

UNIVERSITY OF CALIFORNIA HEALTH

UC Population Health
Annual Report
FY 2025–2026

# Innovating and transforming for better health



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# A welcome letter from the Chief Population Health Officer

## Welcome to the UC Population Health annual report

Approaches to healthcare are dynamic, as new discoveries are applied and expectations evolve. The need has never been greater to improve health while making care more accessible, affordable, equitable and sustainable.

UC Population Health connects clinical and operational experts from across UC academic health centers to develop new approaches to care. We amplify ideas that the health locations in our network use to prioritize their work. Three principles shape our efforts across the UC system, and these ideas reflect what we believe will define the future of healthcare: whole-person care, learning and evolving and value for patients.

**Whole-person care** requires us to see beyond a diagnosis and put the patient first. It means designing care from the patient's perspective, bringing together primary care, specialty care, pharmacy, behavioral health, preventive services, social circumstances and community resources so that care is easy to access, coordinated across settings and delivered efficiently. When we care for the whole person, we help people stay healthier, not simply recover from illness.

Our distinction as a **"learning" healthcare system** uniquely positions UC to lead and innovate. UC healthcare professionals constantly evaluate patient outcomes, listen to patients and peers, rethink conventional approaches, work across disciplines, measure, test, share and launch successful ideas systemwide for better health outcomes, lower costs and reduced complexity.

**Value for patients** is our measure of success. We consider value from the patient's perspective: safe, timely, efficient, effective and equitable care. When we improve all these elements together, not only our patients but also our clinicians, the UC academic healthcare system and society benefit from the value created.

This year's report highlights the progress we've made in our population health initiatives and demonstrates our principles — whole-person care, innovation based on our collective learning and value for patients — in action. In the next year, we look forward to continuing to address existing and new healthcare needs of Californians in innovative ways.

Our strength lies not in the work of any one academic health center, but in all UC locations' ability to learn from one another, launch and expand successful programs and accelerate innovation.



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



# About our work

## In most industries, value is defined by the balance of quality and cost. In healthcare, value also means improving health outcomes and supporting better health over a lifetime.

Driving UC's population health efforts is a vision to help all our communities across the care continuum to live healthier lives. It's why systemwide collaboration is our solution to every problem we're presented with. It's why our programs organize care across disciplines and connect with the real world of our patients' communities, to deliver the right care at the right time in the right place of service. It's also why we participate in testing new models that involve multiple specialties — such as those from Centers for Medicare and Medicaid Service (CMS) — that reward efficiency, quality and meaningful outcomes important to patients.

**Ultimately, our approach results in the best health outcomes, with lower costs and improved care coordination for patients and clinicians.**



**Strong outcomes for patients**



**Positive experiences for patients and clinicians**



**Efficient and cost-effective care**

UC Population Health builds upon a shared foundation of resources, technology and collective learning, so that UC academic health centers can go faster and further as a collective to develop, test and scale new approaches to care. This foundation includes a partnership with the Center for Data-driven Insights and Innovation (CDI2), stewards of the UC Health Data Warehouse (UCHDW), a valuable resource in accessing and visualizing comparative data across the six UC academic health centers.

Challenges tackled by one UC location become shared opportunities for learning, allowing successful approaches to be adapted, refined and scaled across the UC system. One way we express our consensus of approach is to refer to specific initiatives as the "UC Way." This collaborative model is an engine for innovation and is what sets UC apart and enables us to deliver greater value in health outcomes, patient experiences and cost-effective care.



# UC Population Health highlights

**Highlights from the population health initiatives featured in this report demonstrate how UC's commitment to learning, collaboration and value is advancing outcomes, improving efficiency and promoting more equitable care across the system.**

## HYPERTENSION MANAGEMENT

Engaging patients where they are

**21%**

**IMPROVEMENT**

in blood pressure management over a five-year period, **resulting in 42,000 hypertension patients achieving blood pressure control**

**Extension of technology-enabled care** beyond the clinic, through home monitoring and personalized support

## DIABETES MANAGEMENT

Expanding access, improving outcomes

**4,000**

**ADDITIONAL PATIENTS**

with diabetes **reached their blood sugar goals**

**95%**

**INCREASE**

**of cardio-renal protective medications** to high-risk patients over a five-year period

## POPULATION HEALTH PHARMACY

Medication expertise for better value and outcomes

**41%**

**FASTER ACCESS**

to specialty therapy and **12% increase in medication adherence** among patients with rheumatoid arthritis using UC pharmacies

