UNIVERSITY
OF
CALIFORNIA
HEALTH

Advancing Care Delivery in a Value-based Era

UC Population Health
Annual Report
FY 2023–2024

Population health refers to the health and health outcomes for defined groups of individuals, including the distribution of outcomes within a group.[1] Therefore, improving population health encompasses understanding the characteristics, disease burden and social drivers affecting health. Taking action includes enhanced models of care, data sharing and appropriate financial resources. Ultimately, a focus on population health leads to higher value care.

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A Welcome Letter From Our Chief Population Health Officer

At University of California Health (UC Health), our view of population health is grounded in what's best for the populations we serve, with the goal that in all communities everyone can be as healthy and live as independently as possible. Supporting this goal requires an expanded view of the work to create new models of care delivery, in recognition that health and health care outcomes are affected by social, environmental, access and other factors that are recognized as social determinants or drivers of health.

Employers, commercial insurers and the government are increasingly pursuing agreements with health care clinicians and organizations that decouple reimbursements from the volume of services provided, and instead use various types of population-based payments and incentives, often based upon fixed budgets or growth targets. These circumstances have lent urgency to UC Health's vision for a focus on population health management that prepares UC's health care system for the growth of population-based contracts. This type of contract is referred to by many as value-based care. Since 2019, University of California Population Health (UCPH) has developed a role providing leadership, expertise and project management to our academic health centers to focus on systemwide initiatives that advance value-based care delivery, improve patient outcomes and optimize resource use and costs.

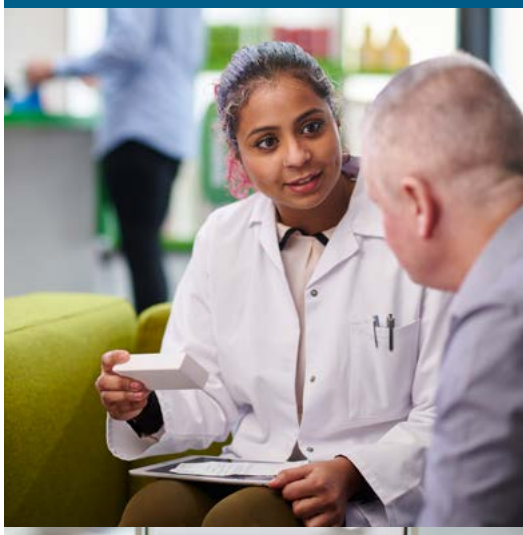
UCPH work also aligns with UC's public service mission and the clear need to advance health equity and justice. Our standard approach includes identification of health disparities. UCPH is partnering with UC academic health centers (AHCs) to ensure UC's world-class health care, knowledge and insights are available to people in *all* of California's communities.

The strategies and framework that direct our efforts toward improved population health — including participation in innovative programs and contracts with state and federal health care entities — are important for future financial success. The challenge is to optimize UC's current health care delivery model for success in a value-based future which includes greater accountability for outcomes, including the patient experience.

I'm pleased to share with you this annual report describing UCPH's recent accomplishments. UCPH continues to identify opportunities to optimize care and facilitate implementation of innovations in care delivery across the UC Health system.

With UC values as our guiding principle, we continue to build capabilities to advance UC's health system in the service of promoting health across all communities in California.

Samuel A. Skootsky
UC Health Chief Population Health Officer



Executive Summary

Welcome to UCPH's second annual report. Across UC Health and in our AHCs, we've had a busy year full of advancements in delivering value-based care to the diverse populations we serve across California. Our pioneering, innovative approach to population health — woven throughout the fabric of the programs we provide — continues to address the many factors that affect our communities' health care considerations and overall well-being.

Some of the highlights from the past year include:

- **Improving care management** in areas including cancer, preventive services and cardiac surgery
- **Developing medication protocols** to address hypertension and diabetes management
- **Capturing the patient voice**
- **Translating patient materials**
- **Screening for social risk factors**, assessing for needs and connecting patients with resources
- **Addressing medication affordability**
- **Advancing health care equity**
- **Addressing care gaps** in improving clinical quality, the patient experience and cost savings
- **Promoting shared innovation and application of best practice care models** through participation in alternative payment models, Medicare Advantage, and the Centers for Medicare and Medicaid Services' (CMS) innovation programs

We look forward to building on our work so far and continuing to advance value-based care across our network and programs moving forward.

