ambassadors would provide peer education as new students enter the University every year.

UC Health also discussed the loosening of mitigation strategies while maintaining preparedness across UC and had provided guidance in areas of vaccination, screening, and testing. The University had found entry screening to be effective at the beginning of each term. At this point, the preferred method was self-testing prior to arrival on campus.

There were many questions remaining about COVID-19, including the question of its origin. UCLA and UC San Diego investigators were actively involved in the genomic analysis of COVID-19 to determine its origin.

Dr. Byington noted that there had recently been a controversial review of mask effectiveness for preventing the spread of respiratory viruses by Cochrane, a nonprofit health policy network, and that this review might be retracted. She emphasized her view that high-quality masks are effective for individuals.

Another frequent question at this time concerned when individuals would receive a second bivalent booster shot. Europe, the United Kingdom, and Canada had already recommended a second booster shot for individuals over 65 and immunocompromised people. The U.S. Food and Drug Administration might make a determination for the U.S. in the coming weeks.

Dr. Byington recalled that UC Health sponsored a long COVID working group. The group had released long COVID training modules, which were being used in California, the U.S., and abroad. UC continued to search for new methods of diagnosis and treatment. A recently published study recognized the benefit of metformin, which changes the metabolism of glucose in patients and is used to treat diabetes. Individuals taking this medication at the time of their COVID-19 diagnosis were much less likely to develop long COVID.

Work was ongoing across UC Health to address climate change by reducing emissions and waste. UC Health was recognized in ten separate categories in the 2022 Practice Greenhealth awards.

The National Institutes of Health had released rankings for medical research. In all categories—medicine, dentistry, nursing, pharmacy, public health, and veterinary medicine—UC Health campuses received high national rankings. UCSF was ranked number one in medicine, dentistry, and pharmacy this year.

On Match Day in March, UC Health matched 734 graduating physicians into medical specialties across the U.S. Seventy percent of those matched would stay in California. The location of a residency is one of the primary determinants of where a physician remains to practice. About 210 of the graduates were matched in primary care specialties, 53 Programs in Medical Education (PRIME) students were matched in California, and 273 would train at a UC facility.

Committee Chair Pérez asked about numbers and percentages of graduates remaining in California, for students overall and for PRIME students. Dr. Byington confirmed that the percentage was roughly the same for the two groups, with 518 of 734 graduates overall remaining in California and 53 of 70 to 72 PRIME graduates remaining in California.

Dr. Byington briefly reported on the success of the UC Health systemwide grand rounds, which had covered the topics of long COVID and reproductive health care following the U.S. Supreme Court decision in *Dobbs v. Jackson Women's Health Organization*. An upcoming grand rounds session in May would present innovative models to advance health and mental health equity across California. UC Health representatives would be making a presentation at the national conference of the Association of American Medical Colleges that week on training in the post-*Dobbs* era.

UC Health's efforts to assist unaccompanied children at the U.S.-Mexico border were described in an article in the journal *Academic Medicine*, and an editorial in the same journal pointed to UC Health as a model for the nation and asked how the knowledge and momentum gained from this effort could be used to better realize the values of academic

medicine. This editorial was a matter of pride for UC Health, and Dr. Byington believed that UC Health's ability to address this public health emergency was directly related to its ability to work together during COVID-19. COVID-19 had taught UC Health how to rapidly mobilize resources across the system. The endeavor to assist unaccompanied children would not have succeeded without the work of each UC pediatric program and hospital.

Dr. Byington concluded her presentation by commenting that the work carried out during COVID-19 had also led to working in partnership with the California Department of Public Health in the area of health security. Dr. Byington reported that she had begun a two-year planning grant as principal investigator for UC Health to create a governance structure that would allow for prioritization of the health security needs of the state with equal representation by UC Health and the California Department of Public Health. The ultimate goal would be the creation of a sustainable infrastructure, taking account of lessons learned during the pandemic, for genomic viral surveillance, wastewater surveillance, and data sharing and modeling, with a lens of diversity and equity. This would be a permanent resource for the state and would improve the security of California citizens.

