UNIVERSITY OF CALIFORNIA
HEALTH

UC Population Health
Annual Report FY 2024–2025

Better Care, Better Value, Healthier Lives

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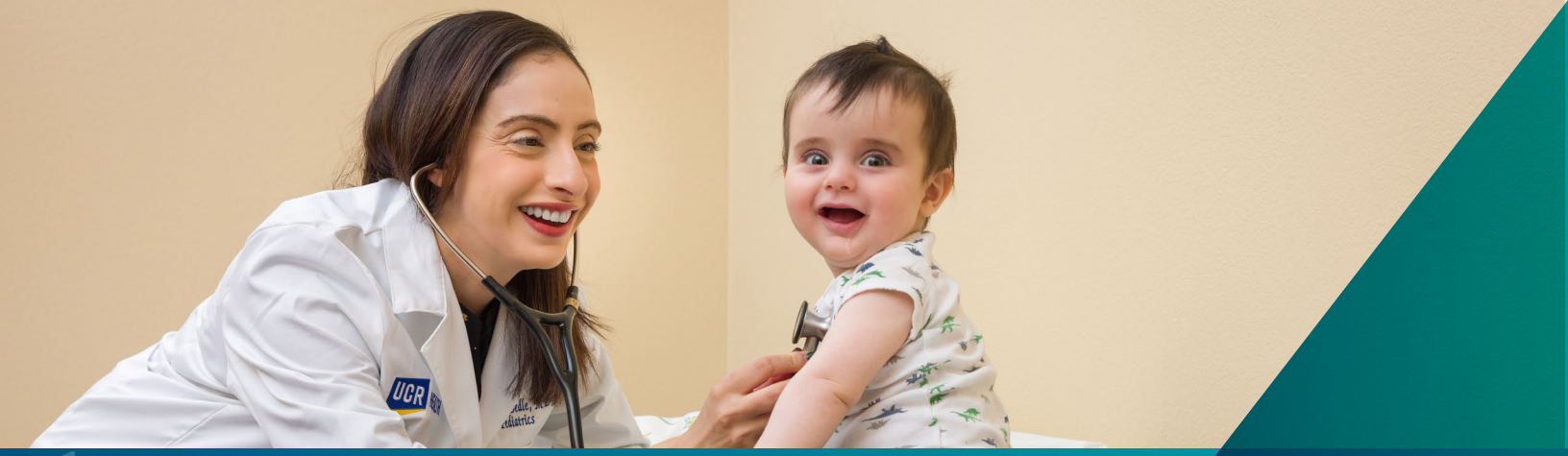


1 About Our Work

At University of California Health (UC Health), we believe in promoting healthier lives and stronger communities. This is reflected in the UC Population Health team's vision that the patients of UC Health achieve their best health and live as independently as possible. UC Population Health works across the academic health system to advance this vision to make care more impactful, more effective, and more equitable for all the people we serve.

Our mission is simple: help patients get the right care, at the right time, in the right place. By improving patient knowledge, refining how care is coordinated and delivered, reducing barriers to access, and ensuring treatment reflects individual needs and preferences, we make it easier for patients to stay healthy and to manage their conditions more effectively. Patients benefit from care that is focused on prevention and designed to optimize health while reducing unnecessary treatments and costs.

Three overlapping concepts set the context for UC's population health program and nine systemwide initiatives.

Population health:

The health and health outcomes of defined groups of people, which requires understanding and addressing the characteristics, disease burden and social drivers affecting their health.

Value-based care:

Models of care delivery that innovate to provide whole person care, which integrates services to address a person's physical, mental, behavioral and social needs in addition to the specific health issue or disease—all while paying close attention to cost and access to care.

Social drivers of health:

Aspects of patients' environment that may influence and contribute to their overall health care trajectory and well-being. We focus on identifying and intervening on health-related social needs, which are the non-medical factors experienced by individual patients.

Photo credit: UCR Health

2 A Welcome Letter From the Chief Population Health Officer

Welcome to the UC Health annual Population Health report.