Our approach to value-based care comes to life in the successes we've achieved in the past year across eight systemwide initiatives. We collaborate with our AHCs to focus on specific chronic conditions and improvements in care management to benefit all patients.

UCPH and the systemwide workgroups of subject matter experts from our medical, nursing, pharmacy, social work and population health teams collaborate to shape strategy, set goals and drive execution. Local leadership, clinical informaticists, IT experts and administrative-clinical operations champions are also critical participants in this work.

Our Key Initiatives:

- Diabetes Management
- Hypertension Management
- Oncology Medical Home
- Social Drivers of Health
- Preventive Services
- Coordinated Care
- Cardiac Surgery Consortium
- Population Health Pharmacy

A collegial community of idea sharing and decision making

Lisa Gibbs
Medical Director, Population Health and Value-based Care at UC Irvine and member, UC Population Health Steering Committee

Lisa Gibbs' medical practice focuses on advocacy for older adults. She applies models of complex care for older adults to value-based care and population health. Her focus includes advance care planning, dementia, and elder abuse and neglect. In her work with UC Population Health, she finds that the collegial environment across AHCs and the entire UC system is a chief driver for the program's success.

"The program allows us to share and discuss divergent opinions around the social determinants of health with the goal of making connections across the system and discovering bi-directional insights that can lead to positive outcomes for the populations we serve across the state."

As the health care system in our state and across the nation continues a shift toward value-based models, UC Health is committed to being part of this movement, advancing efforts that focus on driving outcomes, quality and patient experiences that each one of our patients values.

About Value-based Care

UC health professionals recognize that each person is unique and so is their journey to improving and maintaining their health. Across UC's health system, we work to continuously improve quality of care, provider performance and the patient experience for each individual. As the Centers for Medicare & Medicaid Services explain, the "value" in value-based care means delivering what each person values most in their care. When physicians and other health care professionals collaborate to focus on informed patient preferences in their care, both health and outcomes can be improved.

The efforts of UCPH and partners at UC AHCs are moving UC Health towards care models that focus on informed patient preferences, such as innovating 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.[2]

The UC health centers also participate in value-based payment model programs, many of which incorporate incentives with targets for quality, utilization or total cost of care and thus are considered alternative payment models (APMs). These APMs span governmental payors and employer and private health plans, and the level of financial risk and accountability varies.

Figure 1: UC AHC Participation in Alternative Payment Model Contracts
Effective January 2024

	# UC AHCs
CMS Innovation Center Alternative Payment Models (Primary Care, Kidney Care, & Dementia Care)	5
CMS Medicare Shared Savings Program	1
CMS Merit-based Incentive Program	6
Commercial HMO Accountable Care Contracts*	6
Commercial PPO Accountable Care Contracts	2
Managed Medi-Cal	6
Medicare Advantage (HMO)	4
Medicare Advantage (PPO)	5

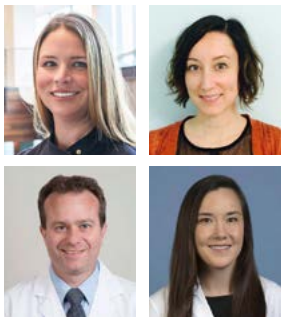
*Includes UC Blue & Gold Accountable Care Contracts

Our Key Initiatives

The leadership, expertise and project management that we provide to our AHCs have strengthened their ability to deliver improved clinical quality, patient experiences, access and screening, cost savings and value of care to the populations and communities served statewide.

1 Diabetes Management

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



This initiative identifies, recommends and implements interventions to improve diabetes care. It employs agreed-upon systemwide approaches to advance health care equity by increasing use of culturally relevant educational materials in preferred languages and integrating patient preferences into clinical workflows.

