The Regents of the University of California

**HEALTH SERVICES COMMITTEE**
August 14, 2024

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

Members present: Regents Batchlor, Makarechian, Park, Pérez, and Sherman; Ex officio members Drake and Reilly; Executive Vice President Rubin; Chancellor Hawgood; Advisory members Marks and Ong

In attendance: Regent Beharry, Regent-designate, Faculty Representatives Cheung and Steintrager, Staff Advisor Emiru, Secretary and Chief of Staff Lyall, General Counsel Robinson, Executive Vice President and Chief Operating Officer Nava, and Recording Secretary Johns

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

1. **APPROVAL OF MINUTES OF PREVIOUS MEETING**

Upon motion duly made and seconded, the minutes of the meeting of June 12, 2024 were approved, Regents Batchlor, Drake, Makarechian, Pérez, Reilly, and Sherman voting "aye."[1]

Committee Chair Pérez welcomed Michael Ong, who has been appointed as an advisory member to the Committee. Dr. Ong was a Professor in Residence of Medicine and Health Policy and Management at UCLA with dual appointments in the David Geffen School of Medicine and the Jonathan and Karin Fielding School of Public Health. His research expertise would help the Committee ensure that the University provides high-quality health care for Californians.

President Drake recognized the service UC Santa Barbara Chancellor Yang, who held the distinction of being the longest-serving chancellor in UC history, having served 30 years in this role. This morning, he announced that he planned to step down in the coming months and that he would return to the faculty in the Department of Mechanical Engineering. Chancellor Yang led multiple transformational initiatives that have solidified the campus's position as a leading public research university. He led the campus through a period of tremendous growth and designation as a Hispanic-Serving Institution. Chancellor and Mrs. Yang have been fixtures on the UCSB campus since 1994, committing countless hours and resources to serving students, faculty, staff, alumni, and other friends of the campus. They would leave behind a legacy of public service and profound impact.

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

President Drake expressed gratitude to Chancellor Yang for his remarkable tenure at UC Santa Barbara and all that he has contributed to the campus, to UC, and to higher education.

Committee Chair Pérez congratulated Chancellor Yang on an amazing career. Recognized for his research, teaching, and public service, Chancellor Yang has helped UC Santa Barbara grow, diversify, and excel. Under his leadership, UC Santa Barbara has achieved high rankings and offered more than 200 majors, degrees, and credentials. Committee Chair Pérez emphasized that Chancellor Yang was accessible for students and listened to their concerns. Chancellor Yang also provided his time and expertise to many vital national and international organizations, making him one of one of UC's finest ambassadors on the world stage.

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. Sonserae Crudup, an employee at UCLA Rheumatology's Wilshire Boulevard site, reported that employees were given tasks for which they were not properly trained or licensed. This put patient care at risk and caused unnecessary delays in patient care. Processing authorizations for medication required correct answers to clinical questions. Ms. Crudup shared that this caused stress for her, because she did not have training to answer these questions and was afraid of giving wrong answers to insurance company representatives. Nurses or others with training were unwilling to help. If an authorization is denied, this delays care and prevents a patient from receiving medication.

B. Michael Harris, retired physician who practiced pediatrics in Marin County for 33 years, referred to news media accounts of the highly politicized workplace and healthcare environment for patients and staff at UCSF. Jewish staff members and patients were being intimidated by displays of anti-Zionist imagery. Identification with the State of Israel, separate from its government, was a key component of identity for the overwhelming majority of American Jews. For other minority groups, an expression is judged to be hostile and intimidating based on the impact it has on the members of that group, rather than the intent behind it. In the midst of a historic spike in antisemitism, Jewish patients and healthcare professionals deserved no less consideration.

C. Lucia Ventura addressed the Committee in Spanish. She worked at the Los Alamitos hospital, which had just been purchased by UC Irvine Health. She stated that UC needed to accept her and her colleagues as UC workers now. Failing to include service workers, as UC had included all the other patient care workers, showed a lack of respect. Ms. Ventura compared this to bullying in high school. She and her colleagues treated the same patients, contributed to the functioning of the hospital, and deserved a place at the table, like the others. They were now part

of UC and deserved the same benefits, wages, and security as other UC workers. Ms. Ventura had worked at the Los Alamitos hospital for 22 years and would not be able to retire soon although she was 61 years old.

D. Olimpia De Paz addressed the Committee in Spanish. She had been working at the UCI Los Alamitos hospital for almost eight years. She did not have health insurance but needed to have surgery. She asked how it was that she and her colleagues were treated so shamelessly, as if they were second class. They demanded to be hired directly and recognized as UC Irvine employees.

E. Javier Nuñez-Verdugo, UCLA Undergraduate Students Association External Vice President, called upon the Regents in the upcoming fiscal year to prioritize the hiring and training of culturally conscious mental health specialists including licensed therapists and psychiatrists. Especially following the spring quarter of violent police presence, repression of free speech on UC campuses, and response to student encampments for a liberated Palestine, Black and Brown students felt irresponsibly left behind and disregarded in their struggle to continue as students in a system that contributed to their oppression. Nuñez-Verdugo declared that UC Santa Cruz students were tortured by so-called law enforcement for hours before release. Students of color were in pain and were in need of professional support.

F. Marissa Muñoz, UCLA employee, reported that she and her colleagues were receiving inadequate and insufficient training, which increased the chances of submitting wrong billing codes, medical errors, increase of denial rates, and decrease in patient care satisfaction. Upper management was condescending and unhelpful, and this has decreased morale in the department as well as the quality of work being produced. She asked that UCLA Health and the Regents intervene.

G. Jason Perez, UCLA employee, reported that his department was having issues and that this was affecting patient care. There was lack of proper training. New employees were training each other. Micromanagement and new policies were not in alignment with the unit's work and pressure to do more work was leading to mistakes in authorizations and improper insurance verification. New employees were being hired at a higher rate, and this was affecting morale.

H. Kira Stein noted that at past meetings, the Jewish Faculty Resilience Group at UCLA (JFrg) has brought to attention inappropriate programming for medical students involving incitement and political propaganda that has no place in a medical school curriculum. JFrg had no information about what is being done to prevent similar events and to address an increasingly hostile environment for Jews in the School of Medicine. UCLA has been ordered by a court to develop a plan for appropriate protection of Jewish students from harassment. JFrg would like to be consulted about this planning for the School of Medicine.

I. Michelle Zeidler, professor in clinical medicine at the UCLA School of Medicine. Apart from clinical and scientific training, medical students attend various

orientation programs and other required or supplementary courses. Last year, some of that training devolved into propaganda related to the Israel-Gaza conflict, material that has no place in clinical training. UCLA has been ordered by a court to develop a plan that protects Jewish students. JFrg would like to would like to play a role in ensuring that this plan includes the School of Medicine.

