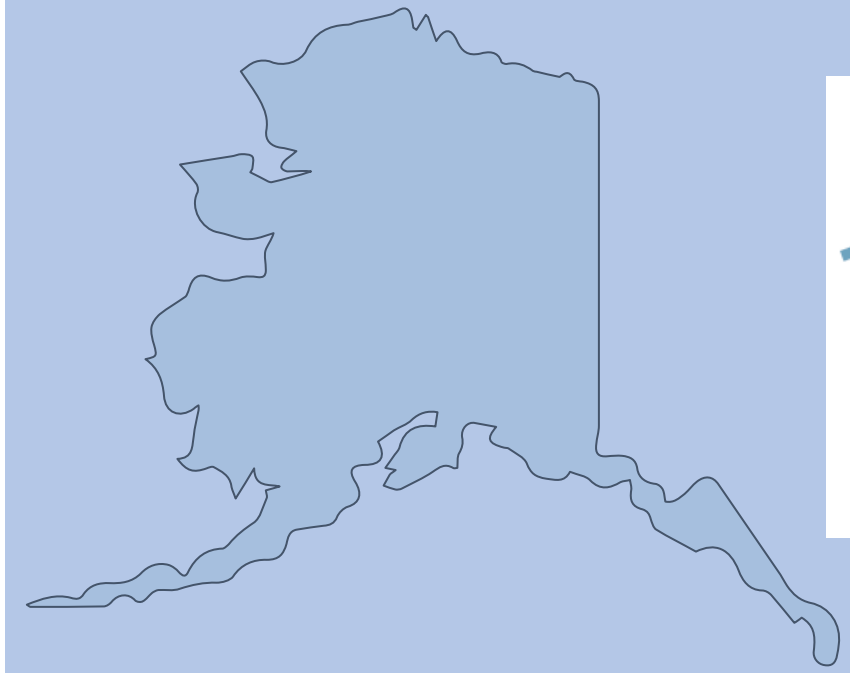
Innovative Outpatient Strategies to Prevent Hospitalizations and Improve Health

Chair: Gene Quinn, Envoy Integrated Health ACO

Innovative Outpatient Strategies to Prevent Hospitalizations and Improve Health



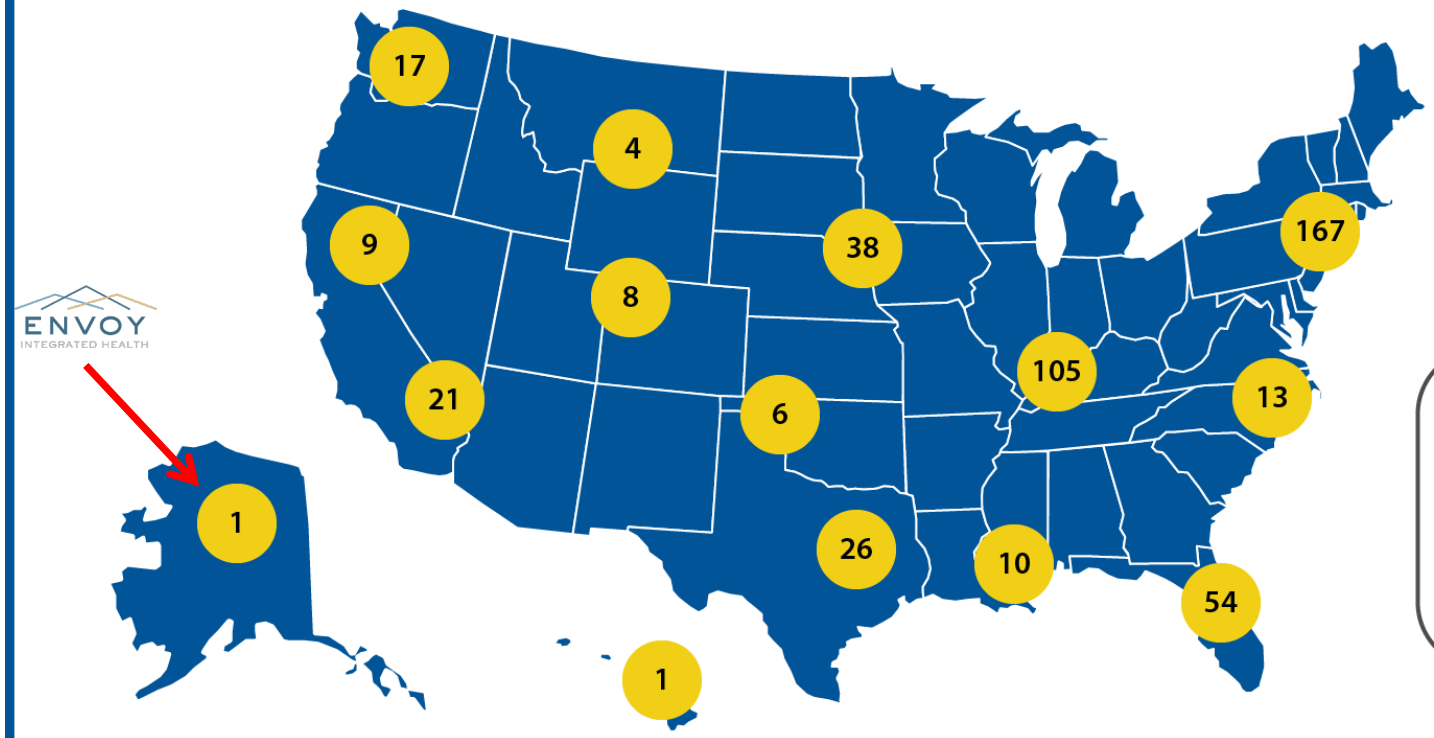
ENVOY
INTEGRATED HEALTH

Gene R. Quinn, MD, MPH

Chief Executive Officer - Envoy Integrated Health Network and ACO

Medical Director of Quality and Population Health – Alaska Heart and Vascular

Envoy Integrated Health ACO



480 Shared Savings Program ACOs are providing care to 10.8 million beneficiaries

 # Number of ACOs in the area.

NOTE: This area may cover organizations serving beneficiaries across multiple states.

Source: Performance Year 2024 Medicare Shared Savings Program Accountable Care Organizations


Greenland
Iceland
Canada
United States
Mexico
Japan
North Pacific Ocean
North Atlantic Ocean
Venezuela
Colombia
Map data ©2026

Community-focused Alaskan ACO

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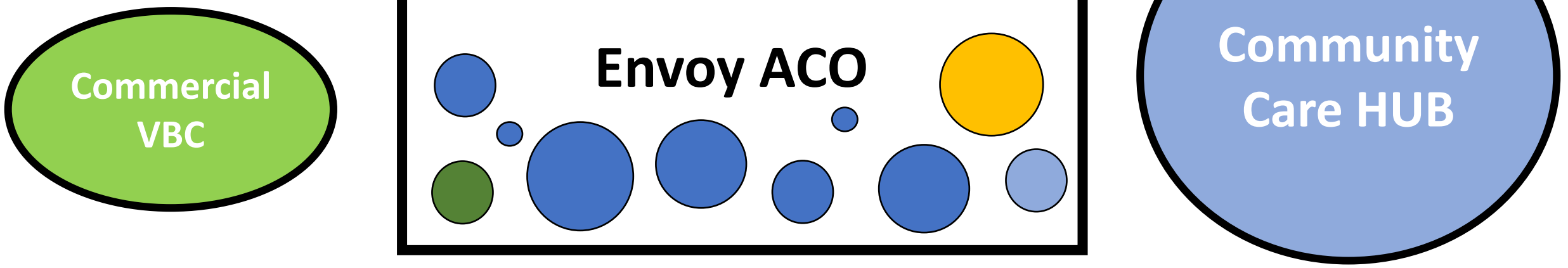
- 100% Physician-owned and Led
- Broad Representation from Medical Community
- Inclusive of Specialists and Primary Care
- Mission > Money
- **RELIED ON NAACOS FOR GUIDANCE**



Envoy Integrated Health ACO

2024 Financial Reconciliation – First Year Results

- Envoy ACO Saved CMS $7.6 million on our population of ~6,300

- Envoy's savings rate was 10.46%

Conclusion:

Value-Based Care models work in Alaska

But… Now What?

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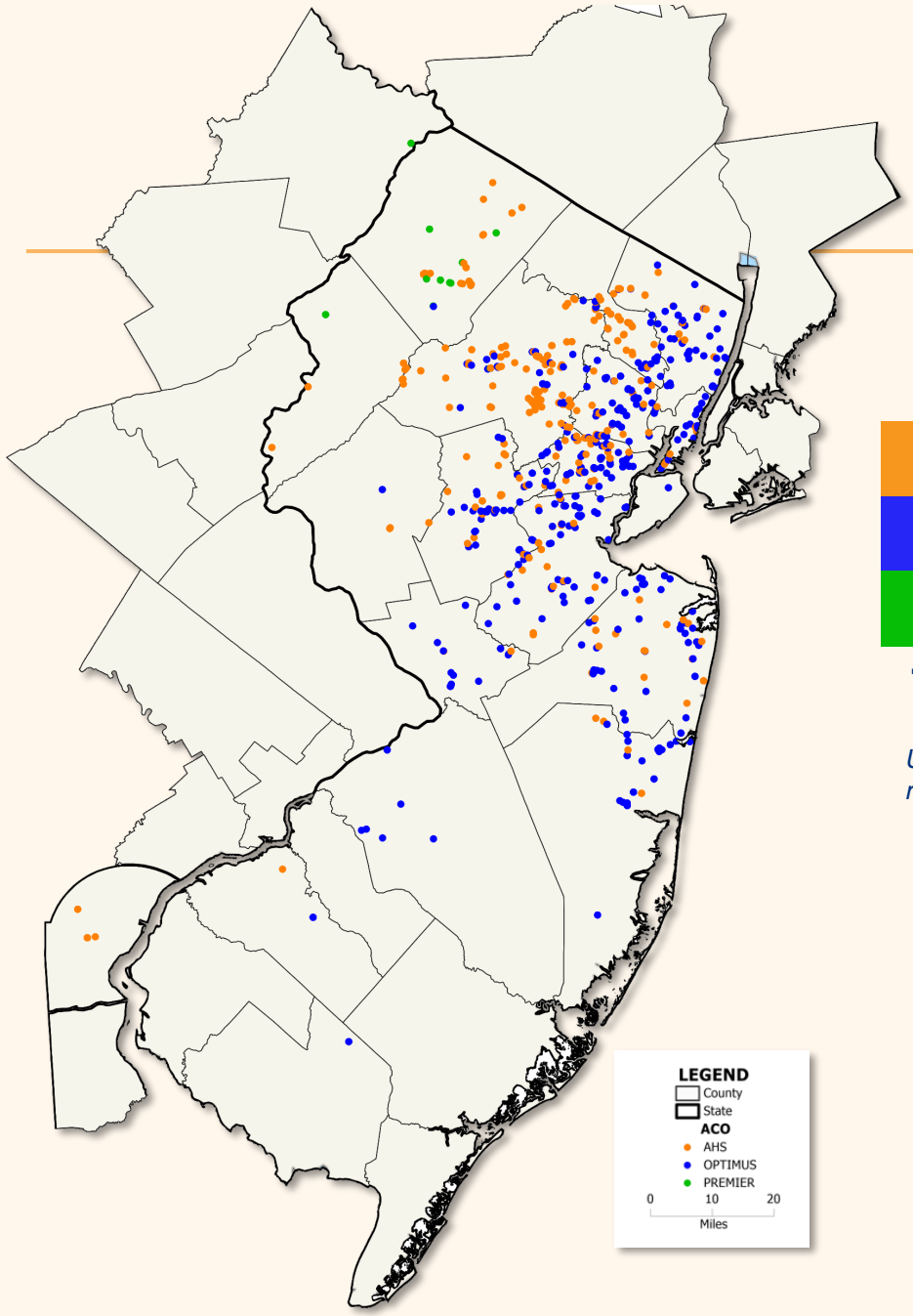
- What are my peers doing?
- What are the best practices?
- Is this a model that I could bring back to my community?