**$4.2M**

**IN SAVINGS**

for one UC employee health plan

## ONCOLOGY MEDICAL HOME (OMH)

Reducing time to treatment, improving quality

**Standardized, cross-system method** for identifying patients with advanced cancer

Improved access to **coordinated, proactive and person-centered care**

**Less time** to initiate treatment



## CARE COORDINATION

Frontline learning, shared solutions and systemwide collaboration

**1st**
**UC WAY CARE COORDINATION RESOURCE GUIDE**
developed

Identified effective practices and standardized **workflows, staffing models, core competencies and productivity measures**

## SOCIAL DRIVERS OF HEALTH (SDOH):

Screening, referrals and community resource partnerships

**6**
**UC "FOOD AS MEDICINE" PROGRAMS**
offered at all UC academic health centers

**New UC Way SDOH Screening Tool Kit** released

**14%**
**INCREASE**
**in patient referrals** to community services for health-related social needs across all UC academic health centers

## PREVENTIVE SERVICES

Evidence-based vaccination practices, expanded access to preventive care

**290,000**
**MORE VACCINATIONS**
administered compared to previous year

**Top-25 placement** in administering vaccines nationwide

**National recognition** for UC academic health centers as leaders in adult immunization

## CARDIAC SURGERY CONSORTIUM

Quality improvements, shorter hospital stays and fewer hospital readmissions

**$3.5M**
**IMPROVEMENT**
**in financial performance**
in CY 2025

**Reduced cardiac surgery patient hospital stays by**
**455**
**HOSPITAL DAYS**
across all UC locations, with sustained excellence in patient outcomes



# Creating value:
## Strengthening chronic disease management and care coordination

Four medications, six injections, and three finger sticks daily, as well as ophthalmic injections to manage vision issues. It's a lot for one 54-year-old with Type 2 diabetes to manage.

The UCSF Diabetes Collaborative Care (DCC) team contacted the patient and identified opportunities to simplify and improve the patient's care, with recommendations for medications, lab testing, nutrition, and physical activity. A healthcare navigator and nurse provided weekly and monthly coaching and support, respectively.

Within 10 months, the patient reduced her blood sugar to a level well within normal range, and her vision issues improved significantly. She did this while taking fewer doses of medication, using a once-weekly insulin injection, and using a continuous glucose monitoring device to more easily track her blood sugar. More than half of the DCC's program participants reached their goals just as quickly, with an average blood sugar level decline from 10% to 7.3% after 12 months.

Diabetes, hypertension and other chronic conditions bring a heavy physical and financial burden to patients, compounded by social drivers of health. One-third of patients screened by the DCC reported food insecurity, and more than 80% accepted referrals to local resources.

**UC Population Health initiatives that rethink chronic disease management in terms of wellness bring value to patients and their care teams.** UCSF's DCC team is just one program among many that UC locations have launched to target chronic disease. UC Population Health Hypertension and Diabetes Management initiatives also expanded access to culturally and linguistically appropriate patient education, making educational resources available in more than 30 languages — and increasing equitable access to care.

## Creating value: UC initiatives strengthening chronic disease management and care coordination



**Hypertension Management:** Blood pressure control is a key part of medical management for many specialties, including primary care, endocrinology, cardiology and nephrology. Over the past five years, the hypertension patient population grew by 40,000 patients. During that same period, blood pressure control improved by 21%, representing 42,000 more patients with controlled blood pressure. In addition to producing patient education in more than 30 languages, the Hypertension Management initiative updated its standardized medication protocol to improve access, adherence and affordability.

Across the UC network, innovative hypertension management programs go beyond the clinic to help patients control their blood pressure through personalized care, home monitoring and multidisciplinary support.

**At UC San Diego Health, for instance, pharmacists and nurses provide individualized hypertension management, medication optimization and ongoing coaching, while their home blood pressure monitoring program helps patients stay engaged in their care. The program also reaches the community through a Mobile Health Van that provides blood pressure screenings, diabetes testing and care navigation in underserved neighborhoods, connecting more patients to preventive care and support.**



**Diabetes Management:** According to the American Diabetes Association's 2024 report "The Burden of Diabetes in California," more than one in 12 Californians suffer from the disease, resulting in higher medical expenses and potentially severe health complications.

