The Regents of the University of California

HEALTH SERVICES COMMITTEE
March 18, 2025

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 Leib, Makarechian, Matosantos, Park, and Sures; Ex officio members Drake and Reilly; Executive Vice President Rubin; Chancellors Frenk, Hawgood, and Wilcox; Advisory members Marks and Ong

In attendance: Regents Anguiano and Beharry, Regents-designate Brooks and Komoto, Faculty Representative Cheung, Secretary and Chief of Staff Lyall, General Counsel Robinson, Provost Newman, Executive Vice President and Chief Financial Officer Brostrom, Executive Vice President and Chief Operating Officer Nava, Senior Vice President Turner, Vice Presidents Brown and Lloyd, and Recording Secretary Johns

The meeting convened at 4:00 p.m. with Committee Chair Sures presiding.

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

Upon motion duly made and seconded, the minutes of the meeting of January 23, 2025 were approved, Regents Drake, Leib, Makarechian, Matosantos, Park, and Sures voting "aye."[1]

2. **APPROVAL OF MARKET-BASED SALARY ADJUSTMENT FOR JOHNESE SPISSO AS PRESIDENT, UCLA HEALTH SYSTEM AND CHIEF EXECUTIVE OFFICER, UCLA HOSPITAL SYSTEM, LOS ANGELES 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 market-based salary adjustment for Johnese Spisso as President, UCLA Health System and Chief Executive Officer, UCLA Hospital System, Los Angeles campus:

A. Per policy, a market-based salary adjustment of 17.3 percent ($316,622), increasing Ms. Spisso's base salary from $1,824,578 to $2,141,200 as President, UCLA Health System and Chief Executive Officer, UCLA Hospital System, Los Angeles campus, at 100 percent time. Ms. Spisso will remain eligible for consideration for any 2025 systemwide salary program increases in accordance with University-wide guidelines.

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

B. Per policy, continued 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 ($428,240) and a maximum potential award of 30 percent of base salary ($642,360), subject to all applicable plan requirements and Administrative Oversight Committee approval. Any actual award will be determined based on performance against pre-established objectives.

C. Per policy, continued eligibility to participate in the Clinical Enterprise Management Recognition Plan's (CEMRP) Long Term Incentive (LTI) component, with a target award of ten percent ($214,120) of base salary and a maximum potential award of 15 percent ($321,180) of base salary, subject to all applicable plan requirements and Administrative Oversight Committee approval. 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.

D. Per policy, continuation of standard pension and health and welfare benefits and standard senior management benefits, including continued eligibility for senior management life insurance and for executive salary continuation for disability (for which she is eligible and vested as a result of five or more consecutive years of Senior Management Group service).

E. Per policy, continued eligibility to participate in the UC Employee Housing Assistance Program, subject to all applicable program requirements.

F. Per policy, continuation of the monthly contribution to the Senior Management Supplemental Benefit Program, subject to all applicable program requirements.

G. Per policy, continuation of an annual automobile allowance of $8,916.

H. Ms. Spisso will continue to comply with the Senior Management Group Outside Professional Activities (OPA) policy and reporting requirements.

I. This action will be effective March 1, 2025.

The compensation described above shall constitute the University's total commitment until modified by the Regents or President, 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.]

Committee Chair Sures briefly introduced the item.

Upon motion duly made and seconded, the Committee approved the President's recommendation, Regents Drake, Leib, Makarechian, Matosantos, Park, Reilly, and Sures voting "aye."

3. **ADVANCING EQUITABLE MATERNAL CARE: AN UPDATE FROM THE UNIVERSITY OF CALIFORNIA HEALTH CLINICAL QUALITY COMMITTEE**

[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 prefaced this discussion by referring to the magnitude of events that had occurred since January 2025. This was an extraordinary time in the U.S., and one must acknowledge the fear and uncertainty felt across the UC Health campuses, in particular because many UC Health programs might be affected by federal governmental actions. UC Health employees were spending a great deal of time preparing for and navigating these challenges, while remaining true to UC Health's mission and values. Patient volumes at UC facilities were higher than they have ever been. UC researchers were trying to navigate a difficult situation in the face of immediate threats to scientific research, while educators remained focused on training the healthcare workforce. The following discussion about equitable maternal care was an example of UC Health's focus on its core mission and values.