J. Vivien Burt, professor emerita of psychiatry at UCLA, reported that she recently took a leave of absence from the Women's Life Center, a program she had founded 31 years ago to care for patients with perinatal depression. She was no longer welcome in the Center she created because she joined JFrg and spoke out about a psychiatry lecture, witnessed by UCLA faculty administrators, which was infused with antisemitic indoctrination. She asked that the Regents end the antisemitic isolation of Jewish faculty and students who speak up about campus antisemitism.

K. Tal Paley expressed concern about increasing antisemitism at UCLA following the October 7, 2023 Hamas attack on Israel. UCLA medical students and trainees were repeatedly exposed to antisemitic and anti-Israel propaganda. She asked that UCLA's response to this situation be grounded in UC anti-discrimination policies and Regents Policy 2301, Policy on Course Content, which forbids indoctrination in the classroom.

L. Sydni Jasper, UCLA Health employee in the financial clearance unit, reported that she had not received the training she needed for her job, which included processing medication requests, in order to avoid denials and delays for patients. She was not paid fairly for the work she was doing and there was a need for additional training.

M. Belinda Trejo, UCLA Health patient communication representative, related that her unit handles patient registration, appointment scheduling, urgent and non-urgent referrals, medical records, and timely receipt of authorizations, among many other tasks. She and her colleagues had the same job title as other teams at the UCLA Health Call Center who did not have nearly the same workload. The burdensome workload was causing staff burnout.

N. Teresa Ortiz, employee in the UCLA Health patient referral team at the patient access organization reported that inequity has led to delays in patient care. For example, 20 to 30 callers must wait for assistance because of the heavy workload. This was causing staff to feel burnt out and undervalued. Patients should not have to suffer due to Ms. Ortiz's team not being adequately recognized or compensated. UCLA Health's mission to deliver leading-edge patient care with compassion and respect should equally apply to how UCLA treats its employees. Along with the well-being of patients, UCLA must also prioritize the well-being and voices of all staff. Ms. Ortiz noted that the physician referral number, which her unit answers, was displayed prominently in UCLA Health advertising and informational material. She asked that employees in this unit receive a raise.

O. Tammie Tillmon, UCLA Health Call Center employee, shared that she has worked at UCLA for 25 years. She and her colleagues have asked upper management, without success, for compensation equity increases and job title changes because their duties were more burdensome than for the average patient communication representative. Ms. Tillmon and her colleagues were feeling burnt out and morale was low. She asked that the UC administration review this situation and recognize the value they bring to the UCLA Health system.

P. Lianne Gensler, UCSF professor of medicine, underscored the duty of healthcare providers to prioritize the comfort, protection, and well-being of every patient and to create a secure environment where every patient feels respected and cared for regardless of their background or belief. Any breach of patients' trust due to identity-based discomfort was a betrayal of providers' ethical responsibilities. When political activism leads to an environment where Jewish patients feel compelled to hide their identities, this was a failure on the part of caregivers. Dr. Gensler urged the Regents to reaffirm the primacy of patient care in the UC system and to ensure that UC community members regardless of belief or identity feel safe and supported.

Q. Naydelin Chimil, UC Berkeley student, expressed solidarity with the essential workers in dietary and environmental services departments at UC Irvine Health's new facilities in Fountain Valley, Lakewood, and Los Alamitos who were demanding to be hired as UC employees, as was the case for patient care workers. These workers provided vital services to patients and visitors of the hospitals and deserved to be treated fairly. They called on UC Irvine to treat them with dignity and respect by hiring them as UC Irvine employees.

3. **PROPOSED REQUEST FOR APPROVAL OF LA JOLLA MEDICAL CENTER TOWER 2 AND LA JOLLA OUTPATIENT PAVILION, 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 La Jolla Medical Center Tower 2 and the La Jolla Outpatient Pavilion; (2) approval of the budget and external financing; and (3) approval of design and action pursuant to 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.]

UC San Diego Health Chief Executive Officer Patricia Maysent explained that these two clinical expansion projects on the La Jolla campus were vitally important to the future success of UC San Diego Health: a new outpatient pavilion to address long-term ambulatory clinical needs for the La Jolla region and to support patient flow on the La Jolla campus, and an additional inpatient bed tower to address critical bed capacity needs on the

main academic campus. These projects were a key part of UCSD Health's broad geographic strategy to increase patient access and to meet its mission. Ms. Maysent presented a map showing the current UCSD Health network, including clinically integrated network partner sites. UCSD Health's reach extended into southwest Riverside County and the Imperial Valley. Other recent examples of expansion were the acquisition of the East Campus Medical Center and the plan to build a large ambulatory hub in Rancho Bernardo via a public-private partnership. This expansion of UCSD Health was increasing access points in the region, but investment in the academic campuses and in the clinical infrastructure was needed to continue to meet the needs of the community.

Ms. Maysent then presented a timeline for major construction projects at UCSD Health. The McGrath Outpatient Pavilion was scheduled to open in June 2025 and would support the Hillcrest campus population and community and the rebuilding of the Hillcrest Hospital, which was currently in the planning stages. The two La Jolla projects that were the subject of this item would create sorely needed capacity on the La Jolla campus, build incremental margin, and support the replacement of the Hillcrest Hospital.

The La Jolla campus was running over capacity. The patient bed utilization rate was extraordinarily high, and every day the medical center had at least 75 patients admitted through the emergency department who were waiting for beds. Infusion services were operating seven days a week, 365 days a year. Imaging services were running 24 hours a day, and it was not unusual for a magnetic resonance imaging (MRI) appointment to be scheduled at 2:00 a.m. or 3:00 a.m.

These capacity challenges were expected to grow and worsen over time. Some factors that accounted for this were an aging population, the increasing complexity of patient conditions, the growth of the UCSD Health network, the elimination of certain types of patient care by other health systems in the region, and shifts from inpatient to outpatient care. These trends all had a negative impact on the UCSD Health mission. UCSD Health was the only hospital in the region able to perform certain quaternary services, but currently, almost every day, UCSD cannot provide these services because of a lack of beds for transfer patients. UCSD has transferred over 1,000 patients to East Campus Medical Center since acquiring this facility in December 2023, but this had not lessened patient demand on the La Jolla campus. UCSD Health needed to invest in the La Jolla campus in order to fulfill the campus' mission.