This past year has brought many meaningful steps forward in our work to improve health and well-being for people across California—from rural towns to large cities, and from coastal communities to inland regions.

We remain focused on tackling some of the state's most persistent health challenges, including diabetes and high blood pressure. At the same time, we are strengthening how care is delivered by drawing on the full breadth of UC's population health management expertise. By bringing together physicians, nurses, pharmacists, social workers, researchers, and data scientists, we are creating more coordinated, patient-centered care that makes a real difference in people's daily lives.

Our approach is grounded in known best practices and continued innovation, and is shaped by learnings from research. We look at the whole person and aim to connect patients with the community resources needed for better health—whether that's clear, relevant information for patients and families, reliable transportation, healthier food, or assistance with financial concerns or insurance status.

We also take seriously our responsibility to provide care that is easily accessible and both effective and affordable. That means finding new ways to increase efficiency and optimize value by delivering care models that make sense for individual patients and our broader community.

Photo credit: Alex Matthews, UC San Diego Health

None of this progress would be possible without collaboration. Our team-based approach—uniting clinicians, data scientists, social workers, researchers, and many others—shows the strength of working together to serve patients in a more coordinated way. We are also grateful for our partnerships linking us to community organizations such as FindHelp and 211, which help us extend support beyond the clinic and into neighborhoods.

Through these efforts, UC is building an even stronger foundation for the continued improvement in the health of people in California. We are committed to addressing today's pressing health needs while preparing to meet the challenges of tomorrow—not only for Californians, but for people across the nation who look to California for innovation and leadership in health care.

In the service of promoting health across all communities in California,

Samuel A. Skootsky, M.D.
UC Health Chief Population Health Officer

Photo credits: (top) UCR Health; (bottom) UCSF

3 Executive Summary: Improving Health, Increasing Access

During the last year, we've witnessed significant progress across our population health initiatives as the UC academic health centers continue to work towards delivering value-based care in California. These initiatives address many important aspects of California communities' health care needs and overall well-being. Some of the key highlights are listed below and are discussed in greater detail later in this report.

In 2024, we introduced a new initiative, **Value-based Care Administrators**. This initiative seeks to advance UC's health system in providing value-based care through a focus on understanding and sharing the elements of successful participation in governmental and commercial alternative payment models.

Some key highlights across our other initiatives in 2024–2025 include:

- In **Hypertension Management**, we witnessed blood pressure control rates improve 16 percent over the past four years, with a one percent gain in the last year.
- **Diabetes Management** has seen an increase of 14 percent in blood sugar control over the past four years, with a three percent improvement in the last year.
- **Social Drivers of Health** initiative expanded its reach and impact by expanding the integration of referrals to health-related social needs platforms such as FindHelp and 211 to connect patients with community resources.
- **Preventive Services: Ambulatory Vaccines** focused on influenza and other common vaccines. UC academic health centers were in the Top 10 nationally in the American Medical Group Association's Rise to Immunize® national campaign.
- The **Coordinated Care** initiative has identified 22 strategies and best practices through its ongoing work, including innovations in patient support and navigation throughout their health care journey.
- **Population Health Pharmacy** reports approximately $2.3 million in overall total cost of care savings achieved through the utilization of prescription biosimilar drugs.
- **Oncology Medical Home** introduced two new access metrics: reducing the time for a new patient to be seen by a cancer specialist and reducing the time to receive cancer-specific therapy.
- Our **Cardiac Surgery Consortium** reduced hospital stays by the equivalent of 380 days, which equates to an estimated $1.2 million improvement in financial performance.

At UC Population Health and through these initiatives, we look holistically at the health of each specific population to gain a more complete understanding of current needs. Our standard approach is to set high goals for everyone, while also monitoring outcomes to ensure tailored community or cultural approaches are utilized when needed.