Regent Makarechian asked about letters that had been sent to UC Davis Health patients with Aetna insurance. The patients were informed that UC Davis Health would no longer accept Aetna insurance as of April 22. This would also occur at other UC medical centers. Committee Chair Pérez explained that negotiations were under way between providers and insurance carriers over the proper rate of compensation for providers. Dr. Byington added that the ongoing negotiations concerned all UC medical centers. She hoped that the University would reach an appropriate agreement and that UC would not have to disrupt patient care. The University was required to inform patients that this may occur. All the medical centers were working to ensure that patient care is not disrupted.

Advisory member Marks referred to the Match Day information and the 734 graduates who had been matched. She observed that there is usually a small percentage of graduates who do not match, for many reasons. She asked if there had been changes in these numbers at UC Health. There was national concern about the fact that medical school enrollments had grown but the number of residency positions had remained level. There should be no continued deterioration of a medical school graduate's ability to match. Dr. Byington responded that the University was fortunate in the fact that its training programs were competitive and its graduates matched well. UC Health graduates were in the 99th percentile or above for matching. UC Health was monitoring these numbers and attentive to specialty selection of fields such as obstetrics and gynecology.

Regent-designate Raznick asked about the long-term impact of COVID-19 on mortality rates and if one expected increased mortality from pneumonia, influenza, and COVID-19, as shown on a chart earlier. Dr. Byington responded that this was a complex issue. She believed that the mortality rates would enter a seasonal pattern. Every year in winter there is an increase in pneumonia, influenza, and now COVID. There would be normal levels of mortality during the years with increases in winter. There was concern about greater risk for individuals with long COVID, and there were some data on fungal infections, bacterial

infections, and other susceptibilities. There had been studies of dysfunction of T cells and B cells for some period following COVID-19 infection. This was a subject that was being intensely studied and monitored. With time there would be more data and clarity.

Regent-designate Raznick supposed that UC Health would build this into its model for patient access and care. Dr. Byington responded that even though the numbers of COVID-19 patients were low, UC hospitals were full. This might be partly due to delays in care during the pandemic. Patients were now presenting with later stage cancer than they had previously and would need to spend more time in the hospital. UC Health was seeing sicker patients, and this might be due to delays in care and to repeated infection with COVID-19.

Regent-designate Raznick asked if the University was providing COVID-19 test kits for self-testing by students and employees. Dr. Byington responded in the affirmative. Each location had been providing free testing on location for students and employees and would maintain some level of test availability.

6. **OVERVIEW OF THE INSTITUTE FOR IMMUNOLOGY AND IMMUNOTHERAPY, LOS ANGELES CAMPUS**

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

Chancellor Block began the discussion by noting that the proposed Institute for Immunology and Immunotherapy had had a long gestation period, with discussions dating back to 2018 and interrupted by the COVID-19 pandemic. The Institute would be a novel model for UCLA and would involve the commitment of precious real estate on a densely packed campus. This would be a significant commitment for UCLA, but the campus believed that this would be a wise investment that would bring benefit to UCLA Health, the wider campus, region, state, and beyond. The scale of the effort would allow UCLA to create an ecosystem based on first-rate science with the capacity to support the many steps from research to implementation, bench to bedside. Importantly, the Institute would establish many connections to other parts of the campus beyond UCLA Health, such as engineering, science divisions, and several professional schools.

UCLA Health Sciences Vice Chancellor John Mazziotta explained that immunology and immunotherapy had always been a strong suit at UCLA. In 2014, faculty had selected seven research themes of focus, and one was immunology. Many successful immunotherapies have been developed by UCLA faculty, resulting in patents, startup companies, and commercialized therapeutics. In addition, the Parker Institute funded cancer immunotherapy research at UCLA and UCSF, an ongoing relationship that would be renewed. It was clear that a better knowledge of the immune system in general would help to inform treatments for many disorders and healthy aging. The sophistication of the knowledge of the immune system was such that almost every new discovery of significance seemed to lead the way to a practical therapy. This was an area ripe for success and there had been recent notable successes in therapies for cancer and serious food allergies.