UCSD Health Chief Strategy Officer Douglas Cates presented a map with the proposed location of the new Outpatient Pavilion. The site would provide good access by car and local transit. The site was relatively flat, easy to build on, and with good access to the rest of the campus. UCSD envisioned that the building would house neurology and neurosurgery, orthopedics and spine medicine, rehabilitation and gymnasium facilities, non-oncologic infusion, outpatient surgery, and advanced imaging. Regarding non-oncologic infusion, UCSD planned to move some services from the Moores Cancer Center, the Koman Family Outpatient Pavilion, and the Perlman Medical Offices and to concentrate them in the La Jolla Outpatient Pavilion. There would be increased capacity for cancer services on campus. The building was designed to be 180,000 square feet in size

at a cost of $250 million to $300 million with occupancy projected by fiscal year 2029. UCSD had purposely been judicious about use of land on the site, using half the site to build on and leaving space for future growth.

UCSD Health Chief Financial Officer Lori Donaldson presented preliminary financial projections for the facility. UCSD expected that the facility would generate a positive profit margin by year two, with volume growth over two years, and then assumed to grow at two to four percent annually. The payer mix used for financial modeling purposes was based on that of the La Jolla campus, with approximately 40 percent commercial payers, slightly higher than the overall percentage of commercial payers when one considered all UCSD outpatient services. The payer mix would include about 40 percent Medicare patients and 18 percent Medi-Cal patients. The forecast included all current assumptions about reimbursement increases and inflation on expenses. Direct patient care expenses, variable indirect expenses, some incremental fixed expenses, and construction costs were included in this forecast. For modeling purposes, UCSD assumed a building cost of about $280 million and a planning rate of 4.25 percent over 30 years. UCSD has assumed that it will need to acquire about $60 million in equipment, funded with a combination of hospital reserves and other financing. UCSD anticipated a slight loss in year one, followed by significant margin generation in year two, growing to nearly $48 million by year five.

Mr. Cates then discussed the second proposed project in this item, the La Jolla Medical Center Tower 2 (or La Jolla Inpatient Tower). He presented a site map with the proposed location. The new tower would have a capacity of up to 400 patient beds, and the campus would present an updated Long Range Development Plan (LRDP) reflecting this growth. For current planning purposes, however, UCSD had a 250-bed scenario, designing the tower to address current capacity needs (51 beds), increased utilization (11 beds), and conversion of the entire campus to private beds (11 beds), but most of the capacity (177 beds) would be attributed to increasing destination services, such as cancer, cardiac, and transplant services. An increase in observation spaces would improve patient flow, and there would be a small increase in emergency department bays. The largest percentage change of any capability provided by this building would be a 172 percent increase for the intensive care unit. UCSD was focused on creating a medical campus that can serve patients with the most complex conditions. UCSD was in the beginning stages of design for the project. The cost for the 250-bed scenario was estimated at between $1 billion and $1.5 billion, and UCSD was pursuing philanthropy.

There were four major considerations affecting the scale of these two projects. The first was financial capacity, including the cost of debt and interest during construction, cash flow, and the sequencing of major projects. The second factor was market dynamics, such as future utilization rates. Outpatient care would grow more than inpatient care. UCSD must be mindful of competitor activity, such as that of Scripps Health. The third factor was logistics and the site, which included consideration of the need to grow the supporting infrastructure for an increasing number of patients on campus. The fourth factor was startup requirements, including transition funding, the need to become cash flow-positive quickly, and the fact that hiring into the San Diego market, which was smaller than Los Angeles or the Bay Area, was challenging.

Regent Makarechian asked about $30 million in preliminary plans funding mentioned in the background material. He asked if this was funding for the Outpatient Pavilion or this project and the Inpatient Tower. Ms. Maysent explained that this was preliminary plans funding for the Outpatient Pavilion only.

Regent Makarechian suggested that the campus might consider building these projects three or four floors higher in anticipation of future need. He asked if the 250-bed scenario for the Inpatient Tower was within the projected 400-bed capacity or in addition to it, and how this related to an LRDP amendment. Mr. Cates responded that the current capacity was closer to 250 but that the updated LRDP would have a capacity of 400 beds for the site.

Regent Makarechian asked if UCSD planned to build the Inpatient Tower with 250 beds and increase the size to 400 beds and 850,000 gross square feet at a later point. Mr. Cates responded in the negative. UCSD could only build to an upper limit of 400 beds and 850,000 gross square feet. Currently UCSD was planning to build only 250 beds, but the campus might build a taller building and was considering scenarios with more beds. In one phase, UCSD would build to that appropriate capacity and bed number, which might be 250, 300, 350, or even 400.

Regent Sherman expressed agreement with Regent Makarechian about the need to maximize the use of land in these projects. The marginal cost of building an extra two to three floors would be much less than the total cost on a per-foot basis. He asked about market dynamics and the reasons for UCSD Health operating to such a degree over capacity. Ms. Maysent responded that, following COVID-19, most emergency departments of large health systems in the region were experiencing high volumes of patients and the trends of an aging patient population and patients with more complex conditions, but UCSD Health had been the most affected. One of the large health systems in the area stopped providing care for Medicare Advantage patients, so that 30,000 patients suddenly needed to find another place to receive care, and many came to UCSD Health. UCSD was growing its regional network as well, and this added to the number of patients. Mr. Cates added that, in addition to short-term pressures, UCSD must consider long-term factors when it designs a facility meant to last 50 years. For the San Diego region, an important factor would be the aging of the patient population.

Regent Sherman asked about possibilities for facility acquisitions in in the San Diego market. Ms. Maysent responded that UCSD's acquisition in December 2023 was one of three possible acquisitions in the local market. UCSD attempted to establish a relationship, a joint powers agreement with Tri-City Medical Center, but was unable to get this transaction done after about nine months of work. The only other location that might provide more patient beds in the short term was the Palomar Medical Center. UCSD was reviewing this possibility but there was no clear path at this point.

Regent Sherman asked if the financial margin projections for the Outpatient Pavilion were calculated after the planning rate cost of financing and after vendor financing or leases on equipment. Ms. Donaldson responded in the affirmative. There would be about $17 million

of debt service on the $280 million borrowing. Regent Sherman asked if a net positive cash flow was projected starting in year two. Ms. Donaldson responded in the affirmative.

Committee Chair Pérez praised UCSD Health for its work in preparing this item and for its commitment to providing more information in the future about maximizing the floor area ratio, parking, and other issues.

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

4. **REVIEW OF THE UC HEALTH STRATEGIC FRAMEWORK AND FISCAL YEAR 2024–25 BUDGET FOR UC HEALTH DIVISION, OFFICE OF THE PRESIDENT**

[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 Rubin began his presentation by asserting the UC Health vision, that the University of California will remain the north star for protecting and improving the health of all people across the State of California, serving as a model for the nation and the world. He recalled that the role of the UC Health Division at the Office of the President, which had multiple points of influence, was somewhat different from the role of UC Health at the campuses.