Target goals met in CY 2023
across important clinical quality diabetes measures:

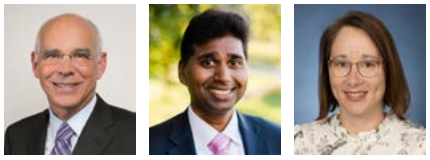
- Optimal diabetes care
- Eye exam
- Glucose control

12%
FY 2024 PERFORMANCE IMPROVEMENT
for optimal diabetes care measure

10.6%
FY 2024 PERFORMANCE IMPROVEMENT
for glucose control measure

2 Hypertension Management

Initiative leads: Samuel Skootsky, UCLA Health; Sandeep (Sunny) Kishore, UCSF Health; Heather Martin, UC Davis Health



This initiative identifies and shares best practices to support blood pressure (BP) control and develop tailored health care strategies to reduce disparities and promote equity. A newly developed Hypertension (HTN) Medication Protocol was introduced, a synthesis of the latest evidence and diverse clinical perspectives into a streamlined practical guidance document.

CY 2023 target goals met
in two important clinical quality HTN measures:

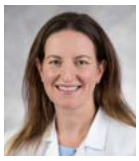
- Overall BP control
- Confirmatory BP readings

4%
FY 2024 PERFORMANCE IMPROVEMENT
for overall BP control for all patients measure

15%
FY 2024 PERFORMANCE IMPROVEMENT
in correct BP measurement (confirmatory BP readings) by implementing a staff-driven workflow with a goal to improve accuracy of BPs taken in clinic

3 Oncology Medical Home (OMH)

Initiative Lead:
Kathryn Gold, UC San Diego Health



In partnership with the UC Comprehensive Cancer Consortium, this initiative developed best practices that improve care for patients with advanced cancer.

These best practices include:

- A common approach to increasing documentation of advance care planning
- Promoting goal-concordant care
- Outcome measurements

OMH-developed utilization measures to drive value-based care and affordability for cancer patients

- Post-hospital discharge follow-up visits
- Inpatient visits at end of life
- Inpatient visits at end of life + mortality

3
UTILIZATION MEASURES IDENTIFIED
Aimed at improving care at the end of life for patients with advanced cancer

4 Social Drivers of Health (SDOH)

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

Social drivers of health (SDOH), sometimes referred to as social determinants of health, comprise social, economic and environmental factors that contribute to health outcomes. Systemwide experts develop common approaches to screening for social risk factors and supporting patients with social needs across the AHCs and in alignment with emerging regulations and incentives.

4 sets of recommendations for screening and addressing social needs developed

1. Food
2. Housing
3. Transportation
4. Utilities

6
AHCs ADOPTED SOCIAL CARE REFERRAL PLATFORMS CONNECTING PATIENTS WITH COMMUNITY-BASED ORGANIZATIONS TO SUPPORT THEIR SOCIAL NEEDS

5 Preventive Services

UCPH's initial focus has been on adult influenza vaccination. UC ambulatory influenza vaccine program leaders convene each year to discuss implementation successes and variation in strategies with a focus on the outcome of vaccination rate performance across the UC Health system to inform and plan for the upcoming flu season.

New pediatrics group focused on influenza vaccine in children

Enhanced population-based dashboards created for both adults and children

6 Coordinated Care

Initiative leads: Michael Helle, UCSF Health; Elizabeth Jaureguy, UCLA Health

This initiative developed a systemwide approach to discover the best practices and models to innovate care coordination and transformation across the UC Health system. This work is focused on innovations operationalizing care management for alternative payment models (for example, Medicare Advantage and Centers for Medicare and Medicaid Services' (CMS') Primary Care First program).

3 focus areas

1. Care in the home
2. Site of care transitions (e.g., from hospital to patient's usual residence)
3. Ambulatory care coordination

7 Cardiac Surgery Consortium

Initiative lead: Richard Shemin, UCLA Health

Across our AHCs we perform the most challenging and complex cardiac surgery cases. This consortium focuses on improving the care model and outcomes, reducing complications and optimizing costs. Two key quality outcome measures we evaluate are: reducing the patient's length of stay (LOS) and readmission to the hospital following a coronary artery bypass procedure.