Vaccines are used for infectious diseases, but in the future might be applied to a wide variety of ailments including cancer.

The lead founder proposed a vision for the Institute in 2018 with a separate building on the campus. This donor considered other institutions, but UCLA met a number of important criteria: UCLA is a complete research campus, not an isolated medical school, and has a complete set of biological research cores; UCLA has a facility for manufacturing drugs and vaccines at commercial pharmaceutical grade for use in experiments and clinical trials; and the UCLA Health System is fully integrated into the academic mission and discovery process. The fulfillment of all these criteria would allow immunological discoveries to be patented and put into clinical trials in large, well-characterized patient populations, with the support infrastructure to manage this in one location and with one team.

The lead founder recruited additional philanthropists in 2019. An initial budget was set at \$1 billion, with half for the building and half for the program. In 2020 to 2022, UCLA began working with the founder group on the principles of how the Institute would be governed and operated. The founders made a commitment to raise the necessary funds of \$1 billion. One of the few positive aspects of the COVID-19 pandemic was a heightened awareness of vaccines and immunology; there was now a larger audience for this topic. In spring 2022, the founders independently approached Governor Newsom and requested State funding of \$1 billion, based on the concept that such an Institute would be an engine of economic development. At a time of State financial surplus, the idea that one could build an “Immunological Valley,” like Silicon Valley, was attractive. The Governor agreed and included the project in the Governor’s budget. Ultimately, the Legislature approved \$500 million for the Institute, divided into different amounts and years: \$200 million in the current fiscal year, \$200 million in the next fiscal year, and \$100 million in the year following that. In December 2022, Governor Newsom changed the funding sequence because the State was now in a deficit. The sequence was now \$100 million in this fiscal year, \$100 million in the next fiscal year, and \$300 million in the subsequent year. UCLA had negotiated and signed a non-binding term sheet with the founders which defines the principles and approaches for the establishment and oversight of the Institute. In the current month, the process was begun to transfer and encumber the first \$100 million of State funds, initiated by the campus through the Office of the President. When plans for the building and financing were completed, they would be presented to the Regents, as well as other items that would require Regents’ approval.

Committee Chair Pérez stated his understanding that the Regents were not involved in the discussion of this project or how it would be funded. Dr. Mazziotta responded that the Regents were not involved. The concept was presented to the President and the Chair of the Board in 2018.

In response to a question by Regent Sures, Dr. Mazziotta indicated the location of the project site as shown in an architectural rendering. For every 250,000 square feet the Institute builds, 50,000 square feet would be made available to the School of Medicine.

Regent Sures asked when the Institute would be built and begin operations, if approvals were received as planned. Dr. Mazziotta responded that this would depend on the process of construction, whether carried out by the University or the founder group with some arrangement with UC. This remained to be determined. He estimated that the construction process would take five years.

Regent Sures asked when the Regents would know who the founders were. Dr. Mazziotta responded that this could be discussed in closed session.

Regent Sherman asked who the owner of the entity would be. He asked if it would be a State entity or perhaps a State entity managed by UCLA, and who would benefit from new discoveries. Dr. Mazziotta responded that various governance structures were considered. For the founders and UCLA, the Broad Institute model was optimal. In that model, buildings are located on university land with contribution by the university, but the buildings are built by the institute. The questions of who would build and own the building had yet to be decided, and this also involved the question of how indirect costs would be managed and maximized.

Regent Guber asked if the Institute would engage in any activities during the five-year construction period. Dr. Mazziotta responded that UCLA had discussed with the founder group the possibility that recruitment for world-class immunologists could begin once an affiliation agreement had been approved by the Regents. Existing space in current School of Medicine inventory could be used to house Institute scientists to begin their work. The work of the Institute would then relocate to the building when construction was completed. UCLA had committed an entire floor of the remodeled former UCLA hospital to immunology and immunotherapy.