At the February 2024 meeting, Dr. Rubin had presented a revised strategic framework with five critical areas: (1) to drive investments to improve access, quality, clinical integration, and patient experience; (2) to expand a diverse interdisciplinary workforce; (3) to advance healthy communities through key partnerships; (4) to accelerate translational and comparative research and innovation; and (5) to facilitate systemwide initiatives that achieve fiscal resilience. He briefly outlined the strategic planning process timeline from October 2022 to the present. Since February 2024, UC Health has been aligning its budgets and working on the reorganization of its programs.

Dr. Rubin identified four key priorities for UC Health leadership. The first was focusing on UC Health's engagement with the State, developing a road map for the UC Health network to improve its partnership as a safety net partner with the State. The second was network development, supporting the expansion of UC-level care and training programs into geographic regions that have been under-resourced. The third was ambulatory access, aligning strategies and work to improve ambulatory access. The fourth priority was UC employee health, positioning the growing UC Health network to offer more affordable and accessible health insurance coverage in the future.

Dr. Rubin presented a series of slides showing specific work streams over five fiscal years. Regarding State engagement, there was a significant amount of work going on to quantify and characterize UC Health's work to support patients with public insurance, whether

Medi-Cal or Medicare, and to develop a safety net road map for work with State and County health plan partners. UC Health was strengthening its relationships with community partners and partnering with the State on Medi-Cal investments and reimbursement. Dr. Rubin was encouraged by partnerships such as that with the California Association of Public Hospitals and Health Systems as UC Health sought a funding formula that would allow UC to responsibly invest in its growing commitment to Medi-Cal patients.

With respect to network development, UC Health was working on the expansion of clinical services for the UC Riverside School of Medicine and recognized the need for similar action in the future for UC Merced. UC Health campuses were partnering in carrying out a gap analysis, of where additional network access is needed to support the delivery of an improved health plan for UC employees in the next few years.

In the area of ambulatory access, UC Health was positioning data to improve clinical integration and adding systemwide responsibilities and goals for reducing waiting lists for services. UC Health was initiating a clinical integration program to accelerate electronic health record-based applications that can help improve access at the point of care, not just in the office but in telephone and text communications, optimizing the patient experience.

Regarding employee health, UC would work on improving its employee health plans, optimizing patient experience and access to specialists. UC Health was working with Human Resources on initiating a modernized Blue and Gold employee plan by January 2027.

Future priorities to which UC Health was already devoting attention included fostering responsible deployment of artificial intelligence, strengthening UC's statewide cancer network, improving the efficiency of multicampus research, and working toward the delivery of improved Medicare Advantage plans. In the meantime, UC Health continued its core work to support priorities: access, quality, clinical integration, and the patient experience; support the interdisciplinary workforce; community benefit work; research and innovation; and work on fiscal resilience, which included payer collaboratives, improving employee and student health plans, strategic sourcing, and value-based initiatives.

Dr. Rubin concluded his remarks by thanking the UC Health leadership team and representatives of the Office of the General Counsel who work with UC Health. He noted that the UC Health Division's budget this year had remained flat; this had been achieved by repositioning resources. UC Health would continue to strengthen its mission in clinical programs, educational programs, and translational and comparative research programs.

Regent Batchlor asked if UC Health had a plan to develop more specific benchmarks so that the Regents would know whether UC Health is achieving the goals and objectives outlined in the framework. Dr. Rubin responded in the affirmative. Strategic planning was occurring in all UC Health units to develop benchmarks and criteria, and these would be shared with the Committee.

Regent Reilly asked what the greatest challenges were for UC Health in pursuing these priorities. Dr. Rubin responded that UC Health must define how it sees itself as a safety net partner to the State of California. Access for Medi-Cal patients had been expanded, but UC's ability to support this access was underfunded. UC Health must hold itself accountable for improving access to care for patients covered by public insurance programs; other partners must be held responsible for contributing their fair share as well. Another challenge for UC Health systemwide was learning how to work together as a group to invest in difficult projects, such as those at UC Riverside and UC Merced, which were critically important for the growth of the UC Health enterprise throughout the state. Patient access issues were a challenge, such as trying to reduce waiting times when the demand for UC Health services was as high as it had ever been, and growing.

President Drake commented that UC Health cannot build capacity fast enough, and as UC adds capacity, there are more patients. There was a tremendous need for high-quality services. The cost of health services was continuing to rise. UC Health had an opportunity, within its own system, to develop better and more efficient ways of delivering care which would allow UC to provide increased access in a way that helps to moderate costs. UC Health can continue to be a model for the rest of the country. The challenge for the nation was providing equitable health care at an affordable cost for tens of millions of people who could not obtain it. UC Health had opportunity to practice this as it looks toward areas of California that are underserved.

Committee Chair Pérez commended the medical center chief executive officers for having a broad vision of how and where UC Health would build and acquire facilities and extend coverage for patients so that UC is truly an engine for more equitable health care. Funding for new facilities was a major challenge. There might be an opportunity for UC with the federal public payer and there were questions of whether those federal reimbursement rates were appropriate overall and in specific geographic areas. Dr. Rubin anticipated that there would be an update on this issue for the Committee later in the year.

5. **EVOLVING LANDSCAPE OF CLINICAL TRAINING: FOCUS ON MEDICAL STUDENTS**

[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 Rubin recalled that a top priority for the UC Health strategic framework was the expansion of the healthcare workforce and UC-quality care to regions of the state that are medically under-resourced. This has been a particular challenge in two regions—the San Joaquin valley and the Inland Empire, which had the worst shortages of physicians and the lowest physician per capita ratios in the state for both primary and specialty fields.

Associate Vice President Deena Shin McRae observed that California needs more medical school graduates who remain in the state to train as residents and fellows and ultimately become fully licensed physicians, proportionately dispersed throughout the state to

adequately address the needs of California communities. However, there were barriers with key training requirements and thus barriers to expanding existing medical schools or establishing new ones. The Liaison Committee on Medical Education (LCME) sets standards for the accreditation of medical schools, ensuring that students successfully complete clinical rotations in core disciplines under the appropriate supervision and instruction of Board-certified physicians with faculty appointments. For each of the training sites, the LCME has many specific requirements with which UC must comply to protect its accreditation status. For example, there must be diverse faculty and a student-to-faculty ratio that optimizes the learning experience.

Most faculty members at affiliate sites volunteer to teach and supervise and are not directly compensated for their time and effort. The required core clinical training experiences typically occur during the third year and include internal medicine, family medicine, pediatrics, surgery, psychiatry, and obstetrics and gynecology. The fourth year typically includes more advanced clinical rotations and electives. Medical school graduates then continue their training in a residency program for a particular specialty. The Accreditation Council for Graduate Medical Education (ACGME) has strict specialty requirements as well to ensure competency. To meet all these requirements and successfully produce primary care and specialty-trained physicians, there must be reliable, long-term educational partners.