"Looking upstream and downstream along the continuum of care": Supporting UC patients through their care journey

Georgia McGlynn, R.N.
Manager, Office of Population Health and Accountable Care, UC Davis Health

From Georgia McGlynn's perspective, population health is all about the patient's journey along a continuum of care. "For me, the metaphor of a patient's journey is like a river or a stream. We have to look both upstream and downstream to get the full picture of a patient's health care needs. What have they experienced previously in their lives? How will these factors contribute to their health care plan and trajectory moving forward? Providing value-based care means meeting them wherever they are to provide the right care at the right time."

McGlynn also cites social drivers of health as critical factors in a patient's health care journey. "We look at the patient's life from a 360-degree perspective. What is their home environment like? Do they have safe and stable housing? Healthy food? Are they able to pay their utility bills? Do they have access to affordable medications?"

> *"We look at the patient's life from a 360-degree perspective."*

4 Meeting the Health Needs of California: UC Population Health's Nine Key Initiatives

UC Population Health's work encompasses an important range of pressing health care needs facing Californians today. Through collaboration with the UC academic health centers, UC Population Health creates opportunities for the sharing of knowledge and best practices to improve care and outcomes that benefit all Californians.

1 Hypertension Management

Leads: Ottar Lunde, UC San Diego Health; Samuel Skootsky, UCLA Health; Tina Zolfaghari, UCSF Health



Hypertension, more commonly known as high blood pressure, remains a leading population health concern, as it affects nearly half of all adults in the United States. It increases the risk of heart disease and stroke, two leading causes of death in the United States.

Our Hypertension Management initiative identifies and shares best practices to support blood pressure (BP) control and develop tailored health care strategies for populations to reduce differences in outcomes.

Over the last year, each UC site developed and began implementing site-specific plans for improving blood pressure control and targeting differences in

Photo credit: Alex Matthews, UC San Diego Health

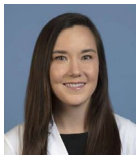
outcomes across populations. In addition, UC clinical leaders identified key education videos that help patients manage their blood pressure. These videos were translated into patients' preferred languages and culturally tailored to make sure the health information is understandable and relevant.

Over the past four years, blood pressure control rates have improved by 16 percent, including a one percent increase in the past year, reflecting the sustained impact of our hypertension initiative. The UC-wide rate of blood pressure control is better than 85 percent of comparable institutions in California.

16%
IMPROVEMENT IN BLOOD PRESSURE CONTROL
over the past four years

2 Diabetes Management

Leads: Matthew Freeby, UCLA Health; Maria Han, UCLA Health; Katie Medders, UC San Diego Health; Christine Thorne, UC San Diego Health

Diabetes represents another major population health concern. Diabetes affects approximately 38.4 million people in the United States, or approximately 11.6 percent of the population.[1] Diabetes can also increase the potential for complications like heart disease, stroke, peripheral artery disease, eye problems and kidney disease.

The UC Diabetes Management initiative works to identify, recommend and implement interventions to improve diabetes care and advance health care equity. Within the last year, UC locations implemented strategies to enhance access to advanced medications and improve medication adherence, with a particular focus on targeting disparities across populations. Also, UC clinical experts selected key diabetes education videos for translation to make them culturally relevant and language-specific for patients.

Blood sugar control across all our populations has increased by 14% over the past four years, with a continued upward trend of 3% in the last year. The UC-wide rate of blood sugar control is better than 95% of comparable institutions in California.

BLOOD SUGAR CONTROL ACROSS ALL OUR POPULATIONS:

14%
INCREASE
over the past four years

3%
CONTINUED UPWARD TREND
over the past year

95%
BETTER RATE UC-WIDE

1 https://www.niddk.nih.gov/health-information/diabetes

Leveraging the collective knowledge of the UC's academic health system

Linda Roney
Director, Performance Excellence, UCR Health

For Linda Roney, one of the chief benefits of working with the population health team is the knowledge sharing across the UC Health system. "When faced with a problem or challenge, you don't have to re-invent the wheel. We're able to share best practices and learn from each other, including workflows and protocols. In the end, our patients benefit from our systemwide knowledge."