7. **AFFILIATIONS WITH ORGANIZATIONS WITH POLICY-BASED RESTRICTIONS ON CARE: FOLLOW-UP ON CASE STUDIES**

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

Executive Vice President Byington recalled that, at the October 2022 meeting of the Committee, a UC faculty physician panel had discussed affiliations with healthcare organizations that have adopted policy-based restrictions on care. Questions were raised about UC Health's ability to work under emergency circumstances and outside of emergency circumstances in particular areas and services.

Committee Chair Pérez stated his understanding that this effort was intended to provide clarity on effectuating compliance with both the letter and spirit of Regents policy. The examples of emergency situations were a subset of the overall questions on compliance. Dr. Byington confirmed that this was correct.

Dr. Byington recalled that one of the first questions that arose in the past discussion was the definition of an emergency. The use of the definition of an emergency under the

Emergency Medical Treatment and Active Labor Act (EMTALA), a federal designation, was discussed. Concerns were expressed that this was a complex definition, but Dr. Byington stressed that the EMTALA definition was written in a way that the general public could understand. According to EMTALA, the term “emergency medical condition” means “a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part...” EMTALA does not state that the emergency condition must be immediately life-threatening. Regents Policy 4405, Policy on Affiliations with Healthcare Organizations that Have Adopted Policy-Based Restrictions on Care, is very clear on the point that it is within the discretion of the UC provider to determine that there is an emergency. The provider may provide any item or service that they deem in their professional judgment to be necessary and appropriate without restriction and without seeking approval from any non-provider. If a physician believes that a pregnant patient presenting at an emergency department is experiencing an emergency and that an abortion is the stabilizing treatment necessary to resolve the condition, the physician not only may but must provide the treatment, with the patient’s consent, at that hospital. A hospital may not penalize or take adverse action against a physician because of the treatment administered in order to save the life of the patient.

Regent Sures asked whether a patient or a doctor deems a situation to be an emergency. Dr. Byington responded that the EMTALA definition was written so that patients could say that they believe they are experiencing an emergency. UC was declaring that its providers can use this language to determine that an emergency exists.

Regent Sures asked if, when a patient says there is an emergency and that they need a procedure, a doctor would be indemnified to perform it. Dr. Byington responded in the affirmative, adding that the provider must agree that the situation is an emergency.

Committee Chair Pérez stated his understanding that under no circumstances could a patient command a doctor to provide a service that the doctor did not believe was medically appropriate. Dr. Byington confirmed that this was the case.

Dr. Byington then reported that UC Health reviewed all the scenarios that were presented by the faculty panel at the October 2022 meeting to define UC Health’s understanding of what would occur under UC policy and UC’s contractual language. She had discussed this with the chief executive officers of UC’s faith-based affiliates and had verbal agreement that UC’s interpretation of what would occur or would be expected to occur was correct. Dr. Byington presented a chart listing eight conditions or diagnoses that had been discussed, identifying whether these were emergencies or not, and stating the expected action of a UC Health provider at a covered organization under Regents Policy 4405. Two of these conditions had been classified as emergent under the EMTALA definition, while the remainder were not emergent. In both conditions that were classified as emergencies, early and later pregnancy complications, the expected outcome would be to perform an

abortion with the patient's consent at the affiliate location. This could be a medical or surgical abortion depending on the condition.

Committee Chair Pérez commented that this presentation of the conditions only considered the question of whether a situation is an emergency or not. Some of the same procedures might be called for, not based on an emergent condition, but based on other factors. Dr. Byington confirmed that this was correct. Even for non-emergent conditions, UC Health had expectations about the ability to perform procedures.

Committee Chair Pérez noted that the question of determining if an emergency exists was not the only controlling question; non-discrimination and the standard of care were also controlling questions.