In cases of significant or full reliance on affiliate sites, as for UC Riverside and UCSF in the San Joaquin Valley, there were growing challenges to securing reliable clinical training experiences as well as qualified faculty who have the skills and available time to teach UC students. One of the key challenges was competition for training sites and clinical rotations. Over the years, there has been a substantial increase in the number of health professional schools and students, which has led to a heavier demand for clinical placements. Between 2010 and 2020, the total number of students enrolled in U.S. medical schools increased by 30 percent. The number of students enrolled in osteopathic schools of medicine was estimated to have increased by 50 percent during this time. Some schools leverage online curricula and expand class sizes, so that even if the schools are not located in California, their students might complete rotations here.

To maintain a high-quality learning environment and to comply with all accreditation requirements, there was a finite number of slots available for health professional training. There was a growing imbalance in supply and demand, with a much larger number of trainees versus number of rotations and available faculty, leading to increasing competition for rotations. Due to this dynamic, there was a growing trend of private institutions paying large sums of money to facilities for guaranteed training slots. This sometimes led to UC learners being excluded.

Other challenges included the financial pressures experienced by healthcare organizations and physicians. Due to economic hardship and high patient volumes, there was greater emphasis on clinical productivity for attending physicians, shifting time away from teaching. This was particularly a concern for volunteer faculty. Teaching a medical student is rewarding but often leads to fewer patients seen or longer work hours. These factors—

the accreditation requirements for graduation, the competitive market for rotations, financial pressures, and the availability of attending physicians—all affect the number of learners that a site can accommodate.

UC Riverside School of Medicine Dean Deborah Deas recalled that the School was established in 2013 with the audacious mission to train a diverse physician workforce and develop clinical programs and research programs to serve the people of Inland Southern California. This was a mostly underserved population with a shortage of both primary care and specialist physicians. There were 41 primary care physicians per 100,000 residents, when the recommended ratio was 60 to 80 per 100,000. When the UCR School of Medicine opened its doors, it enrolled 50 students. It currently had about 360 medical students and 44 percent of its student population were from groups underrepresented in medicine. The School was proud to report that, among its trainees, 40 percent remain in the Inland Empire to practice after completing their training.

The UCR School of Medicine was a community-based medical school and did not own or operate a hospital. It must develop affiliate relationships with multiple hospitals in order to secure a clinical platform to train its medical students and residents. The School's clinical training sites were dispersed throughout the Inland Empire. There was significant competition for clinical placements. The School constantly competed with other community-based medical schools as well as offshore medical schools for training sites. The UCR School of Medicine must make a significant investment to ensure the quality of medical education at affiliate sites. UCR must pay site directors and coordinators to ensure that learning objectives are adequately implemented and to maintain LCME accreditation standards. In some cases, for training sites in distant locations, UCR must provide housing for its students.

There were challenges and limitations in having a community-based model and a medical school without a hospital. With no hospital, there was no clinical income flow from the clinical enterprise to the academic enterprise. The School had recently opened a new building and had room to accommodate 500 students, but did not have a path to increase enrollment to 500 students due to the limitations imposed by UCR's affiliate partners. There were sometimes questions about the quality and stability of clinical partners, whose mission might not be in alignment with UCR's mission. UCR had a primary partner for medical education, and about 90 percent of its residency and fellowship programs were housed at one hospital. However, this was not enough to provide essential clinical training sites and UCR needed other partners as well. The UCR School of Medicine was exploring opportunities for new hospital partners as well as opportunities for ownership of a hospital.

UCSF Executive Vice Chancellor and Provost Catherine Lucey recalled that UCSF and UCSF Fresno have been training doctors for the San Joaquin Valley since 1975, initially as a graduate education program with residents and interns, and since 2000 at a clinical training site for UCSF medical students who travel to the San Joaquin Valley for rotations that range from six weeks to six months and then return to San Francisco for the remainder of their clinical training. Fully 50 percent of the graduates of these residency and fellowship

programs at UCSF Fresno remain in that community, providing care and educating the next generation of UCSF physicians for the Valley.

Since 2020, UCSF and UCSF Fresno have partnered with UC Merced to expand medical education programs in the San Joaquin Valley to include an eight-year integrated baccalaureate/ M.D. program. This new program, known as San Joaquin Valley Programs in Medical Education (PRIME) Plus, recruits students from the Valley who are committed to remaining in and serving Valley communities. The program educates students entirely within the Valley: at UC Merced for the baccalaureate degree, at UC Merced for the first phase of the medical school non-clinical training, and at UCSF Fresno, where students complete the clinical aspects of their medical school training. This strategy of education embedded in a community that needs physicians provides the highest likelihood that students will remain in that community for the duration of their career. Dr. Lucey noted that the program would be welcoming its second class into UC Merced for the baccalaureate degree this month.

This work has also been designed to scaffold the development of a fully accredited, independent UC Merced medical school. Achievement of this exciting goal would require not only additional operating and capital funds as the class size increases from its current 12 to 15 to ideally 50, but, critically, greater availability and stability of clinical training sites in the San Joaquin Valley. Dr. Lucey stressed that, even if the program now received enough operating and capital funds to support a 50-student class, it would not be able to proceed until it had addressed the stability and expansion of clinical training sites. She presented a map of the San Joaquin Valley showing the two training locations that currently accepted UCSF students as well as a number of potential partners for future clinical training. Some of these sites were already training clinical students from outside the UC system, many from for-profit institutions in California, across the U.S., and abroad. This made it difficult to establish new partnerships due to the student-faculty ratio requirements mentioned earlier. It was difficult to obtain places for UC trainees in institutions already occupied with students from other programs.

In addition to a medical center willing and able to accept medical students for training, schools need committed faculty in these medical centers to supervise students and residents as they increase their clinical expertise. The UCSF School of Medicine in the Bay Area employs faculty and residents who provide clinical care at UCSF facilities and at major Bay Area affiliates. This decades-long model of School of Medicine employment allows for full alignment between the School and the medical centers. The UCSF School of Medicine recruits high-quality faculty and residents who provide care in these hospitals and, in turn, hospitals and owners of hospitals provide funds to the School of Medicine to pay salaries of faculty and residents and to support medical student educational programs.

UCSF had used a different model for its work in the San Joaquin Valley, but this model was becoming increasingly challenging, even for the current cadre of students, and for this reason, diversification and stabilization of clinical training sites was important. Community Regional Medical Center in Fresno, 685-bed community benefit hospital, has been UCSF's main partner.