One such area is point-of-care testing, especially for diabetes patients. "Point-of-care testing allows us to collect as much information as possible at the time of a patient's visit. For example, with a blood draw for blood sugar levels in our clinic, we don't have to have our patients go to a separate lab for that test. It consolidates the procedures and eliminates the providers' need to schedule a follow-up appointment to review lab results and create a care plan.

Guidance on selecting retinal screening cameras—another important piece of the point-of-care approach for diabetic patients—is another area where UCR Health benefited from systemwide knowledge sharing. "UC Population Health developed a robust playbook that provided guidance for best practices in selecting retinal cameras. We were able to leverage knowledge shared by the Diabetes Management Initiative leadership to then help us select the best camera type for our locations."

For Roney, these examples sum up the resulting benefits for patients. "It's all about ensuring our patients are living the best and highest quality life they can. These care approaches help build in preventive measures as part of their care journey, which is always the way to go."

> *"It's all about ensuring our patients are living the best and highest quality life they can. These care approaches help build in preventive measures as part of their care journey, which is always the way to go."*

3 Social Drivers of Health

Leads: Matt Pantell, UCSF Health; Naveen Raja, UCR Health

As both an important component of UC population health initiatives and in its own right, Social Drivers of Health (SDOH) comprises the social, economic and environmental factors that may contribute to a patient's health outcomes.

In the last year, this initiative has witnessed several advancements across seven primary SDOH areas (food, housing, utilities, transportation, social isolation, loneliness and financial strain). Given these areas, the UC Population Health initiative team expanded its mission by publishing and sharing V2.0 of the "UC Way Recommendations for SDOH Screening" tool kit, which expands common screening questions, tools and best practices. This advanced screening results in improved identification of health-related social needs in our patients.

In addition, the initiative expanded, taking action on social needs by the integration of two social care referral platforms—FindHelp and 211—to connect patients in need with valuable community resources. It also continued to bolster its work through enhanced partnerships with community-based organizations to ensure patients are connected to trusted, local support services.

Health Beyond the Clinic

Understanding social drivers of health—like food, housing and transportation—is essential to patient care. In this UCLA Health *Medically Speaking* podcast, Dr. Eve Glazier talks with Jasper Kump, a clinical social worker, and Niki Miller, Chief of Staff for UCLA Health's Faculty Practice Group, about how addressing social drivers of health transforms outcomes and advances health equity. Together, they highlight unique patient stories—and how even small interventions can make a difference in patients' health.

Listen Here: https://www.youtube.com/watch?v=k_CosP7hGzw

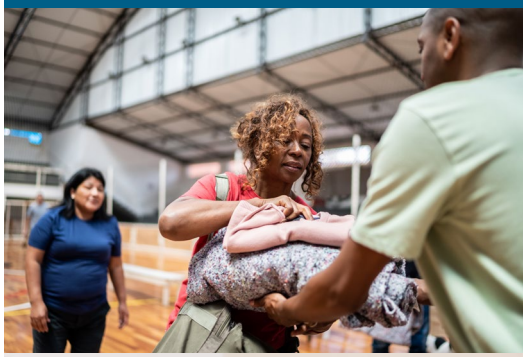


Photo credit: (center) UCR Health

4 Preventive Services: Ambulatory Vaccines

In the last year, this initiative has expanded its initial focus on improving access to adult and child influenza vaccinations to include the American Medical Group Association's Rise to Immunize® campaign for adult vaccines, including Influenza, Pneumococcal, Td/Tdap, and Zoster, and expanded reporting to both Respiratory Syncytial Virus (RSV) and COVID-19. In the past year, UC academic health centers were recognized as ranking among the top performers nationwide across these immunizations. This collective achievement demonstrates the UC system's strong commitment to preventive care and its measurable impact on promoting health.

TOP 20
RANKING
All UC AHCs ranked in the top 20 for bundled vaccination rates

5 Coordinated Care

Leads: Michael Helle, UCSF Health; Elizabeth Jaureguy, UCLA Health

This initiative continues its mission to deliver a systemwide approach to discover best practices and care models, innovate care coordination, and transform how care is delivered across UC's academic health centers. In the last year, the initiative has expanded its areas of focus to include innovations for:

- care at home services
- vendor partnerships
- advanced care teams
- electronic medical record optimization
- opportunities for enhanced revenue
- patient navigation of mental health services

To date, this initiative's team has identified 22 strategies and shared best practices through its ongoing work.