Regent Leib requested more detail about UC's expectations for non-emergent conditions. Dr. Byington discussed one such situation, a pregnant patient seeking tubal ligation at the time of delivery who has a history of placenta previa and for whom future pregnancies are determined to present a very high risk. This is not considered an emergency under EMTALA although it is a serious medical condition that must be addressed. In this situation, UC providers would be expected to identify a facility for the planned delivery so that elective sterilization can take place. Elective sterilization in California would require informed consent to be obtained at least one month or at a maximum six months prior to the scheduled procedure. Ideally, at a pre-natal visit, the individual provider would speak to the patient and determine a birthing plan that would allow an elective tubal ligation to take place.

Another non-emergent situation was the provision of long-term contraception in the immediate postpartum period, while the patient is in the hospital. While this is not an emergency, UC Health would expect a UC provider to know if long-term contraception, injectable or mechanical, is available on the formulary of the hospital where the patient intends to deliver. It was UC Health's understanding, from discussions with the chief executive officers of these institutions, that if the device or medication is on formulary, UC providers may prescribe them in any way they deem appropriate. If the provider knows, at the time of a pre-natal visit, that there is no long-term contraception available on the formulary, it is incumbent on the provider to arrange delivery in a hospital where these devices or medications are available. When UC Health cares for a pregnant woman in the prenatal period, the provider is obligated to create a birth plan, including location and instructions from the family.

A third non-emergent situation was the performance of a hysterectomy. One example would be a patient with symptomatic uterine pathology such as fibroids, abnormal bleeding, or cancer. If the appropriate treatment is deemed to be a hysterectomy, this could be performed at any location with the patient's consent. California law requires consent between one and six months before the procedure. This legal requirement was based on the fact that, in the past, and in California, sterilizations had been performed on women without their consent.

Committee Chair Pérez referred to language on the chart regarding performance of a hysterectomy, “(informed consent required one to six months prior to the scheduled procedure)” and suggested adding to that statement “or successor time as dictated by law,” in case California law changes and the informed consent period changes. Dr. Byington responded that this would be done, indicating the period prescribed by law.

Regent Sherman referred to the provision of Regents Policy 4405 that a provider may provide any service without seeking approval from any non-provider. He asked who a non-provider would be. Dr. Byington responded that this might be an individual with a religious affiliation, such as a bishop, priest, or nun, but not a physician.

Regent Sherman asked if the affiliated hospital is considered a non-provider, so that a provider does not have to request permission from the administration of the affiliated hospital to perform a procedure. Dr. Byington explained that a hospital is not a provider. “Provider” refers to a person. There is no need for a UC provider to ask permission from a hospital administrator.

Faculty Representative Cochran referred to the two conditions discussed in which a UC provider is allowed to provide an abortion. She asked if these were the only two conditions. She asked if a UC provider could perform an abortion in the case of a woman with acute anemia or multiple health risks who is found on admission to the hospital to be pregnant. Dr. Byington responded that an abortion could be performed if the situation was considered an emergency. The two conditions discussed were scenarios that had been presented by the faculty panel, but there might be thousands of scenarios that could occur within the normal care of a pregnant woman that would be emergency situations.

Committee Chair Pérez explained that the information presented here was meant to elaborate on scenarios outlined by the faculty panel at the October 2022 meeting. These scenarios were by no means exhaustive, and the question of emergency versus non-emergency situations was not the only controlling question. Dr. Byington added that, in this presentation, she wished to answer the specific questions raised by the faculty panel, because in most of the scenarios listed on the chart, the faculty panel members believed that these actions would not be able to take place, which contradicted UC Health’s understanding of its legal, contractual agreements with its affiliates.

Regent Park asked where the definition of an emergency would reside. Dr. Byington responded that it would be language in the Presidential policy.