Innovative Outpatient Strategies to Prevent Hospitalizations and Improve Health

Anjali Kakwani, Pharm.D., BCPS, CACP
Manager of Pharmacy, Accountable Care Organizations
Atlantic Health

Atlantic Health



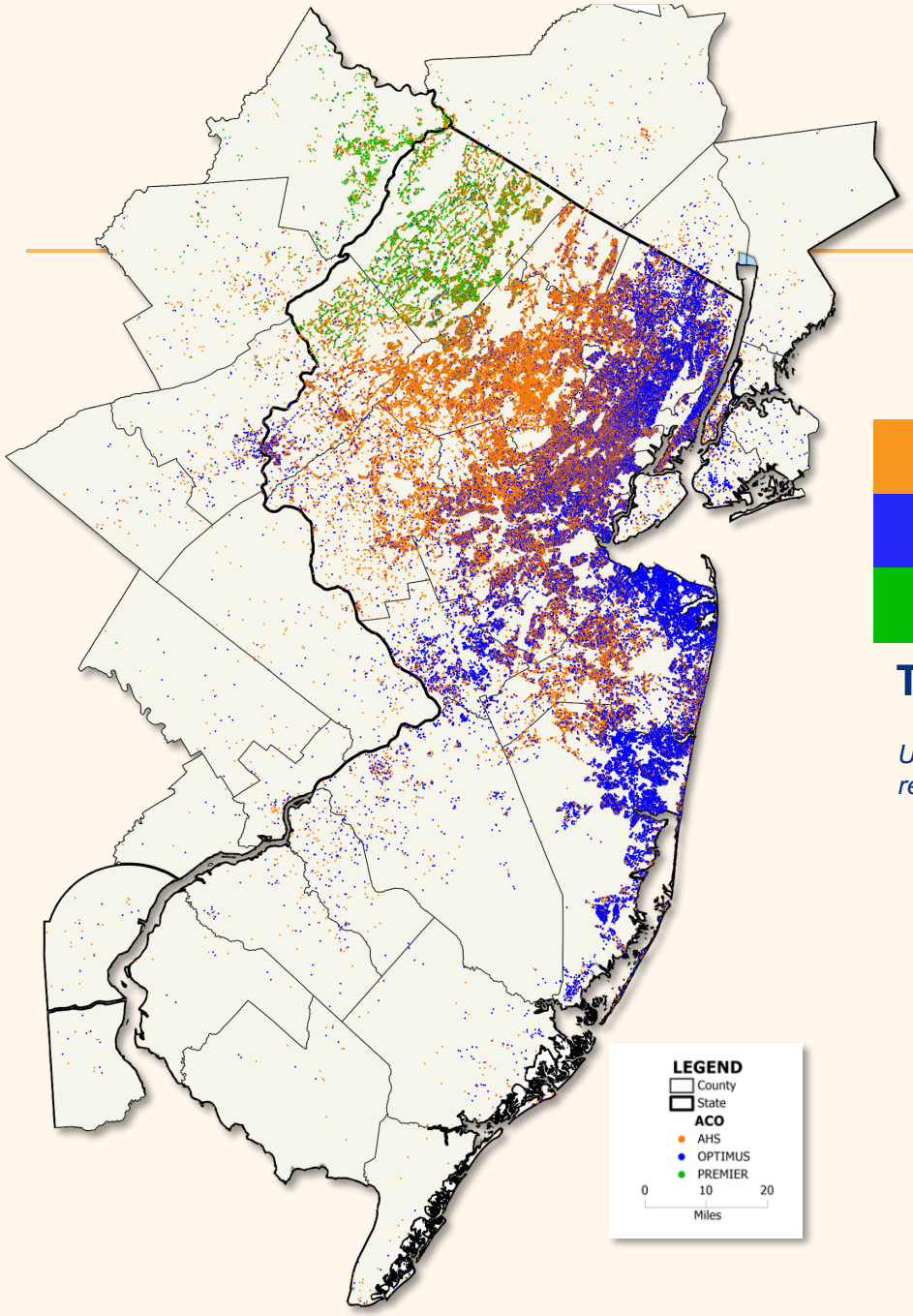
Accountable Care Organization

Physician Network

	Primary Care	Specialists	Grand Total
Atlantic ACO	572	2,488	3,060
Optimus ACO	494	592	1,086
Premier ACO	24	16	40
Total Providers	**1,090**	**3,096**	**4,186**

Updated Mar 2026: Displays the number of providers by aco and commercial/mssp, batch_yearmonth 2025_09 from refined_aco_attribution.aco_attribution_current

Atlantic Health



Accountable Care Organization

Patient Attribution

	Commercial Attribution	MSSP Attribution	Grand Total
Atlantic ACO	255,898	43,465	299,363
Optimus ACO	183,957	30,997	214,954
Premier ACO	12,418	6,908	19,326
Total Attribution	452,273	81,370	533,643

Updated Mar 2026: Displays the number of providers by aco and commercial/mssp, batch_yearmonth 2025_09 from refined_aco_attribution.aco_attribution_current

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Objectives

- Define Clinical Pharmacist & Clinical Pharmacy Specialist
- Define Comprehensive Medication Management
- Describe the journey of value-based clinical pharmacy services at Atlantic Health
- Discuss the role of artificial intelligence and predictive analytics in medication management

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What is a Clinical Pharmacist?

- Practitioners who provide **comprehensive clinical pharmacy services** to achieve **medication optimization** for patients in all healthcare settings
- Licensed pharmacists with **specialized advanced education and training** who possess the clinical competencies necessary to practice in team-based, direct patient care environments
  - Doctor of Pharmacy (Pharm.D.)
- **Accredited residency training** or equivalent post-licensure experience is required
- **Board certification, in their specialty, is also required** once clinical pharmacist meet eligibility criteria set forth by the Board of Pharmacy Specialties (BPS)
  - **Clinical Pharmacy Specialist** is a commonly used title to distinguish a Clinical Pharmacist with board certification

1. ACCP Position Statement. Standards of practice for clinical pharmacists. J Am Coll Clin Pharm. 2023;6:1156-1159.

Atlantic Health

Comprehensive Medication Management is a Critical Component of Whole Person Care

- Definition:
  - "a **patient-centered** approach to **optimizing medication use** and **improving patient health outcomes** that is delivered by a **clinical pharmacist** working in **collaboration** with the patient and other health care providers"
- Includes: individualized care plan that achieves the intended goals of therapy with appropriate follow-up to determine actual patient outcomes
- Requires: shared decision making and understanding from the patient, who agrees with treatment regimen and actively participates in care plans
- Goals: optimize patient's medication experience & clinical outcomes, improved prescriber satisfaction

1. J Am Coll Clin Pharm. 2020;3:520–531.

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Collaborative Care Models Encompassing Clinical Pharmacists Improve Clinical Outcomes

Image from: https://thumbs.dreamstime.com

Atlantic Health

Journal of the American Pharmacists Association 63 (2023) 269–274

Contents lists available at ScienceDirect

Journal of the American Pharmacists Association

journal homepage: www.japha.org

RESEARCH

Impact of a COPD care bundle on hospital readmission rates

Moira E. Kendra, Anjali Kakwani*, Amulya Uppala, Rupal Mansukhani, Darriea K. Pigott, Maria Soubra, Jeri Jacobson, Federico Cerrone, Mary Farrell, Stephanie Chiu, Kathleen Lieder, Danielle Tonzola, Chirag V. Shah, Sibyl Cherian

ARTICLE INFO

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ABSTRACT

Background: Chronic obstructive pulmonary disease (COPD) is one of the leading causes of mortality worldwide and contributes considerably to morbidity and health care costs. In October 2014, the Centers for Medicare and Medicaid Services introduced financial penalties followed by bundled payments for care improvement initiatives in patients hospitalized with COPD.

Objectives: This study seeks to evaluate whether an evidence-based interprofessional COPD care bundle focused on inpatient, transitional, and outpatient care would reduce hospital readmission rates

Results: Baseline Characteristics

Table 3
Demographics of the control arm and the COPD care bundle arm

Characteristics	Control[a] (n = 189)	COPD care bundle[a] (n = 127)	*P* values
Admission source			
Clinic referral	11 (5.8)	16 (12.6)	0.046
Home	168 (88.9)	96 (75.6)	0.003
Skilled nursing facility	10 (5.3)	7 (5.5)	0.932
Transferred from another facility	0 (0)	8 (6.3)	0.001
Age, years, mean (SD)	74.7 (11.1)	71.9 (10.9)	0.027
Sex, female	105 (55.6)	79 (62.2)	0.24
Race			
White	134 (70.9)	94 (74.0)	0.524
Black	32 (16.9)	24 (18.9)	
Asian	2 (1.1)	1 (0.8)	
Declined/other	21 (11.1)	8 (6.3)	
Primary payer			
Traditional Medicare	120 (63.5)	63 (49.6)	0.014
Managed Medicare	34 (18.0)	31 (24.4)	0.174
Medicaid	10 (5.3)	19 (15.0)	0.007
Commercial	22 (11.6)	13 (10.2)	0.693
Charity care	3 (1.6)	0 (0)	0.277
Self-pay	0 (0)	1 (0.8)	0.402
Discharge status			
Home	147 (77.8)	107 (84.3)	0.132
Long-term care	39 (20.6)	16 (12.6)	
Hospice	3 (1.6)	4 (3.1)	
Smoker at admission	47 (24.9)	38 (29.9)	0.325
Hospitalized in the past year	80 (42.3)	58 (45.7)	0.557

Abbreviation used: COPD, chronic obstructive pulmonary disease.
[a] All values are n (%) unless otherwise specified.