Helping patients navigate their health care journey

Natalie Maton
Director, Network Operations, UCI Health

One aspect of the work being implemented by the teams is the involvement of a health navigator, who is a health care professional embedded in a patient's primary care team.

Natalie Maton sums this role and its importance: "Health coaches help close care gaps. They provide education and resources to help a patient understand what a particular condition's pathway might mean for them. For example, with a pre-diabetic patient, a health coach can provide information on nutrition and how that relates to their blood sugar levels."

For Maton, early access to these resources is key to supporting a preventive model of care. "When introduced early in the care model, these patient advocates contribute to a preventive model of care that helps the patient navigate the health care system, connect the dots, and close the gaps among various parts of a patient's life and health care journey."

As expressed across many Population Health initiatives, the health navigator (or care manager) looks at the whole picture of a patient's life—including social drivers of health—and seeks to integrate the various aspects of that patient's care journey. "It's a unique role that provides a sense of empowerment to equip the patients with what they need." While the role originated with complex, high-risk patients, by leveraging a value-based care approach, the role has expanded to encompass patients who are potentially high risk. "The health navigator helps get them on the right path early," Maton notes.

> *"Health coaches help close care gaps. They provide education and resources to help a patient understand what a particular condition's pathway might mean for them."*

6 Population Health Pharmacy

Lead: Katie Medders, UC San Diego Health

In partnership with UC Population Health and the UC self-funded health plan teams, our Population Health Pharmacy team focuses on three key strategies:

- Improve the affordability of pharmaceutical therapy for all stakeholders (patients, health plans, and providers)
- Improve pharmacy-related quality of care metrics (for example, medication adherence)
- Integrate pharmacists and pharmacy technicians into team-based care

Over the last year, we've been focusing on increasing the adoption of prescription biosimilars across UC's health system to increase access to advanced therapeutics and lower the significant barrier of these costly drugs. Since its introduction, we've witnessed a 120% increase in advanced therapeutic use of these biosimilars.

To support the engagement, adoption and integration of biosimilar drugs, the team has employed several strategies, including:

- hosting systemwide education and training sessions for clinicians, led by UC clinical experts, on managing prescription biosimilar therapies;
- leveraging a shared decision-making framework with a focus on patient preferences and social drivers of health to improve the quality and satisfaction of biosimilars utilization;
- using UC pharmacies and physician-pharmacist dyads as part of a successful team-based model.

To date, the overall total cost-of-care savings from the Population Health Pharmacy initiative is approximately $2.3 million.

120%

INCREASE

in use of advanced therapeutic biosimilars since introduction

$2.3M

OVERALL TOTAL COST-OF-CARE SAVINGS

from the Population Health Pharmacy initiative

The role of pharmacists in advancing a value-based care team model

Tina Zolfaghari, Pharm.D.
Ambulatory Pharmacist Specialist, UCSF Health

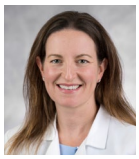
UC ambulatory care pharmacists, like Tina Zolfaghari, are a crucial part of a patient's care team.

When reflecting on her role as a pharmacist, Zolfaghari says that pharmacists help patients meet their health goals by collaborating closely with primary care and specialty providers in a team-based approach. By seeing patients more frequently, adjusting and initiating medications as needed, and providing education on the importance of treatments, they support better health outcomes and help prevent further complications from the chronic diseases they co-manage. UC pharmacists also ensure medications are safe, effective and affordable, building trust and promoting smoother transitions across the continuum of care.

"UC pharmacists also ensure medications are safe, effective and affordable, building trust and promoting smoother transitions across the continuum of care."