311
BED DAYS SAVED BY MINIMIZING LENGTH OF STAY AND REDUCING READMISSIONS

$1.7M
ESTIMATED SAVINGS (CY 2023)

8 Population Health Pharmacy

Initiative lead: Katie Medders, UC San Diego Health

Population Health Pharmacy partners with UCPH and the UC self-funded health plan teams to improve the affordability of pharmaceutical therapy for all stakeholders (including patients), improve pharmacy-related quality of care metrics (e.g., medication adherence) and integrate pharmacists and pharmacy technicians into team-based care.

2 new initiatives
launched to help doctors and patients make informed decisions and help patients save money

1. Prescription biosimilars utilization
2. Real-time prescription benefit tools

A driving force for patient-centered care

Elizabeth (Betsie) Jaureguy
Director Ambulatory Care Management

Betsie Jaureguy is a health care innovator. As a nurse leader, she has created systems that improve efficiency while increasing value for patients. At UCLA Health, Betsie leverages multidisciplinary team collaboration to develop models to innovate care coordination.

"This work is emblematic of UC Health's dedication to patient-centered care and our collective goal to successfully participate in alternative payment models, ensuring the best outcomes for patients and the health care system."

Advancing our goals: Charting our progress against key performance indicators (KPIs) and quality-of-care (QOC) benchmarks

The collective success of the above initiatives indicates how we are advancing our goals. Our progress against KPIs, QOC benchmarks, and other metrics illustrates the strides and impact the UC AHCs and UCPH have made together and reflect the commitment to improving patient outcomes, standardizing care, ensuring accountability, driving continuous improvement and innovation, and optimizing resource use and costs.

In FY 2024–2025, we will begin to track **3 systemwide measures** to drive accountable care and affordability for cancer patients:

1. Post-hospital discharge follow-up visits
2. Hospitalizations within the last 30 days of life, within a UC hospital
3. Hospitalizations within the last 30 days of life, and died within a UC hospital

In addition to these important metrics, we have met or exceeded our targets in support of two of the priorities that UC President Michael V. Drake established for the university in the fall of 2022, as shown in Figure 2. These Presidential Priorities are in areas in which the university is uniquely positioned to positively impact the state of California as well as the larger world.

Figure 2: UC Presidential Priority goals met in FY 2023–2024

KPI	Target	FY 2024 Performance
Optimal Diabetes Care	65th percentile	70th percentile (improved by 9.5%)
Controlling High Blood Pressure	80th percentile	80th percentile (improved by 3.1%)

Figure 2 reflects the FY 2024 Presidential Priority goals met for improving chronic conditions.

OUR PROGRESS:

Facilitating

76%

IMPROVEMENT

across

13

CLINICAL QUALITY METRICS to improve chronic disease management

Facilitating

22%

IMPROVEMENT

across health equity-focused measures

Setting New Standards in Delivering Value-based Care:

UC Programs Fuel Action and Innovation

Collectively, our key initiatives support our broad-based mission of furthering the development of value-based care across our system. The partnership of UCPH and our six AHCs is truly a collaborative effort to address the wide range of population health management challenges that the populations we serve routinely face.

Advancing best practices and tools

Through partnerships across the UC system and with our individual AHCs, UCPH continues to be a catalyst for innovation in population health and improving the patient experience. UCPH supports the work of subject matter experts in fields such as medicine, nursing, pharmacy, social work and population health leading the multidisciplinary, systemwide workgroups. UCPH then facilitates the spread of what's working in one location to the other UC academic health centers, extending care delivery innovation and excellence to every location.

UCPH has compiled evidence-based and local best practice interventions that address common challenges to controlling blood pressure and optimizing diabetes care, medication affordability, advancing health care equity, and supporting social needs (see box). We developed these guides in response to requests from our UC AHCs to have a succinct central resource for implementing improvement strategies into practice.