Interim Chief Clinical Officer Robert Cherry observed that UC Health's efforts to improve maternal care address essential UC goals for positive outcomes in equity, patient and clinical experience, safety, quality, efficiency, and value. UC considers the various factors that affect outcomes. These can be related to science and evidence-based practice as well as environmental and socioeconomic factors. It is UC Health's obligation to understand why the same intervention can produce different outcomes for different individuals, groups, and subgroups.

UCSF Adult Services Chief Medical Officer Nerys Benfield referred to the substantial inequities that exist in maternal care and outcomes, especially for Black-identified patients. These disparities continued to exist despite efforts focused on improving maternal care overall, and this issue has been reported and discussed in news media. UC Health examines maternal mortality and maternal morbidity. Severe maternal morbidity is defined as a delivery or procedural complication with significant and organ damage. Maternal morbidity and mortality were increasing overall. Dr. Benfield presented a chart with the pregnancy-related mortality ratio in the U.S. from 1987 to 2021, and which showed a sharp increase in 2019 to 2021. She explained that the increase was due to the COVID-19 pandemic, as pregnant individuals were significantly more vulnerable to contracting COVID and experiencing severe illness compared to others. Fortunately, the ratio had again decreased to 2019 levels, but the overall trend and number of pregnancy-related deaths had been increasing since 1987. In part, this might be due to improved documentation. At the state level, maternal mortality commissions have worked diligently to ensure that they are capturing data on pregnancy-related deaths. The increase also indicated an increasing prevalence of comorbidities among pregnant patients such as

cardiac disease, hypertension, and diabetes. More recently, increasing rates of mental health conditions, including addiction, were adding to this number.

As was the case for many other health conditions, there were substantial disparities by race and ethnicity with respect to maternal mortality in the U.S., with more than double the rate of death among Black-identified patients. This unfortunate and dramatic statistic motivates UC Health to action. The maternal mortality rate in California was lower than the national average, at ten to 12 per 100,000 live births. Nevertheless, the California average covered a wide range of geography, patient populations, patient access, and social and environmental health factors.

Dr. Benfield presented a map of California showing variations in the median days to the first prenatal care appointment, which has an impact on maternal outcomes. The map clearly indicated disparities across the state. Preliminary analysis has shown that UC Health, like the state and the nation, has disparities in severe maternal morbidity for Black-identified patients, patients with government insurance, and patients who have limited access to prenatal care. These data would guide UC Health in pursuing opportunities to minimize these disparities.

Dr. Cherry discussed UC Health's efforts to reduce severe maternal morbidity and address conditions that are recognized by the Centers for Disease Control and Prevention as criteria for this morbidity. UC was analyzing data and trying to identify the causes of disparities among groups. The first and foremost objective was to improve access and ensure timely access to prenatal care. One wished to avoid excessive wait times beyond five days. UC Health was carefully monitoring differences among its medical centers in complications in maternal care, trying to understand the reasons for these differences, and seeking to integrate evidence-based practices into the electronic medical record. UC would leverage its electronic medical records to lower complications due to hypertensive disorders, renal failure, sepsis, and acute heart attacks and promote consistency of practice among UC institutions. In different parts of the state and in different communities, the solutions for increasing access to prenatal care and improving maternal care would vary. Each UC medical center would study this question in order to understand its impact within the local context. If UC Health's efforts are successful, they should lead to a reduction in severe maternal morbidity, even among patients who do not receive prenatal care from a UC physician. UC was striving to provide access to screening programs for high-risk pregnancies. About 400,000 live births occur each year in California. While UC medical centers take care of only a small proportion of these, UC cares for many patients with high-risk pregnancies.

Committee Chair Sures referred to patients with mental health, drug addiction, and comorbidity issues. He asked if this group, mothers delivering with these issues, was the highest-risk group, and if the problem could be solved more quickly if these patients received UC care at an early stage. Dr. Cherry responded in the affirmative. UC wished to redefine the term "high-risk pregnancy." Individuals might have healthcare challenges that UC Health should address before pregnancy. Subject matter experts were studying how to identify and work with these patients and perform effective preventative measures. High-

level data indicated that this was particularly a matter of concern for the Black/African American and Medi-Cal patient populations, and for those who experience delays in receiving prenatal care. Dr. Benfield commented that, in addition to addressing comorbidities and various conditions in advance, one must consider transitions of care during the postpartum period as well. This period also carried a substantial burden of maternal mortality. It was important to use the labor and delivery care event as an opportunity to arrange continuous care for the patient if this had not already been done.