7 Oncology Medical Home

Lead: Kathryn Gold, UC San Diego Health



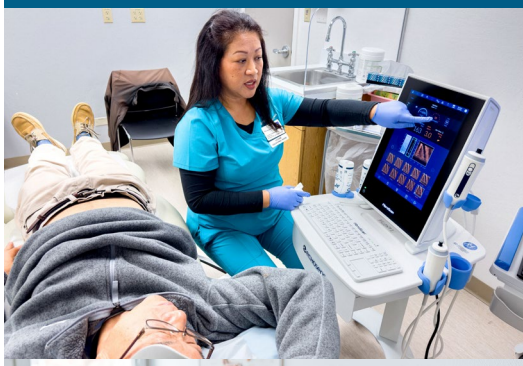
The Oncology Medical Home (OMH) initiative's goal is improving the quality of cancer care for all our patients through metric-based quality-of-care-related projects. The focus of these efforts has included establishing best practices for standardizing documentation for advance care planning and documentation of goal-concordant care. Robust outcome measurements have included looking at utilization patterns in the last few months of life. This year, the OMH initiative introduced two new access metrics: the time for a new patient to be seen by a cancer specialist and the time from referral to receipt of cancer-directed therapy. Reducing the time for a new patient with cancer to be seen is now a systemwide goal.

8 Cardiac Surgery Consortium

Lead: Richard Shemin, UCLA Health

UC academic health centers perform some of the most challenging and complex cardiac surgery cases. Annually, UC's health locations perform 2,500 routine and complex cardiothoracic operations.

The Cardiac Surgery Consortium represents an example of a specialty care collaboration to improve clinical outcomes and create value for patients and payors. For example, a recent focus has been on the patient's length of hospital admission ("length of stay") for these complex procedures. Within the last year, we've recorded a reduction in hospital stays by the equivalent of 380 days, resulting in an estimated $1.2 million improvement in financial performance.



2,500

ROUTINE AND COMPLEX CARDIOTHORACIC OPERATIONS

performed annually

$1.2M

IMPROVEMENT

in financial performance

Photo credits: (top) UCSF; (bottom) Alex Matthews, UC San Diego Health

Collaborating to deliver high-quality value-based care

Parag Agnihotri, M.D.
Chief Medical Officer, Population Health Services
Chief Medical Officer, UCSD Health Clinically Integrated Network
HS Clinical Professor, UC San Diego Health

For Dr. Agnihotri, value-based care is a strategic framework that moves away from traditional volume-based care models to one that emphasizes quality divided by cost. "It's about providing high-quality care with good outcomes that is cost-effective. We look at risk stratification, care coordination, and transitions of care. We are trying to see how we can integrate the clinical, operational, and financial domains to deliver high-value care both within and outside of the faculty practice."

In addition, Agnihotri cites the many aspects of social drivers of health as critical inputs into the overall landscape of population health. "One has to account for the factors that impact our communities," he notes. "While things such as housing, education, food security, and transportation have traditionally been outside the realm of health care, we must consider them to understand the holistic picture of individuals, their communities, and the population as a whole."

For Agnihotri, the UC's systemwide progress on population health "has created a learning collaborative where we can share best practices and keep members engaged across the system. For me, it's akin to the African proverb that says, 'if you want to go fast, go alone; if you want to go far, go together.' UC Population Health is that group."

"We are trying to see how we can integrate the clinical, operational, and financial domains to deliver high-value care both within and outside of the faculty practice."

9 Value-based Care Administrators

The newest UC Population Health initiative began organically to fill a collaborative need, and last year was organized formally by the Population Health Steering Committee into a distinct group with its own charter. The Value-based Care Administrators (VBCA) initiative's primary goal is to prepare UC academic health centers for success in the evolving environment of value-based models of care by participation in various alternative payment model (APM) contracts. VBCA uses lessons learned from APM participation at each site to inform successful approaches that are adopted more broadly within UC. This includes ensuring the needed capabilities and services are developed to improve patient care and outcomes at a lower cost to patients and payors. These value-based care experts also serve as critical thought leaders and partners with their health system's financial and contracting teams.