1. Kendra ME, Kakwani A, Uppala A et al. Journal of the American Pharmacists Association 63 (2023) 269e274.

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Reduced Hospital Readmissions

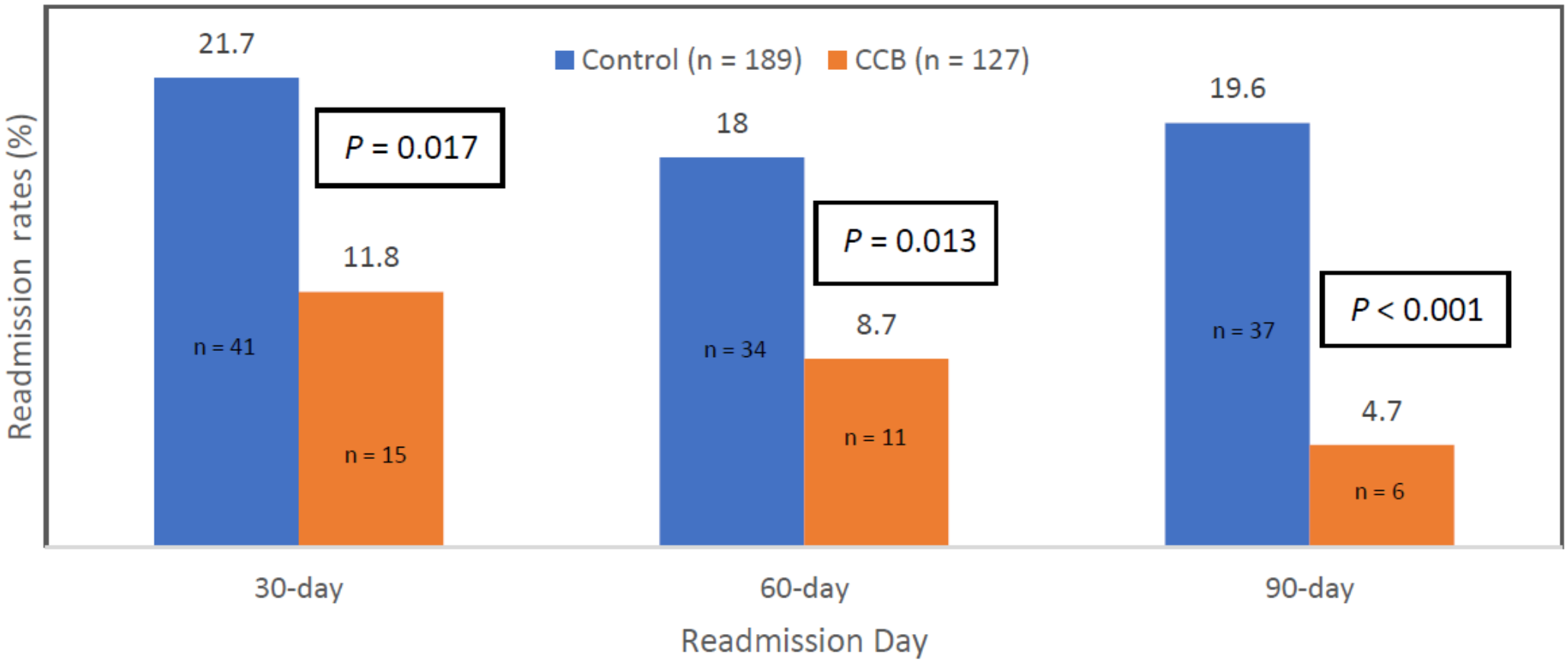

Figure 1. Primary and secondary outcomes: Readmission rates. Abbreviation used: CCB, COPD care bundle.

1. Kendra ME, Kakwani A, Uppala A et al. Journal of the American Pharmacists Association 63 (2023) 269e274.

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Secondary Outcomes: Clinical Pharmacist Interventions

Table 5
Secondary outcomes: Clinical pharmacist interventions in COPD care bundle

TOC clinical pharmacist interventions	Number of patients, n (%)	Time spent, average min (minimum–maximum)
TOC clinical pharmacist interviews	87 (68.5)	67.1 (10–220)
Disease state management	85 (66.9)	31.5 (10–90)
Assistance with access to medications	58 (45.7)	31.8 (10–90)
Medication reconciliation	65 (51.2)	32.9 (10–115)

Abbreviations used: COPD, chronic obstructive pulmonary disease; TOC, transitions of care.

Clinical pharmacists:

- Consulted with 68.5% of patients
- Spent an average total time of **67.1 minutes per patient**
- Provided **disease state management** for 66.9% of patients
- Assisted with **access to medications** for 45.7% of patients
- Identified an average of **2.8 medication errors per patient**

1. Kendra ME, Kakwani A, Uppala A et al. Journal of the American Pharmacists Association 63 (2023) 269e274.

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Statistically Significant Increase in Guideline Directed Medical Therapy at Discharge

Table 4
Secondary outcomes: Length of stay and escalation of COPD maintenance therapy

Secondary outcomes	Control[a] (n = 189)	COPD care bundle[a] (n = 127)	*P* values
Length of stay, days, median (minimum–maximum)	4 (1–21)	1 (1–29)	0.170
Escalation of COPD maintenance therapy			
Yes	42 (22.2)	57 (44.9)	< 0.001
No	113 (59.8)	25 (19.7)	< 0.001
No escalation necessary	34 (18)	45 (35.4)	0.001

Table 6
COPD medications at discharge

Medication class	Control[a](n = 189)	COPD care bundle[a] (n = 127)	*P* values
SABA	129 (68.3)	122 (96.1)	< 0.001
SAMA	59 (31.2)	26 (20.5)	0.029
LABA	111 (58.7)	112 (88.2)	< 0.001
LAMA	85 (45)	97 (76.4)	< 0.001
ICS	116 (61.4)	92 (72.4)	0.037
Antibiotic agents	29 (15.3)	18 (14.2)	0.773
Steroids	112 (59.3)	111 (87.4)	< 0.001

Abbreviations used: COPD, chronic obstructive pulmonary disease; ICS, inhaled corticosteroid; LABA, long-acting beta agonist; LAMA, long-acting muscarinic antagonist; SABA, short-acting beta agonist; SAMA, short-acting muscarinic antagonist.
[a] All values are n (%) unless otherwise specified

1. Kendra ME, Kakwani A, Uppala A et al. Journal of the American Pharmacists Association 63 (2023) 269e274.

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Clinical Pharmacists Bring *Value* to Value-Based Care

- Suboptimal medication management costs the nation an estimated **$528 billion each year**[1]
- **Integration of clinical pharmacists into value-based care** teams is critical to **improve medication safety and effective guideline-directed medical therapy**
- **Atlantic Health's ACO Clinical Pharmacy team** has demonstrated a **5:1 to 9:1 return on investment** over three consecutive years (2022 - 2024) through medication management[2]

References:
1. *Watanbe et al. Cost of Prescription Drug-Related Morbidity and Mortality. Ann Pharmacother. 2018 Sep;52(9):829-837. https://pubmed.ncbi.nlm.nih.gov/29577766/*
2. *https://www.horizonblue.com/providers/news/news-legal-notices/pharmacy-collaboration-leads-better-patient-outcomes-and-cost-savings*

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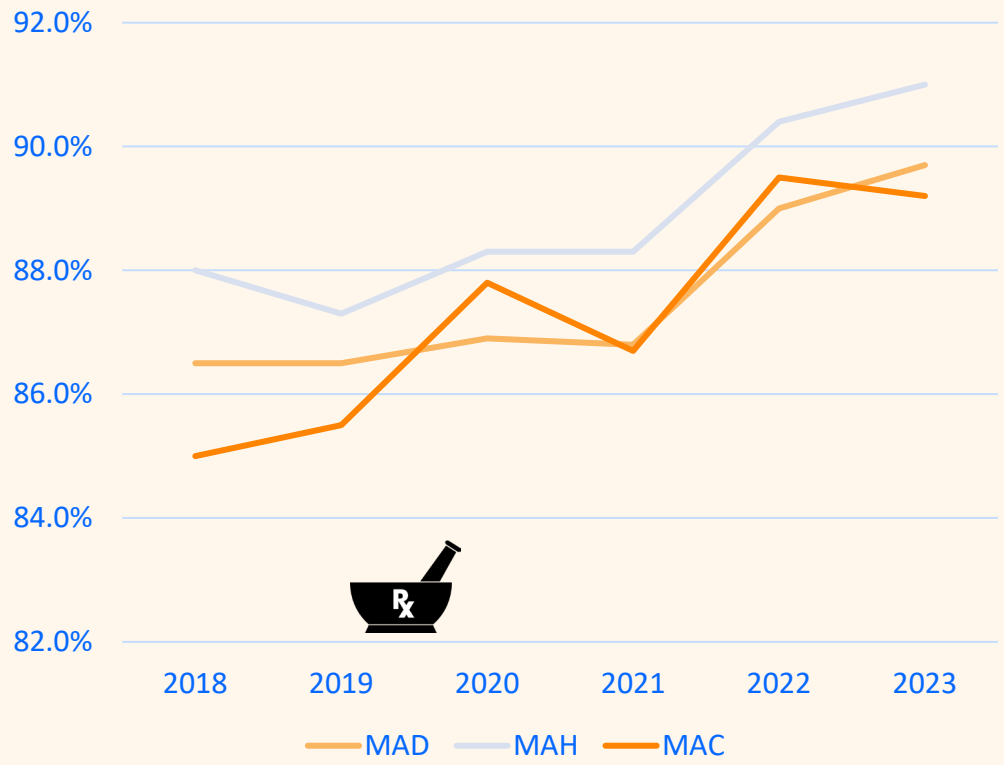
Clinical Pharmacists Improve Medication Adherence

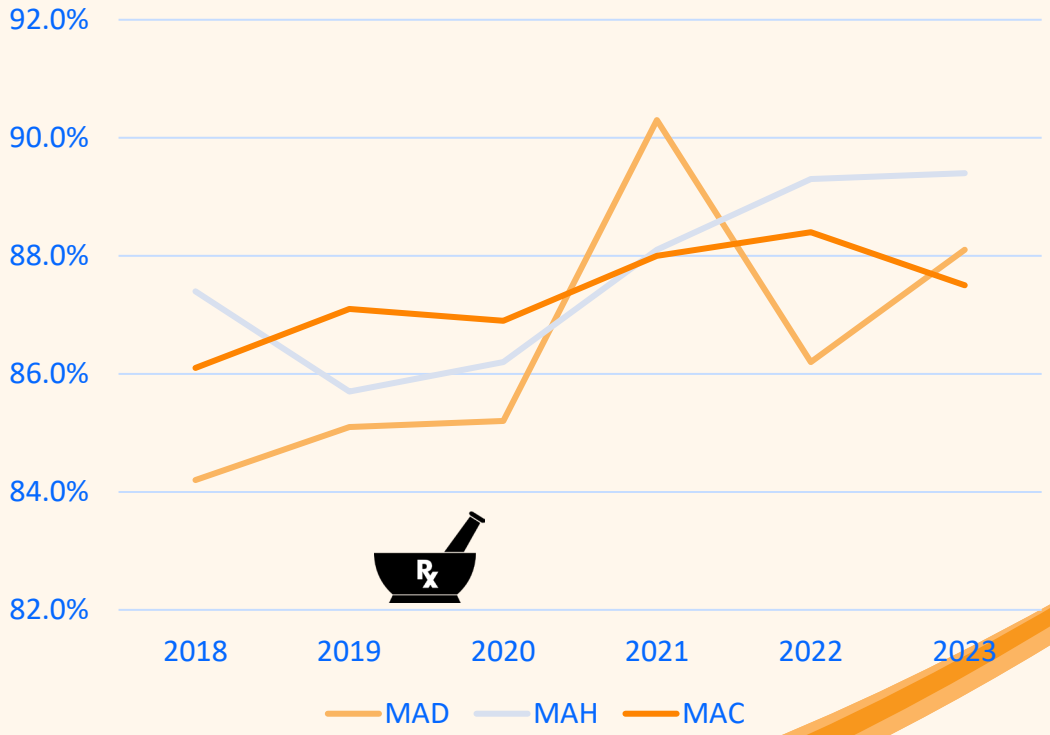
Nonadherence leads to 125,000 unnecessary deaths each year!
Nonadherence is estimated to cost $300 billion in wasted healthcare resources each year!