Committee Chair Sures asked how long after delivery there was a risk of maternal morbidity. Dr. Benfield responded that this risk, related to the conditions of pregnancy, lasted for a period of up to a year after delivery. Dr. Cherry added that postpartum depression was a major issue that needed to be tracked.

UC Health was making progress in the area of patient access. Dr. Cherry presented a chart showing the median number of days before the first prenatal visit. This number had decreased during 2024. He then presented a chart showing percentages of risk-adjusted severe maternal morbidity at UC Health by ethnicity from July 2023 to June 2024. There were obvious differences among groups, and UC Health wished to ensure that all groups were below a certain target. Dr. Cherry concluded the presentation with questions for the Committee. In order to advance equitable maternal care, were there other milestones that UC Health should try to achieve? Were there other strategic partnerships that UC Health should consider?

Regent-designate Brooks commented that the situation of maternal mortality rates for Black women far exceeding the rates for all other groups was not merely a health disparity but a public health emergency that called for immediate and comprehensive action. This issue affected not only low-income women, but Black women across the income span. Doulas were a major source of support and education for pregnant women. She asked why UC only had volunteer doula programs. It would seem incumbent upon the UC system to identify and acknowledge doulas as a marketable asset and worthy of a certification program as well as being an integral part of the healthcare system. Recognition and expansion of doula services would help to decrease the maternal mortality statistics that had been presented. She asked about a timeline and accountability measures and by what criteria and benchmarks UC Health would measure its progress in advancing equitable maternal care for Black women and women in general, and how leadership would be held accountable. Dr. Cherry responded that, with respect to a timeline, UC Health was in the first year of a three-year initiative. The objective was to ensure that milestones listed on a slide earlier were met—reduction in wait times, clinical pathway integration, removal of barriers to care, effective local interventions, and reduction in severe maternal morbidity. The last goal, reduction in severe maternal morbidity, had a specific benchmark of a five percent reduction among patients who have not received prenatal care within the UC system. He agreed that doula services were an evidence-based practice that UC should strive to develop. UC Health would review its doula services and variations among programs, identify best practices, and try to ensure that programs are consistent across the UC system. Dr. Benfield outlined efforts at UCSF for the sharing of best practices. UCSF

had almost eliminated disparities in cesarean sections, and she underscored that this required many layers of work.

Regent-designate Komoto asked if UC Health would seek to partner with organizations such as Medi-Cal managed care plans in particular regions and with interest in particular populations. One example was asthma in Kern County, which was a major problem. Payments provided to providers and pharmacies were not sufficient to cover extra time for effective interventions. Mr. Komoto's organization discussed this with the local health plan. Community health workers became involved, met with patients early on, and were able to intervene and change the course of the disease and improve patients' situations. He believed that health plans would be interested in trying to support UC Health's effort, which had specific targets. Dr. Cherry responded that UC Health was interested in these types of strategic partnerships, including with counties and Federally Qualified Health Centers, especially at a time when obstetrical programs around the state have been closed. Medell Briggs-Malonson, Chief of Health Equity, Diversity and Inclusion for the UCLA Hospital and Clinic System and Associate Professor of Emergency Medicine, explained that part of this initiative was a partnership not only among UC clinicians and health equity leaders but with the community, including health plans. UC has already started discussions with multiple health plans throughout the state to ensure that services are combined. Health plans often included paid doula services and other comprehensive services. This was an effort to ensure that all these entities are working together to save lives and prevent harm. Dr. Briggs-Malonson confirmed that maternal mortality outcomes for Black women cut across different socioeconomic and educational backgrounds. The reasons for this needed to be better understood to advance care and prevent harm. UC Health would take a comprehensive approach to this work to ensure optimal outcomes for all women in California.

Regent Reilly asked if there were communities within UC Health that had been particularly successful in reducing mortality rates, or if there were model programs. Dr. Benfield responded that there was no one health system that came to mind. There were programs and initiatives that have an impact, but no one has solved the problem. Knowledge gained across UC Health would have an impact for UC and would be useful for others as well.

Staff Advisor Frías referred to the chart shown earlier indicating that the median number of days before the first prenatal visit had decreased during 2024 from seven to six days. She doubted that this fact would make much difference when contributing factors to maternal mortality were diabetes and hypertension. While the goal of reducing the number of days before the first prenatal visit was a good one, intervention needs to take place over a much longer period and health factors need to be addressed long before a person even becomes pregnant. Dr. Benfield responded that this statistic was a process indicator which reflected UC Health's efforts to prioritize access and to begin care early. The earlier a patient is in care, the better the outcomes. The difference of one day might mean substantial improvements for some patients. UC Health wishes each campus to improve early prenatal care access.