Regent Park asked if the definition of an emergency used by the California Department of Managed Health Care (DMHC) and the EMTALA definition were the same, using different words, or if they were different, and how they would be interpreted. Dr. Byington responded that she believed the definitions were compatible. EMTALA was federal guidance that practicing physicians had worked under for decades. Deputy General Counsel Rachel Nosowsky explained that the DMHC definition would be woven into an expanded policy description. The major difference was that the DMHC definition takes the perspective of a patient and underscores that a payer cannot deny payment when a patient

went to the emergency department because he or she believed they had an emergency. UC Health hoped to merge the two definitions.

Regent Park asked how this merging was manifested. Ms. Nosowsky pointed out language on a slide taken from the DMHC definition.

Committee Chair Pérez asked if there would be a problem in referring to DMHC in the policy. Ms. Nosowsky responded in the negative. Committee Chair Pérez suggested that there be a specific reference to the DMHC language in the policy.

Faculty Representative Steintrager referred to emergency definition language shown on a slide: “Emergency conditions include, but are not limited to: A patient reasonably believing that it is an emergency...” He expressed concern that this would cause confusion. While the following language (“Waiting to get care would risk the patient’s life or a part of the patient’s body; A bad injury or a sudden serious illness; Severe pain; Active labor”) was meant to clarify this, he suggested that this language might be rephrased so that it is well understood that the definition of an emergency is not based on a patient’s subjective belief. Ms. Nosowsky responded that when individuals believe that they are experiencing an emergency, they go to the emergency department, and this starts the process. Believing that one has an emergency does not mean that a physician would provide the care that the patient thinks he or she needs. The physician will determine what the patient’s needs and options are, discuss this with the patient, and they come to some agreement. Mr. Steintrager observed that this was not clear in the paragraph referred to. Ms. Nosowsky responded that this language would be refined as UC works on this policy.

In response to a question by Ms. Cochran, Dr. Byington emphasized that it is the provider who determines if there is an emergency. Committee Chair Pérez reiterated that the determination of an emergency was only one of the questions that allows a physician to exercise professional judgment.

Regent-designate Raznick asked about policy implementation, if UC would provide training and how the University would ensure that providers are aware of this policy and adhering to it. Dr. Byington responded that, under Regents Policy 4405 and the interim Presidential policy, there were work groups at every location to address various parts of implementation. The education of providers, trainees, students, and patients was ongoing in the form of different activities. Dr. Byington believed that, as UC Health lived out the policy day by day, there would be growing awareness. She emphasized that UC was living under these policies now and acting in accordance with them now. One of the most significant changes and one of the strongest protections was that the University now had contractual language according to which UC providers determine, in their sole discretion, if there is an emergency; and they are able to act without seeking approval from any other administrator.

Committee Chair Pérez observed that the medical center chief executive officers and their teams had all been engaged in developing the policy language and considering the reality on the ground.

Dr. Byington then recalled that UC Health had been operating under Regents Policy 4405 since July 2021 and the interim Presidential policy since September 2021. The policies have been implemented. There were numerous rounds of stakeholder review. In August 2022, UC Health presented its first annual report on covered affiliations as an information item. There had been a systemwide review of the interim Presidential policy, including review by the Academic Senate. There had been ongoing discussions of the policy and implementation. Currently, drafting and consultation were under way. Once the language of the interim policy was finalized, it would be submitted to the Office of the President Policy Advisory Committee for final review and then become a finalized rather than an interim policy. Dr. Byington explained that the Policy Advisory Committee has membership across the campuses. Ms. Cochran stated her assumption that the Academic Senate was represented on the Policy Advisory Committee. She believed it likely that the policy would go out for review again.

Committee Chair Pérez wished to ensure that there would be substantive instruction and engagement by the Academic Senate in the next phase. Dr. Byington responded that there would be systemwide review and that the Academic Senate would be well represented. She stated that UC Health believed that it has taken policy implementation very seriously and that the policies were working. There was good engagement with affiliates.