**In FY 2025–2026, UC academic health centers received 3,600 new patients with diabetes, totaling more than 59,000 across all locations. At the same time, through UC locations' work to coordinate and share insights, 4,000 more Californians met their blood sugar goals.**

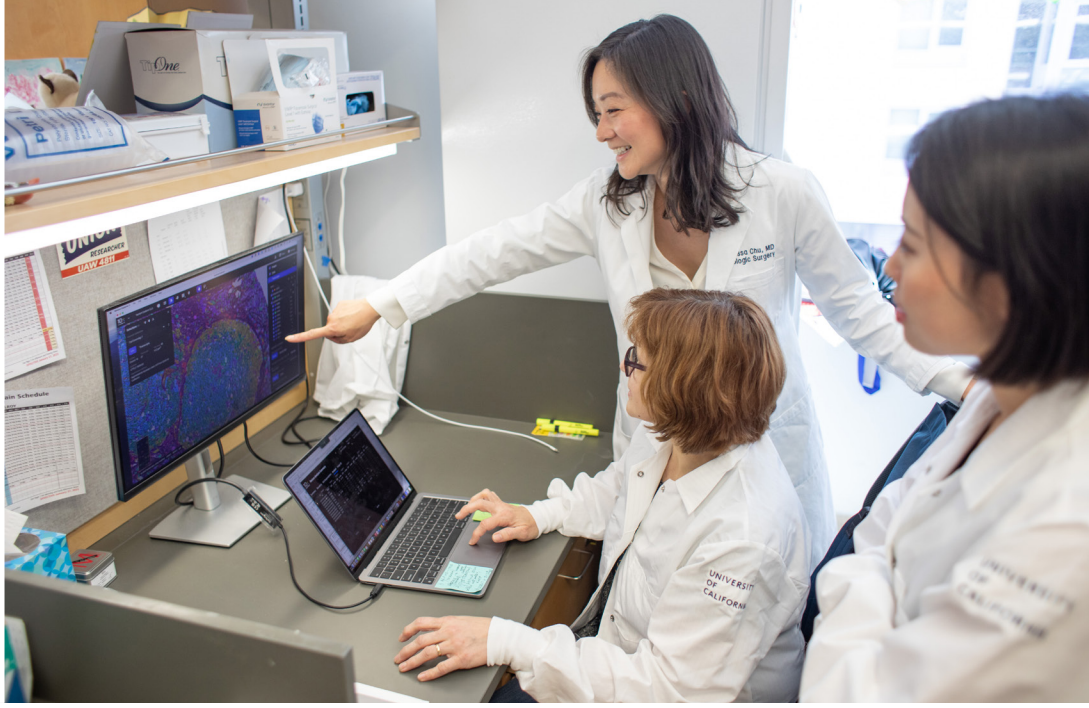
Diabetic eye disease is a leading cause of blindness in the United States, but early detection and treatment can help prevent vision loss. In FY 2025–2026, the UC Population Health Diabetes Management initiative also expanded access to diabetic retinal screening so that more patients received recommended eye exams. UCR Health joined other academic health centers in implementing retinal cameras, with a 95% increase in eligible patients at UCR Health receiving the examination.

The Diabetes Management initiative prioritized cardio-renal protective medications for high-risk patients with diabetes, as well. These individuals face the greatest risk of heart attack, heart failure and kidney failure. Since UC's systemwide efforts began in 2021, prescriptions for cardio-renal protective medications among high-risk patients have increased by 95%, providing 7,000 more patients access to these potentially lifesaving medications.

**42,000**
**MORE PATIENTS**
with controlled blood pressure

**7,000**
**MORE PATIENTS**
provided access to potentially lifesaving medications





**Care Coordination:** All UC academic health centers prioritize care coordination, not only through transitions from acute care to home, rehabilitation or skilled nursing facilities, but also through ambulatory care. Optimizing care coordination ensures relevant information is shared among clinical teams and the patient, and strengthens the ability of the patient to remain at their place of residence.