Atlantic ACO Medication Adherence



N= 5311 Medication Adherence Opportunities in 2023

Optimus Medication Adherence



N= 2990 Medication Adherence Opportunities in 2023

1. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5317296/#:~:text=They%20calculated%20that%20improved%20adherence,a%20saving%20of%20%244.7%20billion.Adsfa

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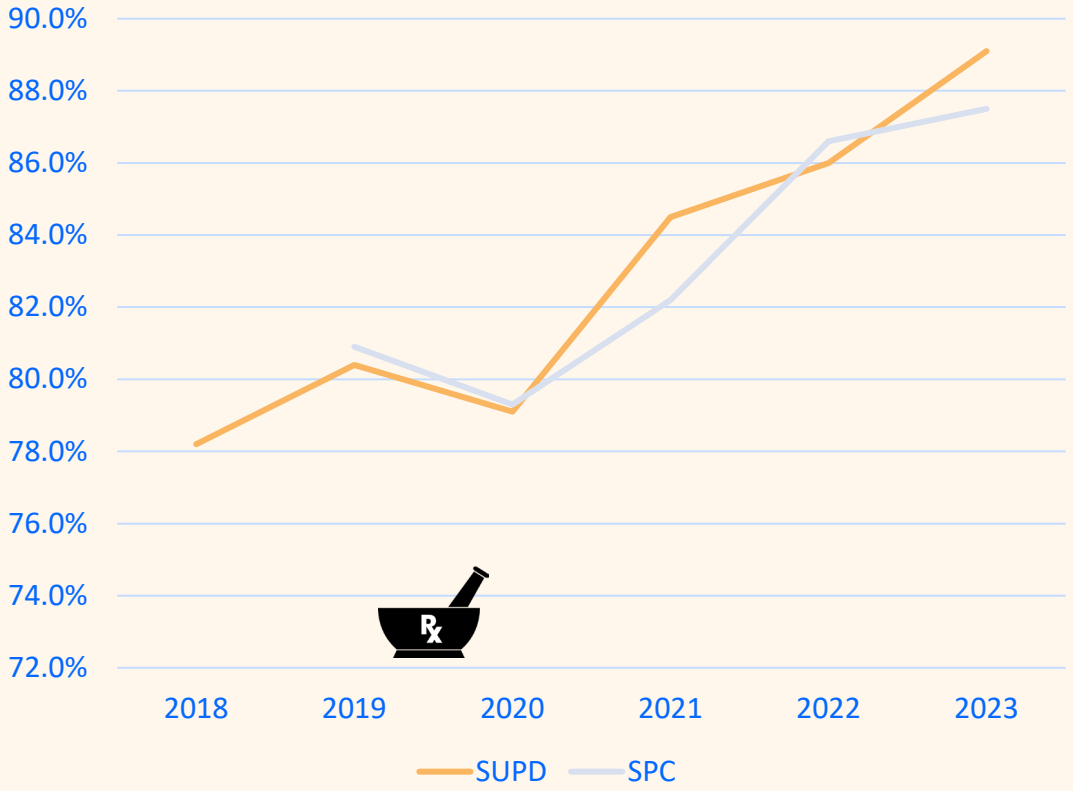
Clinical Pharmacists Improve Statin Quality Outcomes

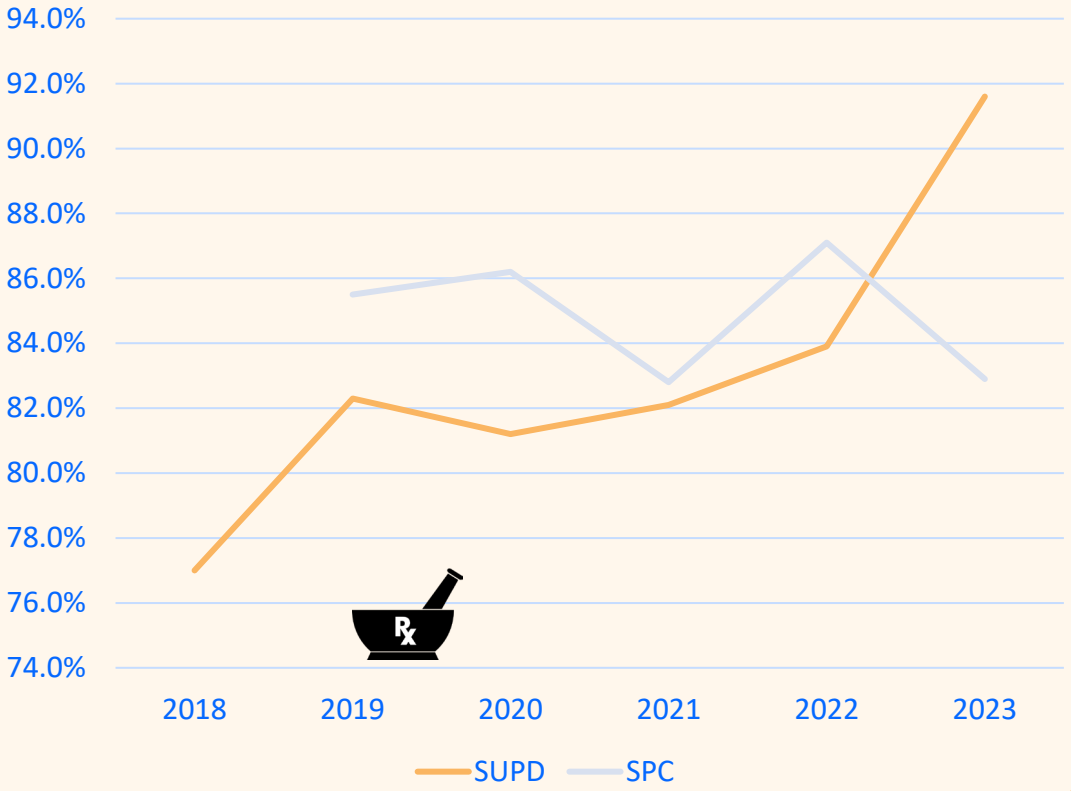
Statins for primary prevention could prevent 14,000 coronary heart disease-related deaths and ~$1.4 billion in healthcare savings each year!

Atlantic ACO Statin Quality Measures



N=690 Patients with Statin Opportunities in 2023

Optimus Statin Quality Measures



N= 416 Patients with Statin Opportunities in 2023

1. https://www.ahajournals.org/doi/full/10.1161/CIRCOUTCOMES.120.007485#:~:text=The%20use%20of%20statins%2C%20hydroxymethyl%20glutaryl%20coenzyme%20A,by%2019%25%2C%20and%20ischemic%20stroke%20by%2016%25.%206
2. https://www.ahajournals.org/doi/10.1161/CIRCULATIONAHA.110.986349
3. Photo: This Photo by Unknown Author is licensed under CC BY-NC

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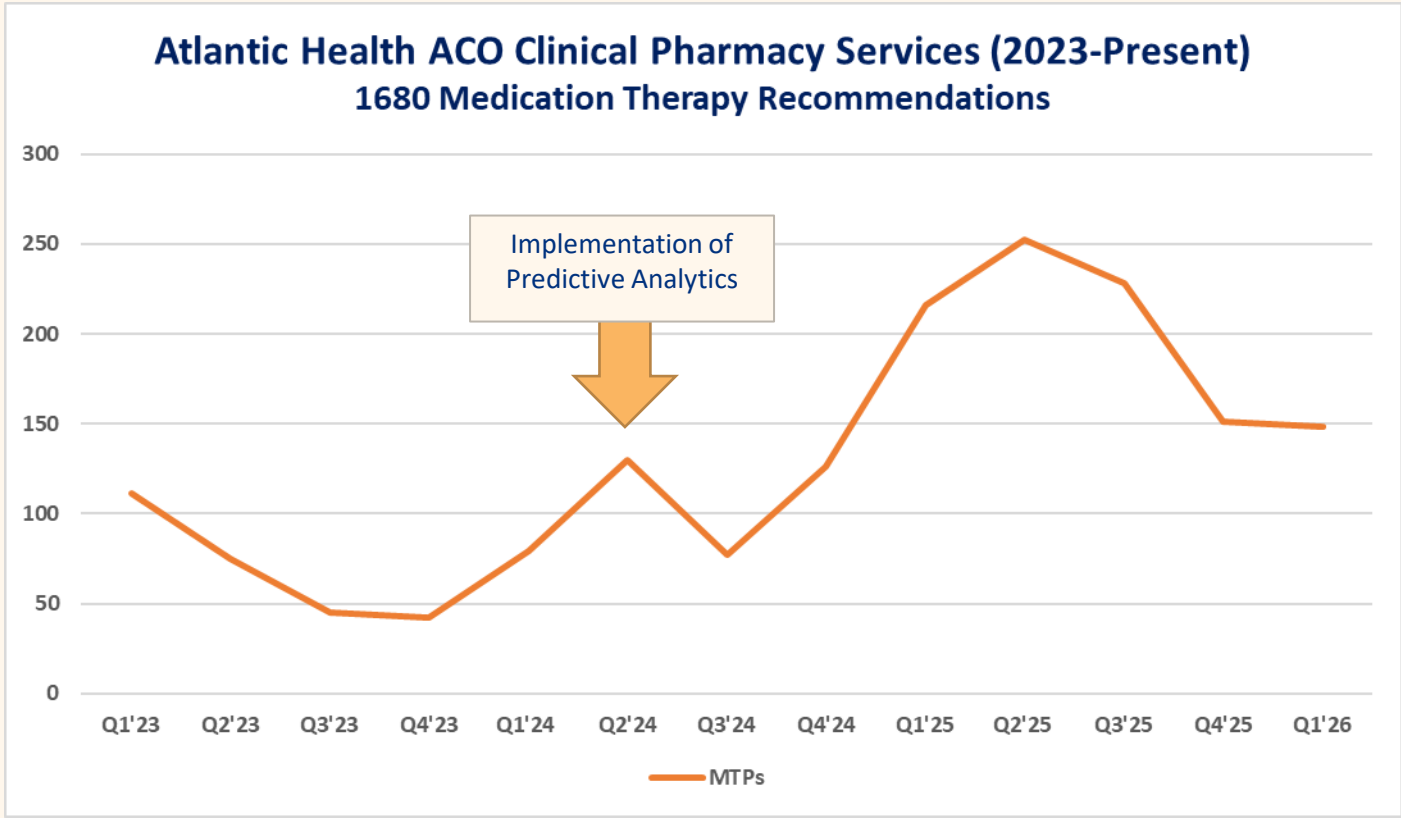
Atlantic Health ACOs Enhance Medication Management through AI & Predictive Analytics