Many hospitals do not employ most of the physicians who care for patients in their institution but rely on private practitioners or practices. These hospitals care for a high volume of Medi-Cal patients and are constantly managing financial stressors, which can result in frequent leadership changes. Funding for resident salaries and investment in education can change abruptly due to these financial challenges. This made it difficult to run an educational program in which UC commits to provide to any individual student or resident eight to 12 years of educational opportunity at a single site. UC Health would continue to work on existing and new relationships and ensuring resources needed for clinical training sites and faculty, but as a system, UC believed that there was a need to develop new strategies and incentives.

Dr. McRae stated that, in seeking solutions to preserve clinical rotations for its trainees at all levels, UC has tried to address the increasingly competitive market for clinical training experiences by establishing new affiliation agreements and revising existing agreements to ensure that they have carefully crafted language to protect UC students' and residents' training experiences. To incentivize physicians at affiliate sites to teach, UC offers faculty appointments, access to online library resources, a variety of professional development opportunities, and continuing medical education credit required by the Medical Board of California and specialty boards. To promote the financial stability of the healthcare environment, particularly healthcare organizations which serve a large Medi-Cal population, the University continues to strongly advocate on the State and federal level for improved reimbursement of clinical services, and UC medical centers have assisted and supported local community partners in various ways.

To increase funding and resources for medical education expansion, the University has advocated on the federal level to direct funds to public medical schools and underserved communities. UC has collaborated with other large organizations such as the Association of American Medical Colleges to lift the Centers for Medicare and Medicaid Services (CMS) cap and increase the number of Medicare-supported residency physicians. UC Health and UCSF have advocated and continue to advocate for support of the San Joaquin Valley PRIME Plus Program and the necessary infrastructure to set up a medical school in that region, and there was continuing advocacy for the UC Riverside School of Medicine. UC successfully advocated for support of PRIME in the 2021 State budget, expanding class sizes for medical students who are committed to providing care in shortage areas and to under-resourced populations.

Dr. McRae outlined some possible future strategies. One could preserve clinical rotations by increasing the number of UC-operated facilities in shortage areas. When faculty and staff are employed by UC, the University has more control over the quality of teaching and patient care, more effective oversight over instruction and implementation of the most up-to-date, evidence-based clinical practices. Having more UC-operated facilities and UC-paid faculty would help preserve clinical training experiences, improve health outcomes, and optimize compliance with the many accreditation requirements. Another strategy would be to increase the number of financial incentives for supervisors and affiliate hospitals and facilities to prioritize trainees from California public institutions, especially in under-resourced regions of the state. Some states have passed laws that provide tax

credits to individual supervisors, while other states have provided grants and other financial incentives to facilities that expand their capacity for clinical training. An ambitious idea would be to change the CMS reimbursement rules for both Medicare and Medi-Cal for teaching residents and students and to increase support of the teaching mission. There could also be loan repayment programs and other financial incentives for attending physicians for participating in the teaching and supervision of UC students. The University could advocate for policy and legislation to protect clinical experiences for trainees from California medical schools. The State might want to consider policies that incentivize medical facilities to prioritize medical students from in-state public institutions for clinical rotations; laws that limit the number or length of clinical rotations by health professional students from out-of-state and international schools; and laws that do not allow hospitals to accept payments for rotations. The State of Florida recently passed "Live Healthy" legislation, which directs that the State's Agency for Health Care Administration shall adopt rules which shall include reasonable and fair minimum standards for ensuring that a hospital does not accept any payment from a medical school in exchange for or directly or indirectly related to allowing students from the medical school to obtain clinical hours or instruction at that hospital. As a final possible strategy, Dr. McRae suggested that one could establish an Advisory Council to share expertise on medical education issues and provide guidance to the State. She concluded her remarks by emphasizing the good return on investment for UC medical school education, and that it was worth spending time and resources on protecting training experiences. Retention rates were high: 62.7 percent of physicians who graduate from medical school in California end up practicing in California, the highest percentage of any state in the nation, while the retention rate was even higher for UC medical school graduates at 68.6 percent. If an individual graduates from a California medical school and has completed a residency in the state, the retention rate was 81.5 percent.

Regent Batchlor commended UC Riverside and UCSF/UCSF Fresno/UC Merced on their outstanding results in increasing the physician workforce and the diversity of that workforce in the Inland Empire and the San Joaquin Valley. She suggested that they share information about their work and programs with other UC medical schools that were struggling to achieve diversity.

Advisory member Marks observed that ensuring the availability of training opportunities was a challenge for medical schools across the country. As medical schools expand their reliance on affiliated hospitals, it was important to consider the nature of the affiliation agreement. A hospital might view an affiliation agreement as a kind of adornment, without being willing to invest in the educational and training activities that allow for the affiliation. There were bad examples in the U.S. of hospitals not making long-term commitments to positions. Ms. Marks offered to further discuss and share her experience in this area.

Regent Reilly referred to the possible strategies that had been outlined. She asked that the presenters give the Committee and the Board two or three items, areas in which the Regents could help address the problem of securing adequate training opportunities for UC medical students. Dr. McRae responded that a finished plan would be developed, involving legislation and policy, and that the Regents' support would be welcome.

Regent Batchlor suggested that the UCR School of Medicine seek training opportunities outside the Inland Empire. Regents Batchlor's safety net hospital in South Los Angeles, MLK Community Healthcare, would be happy to host students from the UCR School of Medicine, and there might be other hospitals interested as well. She asked that Dr. Deas and the School follow up with her about this.

President Drake expressed concern about the new phenomenon of offshore and for-profit medical schools purchasing spaces at hospitals; this made one wonder about the quality of care and training at these sites. He reflected that UC's reason for providing health care was rooted in the need to support the training of its medical students. UC was a university, not a healthcare provider, as a primary business. UC must ensure that the care and training provided at affiliate sites is of the highest quality. The training of medical students has changed over time, with students now able to train using mannequins and to have learning experiences without having to go to remote sites. The University would continue to review educational objectives and means of training students other than the apprenticeship model in a hospital, particularly in undergraduate medical education. This would continue to evolve.

Regent-designate Komoto stated that Medi-Cal managed care programs in Riverside County and the San Joaquin Valley were interested in promoting medical training in these geographic areas. They were willing to invest and had resources to invest. Dr. Deas responded that UCR has explored this avenue. Some UCR School of Medicine students train at a County facility, but the capacity there for more UCR students was limited. Dr. Rubin confirmed that developing relationships with these County health plans was critically important, and UC Health was pursuing this.