Center for Data-driven Insights and Innovation

The Center for Data-driven Insights and Innovation (CDI2) supports the collaborative work that we conduct across our programs and initiatives. CDI2, in managing the UC Health Data Warehouse (UCHDW) systemwide data asset, serves as a unique and valuable resource in accessing and visualizing comparative data across UC Health sites; applying advanced statistical techniques that enable our clinical experts to uncover patterns, trends, and insights; and informing decision-making that allows our leadership and teams to take appropriate action.

"Partnership is essential to advancing population health across the University of California. By partnering with the Center for Data-driven Insights and Innovation, we're able to bring together data, expertise, and collaboration from across our academic health centers to uncover insights that improve health outcomes. Together, we're transforming data into action for the communities we serve."

Rachael Sak, Director, Population Health, UC Health

75+

POPULATION-BASED DASHBOARDS

developed in partnership with CDI2

Photo credit: (top) UCSF

Measuring, managing, monitoring: Collaborating around trustworthy data to advance population health

Ottar Lunde, M.D.
Chief, General Internal Medicine
Professor of Medicine, UC San Diego Health

For Ottar Lunde, population health can be summarized in one phrase: "If you can't measure it, you can't manage or monitor it." Lunde believes that quality data and statistics tell a compelling story and hold doctors, staff, the system and even patients accountable to historic and emerging health care trends and needs. "Data provides us a window to look through to see why things are working—or not working. And if they're not working, we can catch them early enough to recalibrate and look for alternative approaches that will lead to better outcomes at the individual patient, community, and population levels."

Lunde focuses on a balance between what should be the gold standard of care and what is chosen to be affordable from both the patient and the system perspective. This is how he looks at value-based care. "Once we have meaningful data, we can choose more wisely based on defined priorities for the patient and for the larger populations we serve."

Ultimately, it's about collaborating around trustworthy data, and especially the kind of work that is done in collaboration with CDI2. "I look for clinical opportunities that can become teaching moments. For me, it's all about collaborating and sharing the knowledge with colleagues towards a greater common goal of improving patients' lives in their health care journey."

> *"Data provides us a window to look through to see why things are working—or not working."*

5 Celebrating Our Successes: National Recognition for Our Work

At UC Population Health, we are proud to be an active participant in larger conversations and programs around the concerns and initiatives that population health programs continue to address both statewide and nationally.

AMGA's Rise to Immunize (RIZE)

One program for which UC Health has received accolades is the American Medical Group Association's (AMGA) Rise to Immunize® (RIZE) campaign to improve adult vaccination rates. The vaccinations in the RIZE program include Pneumococcal, Td/Tdap, Zoster, and Influenza. In 2025, four of the UC academic health centers ranked in the top 10 for all vaccination rates, and all UC academic health centers ranked in the top 20 for the bundle of the four vaccinations (out of 82 medical groups nationwide).

American Heart Association and American Medical Association's Target: BP™ Program

We are honored to have received the highest Recognition Awards for our participation in the joint American Heart Association and American Medical Association's Target: BP™ program. One UC academic health center received the Gold award, and five of the six UC academic health centers received the Gold+ award, meaning they achieved a greater than 70 percent blood pressure control rate and completed at least four of six evidence-based blood pressure activities. These honors highlight the UC system's ongoing efforts to improve blood pressure control and reduce the risk of heart attacks and strokes across the communities we serve.

American Heart Association's Target: Type 2 Diabetes℠ Program

All six of the UC academic health centers have received the American Heart Association's Target: Type 2 Diabetes℠ Gold award for their commitment to addressing the relationship between diabetes and the risk of heart disease and stroke. This means that all of our locations achieved an annual rate of 25 percent or less for HbA1c Poor Control (>9%) and an annual rate of:

- 70 percent or greater for blood pressure control and/or
- 70 percent or greater for appropriate statin therapy.

6 Looking Ahead: What We're Mapping and Charting for the Next Year

Health care in the United States, and in California specifically, faces numerous challenges across several fronts, including political, economic, and societal. At UC Population Health, we remain steadfastly committed to continuing our mission of providing the highest quality value-based care to the diverse populations who comprise our state.