Improved Clinical Pharmacist workflow

- 1.5-fold increase in patient encounters

Improved Medication Safety & Patient Outcomes

- 2.1-fold increase in medication therapy recommendations
- Improved identification of adverse drug events
- Acute care utilization
  - 40-60% reduction in hospitalizations and ED visits following Clinical Pharmacist delivered CMM
- Total cost of care



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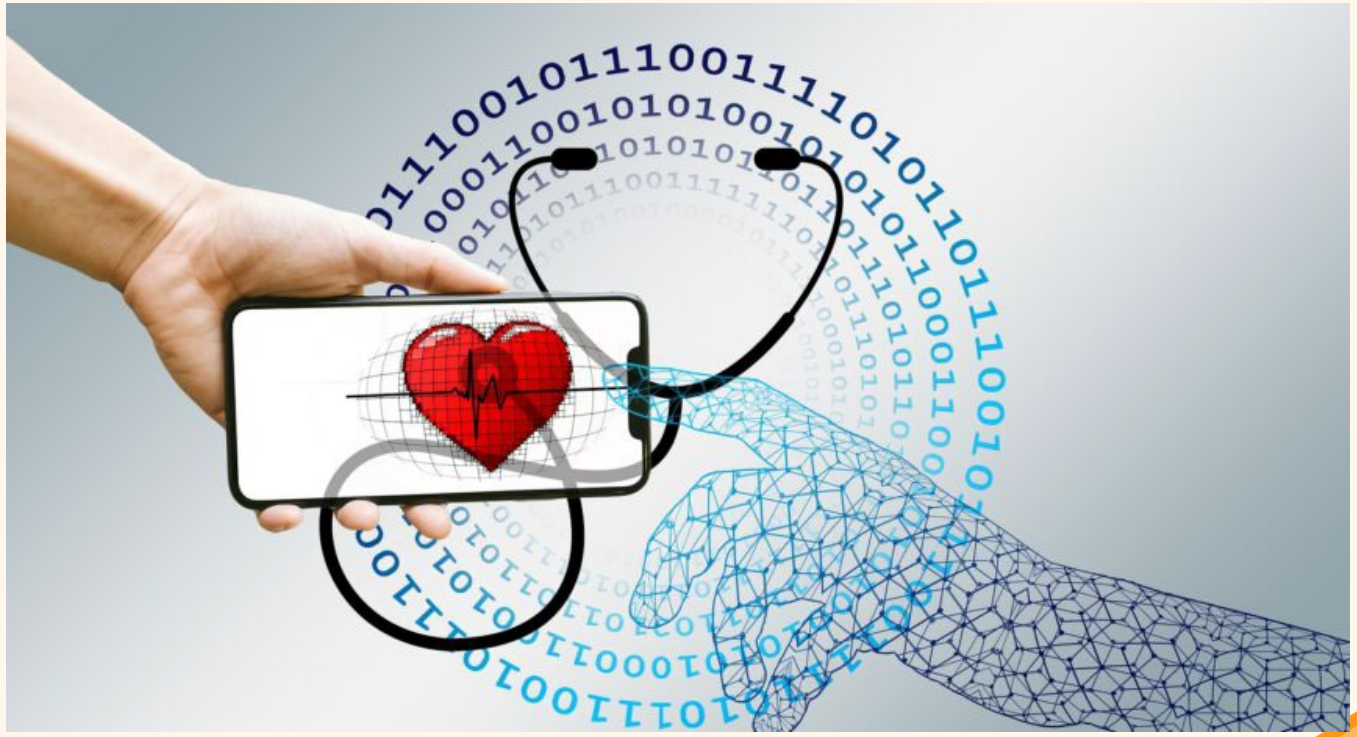
Empowering Clinicians & Patients through Generative AI

- Providers and care teams must understand how to use **proactive, personalized solutions** that address the root causes of diseases, and the patient distress that leads to nonadherence with managing the disease
- This requires use of **ongoing personalized narratives and monitoring of patients** – not just when they are in the examining room
- Remote patient monitoring (RPM), sensors, and chronic care management (CCM) can provide **data and feedback** for management
- AI-Agent technology (AI Chatbots, AI Navigators) can help **empower** the patient, **unburden** providers, and provide **evidence-based** clinical education
- **Improved patient outcomes** with AI-powered clinical assistant and AI chatbot
  - Early results at Atlantic Health show significant improvements in key clinical measures such as A1C & blood pressure



https://journalistsresource.org/wp-content/uploads/2024/06/digitization-6939537_1920-860x466.jpg

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Conclusions

- Clinical Pharmacists & Clinical Pharmacy Specialists bring **value**
- Collaborative care models encompassing clinical pharmacists improve clinical outcomes
- Partnership with healthcare AI companies is critical to scale value-based clinical pharmacy services
- AI solutions such as agentic AI optimize workflows & support clinicians & patients in improving patient outcomes while unburdening providers and clinical teams

“We are not merely a collection of organs in need of repair. We are people with hopes and fears, and medicine must attend to this humanity.”

— Dr. Atul Gawande

1. Gawande, A. Being Mortal: Medicine and What Matters in the End. Metropolitan Books, 2014. 🔗 https://www.penguinrandomhouse.com/books/227890/being-mortal-by-atul-gawande/

Atlantic Health

BILH TECH ENABLED CARE DELIVERY

NAACOS SPRING 2026

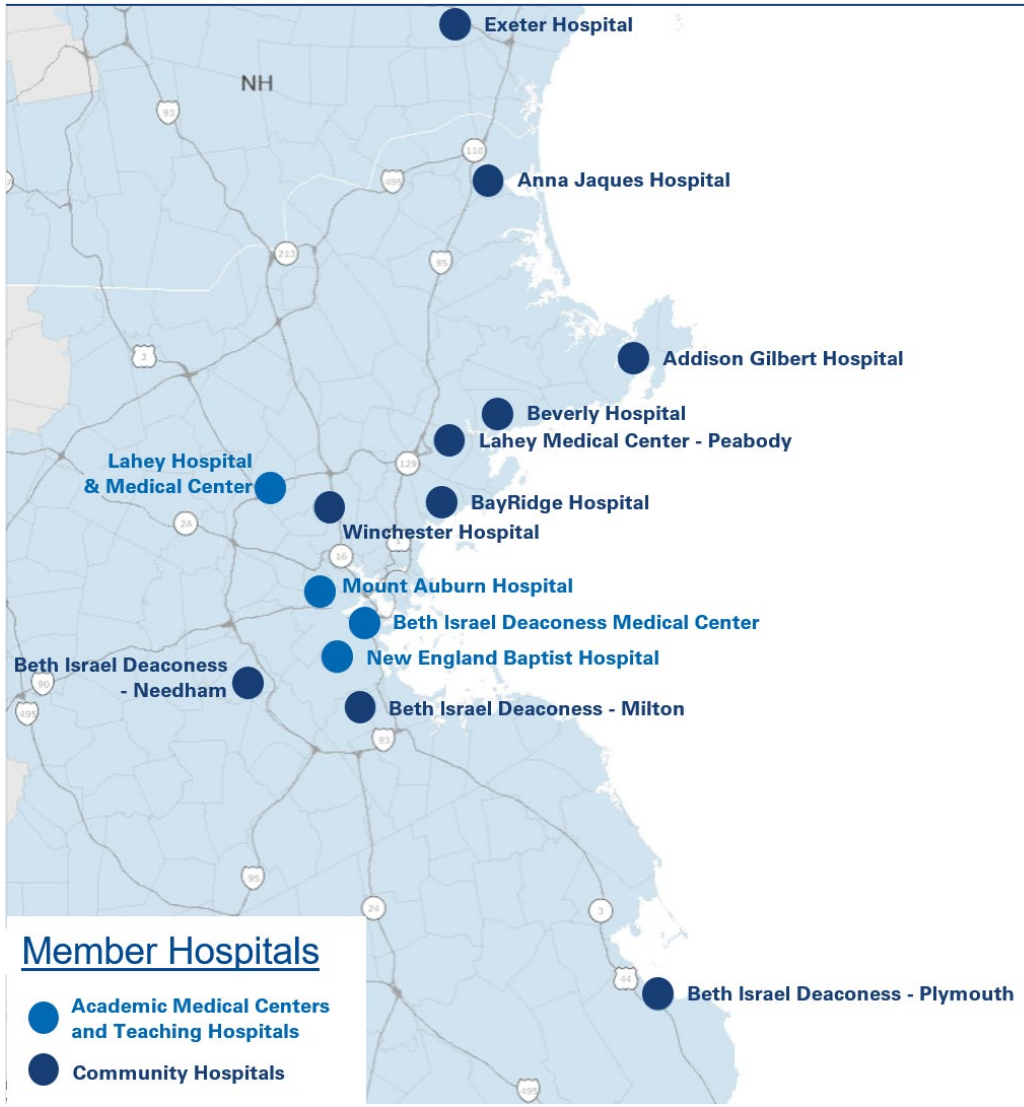
Rob Fields MD MHA
EVP, Chief Clinical Officer

Beth Israel Lahey Health

BILH System Overview

A Comprehensive System of Care

Beth Israel Lahey Health



A Coordinated System of Care

Beth Israel Lahey Health is a comprehensive, high-value system of care across Eastern Massachusetts and Southern New Hampshire. **BILH offers the full continuum of care**, from community and ambulatory care, and post-acute services to advanced tertiary/quaternary care. Our 5,900 physicians and 36,000 employees are committed to our shared purpose to **create healthier communities – one person at a time – through seamless care and ground-breaking science, driven by excellence, innovation and equity.**

Together, as a coordinated system of care, we are doing more than we ever could alone. We are solving more problems. Helping more people. Making more breakthroughs. Making a difference.

Beth Israel Lahey Health Performance Network (BILHPN)

Overview

Physicians

Approx. 6,500 physicians and APPs, including 1,000 PCPs and AP/PCPs

Hospitals

13 participating hospitals in eastern Massachusetts

Patients

Patient population of ~1.7 million; 500K covered risk lives

288K Commercial
105K MSSP ACO
45K Med Adv
62K Mass Health ACO

Services

Joint contracting and population health network for Beth Israel Lahey Health

Resources

More than 200 colleagues partnering with local leaders across our network

Technology-Driven Value

"Value" Is In The Eyes Of The Beholder

Beth Israel Lahey Health

BILH is pushing technology to address value for all stakeholders.