Faculty Representative Cheung underscored the significant changes in medical education and training over the past three decades. The evolution of UC's commitment to the State and to the people of California to provide health care as a safety net hospital was creating challenges for training, the meaning of training, and the quality of training. He emphasized the importance of maintaining the high quality of training across all sites used by UC.

Advisory member Ong echoed the remarks of Dr. Cheung, adding that UC must ensure that it has the right kind of faculty to train future generations of healthcare providers. UC was a leader in educational innovation and should think about how it would include telehealth and new ways of interacting with patients in the training models for medical education in order to expand its reach to medically underserved regions.

6. **SPOTLIGHT ON INTEGRATIVE HEALTH ACROSS 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 Rubin introduced the item, in which representatives from UC Irvine, UCLA, and UCSF would discuss innovative research, expanding educational opportunities, and complementary clinical services offered to patients. A defining feature

of UC medical centers is their pursuit of innovation to improve the care of patients. In this case, attention to "whole person care" included a willingness to challenge orthodoxy and assumptions about Eastern versus Western medicine. As UC's integrative health centers grow, they are at the forefront of developing an evidence base that could support a broader holistic approach to the services UC Health can provide. This topic would encourage UC to think differently about health and health care using a combination of Eastern and Western medicine as well as the critical components of self-care and wellness.

Shelley Adler, UCSF Professor and Director of the UCSF Osher Center for Integrative Health, explained that five UC schools currently had integrative health centers. Two concepts were foundational to the work being presented in this discussion: integrative health and whole person health. The National Institutes of Health (NIH) define integrative health care as a combination of complementary and conventional therapies that comprise a patient-centered, evidence-informed approach. Whole person health involves looking at the whole person, not just separate organs or body systems, and considering multiple factors that promote either health or disease. Whole person health considers individuals in their full environmental context, taking into account the complex interplay of factors that contribute to overall well-being.

The three UC programs being presented in this discussion took a holistic approach to integrative health, with education programs to teach people the science and principles of integrative health, the provision of integrative health care to patients, and rigorous research to provide evidence to advance the field. UCSF used the term "integrative health equity" to indicate the ultimate goal of achieving optimal health for everyone through a whole person approach that recognizes the cultural, social, and structural determinants of health.

With respect to education, the UC integrative health centers addressed the needs of students, trainees, faculty, staff, and the community. Their goal was not just to increase awareness of the widespread use of these modalities but also to understand their safety and effectiveness when integrated into conventional medical settings. This was one of the great strengths of integrative health across the UC system—the way that it was integrated into biomedicine. Core integrative health content was required of all medical students. Whether or not a student was planning to practice integrative medicine, it was important to be aware of the principles and evidence. More than one-third of the general population in the U.S. used some form of complementary and alternative medicine regularly, and over three-fourths of cancer survivors reported use in the previous year. Future physicians clearly need to understand who uses which form of medicine and why, as well as the outcomes of use, so that they can provide optimal and coordinated care.

The field of academic integrative health was still relatively new, and UC recognized that to provide the highest quality of care, it needs to accelerate the efforts of its training programs. UC Health used a "grow your own" model for a faculty development. The three campuses in this discussion provided fellowship training. UCSF, for example, had a faculty fellows program that provides specialized advanced training for currently practicing physicians and nurse practitioners. UC Irvine had an integrative nursing initiative through which fully 93 percent of inpatient nurses have been trained in the principles and practices

of integrative nursing care. Educational programs also included training in integrative health research. UCSF's NIH pre- and postdoctoral fellowships trained 14 fellows each year to conduct research that advances the field by solidifying the evidence base and by helping to increase the capacity and diversity of the integrative medicine research workforce. These fellowships, like clinical fellowships, form an important pipeline to being hired as faculty at UC's centers. UC integrative health centers' goal was to provide the highest-quality integrative medicine education and training to current and future healthcare practitioners and researchers in the UC system and beyond. As UC centers increasingly collaborated across schools and health systems, they built on each other's unique strengths to advance the collective mission.

Katie Hu, Associate Clinical Professor in the Department of Medicine and the Associate Director of the UCLA Health Center for East-West Medicine, discussed clinical practice and drew attention to variation among the UC integrative health clinical programs. Services varied by institute and not all services were available at each institution. Patients come to UC's integrative health centers for a variety of reasons. Many come to UC as the last resort due to persistent symptoms and suffering despite standard of care. Examples of conditions included fibromyalgia, a chronic pain condition; tinnitus, ringing of the ears; irritable bowel syndrome; and chemotherapy-induced side effects. Some patients seek out UC for alternative pathways to medication therapies, either because they prefer not to take medications or because they are unable to tolerate medications due to side effects. Other patients come to UC for guidance on how to be the healthiest version of themselves, to prevent chronic illness, and to improve quality of life and longevity.

Regardless of the patient's reason for seeking care, all UC programs have a team-based approach and offer integrative medicine consultations from M.D. and D.O. physicians. These consultations focus not only on the presenting symptom but also emphasize the concepts of lifestyle and self-care, and address root factors such as psychological and social determinants of health. UC programs included integrative primary care as the first line of access to care, but also offered many forms of subspecialty care including oncology, cardiology, sleep medicine, gastroenterology, and others. The integrative health teams also work with clinicians such as health coaches and psychologists.

Dr. Hu presented a hypothetical example of a patient with chronic low back pain. The patient might begin with an integrative medicine consultation from a physician to help them understand all the factors contributing to the pain, and subsequently be referred to an acupuncturist to address the pain itself, to a nutrition therapist to reduce inflammation from dietary sources that are further affecting the condition, to a cognitive therapist to address the emotional component of the chronic pain, and finally to physical therapy to stretch and strengthen core and back muscles. This comprehensive approach not only alleviates the pain but prevents it from returning. It was one thing to guide patients on what to do but another to teach them exactly how to do it and to give them the lifelong skills in taking care of themselves. This whole person approach accounted for consistently high patient satisfaction scores among integrative health clinicians.

The clinical care models for UC's integrative health services were variable, but all UC integrative health centers were primarily insurance-based, and all accepted Medi-Cal. For services not covered by insurance, UC offered low-cost, cash-based options and, due to high demand and long wait times, all UC centers had extended hours, including nights and weekends. UC has added group medical visits, which were also insurance-based. Group visits help to improve access but have also been shown to improve practitioner well-being and reduce burnout. They were also a financially sustainable model. For those unable to get in as patients, UC offered education on whole person health through community lectures, undergraduate courses, public education classes such as those at UCSF, and online social media content. UC also offered conferences and community seminars each year open to the public. UC centers also expanded access to integrative health by training other healthcare professionals who then disseminate this knowledge in their practice departments and institutions. All the centers offered "train the trainer" courses for physicians, nurses, and other allied healthcare professional colleagues.