The Care Coordination workgroup developed the UC Way Resource Guide for Population Health and Ambulatory Care Coordination Programs, beginning with post-hospital discharge follow-up and transitions of care (TOC). The collaborative assessed care coordination across UC locations and engaged subject matter experts to identify best practices and recommendations for standardized workflows, staffing models, core competencies and productivity measures.

**The new Value-based Care Administrators initiative is strategizing how UC locations will prepare their operations for emerging payment models. Four UC locations participating in the CMS Primary Care First program concluded that proactive care raises quality and reduces avoidable hospitalizations, and that accessible coordinated care led to better outcomes and a positive patient experience. The Value-based Care Administrators effort will build on these lessons as they focus on coordinated efforts for other value-based care initiatives.**



# 2 Advancing whole-person care:
## Looking beyond the diagnosis

When UC Davis Health found that even expertly prepared medically tailored meals were not reaching families because they did not reflect their cultural preferences, it was clear that improving health requires more than nutrition expertise: It requires understanding people, communities and the systems that shape what ends up on the plate.

Food insecurity affects chronic disease, maternal health, mental health, medication adherence, emergency department utilization, hospitalizations and overall healthcare costs. Yet traditional "Food as Medicine" programs often focus narrowly on medically tailored meals.

**Along with UC Davis Health, all UC academic health centers are expanding the definition and scope of these programs to address the whole person, including social and economic barriers to good nutrition. Their complementary strategies and partnerships are shifting the focus of food-as-medicine from delivery networks to systems that serve people.**

- **Local partnerships** like the nationally recognized UC Davis Health initiative engage community organizations, restaurants and food producers to source medically tailored meals locally. In addition to producing meals that have reduced patients' blood pressure, these partnerships have trimmed food-related carbon emissions by nearly one-third.
- **Automated food insecurity screening** for more than half a million UCLA Health and UC San Diego Health patients has led to interventions that provide meals and meaningful connections to people like an 82-year-old living with oxygen dependence and significant social isolation.
- **Innovative food equity and food justice programs** serve 6,000 UCSF Health patients through food pharmacies, produce vouchers, grocery delivery and nutrition education.
- **Expanded nutrition education and interdisciplinary programs** have prepared more than 400 students, residents and practicing clinicians at UC San Diego Health and UCI Health to make nutrition counseling a routine part of care.





## Advancing whole-person care: UC initiatives looking beyond the diagnosis

**Social Drivers of Health (SDOH):** This workgroup advances coordinated, equitable and sustainable approaches to address patients' social drivers of health. The workgroup also expanded its UC Way SDOH Screening Tool Kit to support greater consistency in SDOH screening practices across the system.

UC locations also launched a systemwide effort to improve community partner engagement, referral navigation, closed-loop referral capabilities within electronic health records and technology-based coordination, through platforms such as FindHelp and county-based 211.

**UCI Health, for example, implemented training across 75 ambulatory clinics and established 12 community-based organization (CBO) partnerships within the first six months of FY 2025–2026.**

**Preventive Services:** UC ambulatory vaccine program leaders convene annually to share implementation successes, examine variation in strategies and identify opportunities to improve vaccination rates across the UC system. Statewide vaccination rates declined after the COVID-19 pandemic, including at UC academic health centers.

Now, UC-wide influenza vaccination performance for both adults and children is improving after two years of decline. In addition to influenza, the initiative focuses on improving rates of other impactful adult vaccinations such as Pneumococcal, Tetanus/Pertussis, Zoster, RSV, COVID-19, and Hepatitis B. UC locations have been recognized among the nation's top performers in the American Medical Group Association's Rise to Immunize® (RIZE) campaign for adult vaccination.



# 3 Better outcomes and cost savings:

## Integrating pharmacy into care

When a patient with rheumatoid arthritis switches from a costly biologic to a clinically equivalent biosimilar medication, the change can lower out-of-pocket costs, improve adherence and make it more likely they will start — and stay — on treatments that achieve therapeutic goals and improve quality of life.

Pharmacists and pharmacy technicians boost the efficacy of care and cost savings in ways unique to their discipline. With medication costs rising and treatment options becoming increasingly complex, UC pharmacists are doing more than dispensing medications. As integral members of UC Population Health and value-based care teams, pharmacists are working alongside physicians, nurses and care managers to improve medication access, manage chronic disease, optimize transitions of care and guide patients through insurance barriers.