Patients

- Convenience, access, experience and sometimes cost are often the biggest drivers
- Can vary by severity and individual context (e.g. a cold vs. cancer treatment
- Quality and safety more often assumed and not usually a significant driver of patient choice

Providers

- Evidence, safety, national or local standards
- Balanced against individual patient factors (anxiety, fear, ability to follow up, personal cost)
- "What do I not want to miss?"

Payers

- Value to the purchaser (cost, HR friction)
- Quality to the degree it improves Star ratings and top line revenue
- Informed by standards but often malleable to economic pressures

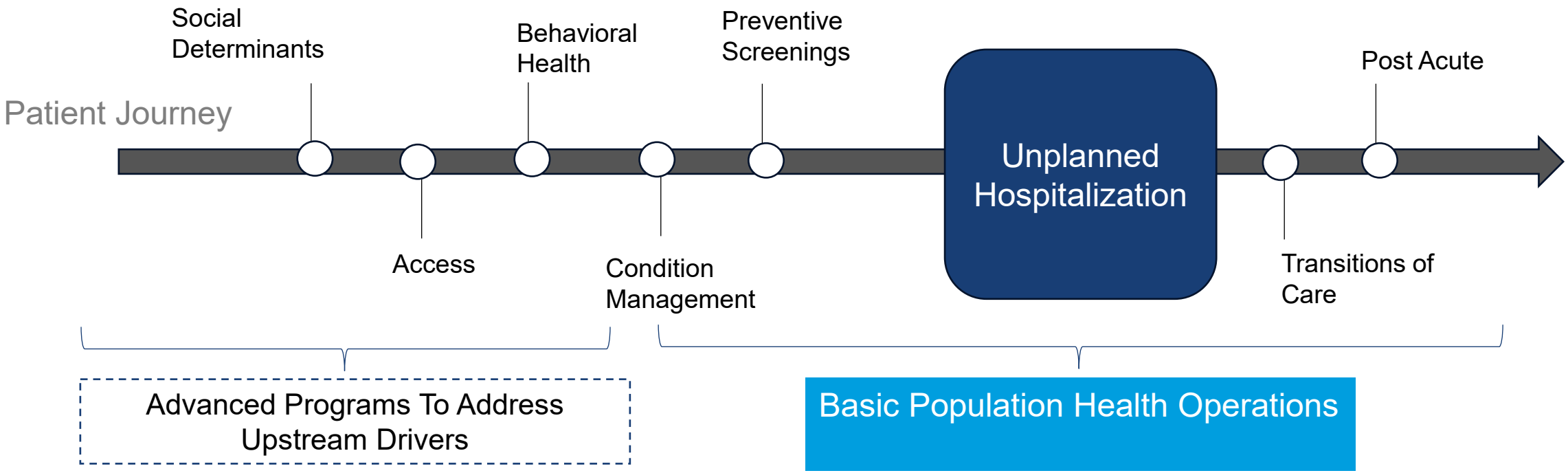
Access, Convenience, Trust	*Evidence*	*Cost, Star Ratings*

Population Health: From Reactive to Proactive

Proactive Strategies to Drive Outcomes

Beth Israel Lahey Health

Beyond care gaps, advanced population health models look at controlling both cost and quality by building upstream. The higher share of the premium dollar, the greater the opportunity to invest in root cause drivers of poor outcomes. Unplanned hospitalizations and end stage chronic disease complications are the target avoidable events.



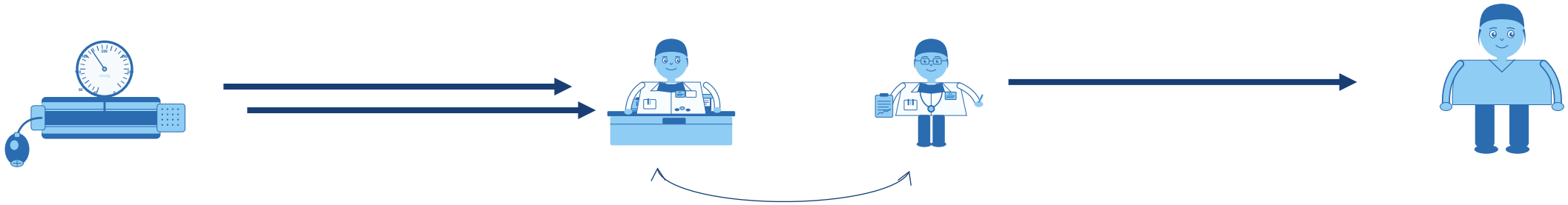
BILH RPM Hypertension Program
Live since February 2025

Beth Israel Lahey Health

Connected Blood Pressure Cuffs

Pharmacists Have Collaborative Arrangements with Doctors To Prescribe

Patient Receive Needed Care Outside of the Doctor Visit in Real Time



476 *patients enrolled in 14 months.*

85 *patients graduated after 5months due to controlled blood pressure*

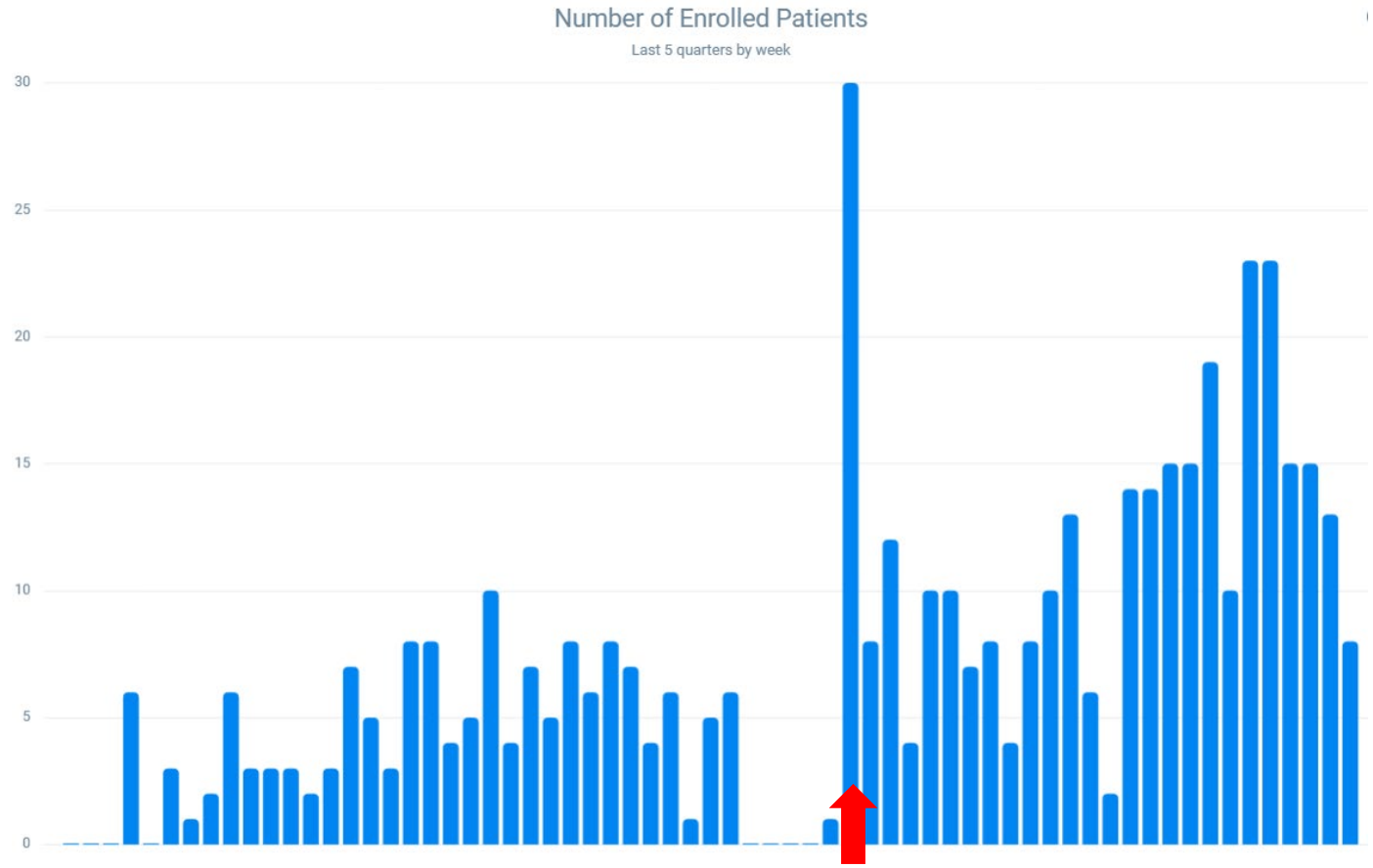
15% *attrition rate; lower than recently published experience with RPM programs*

BILH RPM HTN Program

Patient enrollments per week (Jan 2025-March 2026)

Beth Israel Lahey Health

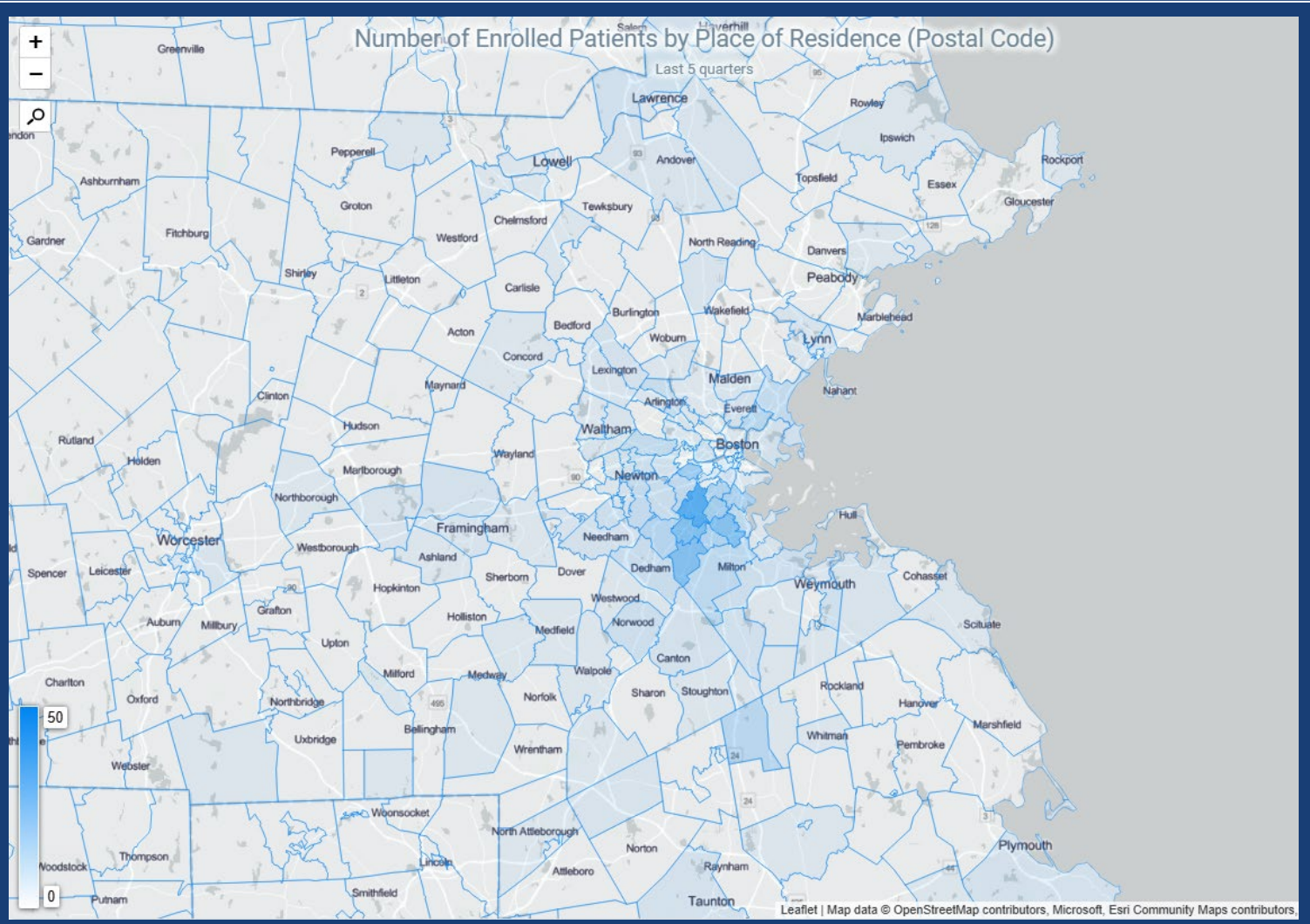
Enrolled pts have been referred from 90 distinct primary care providers and > 32 primary care practices across BILH