UC recommended intervention guides

1. Biosimilar Medication Utilization
2. Advancing Health Care Equity in Clinic
3. Screening for Social Needs

An integrated patient view with pharmacists at the table

Katie Medders
UC Health Pharmacist Lead for the UCPH Pharmacy Group

Katie Medders works with the UC Population Health team to reduce the cost of medications to patients, UC medical plans for employees, and UC Health. Medication protocols and best practices for prescriptions help reduce disparities and overcome barriers. Medders emphasized that including a pharmacist in a patient's interdisciplinary medical team results in better outcomes, fewer side effects, and an overall lower cost of total care for the patient.

"Involving a pharmacist in a patient's care plan supports a clinical care pathway to help get patients on the right medication. It supports a comprehensive view of the patient and points toward a more proactive, preventative care model."

Championing medication protocols

Medication Protocol leads: Katie Medders, UC San Diego Health; Sandeep (Sunny) Kishore, UCSF Health; Heather Martin, UC Davis Health

Hypertension and diabetes are modifiable cardiovascular disease (CVD) risk factors that contribute to nearly one-third of all deaths in the Americas each year.[3] CVD remains a leading cause of death in the U.S.,[4] with an average of 2,552 deaths from CVD occurring each day. UCPH has prioritized a systemwide focus on improving clinical outcomes and reducing costs related to these CVD risk factors.

Medication protocol advantages

- Practical, scalable and evidence-based
- Streamlined clinician and staff education & implementation practices
- Better patient adherence and achievement of outcome goals (e.g., blood pressure control)

UCPH has led a collaborative effort to develop and disseminate two medication protocols that serve as a standardized, systemwide approach to improve health outcomes for patients with hypertension and diabetes. Informed by teams of UC experts, systemwide data and consensus on best practices, these protocols aim for patients to receive the right medications with attention to issues of access, patient adherence and affordability. All clinicians can use these medication protocols to decrease variation in care decisions and improve outcomes in hypertension and diabetes control.

UCPH developed a comprehensive program to support the efforts of this initiative, including:

- Providing socialization and implementation resources to each UC location along with a communications tool kit to help operationalize and scale the approach
- Initiating clinician in-service trainings
- Creating checklists to help track socialization and adoption practices at each campus site
- Developing process outcome measures to track progress over time

Figure 3: Diabetes Cohort – Newer Cardioprotective Medications Scorecard

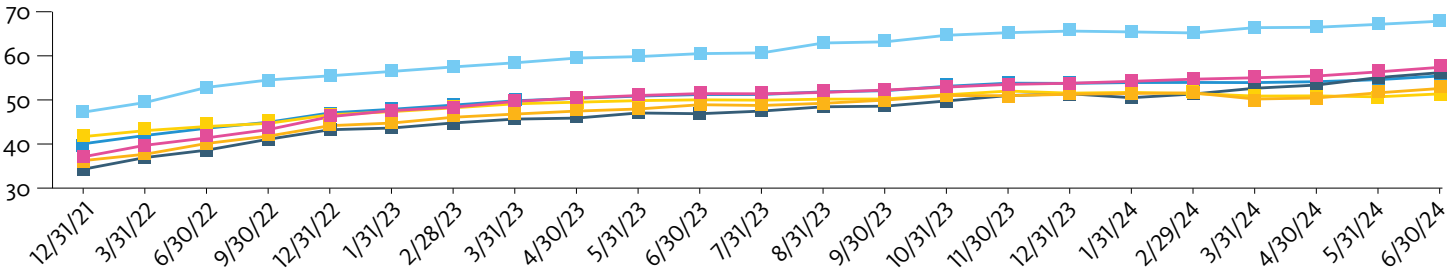


Figure 3 is an example of a custom metrics dashboard developed through subject matter expert insight from the UC diabetes management initiative. Recent national guidelines recommend the use of newer cardiorenal-protective drug use in diabetes. There was an organized, systemwide effort to develop the medication protocol and improve the use of these life-saving drugs. The upward trend in the use of these agents is the result of improvement work and protocol implementation.