Ms. Frías stressed that diabetes and hypertension must be addressed. Dr. Rubin responded that UC Health has a vibrant population health program and emphasized that UC Health has been making a special effort in the management of hypertension and diabetes systemwide for several years. He believed that UC Health outcomes in this area were among the best in the U.S. Dr. Briggs-Malonson added that each step of this initiative was meant to get closer and closer to the goal of addressing not only medical factors but social factors that contribute to poor outcomes as well. Seeing as patients as soon as possible was one step in this initiative.

Regent Anguiano referred to the BLACK Wellness and Prosperity Center in Fresno, which trains doulas and promotes culturally competent care. She asked how UC Health works together with organizations like this. Dr. Briggs-Malonson responded that most of the UC Health locations have partnerships with doula programs or other community-based organizations focused on improvement of maternal outcomes. UC Health wished to strengthen these partnerships and ensure that they are embedded in UC practices. UC Health wished to engage more doula services but also more health professional intermediaries, individuals, who might be UC employees, who assist patients with navigating the healthcare system and serve as a bridge between the community and UC Health. UC Health sought to strengthen partnerships with community-based and public health programs, bring more services in house, and develop additional innovative solutions.

Regent Beharry drew attention to the NIH Implementing a Maternal health and PRegnancy Outcomes Vision for Everyone (IMPROVE) Act, co-sponsored by California Senator Laphonza Butler and Alabama Senator Katie Britt in 2024, which would authorize $53 million in funding to address infant mortality. UC should advocate for this bill.

4. **STUDENT HEALTH SERVICES AT A CROSSROADS**

[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 the discussion by noting that the student health services function was different on every UC campus. The services, a variety of physical and mental health services, came under the authority of different vice chancellors. There was a complex shared governance process at the campus level and at the Office of the President (UCOP). A number of converging challenges at this time warranted a discussion about how this function should develop.

Committee Chair Sures underscored his concern about the viability of UC student health services and the significant economic challenges to the provision of these services. The governance and reporting structure varied among the campuses. UC must identify systemwide best practices and determine how it can offer these services to students with the shortest wait times with the best quality of service possible and how it can recruit and retain good personnel.

Dr. Rubin underscored the high quality of UC student health services. When students graduated or left the University, they were unlikely to find the same kind of access, service coordination, and focus on overall wellness that were provided at UC. Over time, the variable use of campus fees and the lack of growth in these fees has led to declining student service fee support as a proportion of the budgets for these programs. This created a challenge for the underlying budget. UC has experienced staff recruitment and retention challenges, in part as a consequence of the COVID-19 pandemic, and in part due to the overall difficulty of recruiting primary care physicians and nurse practitioners in California. There were challenges in care management and information technology and ensuring support and maintenance of the electronic medical records system. Following COVID-19, there was also a change in the behavior of students who, rather than accessing student health services, were disproportionately using emergency department services. UC's ten student health programs were all in different situations, but all the programs faced these emerging challenges in one way or another. In addition, there were challenges related to the UC Student Health Insurance Plan (UC SHIP), the cost of medical supplies and pharmaceuticals, appropriate billing, and appropriate drawing down of Medicaid or Medi-Cal funding. There was a variety of payers for UC students, and while UC SHIP covered just under half of UC students, a large number of students was covered through employer-based insurance, some with individual plans and a small minority covered by Medi-Cal.

Committee Chair Sures asked how UC SHIP was funded, how it received revenue and built its revenue base in order to pay out claims. Executive Vice President and Chief Financial Officer Brostrom explained that under UC SHIP, students pay a premium for the year which covers care at the student health centers and external care. Following COVID-19, there was an increase in use of emergency room, mental health, and pharmacy services, and UCOP had taken measures to standardize and stabilize premium increases. UC SHIP compared well to Covered California in terms of cost to students and quality of services.

Regent Leib asked how much students pay for UC SHIP. Mr. Brostrom responded that the cost varied by campus and for undergraduate and graduate students. The lowest cost was at UC Riverside, with a per annum cost of $2,500 for undergraduates and $6,000 to $7,000 for graduate students.

Committee Chair Leib asked about the Student Services Fee. Mr. Brostrom responded that this fee varied by campus and had to be approved by a student vote. In response to another question by Committee Chair Leib, he confirmed that the Regents did not have control over this fee.