Community engagement and health equity for underserved communities were priorities for all UC's integrative health centers and medical centers. UCLA and UC Irvine had formal partnerships with Federally Qualified Health Centers (FQHCs) serving primarily the Medi-Cal and uninsured populations, and this allowed UCLA and UCI to replicate their integrative health services within these communities. This year, UCI launched the first teaching kitchen program in the country at an FQHC and UCLA created a 40-hour integrative health curriculum to teach healthcare providers from three Los Angeles County clinics about non-pharmacological- or non-medication-based therapies for chronic pain. Dr. Hu asserted her belief that the integrative health model offered solutions to gaps in care. It was a model that was inherently proactive, driven to address root causes, and truly preventative. She believed that all patients from all communities would benefit from this model.

Shaista Malik, Professor in the Department of Medicine, Division of Cardiology, and the Founding Associate Vice Chancellor of Integrative Health at UC Irvine, discussed the research mission of integrative health. In order to incorporate the nascent field of integrative health broadly across an enterprise, one needed evidence not only about the mechanisms of integrative health modalities across cellular and molecular pathways but also about how this form of medicine and the framework of the whole person can improve patient outcomes and result in cost savings. This research was occurring at UC campuses, and much of it was funded by the NIH. The NIH has an institute dedicated to this field, the National Center for Complementary and Integrative Health (NCCIH). One NIH-funded research study examined acupuncture's mechanism of action. Acupuncture was long thought to be a placebo, like many other integrative health modalities. UC was using modern bench science to show that molecular and genetic pathways and neural circuits are involved in acupuncture. One study demonstrated how these mechanisms work in lowering blood pressure in patients with hypertension.

UC has also been examining how integrative health has affected patient outcomes and cost effectiveness. At UC Irvine, an observational study using data from over 4,000 non-intensive care unit hospitalized patients receiving acupuncture compared to patients who

did not receive acupuncture within the same diagnosis-related group showed that hospitalized patients receiving acupuncture had a length of stay shorter than expected and were discharged earlier. This produced cost savings of approximately $10,000 per patient and saved the enterprise $4.5 million over the course of the year. Similarly, a study at UCLA showed an 85 percent reduction in 30-day readmissions among patients receiving integrative care.

UC research in this field also extended into program evaluation, assessing not only the wellness and well-being of patients but also that of the care team. Integrative health programs on nutrition, mindfulness, and acupressure offered to UC faculty and staff resulted in lower measures of burnout, stress, and anxiety. A well-being program launched at the height of the COVID-19 pandemic with funding from the Office of the President reached all ten campuses, and nearly 10,000 faculty and staff participated in this program over the course of two years. After the program ended, UCI was able to find local resources to continue the program and these efforts were recently recognized by the American Medical Association with the "Joy in Medicine" award, with UCI identified as one of 28 enterprises in the nation prioritizing and championing physician well-being.

Integrative health was a new field that the UC system has pioneered over the last two decades. The momentum UC Health has built with the collaborative of its integrative health centers put UC in a position to be a national leader in this field. Dr. Malik outlined some challenges. First, in order to meet patient access demands, one needed a larger integrative health workforce. Currently, only two percent of physicians were trained in integrative medicine, and the robust education and training programs across the UC system needed to grow to increase this capacity. Second, UC has been successful in creating sustainable programs but needed a cost model that would work in all care settings. True integration of these services might require examining the possibility of integrative medicine units within UC's cost structure. Third, UC needed to continue building the evidence base. UC's centers for integrative medicine were collaborating on grant opportunities such as UC systemwide funding through the Office of the President for multicampus research programs and initiatives and sought funding to continue their shared work on efforts to increase health equity using integrative health programs. Data coordination was a central element of work in the UC system. The UC centers have started to generate single-site data on patient outcomes and cost benefit, but by leveraging data more widely, UC could begin to show at a national level how, at multiple sites and across diverse populations, one can improve patient outcomes and experience, improve population health, reduce cost, increase care team well-being, and advance health equity.

Regent Reilly asked if there were specific data points showing improved outcomes for particular diseases or pain management, statistical data that the speakers could share. Dr. Malik responded that the specific outcomes she had shared came from the Patients Receiving Integrative Medicine Interventions Effectiveness Registry (PRIMIER) study. UC's integrative health programs were part of the BraveNet collaborative, a practice-based research network. The study showed reductions in pain and stress and improvements in the Patient Activation Measure, a new patient-reported outcome linked to lower utilization of urgent care and the emergency department. She stressed the importance of giving patients

agency, which included self-care and building on the foundations of health in areas like nutrition and mindfulness. Patient agency combined with the contributions of healthcare professionals leads to an enhancement of health, as shown in publications from this study.

Regent Batchlor noted that one speaker had used the term "evidence-informed" in discussing integrative medicine and requested clarification of the difference between this term and "evidence-based." She asked why one would promote an evidence-informed approach rather than an evidence-based approach. Dr. Malik responded that, in traditional disciplines in medicine like cardiology, one is used to 10,000-person randomized control trials. The new field of integrative medicine did not have this kind of study and chose to describe small studies as evidence-informed. There were currently more data on the safety of integrative medicine approaches than on their efficacy. Nevertheless, the Department of Veterans Affairs (VA) has decided that some integrative medicine makes common sense and was using these approaches, which were known to be safe and not cause harm, while data were being gathered on their efficacy.

UCLA Health Sciences Vice Chancellor John Mazziotta stated that he had been impressed by the neurophysiological responses to acupuncture and acupressure. While there might not be an evidence base for outcomes, there was an evidence base in terms of the physiology of the nervous system. As the base of information and basic science grows, one would begin to understand the molecular, physiological, and other aspects of some traditional medical treatments that were effective and have been used for millennia.

Advisory member Ong noted that the VA has long recognized the value of complementary and integrative health approaches. The VA's Complementary and Integrative Health Evaluation Center was based in Los Angeles and led by UC faculty. He expressed confidence that one would move quickly from evidence-informed discussions to evidence-based discussions. UC was a national leader in this field, and it was exciting to hear about this research, education, and clinical practice.

Dr. Hu recalled that the VA had released a study the prior year showing that, among patients who received integrative or whole health treatment versus those who did not, opiate use decreased by over 30 percent. Patients who received integrative health treatment were able to reduce pain and stress and were much more engaged in their self-care. This fueled more revenue and funding for the program.

Dr. Adler commented that one speaks of this field as being evidence-informed, but there were modalities with a sufficient base of evidence that allowed one to say that they were evidence-based. The field in general was evidence-informed, but there were pockets of well-done research that provided a base of evidence, such as different types of mindfulness interventions for depression.

The meeting adjourned at 1:25 p.m.

Attest:

Secretary and Chief of Staff