A data-driven, comprehensive approach to population health

Christine Thorne
Primary Care Physician

Christine Thorne is a professor in family medicine at UC San Diego whose medical practice focuses on preventative medicine and public health. In her work in population health, she integrates information and knowledge across the health care system to reduce fragmented approaches in medical care and promote better outcomes.

"With population health, it's important for us to look at the data that emerges from all the populations we serve. Given the complexity of health care delivery today, we must approach population health systematically and drive improvements in clinical quality."

Advancing health equity

We remain committed to serving the diverse populations that comprise the rich fabric of life experiences in California. We continue to advance equity in access and outcomes with programs and services to support the various needs of our state's residents.

- **Capturing the patient voice.** Direct patient interviews help us capture patients' experiences, concerns and suggestions, and identify barriers to care and patient preferences. These help us calibrate our resource planning and provide more effective outreach and care delivery services and interventions.
- **Translating resources.** By providing patients with translated and culturally appropriate resources, we provide information about their health and help inform personal decisions about their care in their preferred language.
- **Advancing social needs.** Our UC Health SDOH workgroup has developed an initial approach to screen for a diverse set of needs and connect patients with the resources and referrals to address these needs. Through a contracted arrangement with social needs referral platforms such as FindHelp or 211 that can be integrated into the electronic health record system, our AHCs can connect patients to community-based organizations and services in multiple ways. All six UC AHCs have adopted an integrated social needs referral platform.

A focus on the whole patient experience

Naveen Raja
Chief Medical Officer at UCR Health and member, UC Population Health Steering Committee

Naveen Raja remains committed to the concept of whole person care by erasing the boundaries that traditional medicine typically erects around a patient's health care, focusing instead on patients' unique needs that are dependent on their specific circumstances.

"Only about 20% of a patient's overall health outcome is due to the health care that the patient receives; 80% of health outcomes are driven by socioeconomic, behavioral and environmental factors. That's why we're focused on incorporating social drivers of health into the care model. It is essential to use whole person care models to help our patients achieve the best possible health outcomes."

Celebrating Our Success:
National Recognition for Our Programs and Initiatives

We're delighted to share the recognition that leading national organizations have provided our AHCs.

American Heart Association Outpatient Program Achievement Awards

The American Heart Association (AHA) awards achievement and participants' commitment to reducing the risk of heart disease and stroke by improving type 2 diabetes and blood pressure (BP) management and aligning with the latest evidence- and research-based guidelines.

Five of our AHCs — UC Davis Health, UC Irvine Health, UCLA Health, UC San Diego Health and UCSF Health — now participate in two programs from the AHA: Target: BP and Target: Type 2 Diabetes. A UCPH assessment against the AHA standards indicates that all AHCs perform at top levels across most or all measures. This reflects multi-year engagement and dedication to improving cardiovascular health, fostering prevention and leading in innovative treatments.

Visit the American Heart Association Outpatient Program to learn more.

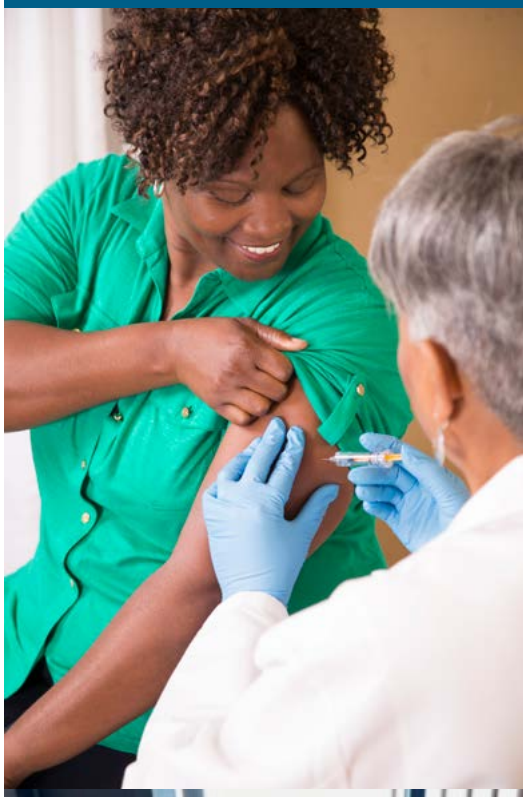
The American Medical Group Association (AMGA) Foundation's Rise to Immunize (RIZE) campaign

The UC AHCs stand out as top performers in the Rise to Immunize (RIZE) campaign which is sponsored by the American Medical Group Association (AMGA) Foundation. This recognition highlights high-performing medical groups and health systems nationwide that have made significant progress in routine adult immunization care.