This spike represents a vendor transition and cutover of patients to HRS devices

RPM HYPERTENSION ENROLLMENT BY ZIPCODE
DATA SOURCE FROM EPIC

Beth Israel Lahey Health



BILH Virtual Primary Care Program

Virtual-First Access Model | Launched June 2025

Beth Israel Lahey Health

What is the Virtualist Program?

A virtual-first primary care practice where the primary location of care is virtual — not a supplement to in-person care, but a distinct care delivery model for BILH patients.

Why It Matters for ACOs

- Expands access without adding brick-and-mortar capacity
- Reduces ED utilization through proactive PCP relationships
- Cross-coverage model: any BILH patient can see any virtualist
- Integrates with population health infrastructure

How Patients Access Care

MyChart self-scheduling • Online Appointment Scheduling (OAS) tool • Direct call-in • After-hours triage • Weekday evenings & Saturdays

811
Empaneled Patients (as of Mar 2026)

+451
Net New Patients Since Oct 2025

21,829
FY26 Visit Volume Target (6,868 YTD thru Feb)

15,632
FY25 Actual Volume (Exceeded Target)

Operationalizing the Model: FY26 Progress

Consolidated regions. All major payers approved

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✓ Payer Integration

BCBS MA, Tufts, Aetna, PHCS, Wellpoint, and HPHC/Point32 have all approved cross-coverage for the virtual panel program. All major commercial plans covered.

✓ Practice Consolidation

North, South, and Mt. Auburn pods unified into one practice by Q2 FY26. Shared EPIC templates, workflows, and administrative infrastructure across all three legacy regions.

✓ Population Health Alignment

BILHPN engaged with dedicated Population Health Specialist and QI Manager. Pharmacist and care management support in progress. Virtualist panel separated in data to measure quality outcomes independently.

Key Implementation Lesson: Policy Risk is Real

Medicare telehealth coverage lapsed 10/1/25 due to government shutdown, disrupting volume for Medicare-eligible virtual patients. Coverage restored 11/19/25 through January 30, 2026. **ACOs building virtual-first models must plan for telehealth policy volatility as a structural risk — not an edge case.**

Virtual Primary Care: Specialty Clinics & Pop Health Expansion

Virtual-first as a platform for innovation

Beth Israel Lahey Health

Virtual Specialty Clinics

LIVE

Collaborative Care (CoCM) — Behavioral health integrated into virtual PCP panel. Launched Feb 2026.

Q3 FY26

Fragility Fracture / Ortho Pilot — Virtualist closes osteoporosis care gaps post-fracture. Ortho referral workflow in development.

Q4 FY26

Menopause Clinic — Certified provider pathway underway. Pilot testing slated for July 2026.

FY27

RPM Program Integration — Virtualist team positioned to absorb RPM chronic disease management under one virtual roof.

ACO / Pop Health Implications

Panel-Based Attribution

811 attributed patients with a designated virtual PCP — enabling proactive outreach, care gap closure, and quality measurement distinct from the broader BILHPC population.

Behavioral Health Integration

CoCM embedded directly in the virtual practice — aligned with MSSP quality measures and total cost of care reduction targets.

ED Diversion Opportunity

Active pilot with BI Emergency Medicine — virtualists follow up on incidental findings for patients without a PCP, converting ED touchpoints into longitudinal relationships.

Lessons Learned

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1. Scale is the only thing that matters
2. Executive involvement helpful for growth
3. Find sustainability model in fee for service until you get to population health scale
4. For any program, it must add value to patients AND providers
5. For any program, the key is to shorten the time to intervention

Trinity Health

Using Community Health Workers to Reduce Preventable Hospitalizations

Tori Bratcher, VP Population Health
Trinity Health
April 2026

Together, we are Trinity Health

One of the largest Catholic health care systems in the nation

$25.4B
Operating Revenue

25
States

1.1M
Attributed Lives

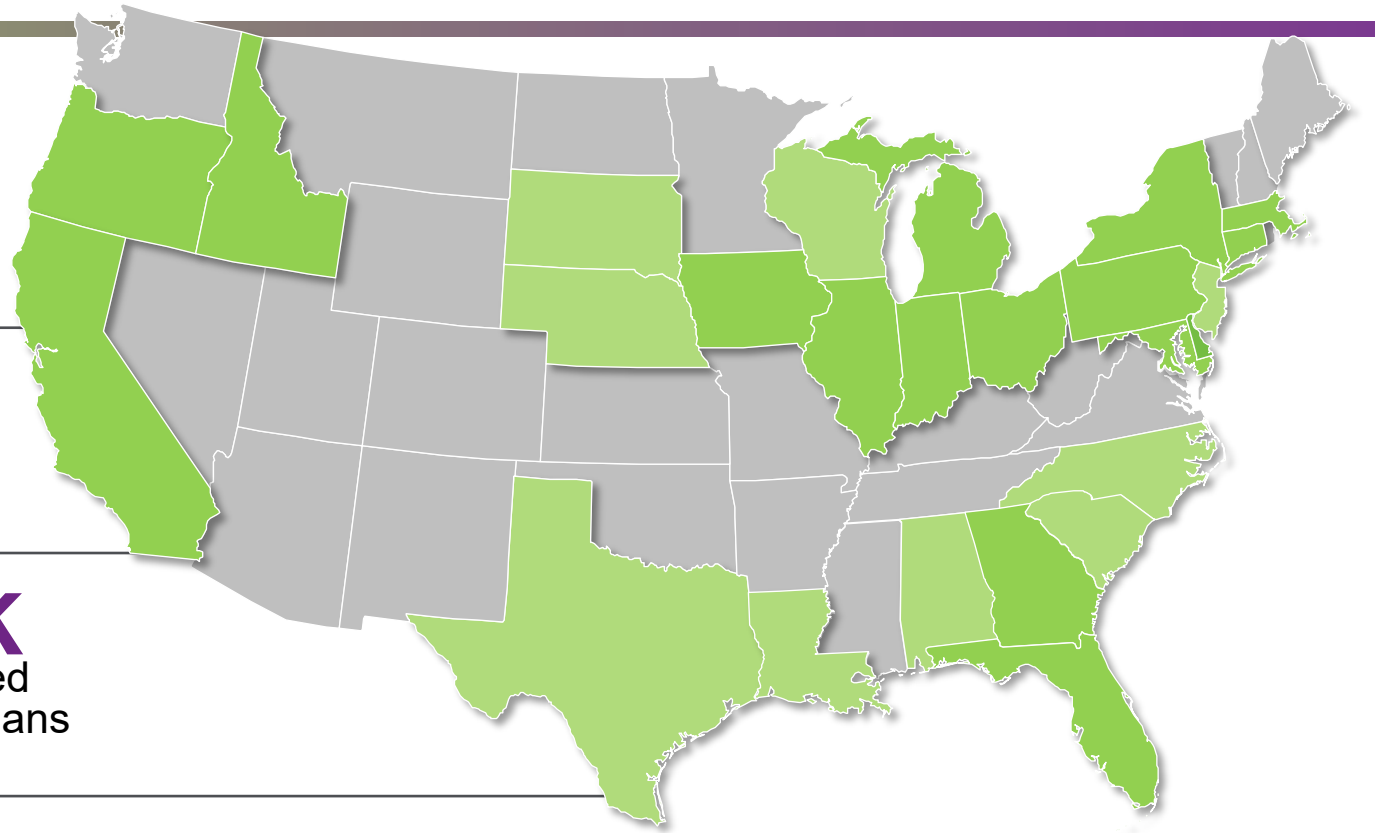
$1.4B
Community Benefit

$2.9B
Community Impact

133K
Colleagues

8.9K
Medical Group Physicians and Providers

30K
Affiliated Physicians



92
Hospitals[1,2]

12
Clinically Integrated Networks

101
Continuing Care Locations[2]

28
PACE Center Locations[2]

121
Urgent Care Locations[2]

FY25 data unless noted. 1. Decreases to 91 hospitals effective 9/1/25 with divestiture of MercyOne Siouxland Medical Center. 2. Owned, managed or in JOAs or JVs. Dark green states: primary ministry locations. Light green states: other services

Trinity Health's Promise: What We Must Deliver

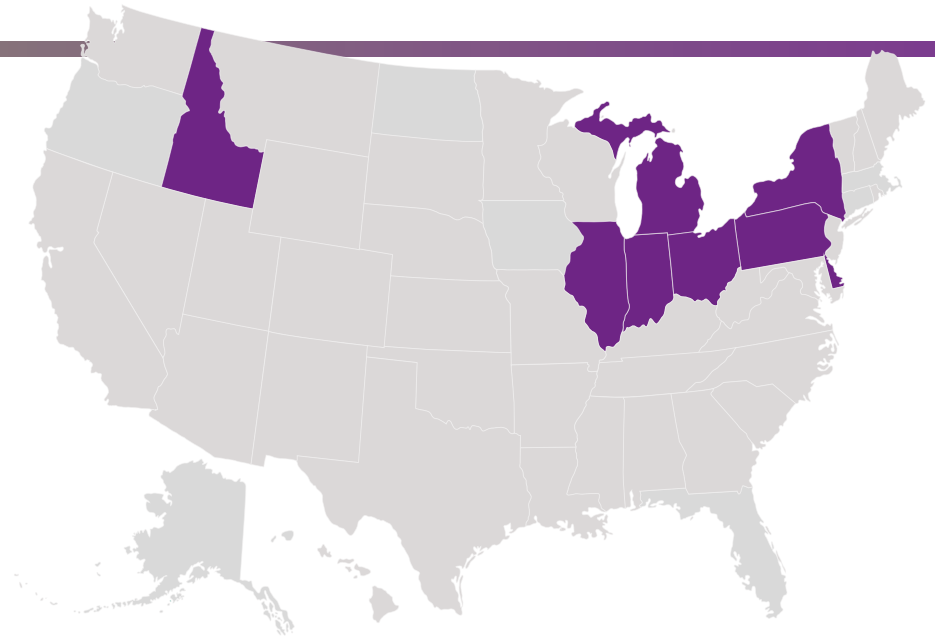
Trinity Health is a Catholic, **mission-driven health organization** that provides comprehensive and coordinated **health and well-being services** through a **network of organizations and partnerships** for our members - colleagues, physicians and people in communities - across the United States.