Regent Leib asked about the low percentage of students covered by Medi-Cal, reported as seven percent according to the background material provided. This seemed low, given the fact that about 35 percent of UC undergraduate students were Pell Grant recipients. Dr. Rubin concurred that this was a surprising percentage. This might be due to greater difficulty in enrolling in Medi-Cal and securing coverage. UC SHIP might have replaced Medi-Cal for some students over time. As UC Health studies the problems of third-party billing, it would gain a better understanding of decisions that some families were making. Mr. Brostrom added that the low cost of UC SHIP and the fact that it was covered by

financial aid motivated students to choose UC SHIP. When undergraduates come to campus, they must use an opt-out waiver in order to use their parents' insurance, Medi-Cal, or other commercial coverage, so it might sometimes be easier simply to enroll in UC SHIP.

Dr. Rubin again underscored the complexity of the shared governance of student health services, with multiple parties owning a part of the decision-making and a need for strong collaboration. At UCOP this oversight was shared by Academic Affairs, which oversees the overall student experience, accessibility, and the impact of student fees and costs; UC Health, which advises on clinical quality and patient safety and accessibility with student health directors, clinical practice standards, policies, and guidance; and UC Finance, through the Risk Services program, which focuses on systemwide budget strategy, resourcing, and UC SHIP administration. Over the last year, there has been a great deal of work at UCOP to bring these parties together to review critical improvement projects that extend through the governance hierarchy, including campus administrators and student health center directors and leaders. Student health directors have been working together on improving after-hours services, service optimization focused on decreasing emergency department use by students, and a third-party billing assessment. Some campuses would charge an access fee for student health in lieu of third-party billing because they lacked the capacity for third-party billing, and an ongoing project was seeking to improve this capacity. UC Health was integrating Medi-Cal reimbursement into its strategies as well as seeking ways to draw down health plan and county funding to support campus programs. UC San Diego has implemented the Epic electronic health records system, and other campuses were interested in moving in this direction. There were budget considerations and risks as UC Health studies value propositions to improve pharmaceutical reimbursement and reduce costs to students through UC SHIP. In this environment of significant challenges, each campus was working through issues in the context of its unique history, considering incremental improvement measures or the role of academic medical centers in student health programs.

Denise Woods, UC Riverside Vice Chancellor for Health, Well-Being, and Safety, explained that Health, Well-Being, and Safety at UCR comprised nine departments: student health, counseling and psychological services, basic needs, campus advocacy, resources, and education (CARE), case management, the student disability resource center, the crisis intervention response team, the health education team, and UCR police. This structure allowed the campus to take a holistic approach to student health, build students' help-seeking skills, streamline access to resources for students, and help build lifelong health skills. UCR was able to examine trends and information across the entire division and develop programs and services to address students' challenges and concerns. UCR has been able to integrate and elevate the level of care for its students with services located together as well as a satellite space for both health education and basic needs. If students come in to see a counselor, clinician, or provider and are having challenges with meeting their basic needs, they can get food on the spot and talk to someone about resources. UCR had a structured teamwork approach, and all the departments collaborated well. At least once a year, departments were randomly assigned to each other to partner and review information and data that both were collecting, so that they could have a targeted outreach to students.

In April, the disability resource center would partner with the crisis response department to put on a program for graduate students specific to that population and its needs. Health, Well-Being, and Safety thought of itself as the public health department for UCR and was able to share costs across the division. Ms. Woods stated that she felt fortunate to be in a system that understands that one size does not fit all and on a campus where leadership has prioritized the health and well-being of students, allowing for a holistic approach.

Pablo Reguerín, UC Davis Vice Chancellor for Student Affairs, noted that his remarks were made on behalf of his campus and of the UC vice chancellors for student affairs who have student health services in their reporting area, which was the case at most campuses. These campuses were committed to delivering high-quality student health and counseling services in a financially sustainable way for students both with and without UC SHIP coverage. As mentioned by Ms. Woods, it was vitally important to serve students holistically through an ecosystem of coordinated support across multiple areas—healthy living, medical services, counseling, case management, campus recreation, and wellness—and by meeting students where they are. UC vice chancellors for student affairs believed that this could be achieved by partnering with students, UC Health leaders, and policymakers. Although vice chancellors had not always been included in the discussion, they were committed to increased engagement across reporting areas. One must consider that UC campuses varied widely in geographic location, community health providers, and resources available in the region. Some campuses had medical centers, others not, and there were different funding sources with different student referenda. If UC policies and practices did not consider this variation, the system would end up with winners and losers, especially if there was not enough flexibility considered at the onset and design stage of policy development. The vice chancellors welcomed high standards and would collectively meet the significant challenges facing student health services. They were in strong support of collaboration and saw Student Affairs divisions at UC as drivers and partners in tackling the challenges and exploring the opportunities presented in this discussion. At UC Davis, UC Davis Health provided specialty care at the student health center, and leadership teams were embarking on a renewed and deepened partnership to maximize opportunities. Mr. Reguerín concluded that UC would be better positioned to tackle the core and underlying issues in this discussion through a collaborative approach that considers the local context and students.