For example, since UC's systemwide efforts began in 2021, pharmacist engagement has driven appropriate cardio-renal protective medication use in high-risk diabetes populations from 36% to 70% in 5 years. In 2025, UC pharmacies improved access to clinically appropriate medications for patients with rheumatoid arthritis, including disease-modifying antirheumatic drugs. UC's collective efforts helped these patients begin therapy 41% sooner and achieve 12% higher medication adherence than patients using non-UC pharmacies.

### PHARMACIST ENGAGEMENT RESULTS

Pharmacist engagement has driven appropriate cardio-renal protective medication use in high-risk diabetes populations **from 36% to**

**70%**
**IN 5 YEARS**

UC's collective efforts helped rheumatoid arthritis patients begin therapy

**41%**
**SOONER**

**and achieve**

**12%**
**HIGHER MEDICATION ADHERENCE**



## Better outcomes and cost savings: UC initiatives integrating pharmacy into care

**Lowering costs:** UC Population Health's pharmacy initiative helps UC manage rising prescription drug costs while supporting affordable, high-quality care for employees and their families enrolled in UC-sponsored health plans. UC pharmacists are instrumental in the transition of appropriate patients to equally effective biosimilar medications and ensuring the same clinical benefit as brand-name biologics — at dramatically lower cost to patients and health plans.

**In FY 2026, through pharmacist outreach, biosimilar conversions, and real-time prescribing tools that identify lower-cost alternatives, a UC-sponsored employee health plan generated approximately $4.2 million in savings.**

**Integrating pharmacy care:** UC pharmacists are increasingly becoming integrated members of care teams. With a UC pharmacist on board, patients start treatment in half the time they do at non-UC pharmacies lacking similar pharmacist support. At all UC locations, pharmacists help patients start, adjust and stay on medications for diabetes, hypertension, obesity and other chronic conditions. Between physician visits, pharmacists address insurance obstacles, medication access and adherence while supporting evidence-based prescribing.

**Site of care:** Just as they have for rheumatoid arthritis and diabetes patients, pharmacists are driving improved outcomes for specific infusion patients. UC Davis Health pharmacists collaborated with medical group utilization management and ambulatory clinical teams on an innovative redesign of infusion services, moving appropriate patients from hospital infusion centers to home infusion or outpatient settings. The program has improved patient convenience while freeing hospital capacity for higher-acuity care, generating more than $1.2 million in savings for participating health plans and demonstrating how pharmacy-led care redesign can improve access, affordability and system capacity.



# Evolving as a learning health system:
## Leveraging local innovation, systemwide

When a 78-year-old patient with multiple complex conditions arrived in the UCLA Health emergency department, people in the waiting room might have been surprised to see that patient leave without being admitted to the hospital for inpatient care. Instead of a lengthy wait and evaluation followed by hospitalization, a unique collaboration involving emergency medicine, hospital medicine and the patient's primary care teams led to a plan for outpatient follow-up in alignment with the patient's goals.

By focusing on high-value decision points through collaborative case reviews across typically separate disciplines, physician-to-physician learning and data-driven conversations, UCLA Health is focused on frontline learning to deliver care in the most appropriate setting.

Another UCLA Health initiative involved detailed case reviews of patients seen in the emergency department within 72 hours of being seen in urgent care. Data-driven physician-to-physician conversation and coaching led to more standardized practice in urgent care and resulted in a 40% decrease in unnecessary emergency department visits following urgent care. This dramatic reduction also demonstrates the power of frontline learning — greater than mandates or even technology — as a tool for change.

UC Population Health initiatives capitalize on the UC network as a learning health system in which sharing across what might otherwise be siloed clinical teams accelerates the spread of insights and innovation for better, more efficient care. Work is underway to develop formal frontline learning networks spanning the UC system. Other UC Population Health initiatives that leverage the learning health system model to reinvent processes for patient benefit include the Cardiac Surgery Consortium and Oncology Medical Home.





## Evolving as a learning health system: UC initiatives leveraging local innovation

**Oncology Medical Home (OMH):** Focused on improving oncology services including timely access to care, this workgroup created a method to measure how quickly new cancer patients are seen and treated by an oncologist. Clinical and administrative cancer care experts then shared their local strategies, learnings and successes related to access and efficiency of oncology services.