As highlighted in this year's report, we've made significant progress across all nine of our population health initiatives. This collaboration serves as a testament to the innovative, life-changing work we continue to pursue and build upon.

In the next year, we look forward to addressing existing and new health care needs of the California population by:

- **Listening** to our patients to understand their health needs and concerns, and how those can be addressed through our programs and initiatives
- **Collaborating** across the UC Health system to share best practices and knowledge to collectively develop solutions to complex challenges, as well as **participating** in larger conversations nationally around health care
- **Focusing** on improving the approach to value-based care across UC Health

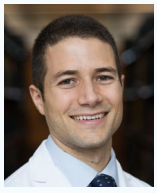
We look forward to what lies ahead in what promises to be another successful year.

Appendix

UC Population Health: People and Organization

UC Population Health Steering Committee

Samuel A. Skootsky
Chief Population Health Officer, UC Health & Chief Medical Officer, UCLA Faculty Practice Group and Medical Group, UCLA



Timothy Judson
Chief Population Health Officer (interim), UCSF & Chief Clinical and Innovation Officer, Canopy Health

Reshma Gupta
Chief of Population Health and Accountable Care, UC Davis

Lisa Gibbs
Chief Population Health Officer, UC Irvine

Parag Agnihotri
Chief Medical Officer, Population Health Services, UC San Diego

Naveen Raja
Chief Medical Officer, UC Riverside

Rachael Sak
(Ex-Officio) Director, Population Health, UC Health

Laura Tauber
(Ex-Officio) Executive Director UC Self-funded Health Plans

Our Executive Sponsor

Patty Maysent
Chief Executive Officer, UC San Diego Health

Our Executive Advisors

Erwin Altamira, UCI Health
Medell Briggs-Malonson, UCLA Health
Elizabeth Brooks, UC Health
Duncan Campbell, UC San Diego Health
Angie Chang, UCI Health
Michael Helle, UCSF Health
Noelle Lee, UCSF Health
Carlos Lerner, UCLA Health
Natalie Maton, UCI Health
Georgia McGlynn, UC Davis Health
Sarah Meshkat, UCLA Health
Magen Montez, UCSF Health
Mikel Whittier, UCLA Health

Our Data and Analytics Partners at the Center for Data-driven Insights and Innovation (CDI2)

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Atul Butte
Lisa Dahm
Cora Han
Timothy Hayes
Ray Pablo
Ayan Patel
Teju Yardi

Our UC Health Population Health Team

Maricel Cabrera
Nicole Friedberg
Kathryn Gold
Ellen Lenzi
Katie Medders
Natalie Nguyen
Rachael Sak
Samuel A. Skootsky

Our UC Academic Health Center Partners by Initiative

Hypertension Management

Ottar Lunde (Lead), UC San Diego Health
Samuel Skootsky (Lead), UCLA Health
Tina Zolfaghari (Lead), UCSF Health
Obioma Agiriga, UCLA Health
Parag Agnihotri, UC San Diego Health
Surabhi Atreja, UC Davis Health
Sarah Bajorek, UC Davis Health
Clare Connors, UCSF Health
Jennifer Zanotti Davis, UCLA Health
Ally Elder, UC Davis Health
Nana Entsuah, UCI Health
Samia Faiz, UCR Health
Jeffrey T. Fujimoto, UCLA Health
Lisa Gibbs, UCI Health
Mark Grossman, UCLA Health
Reshma Gupta, UC Davis Health
Natalie Halanski, UC San Diego Health
Allen Hall, UC Davis Health
Maria Han, UCLA Health
Dennis P. Harris, UCLA Health
Anthony Jerant, UC Davis Health
Andrew Jones, UC Davis Health
Parmis Khatibi, UCI Health
Sandeep (Sunny) Kishore, UCSF Health
Chris Kroner, UCI Health
Hannah Kwak, UCLA Health
Sylvia Lambrechts, UCLA Health
Heather Leisy, UC Davis Health
Rebecca Leon, UCSF Health
Carlos Lerner, UCLA Health
Mina Malaak, UCLA Health
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