Dr. Rubin noted that the following two speakers were student health directors, one from a campus with a medical center, and one without, and they would compare their experiences.

Edward Junkins, UC San Diego Executive Director of Student Health and Well-Being, explained that his division included physical health, counseling and psychological services, health promotion, analytics, and strategic planning. Dr. Junkins reported directly to UC San Diego Health Chief Executive Officer Patricia Maysent and worked closely with Vice Chancellor for Student Affairs Alysson Satterlund. About five or six years prior, student medical records were converted to the Epic system, so Student Health and Well-Being had gained experience with Epic, including analytics and population-based decision making, and was able partner with and draw on the resources of UCSD Health in population health, infrastructure, information technology, and analytics. This partnership allowed Student

Health and Well-Being to expand third-party billing and Medi-Cal opportunities. The partnership with UCSD Health did not come at a cost to holistic, student-centered care, and the partnership with Student Affairs facilitated a student-centered approach to care.

Vejas Skripkus, Executive Director of UC Santa Barbara Student Health Service, described his campus as an island many miles away from the nearest academic medical center, and one hospital system in the City of Santa Barbara. Dr. Skripkus came to UCSB in 2020, and Student Health was tasked with managing COVID-19 and other matters that are usually beyond the scope of Student Health. Nonetheless, Student Health was able to protect the campus and keep operations going thanks to strong support from the Vice Chancellor for Student Affairs. Fortunately, this support continued, but UCSB was not able to leverage the resources of an academic medical center. UCSB must prepare itself for third-party billing. UCSB had been reducing premiums for undergraduate and graduate students while providing excellent service for students and even expanding services for our students, but this was a challenge for a campus without an academic medical center.

Dr. Rubin noted that the preparations for this discussion had engaged questions of strategy regarding third-party billing, Medi-Cal, and coming changes in UC SHIP, likely in August 2026. By this date, campuses would need to work together to refine their strategy to ensure that UC student health programs continue to grow.

Committee Chair Sures acknowledged the complexity of student health services across UC, where some campuses have medical centers and others do not. Certain measures would have to be implemented over time. First, third-party billing should be implemented as soon as possible, given the number of students with third-party insurance. UC should establish a clear timeline and target date for implementing third-party billing. Second, student health programs at campuses with medical centers must adopt the Epic medical records system. While this would be a significant investment, it is essential to ensure that UC has comprehensive medical histories of students and can provide high-quality care to students. He believed that this investment would lead to synergies and cost savings. Third, while this would be an unpopular measure, the University should review the UC SHIP premium to ensure that it is set at an appropriate level. Committee Chair Sures also raised concerns about the oversight of student health by Academic Affairs and Student Affairs. While this structure might be a best practice at many universities, UC should review whether it is the most effective model for UC. He was concerned whether students were receiving the best possible care, if academic medical centers were not overseeing doctors at student health centers. Additionally, he suggested that UC medical centers should take responsibility for credentialing physicians at student health centers to ensure high-quality care. He stressed that health care is a right, not a privilege. In order to be able to afford to provide excellent care, UC must review this cost structure. If UC failed to carry out such a review, it would be faced with greater problems in the future

Regent Leib recalled that there was a significant amount of Mental Health Services Act funding at the County level for mental health services. He suggested that the campuses should seek this County funding. Director Genie Kim confirmed that there was funding at the County level for behavioral health services. The Mental Health Services Act was

recently updated to become the Behavioral Health Services Act. The State was currently consulting with representatives of higher education and other partners on the strategic plan process. She encouraged the campuses to work closely with their County administrators to leverage these funds.

Committee Chair Sures requested a report and update at a future meeting on each campus' efforts in this area in its respective county. Dr. Rubin responded that as UC Health builds its strategic relationships with the State, these relationships would benefit student health as well. UC Health could present this information by the summer.