Committee Chair Pérez observed that the Presidential policy was subordinate to and cannot be in conflict with Regents Policy 4405. The idea was to align and give greater depth in guiding implementation consistent with the language and spirit of Regents Policy 4405. Ms. Nosowsky confirmed that this understanding was correct.

Ms. Cochran referred to information in the presentation according to which a non-emergency hysterectomy in the absence of a specific diagnosis of uterine pathology would not be allowed. But there could be situations in which a person has a need for a hysterectomy not based on pathology of the uterus, such as gender-affirming care, chronic pelvic pain, and elevated risk for uterine cancer. She asked if a UC provider could perform a hysterectomy in an affiliate hospital in these three circumstances. Dr. Byington responded that, in the case of gender-affirming care, the UC provider would not be allowed to provide the service.

Committee Chair Pérez noted that, if a similarly situated patient, in terms of how the patient presented, was afforded a hysterectomy, then a patient seeking gender-affirming care would also have access due to the University's non-discrimination policy. Dr. Byington confirmed that this was the case. Regarding the other scenarios mentioned by Ms. Cochran, Dr. Byington confirmed that the risk of cancer and pelvic pain would be considered pathologies of the uterus. If those conditions existed and a hysterectomy was recommended for one patient, it would be available for another patient with the same condition. The provision of the service in case of gender dysphoria would depend on what other medical conditions might be present at the same time. Committee Chair Pérez added that it would also depend on the practice of the hospital in question.

UC San Diego Health Chief Executive Officer Patricia Maysent observed that gender-affirming care requires significant infrastructure. No health system in the San Diego region would provide this care other than UC San Diego and it would be unusual for any health system other than an academic medical center to have this infrastructure.

Committee Chair Pérez recalled that the Regents had heard testimony and there had been news media coverage about a case in Sacramento in which a patient had a hysterectomy scheduled and approved at a hospital with policy-based restrictions. When the hospital learned that the patient was having the procedure as part of gender-affirming care, it withdrew approval a day before the scheduled procedure. He asked if, in such a situation, under UC policy, this patient would have been allowed to have the procedure and the UC physician would have been allowed to perform the procedure. Dr. Byington responded that if a procedure is offered for one set of conditions, it would be offered to everyone with the same set of conditions.

Regent Park asked which sets of conditions were meant. Pathology of the uterus had been mentioned, but in her view, non-discrimination applies more broadly than a particular task or pathology. She asked how far non-discrimination would apply. Dr. Byington responded that her understanding, from speaking with the leaders of these institutions, was that the procedure that is not allowed under the ethical and religious directives is the removal of healthy reproductive organs. This was not allowed for any person. In the case of pathology, it would be allowed for any person. These conditions would apply to a hysterectomy. In the field of gender-affirming care, top surgery, facial reconstruction, hormone therapy, and counseling were provided across the board. The procedure that was limited was the removal of healthy reproductive organs, called elective sterilization.

Committee Chair Pérez noted that not all UC Health affiliate hospitals were governed by ethical and religious directives. Not all affiliations with hospitals that have other controlling policies were the same. Different organizations had a variety of approaches to these questions. The University was seeking to establish consistency in its expectations. He suggested that the Committee should further review policy language about non-discrimination to gain a better understanding of the implications of this language. Dr. Byington remarked that UC Health had included anti-discrimination language in its contracts.

Committee Chair Pérez praised the excellent progress many individuals and offices at UC had made in this work since October 2022. These were difficult issues, and a superb level of care had been exercised in working through these definitions. The discussion would never be truly final, and there would always be new questions. In his view, there was nothing inherently problematic in the materials before the Committee, but the Regents should continue to work on UC's non-discrimination language.

Regent Leib expressed his approbation for the progress the University had made on these questions.

Dr. Byington concluded the discussion by observing that this progress represented thousands of hours of work across the campuses to understand the issues, resolve gaps, and proceed in a way that respects the values of the University.

The meeting adjourned at 2:15 p.m.

Attest:

Secretary and Chief of Staff