RIZE is a four-year initiative by the AMGA Foundation aiming to empower medical groups and health systems to administer 25 million vaccines by 2025, focusing on increasing adult immunization rates and reducing vaccine-preventable diseases.

Our AHCs hold the top 5 slots nationally for influenza immunization in the national AMGA program. They also have the highest bundle vaccination rates (includes Influenza plus Pneumococcal, Td/Tdap and Zoster). All UC AHCs are in the top 15 for the immunization bundle, with 3 holding the top 3 slots. This performance reflects the sustained engagement and improvement work at each site.

Visit AMGA's Rise to Immunize site to learn more about the program.



Community event, courtesy of UCSF Health

A broad-based view of social drivers and population health

Matt Pantell
Pediatric Physician and Researcher

In addition to Matt Pantell's work as a pediatrician, he focuses on integrating both social and medical perspectives in screening for social drivers of health through programs such as the Social Interventions Research & Evaluation Network (SIREN). He believes that incorporating the social context of patients' situations contributes to improving broader social and health outcomes in population health.

"People are struggling with social situations in all walks of life. When we reduce screening inequities and address socioeconomic hardships and barriers that exist across populations, we can better understand the information we're collecting, aggregate that data, and extrapolate that knowledge and scale it to develop solutions that address broad-based social population health needs."

Looking Ahead:
Continuing Our Mission

We've built a successful foundation to execute UC Health's vision for a population health management strategy, one that strives to serve diverse communities and to prepare UC's health care system for growing value-based care and contracts across California.

We continue to pursue our objectives to deliver the best possible care for defined populations and to ensure the financial stability of our institutions. We are committed to increasing investment in our infrastructure to focus on improving our models of care delivery and the patient experience, monitoring metrics to measure our impact on closing health disparities, and delivering value to patients, employers and insurers. This includes building capabilities to understand barriers to access and incorporate patient preferences.

UCPH remains committed to ensuring that we align our leadership with local and systemwide priorities to deliver the highest quality care with the most effective impact. We will expand our data and analytics platform as we continue to engage UC experts and leaders across our work.

In our steadfast spirit of collaboration and innovation, we will broaden our focus on providing high-value, patient-centered and value-based care for our patients and the communities we serve across California.

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

Gina Shuler
Vice President and Chief Population Health Officer, UC San Francisco

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

Lisa Gibbs
Medical Director, Population Health and Value-based Care, 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, UCSD Health