Regent-designate Brooks reported that students have stated their wish for testing at the campuses for attention deficit/hyperactivity disorder (ADHD). Currently they must pay out of pocket for these tests, the cost of which ranged from $200 to $500. She asked if these tests could be covered by UC SHIP. Dr. Rubin responded that UC SHIP was a cooperative program, students participated in the design of UC SHIP benefits, and psychoeducational assessments were a covered benefit.

Regent Beharry referred to Regent Leib's suggestion and noted that he had communicated with Merced County representatives. There was sometimes a lack of alignment between the Counties and the campuses, and this could be addressed by advocacy and ensuring that County officials understand the mission and value of UC. Regarding emergency department use by UC students, he asked if there were data indicating specific times of year with increases in use rates, such as flu season, midterm and final examination periods, or during major campus events. He asked if such data could inform student health center operations, such as extending hours of operation, not to 24 hours a day, but during these high-impact times, when alcohol and drug use or injuries were more likely. Dr. Junkins responded that at UCSD, with the Epic system and place and the relationship with the medical center, the student health division has built real-time dashboards that allow one to see the number of students using the emergency department, diagnoses, and costs to UC SHIP and non-UC SHIP patients. Some students using the emergency department could, in fact, be seen at the student health center. The UCSD Health emergency department team was working with the student health services team to get these students back into student health services. The student health division asked students why they were using the emergency department and reducing barriers for students to use UCSD Health Express Care rather than the emergency department.

Regent Beharry asked about students' stated reasons for going to the emergency department. Dr. Junkins responded that, in spite of information posted on the student health and UC SHIP websites, students seek care in the emergency department because this is what their parents told them to do, or due to the location. Sometimes students simply do not know about the availability of student health services. UCSD student health nurses and peer educators were working with student groups to try to reduce the number of students using the emergency department. Mr. Reguerín added that UC Davis regularly reviewed data on students' use of emergency care. This was a matter of navigating resources. UC Davis was using its health education promotion teams to engage in additional outreach to students.

Chancellor Gillman advised that the University should take time and think carefully about a requirement that any campus with a medical center adopt the Epic system. Regarding the quality of care, he was not aware of any relationship between using the Epic system and the quality of care, and he did not have information indicating a particular lack of quality of care at UC Irvine. Implementation of Epic would be challenging and expensive. The Irvine campus would need a better understanding of the benefit of Epic in relationship to the effort required to implement the system. Committee Chair Sures responded that there would be substantive discussion of this matter.

Staff Advisor Frías referred to physician vacancy rates in student health centers, which has been a matter of concern. She asked if those students who have been going to emergency departments and are brought back to student health centers would be seen promptly. Mr. Reguerín responded that this depended on the day, time, and use. A work group was considering evening and after-hours care, but even having students use urgent care services rather than the emergency department made a big difference. Dr. Rubin added that students need to know where to go, and UC must use up-to-date methods of communicating this information to students. Convenience was an important factor. The availability of an urgent care location near campus can reduce emergency department use. Care management and identifying students for timely care and follow-up was also important. Regarding Chancellor Gillman's statement, he commented that he had seen the advantages of the Epic system in his career with respect to integrated care management, especially in cases of serious illness. UC Health should ensure that it supports campuses without the resources needed for the implementation and maintenance of Epic.

Ms. Frías identified two elements of the problem. One was communication and the education of students, so that they know that there are alternatives to the emergency department, and the other was the question of sufficient capacity to see students at these alternative sites in a timely manner. If students were suffering and had to wait three to five days at an alternative site, they would go to the emergency department.

Advisory member Marks referred to a suggestion in the background materials for a $25 student fee to support the implementation of Epic. This would be a wise investment that students could make in their health. The Epic system provides a great deal of value to patients beyond data. Patients have immediate access to medical record notes and test results and have the ability to renew prescriptions and make appointments. Epic's patient portal is effective, and it simplifies the billing process through the coding and capture of services. Ms. Marks acknowledged that Epic was costly but outlined how Epic was an effective tool for her institution, the University of Colorado, which also had mandatory student health insurance. In cases of third-party insurance, University of Colorado students receive the bill and have the obligation to pay the bill and submit a claim to their insurance company. She believed that Epic could be implemented effectively on campuses without an academic medical center. Many billing and contracting activities can be carried out remotely. UC campuses without a medical center could enter an agreement with campuses with a medical center and the existing infrastructure for providing administration and billing. Epic implementation would benefit students and the student health program. Regarding program governance, Ms. Marks observed that the provision of health care and

billing for health care were not matters for amateurs. This was a very complex business model, and there was expertise within UC that could assist with this. There was sometimes fear or lack of trust and a belief that if students were not directly involved in the program governance, their interests would not be served. Ms. Marks underscored her view that this was not the case.