OMH also validated and adopted a locally developed, standardized method to identify patients with advanced cancer using electronic health records across five UC academic health centers. The standard definition supports consistent quality measurement, meaningful comparisons across UC medical centers, and better supportive care for patients. This work allowed OMH to focus on patient-centered interventions for this complex population like attention to goals of care and avoiding unnecessary hospitalization. Examples of this work were featured at the 2026 National Comprehensive Cancer Network Annual Conference.

**Cardiac Surgery Consortium:** This group continued to improve outcomes and value for patients undergoing cardiac surgery. In 2025, the consortium reduced inpatient hospital days by 455 days through shorter stays, fewer hospital readmissions and other quality improvements, while improving financial performance by an estimated $3.5 million.

**$3.5M**
**IMPROVEMENT**
**in financial performance** in CY 2025

**Reduced inpatient hospital stays by**
**455**
**HOSPITAL DAYS**



# Stronger together:
## Collaboration that drives impact

The work of UC Population Health is grounded in meaningful partnerships and extends beyond UC's academic health centers.

**Partnership turning data into action:** Our partnership with the UC Center for Data-driven Insights and Innovation (CDI2) strengthens population health efforts across the University of California. CDI2's expertise, leadership and collaborative approach help connect data and insights across UC academic health centers so that we can better understand health needs and identify opportunities for improvement. Together, we are translating data into information that supports meaningful action leading to better health outcomes for the communities we serve.

**Celebrating our collaborative successes:** The UC academic healthcare system again earned national recognition for demonstrated leadership in adult vaccination efforts, and accolades for our commitment to preventive medicine, community health, health equity and value-based healthcare.

The **American Medical Group Association's (AMGA) Rise to Immunize® (RIZE) campaign** to improve adult vaccination rates measures delivery of the seven most widely administered and impactful adult vaccinations: Pneumococcal, Tetanus/Pertussis, Zoster, Influenza, RSV, COVID-19, and Hepatitis B. In 2025, UC academic health centers again surpassed nearly 80 participating organizations in adult immunization. UC locations achieved top quartile placement across all seven RIZE campaign measures by administering approximately 290,000 more vaccinations than in 2024, expanding access to preventive care across the system.

UC Population Health also is proud to be an active participant in **American Heart Association and American Medical Association** joint initiatives targeting prominent health issues statewide and nationally. UC locations' efforts have earned Gold and Gold+ awards for excellence in evidence-based care for both hypertension and diabetes from the associations' Target: BP™ and Target: Type 2 Diabetes℠ programs.



# Learn more about our work

Many of the stories and outcomes in this FY 2025–2026 Population Health Annual Report were shared at the 2026 UC Population Health Conference. We host this annual conference for UC Population Health workgroup members to exchange ideas and share what they are learning as they lead high-impact programs.

The two-day event, themed "Succeeding Together in Value-based Care," brought together more than 100 population health, ambulatory care and technology experts from across the UC system to align priorities, explore best practices and accelerate systemwide improvement. Presenters and panelists at the Cove @ UCI Beall Applied Innovation showcased practical strategies, measurable outcomes and lessons learned on topics including:

- Key learnings from value-based care contracts and alternative payment models
- Insights from Medicare and Medicare Advantage participation
- Pharmacy-focused interventions that support value-based care
- Innovative applications of technology to optimize care and improve access
- New approaches to increase value for patients through flow and care transitions
- Ways to advance care for all our communities
- Improving access to care systemwide

As a learning healthcare system, we are proud of the systemwide collaborations that are delivering on our vision for all Californians to live healthier lives. **Read more about the UC Population Health conference here.**










# Appendix

## UC Population Health: People and organization

### UC Population Health Steering Committee



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



**Lisa Gibbs**
Chief Population Health Officer, UC Irvine



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



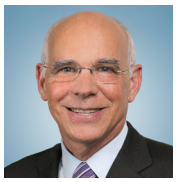
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**Samuel A. Skootsky**
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**Laura Tauber**
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## Our Executive Sponsor



**Patty Maysent**
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## Executive Advisors

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Angie Chang, UCI Health
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Kalpan Patel, UCLA Health
Alan Phan, UCI Health
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## Oncology Medical Home

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