Additional UC Population Health Leadership

Erwin Altimira, UC Irvine Health

Duncan Campbell, UC San Diego Health

Angie Chang, UC Irvine Health

Eileen Haley, UC San Diego Health

Michael Helle, UC San Francisco Health

Tim Judson, UC San Francisco Health

Natalie Maton, UC Irvine Health

Vanessa McElroy, UC Davis Health

Georgia McGlynn, UC Davis Health

Sarah Meshkat, UC Los Angeles Health

Noelle Lee, UC San Francisco Health

Our UC Health Population Health Team

Maricel Cabrera

Nicole Friedberg

Ellen Lenzi

Natalie Nguyen

Rachael Sak

Samuel A. Skootsky

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

Nadya Balabanova

Lisa Dahm

Ray Pablo

Ayan Patel

Teju Yardi

Our UC Academic Health Center Partners by Initiative

HYPERTENSION MANAGEMENT

Sandeep (Sunny) Kishore (Lead), UC San Francisco Health
Heather Martin (Lead), UC Davis Health
Samuel Skootsky (Lead), UC Los Angeles Health
Parag Agnihotri, UC San Diego Health
Surabhi Atreja, UC Davis Health
Peter Barakat, UC Los Angeles Health
Quanna Batiste-Brown, UC Los Angeles Health
Chidinma Chima-Melton, UC Los Angeles Health
Clare Connors, UC San Francisco Health
Lisa Dahm, UC Irvine Health
Nana Entsuah, UC Irvine Health
Samia Faiz, UC Riverside Health
Lisa Gibbs, UC Irvine Health
Mark Grossman, UC Los Angeles Health
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Natalie Halanski, UC San Diego Health
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Dennis P. Harris, UC Los Angeles Health
Anthony Jerant, UC Davis Health
Andrew Jones, UC Davis Health
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Chris Kroner, UC Irvine Health
Hannah Kwak, UC Los Angeles Health
BJ Lagunday, UC Davis Health
Sylvia Lambrechts, UC Los Angeles Health
Helen Lau, UC Riverside Health
Heather Leisy, UC Davis Health
Rebecca Leon, UC San Francisco Health
Ottar Lunde, UC San Diego Health
Mina Malaak, UC Los Angeles Health
Mary Martin, UC San Francisco Health
Katie Medders, UC San Diego Health
Sarah Meshkat, UC Los Angeles Health
Neeki Mirkhani, UC Los Angeles Health
Cassandra Morn, UC San Diego Health
Maryam Rahimi, UC Irvine Health
Ajit Raisinghani, UC San Diego Health
Naveen Raja, UC Riverside Health
Ben Rasmussen, UC Davis Health
Linda Roney, UC Riverside Health
Gabrielle Salter, UC Davis Health
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Matthew Satre, UC San Diego Health
Ally Schlofner, UC Davis Health
Shirley Wong, UC San Francisco Health
Nghe Yang, UC San Francisco Health
Crystal Zhou, UC San Francisco Health
Tina Zolfaghari, UC San Francisco Health

DIABETES MANAGEMENT

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Maria Han (Lead), UC Los Angeles Health
Katie Medders (Lead), UC San Diego Health
Christine Thorne (Lead), UC San Diego Health
Nicole Appelle, UC San Francisco Health
Katya Avakian, UC Los Angeles Health
Susan Baer, UC Irvine Health
Sarah Bajorek, UC Davis Health
Mackenzie Clark, UC San Francisco Health
Lisa Gibbs, UC Irvine Health
Reshma Gupta, UC Davis Health
Corinne Hajjar, UC San Diego Health
Pawny Kelly, UC San Diego Health
Lisa Kroon, UC San Francisco Health
Kristen Kulusa, UC San Diego Health
Sylvia Lambrechts, UC Los Angeles Health
Helen Lau, UC Riverside Health
Heather Leisy, UC Davis Health
Rebecca Leon, UC San Francisco Health
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Sarah Meshkat, UC Los Angeles Health
Tracy Moor, UC San Diego Health
Cassandra Morn, UC San Diego Health
Michael Nies, UC San Diego Health
Carolina Noya, UC San Francisco Health
Terrye Peterson, UC Irvine Health
Alan Phan, UC Irvine Health
Naveen Raja, UC Riverside Health
Linda Roney, UC Riverside Health
Gabrielle Salter, UC Davis Health
Vanessa Schmidt, UC Los Angeles Health
Joann Seibles, UC Davis Health
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Shawn Torres, UC San Francisco Health
Tiffany Vo, UC Irvine Health
Shirley Wong, UC San Francisco Health
Glenn Yiu, UC Davis Health
Tina Zolfaghari, UC San Francisco Health

SOCIAL DRIVERS OF HEALTH (SDOH)

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Endnotes

1 Kindig, D., Stoddart, G. "What is population health?" *American Journal of Public Health*, 93, no. 3 (2003), pp. 380–383; Silberberg, M., Martinez-Bianchi, V., Lyn, M.J. "What Is Population Health?" *Primary Care*, 46, no. 4 (2019), pp. 475–484.

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