Ms. Maysent commented on the cost of Epic. UCSD implemented the Epic system in its student health program in 2019 at a cost of $1.6 million to $1.8 million. UCSD Health paid this cost, which it viewed as a good investment for creating the kind of environment and continuity of care that UCSD wished to see. The ongoing operating costs were considerable, around $700,000 to $800,000 a year. UCSD Health underwrote this cost until the student health division could start paying the cost because the division was generating more revenue through these new tools. Ultimately, the system paid for itself, and student health now paid the entire cost. With respect to cyber security, Ms. Maysent noted that the Epic system was much more secure than other systems. UCSD student health was able to take advantage of UCSD's population health infrastructure and teams. This had helped to identify problems with student access to UCSD Health Express Care, remove barriers, and direct students to Express Care rather than the emergency department.

Regent Matosantos referred to the suggestion of using student fees to pay for Epic implementation. This gave her pause, given the percentage of UC students who were Medi-Cal enrollees. The University should consider other ways of funding this implementation. Improving third-party billing would be beneficial, but it is equally important for UC to engage in proactive case management and ensure that students are receiving the full benefits from their health plans. Efforts to reduce emergency department use by students were helpful as well, but UC should also look at this as a "repatriation" of students into UC student health centers and pursue a care coordination approach so that they can be served at UC. Dr. Rubin responded that Regent Matosantos' last point was a strong argument in favor of Epic, which would enable wraparound services.

Student observer Joselen Contreras observed that student health centers were more than a resource; they were a lifeline for students, offering primary care, mental health support, addiction treatment, sexual health services, and public health crisis management. The need for well-staffed and well-funded health care on UC campuses had never been more urgent, but healthcare costs were rising, staff vacancies were stretching services thin, and Governor Newsom's proposed cut to UC's base budget would undoubtedly affect these services. Student health centers were operating under outdated and inconsistent funding models, with some campuses heavily reliant on UC SHIP reimbursements, while others left students with high out-of-pocket costs. Ms. Contreras suggested that there be a systemwide review that would standardize funding for student health services and ensure that all students, regardless of insurance status, have access to services. Third-party billing was a promising solution which would allow students with private insurance from their parents' employer to use this insurance for services at UC student health centers. Many students faced high fees or limited access simply because their campus did not accept their insurance. This forced students to seek costly care in the emergency room or from off-campus providers.

A standardized third-party billing system across all the campuses would be essential to lower student healthcare costs and improve access.

Staffing shortages made it harder than ever for students to receive timely care. Physician staffing was inadequate and the situation for mental health services was even direr. Some campuses had psychiatrist vacancies as high as 56 percent, with students waiting weeks and sometimes months for an appointment. While the mental health services provided by Lyra were not without flaws, as noted by students and the systemwide union that represented UC behavioral health counselors, the termination of this service exacerbated gaps in access to care. The termination of Lyra services was an opportunity for the University to redirect its resources and ensure that campus counseling centers were adequately staffed.

The governance structure of the student health centers was also a critical issue. A newly launched UCOP initiative for effective joint guidance, bringing together Academic Affairs, UC Finance, and UC Health was a step in the right direction. Creating a standardized communication framework for all campuses would ensure the longevity of these centers. One critical component was missing, however—the student voice. Ms. Contreras stressed that she had seen first-hand the value of student input when it is actively implemented rather than dismissed. In matters of student healthcare governance, the student vote should be final, and if UC's model is to succeed, it must include a formalized student advisory role. No matter how well-intentioned UC initiatives were, they would fail if students did not trust or engage with them. Trust begins with inclusion in decision-making. These issues affected real students who were trying to balance academic and personal responsibilities while navigating an increasingly complex and costly healthcare system. To protect student health, UC needed real solutions including standardized fees to ensure consistent funding, improved staffing, expanded insurance access, and ensuring student representation in governance.

5. **EVIDENCE FOR MASKING TO REDUCE RESPIRATORY ILLNESS FOLLOWING COVID**

[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.]

This discussion item was deferred.

The meeting adjourned at 5:45 p.m.

Attest:

Secretary and Chief of Staff