Trinity Health provides care for *all* in body, mind and spirit, demonstrating that:

- **We Listen**
- **We Partner in Achieving Health Goals**
- **We Make It Easy**

Trinity Integrated Care, LLC

MSSP ENHANCED Track ACO



2017
Entered 1st Agreement Period

2020
Entered 2nd Agreement Period

2025
Entered 3rd Agreement Period

8
States

8
Participating CINs

115k
Attributed Lives

104
ACO Participant TINs

59
SNF Affiliates

1,924
PCPs

5,653
Specialists

91.9%
Average Quality Score

8
Number of Years of Earned Shared Savings

3.0%
Average Savings Rate

$220.0M
Total Savings to CMS

$160.1M
Total Earned Shared Savings

Trinity Health

Performance Results consist of PY2017-PY2024

Framing the Problem – Preventable Hospitalizations

Trinity Health

Preventable Hospitalizations

The rate of Medicare value-based care patients being admitted for an ambulatory care-sensitive condition. **Heart failure admissions are the primary driver of this rate at over 50%.**

13%

of our MSSP patients are dually-enrolled in Medicaid.

Rate of Preventable Hospitalizations is a system-wide quality metric, and was adopted as a Trinity Health key performance indicator.

Patients dually-enrolled in Medicaid experience health and social **disparities**, including a higher rate of preventable hospitalizations.

Why preventable hospitalizations?

Historical Data (2023-2024)

13.9% of IP Admits due to ACSC – 9.7% of total IP cost – Top DRG – Heart Failure

14.1% Readmission rate – top DRG – Heart Failure

All ACO

Ambulatory Care Sensitive Admission Types

PQI	PQI Description	Baseline Admits	Admits	Percent of Total
PQI01	Diabetes STC	10	69	2%
PQI03	Diabetes LTC	48	209	6%
PQI05	COPD / Asthma	78	387	11%
PQI07	Hypertension	31	140	4%
PQI08	Heart Failure	330	1,390	43%
PQI11	Bacterial Pneumonia	113	394	12%
PQI12	Urinary Tract Infection	108	519	16%
PQI14	Uncontrolled Diabetes	16	67	2%
PQI15	Asthma (young adults)	0	2	0%
PQI16	LE Amputation	13	73	2%

Dual Eligible

Ambulatory Care Sensitive Admission Types

PQI	PQI Description	Baseline Admits	Admits	Percent of Total
PQI01	Diabetes STC	0	15	3%
PQI03	Diabetes LTC	12	52	9%
PQI05	COPD / Asthma	17	82	14%
PQI07	Hypertension	3	13	2%
PQI08	Heart Failure	57	214	37%
PQI11	Bacterial Pneumonia	27	91	16%
PQI12	Urinary Tract Infection	13	82	14%
PQI14	Uncontrolled Diabetes	5	17	3%
PQI15	Asthma (young adults)	0	1	0%
PQI16	LE Amputation	3	16	3%

Multiple disparities exist between Medicare-only patients and those who also have Medicaid

Dually-enrolled are:

- Younger
- Lower income
- More likely to be persons of color
- More likely to be disabled
- More likely to report fair or poor health
- Higher cost
- More likely to have a preventable hospitalization

	Medicare Only	Duals
Income <$20,000/yr	20%	87%
Under age 65 (disability)	8%	40%
From a racially/ethnically diverse group	<20%	49%
In fair or poor health	17%	44%
At least one activity of daily living limitation	23%	48%
Live in a long-term care facility	1%	13%
Avg annual spend	$9,448	$20,831*
Preventable Hosp rate (Mar '25)	34.4	50.4

Sources: A Profile of Medicare-Medicaid Enrollees (Dual Eligibles) | KFF; Enrollment and Spending Patterns Among Medicare-Medicaid Enrollees (Dual Eligibles) | KFF

Crafting the Solution – Community Health Workers

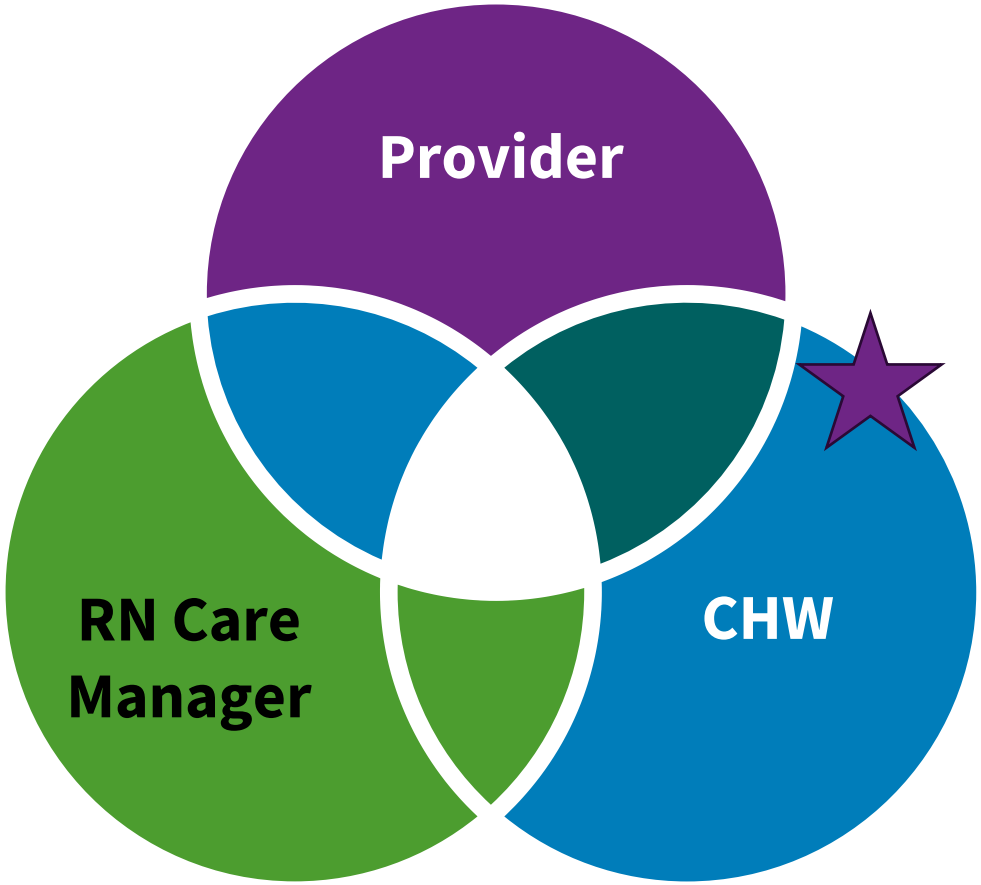
In 2022, three departments began sharing accountability for reducing preventable hospitalizations

Population Health
operates CINs and provides ambulatory care management services

Trinity Health Medical Groups
provides ambulatory medical care

Community Health & Well-Being
provides social care

Members of the Population Health Care Team



In collaboration with patient's provider, Care Managers and CHWs work together to support patient's clinical and social needs.

RN Care Manager

Focus: Medical
Care coordination, comprehensive assessments, care plan development, etc.

CHW

Focus: Lived Experience
Cultural brokering, peer support, social service navigation, etc.

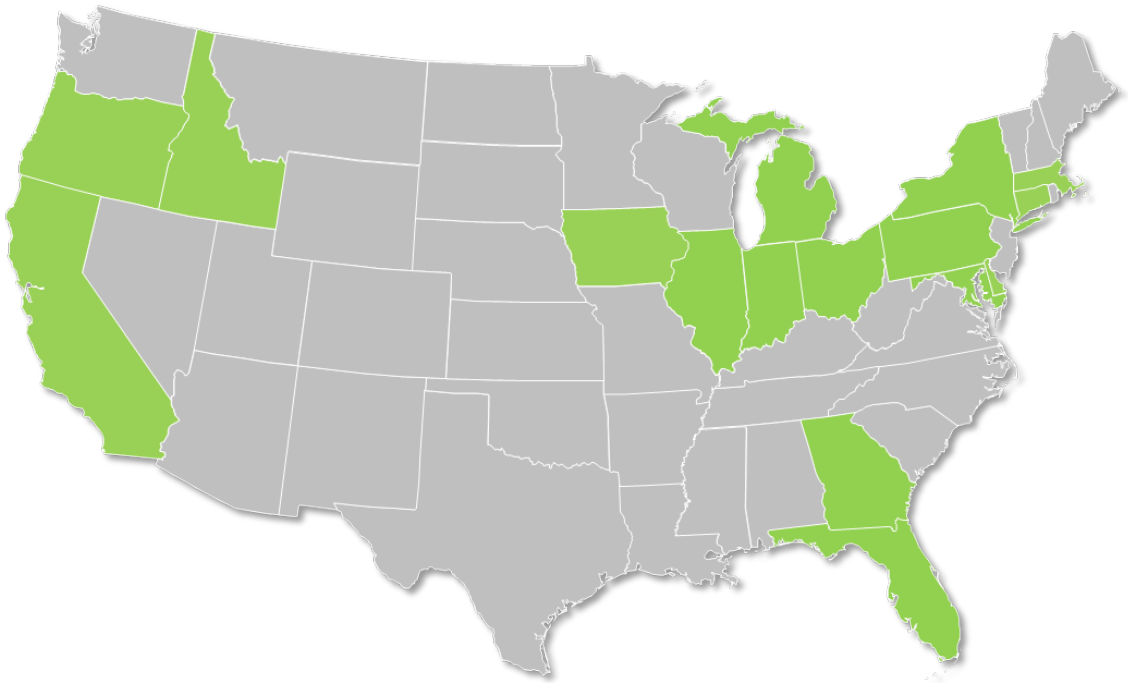
Trinity Health's CHW Program

Social Care Evolution

- About 155 CHWs across health system (75% growth since 2019)
- CHWs help patient social needs and barriers as part of the clinical care team
- 41 CHW FTEs funded by CIN

CHW Standardization Work

- Standard job descriptions and desired qualifications
    - Emphasis on lived experience, reflects the community served
- Standard CHW core skills training
- Maintain internal CHW certification standards



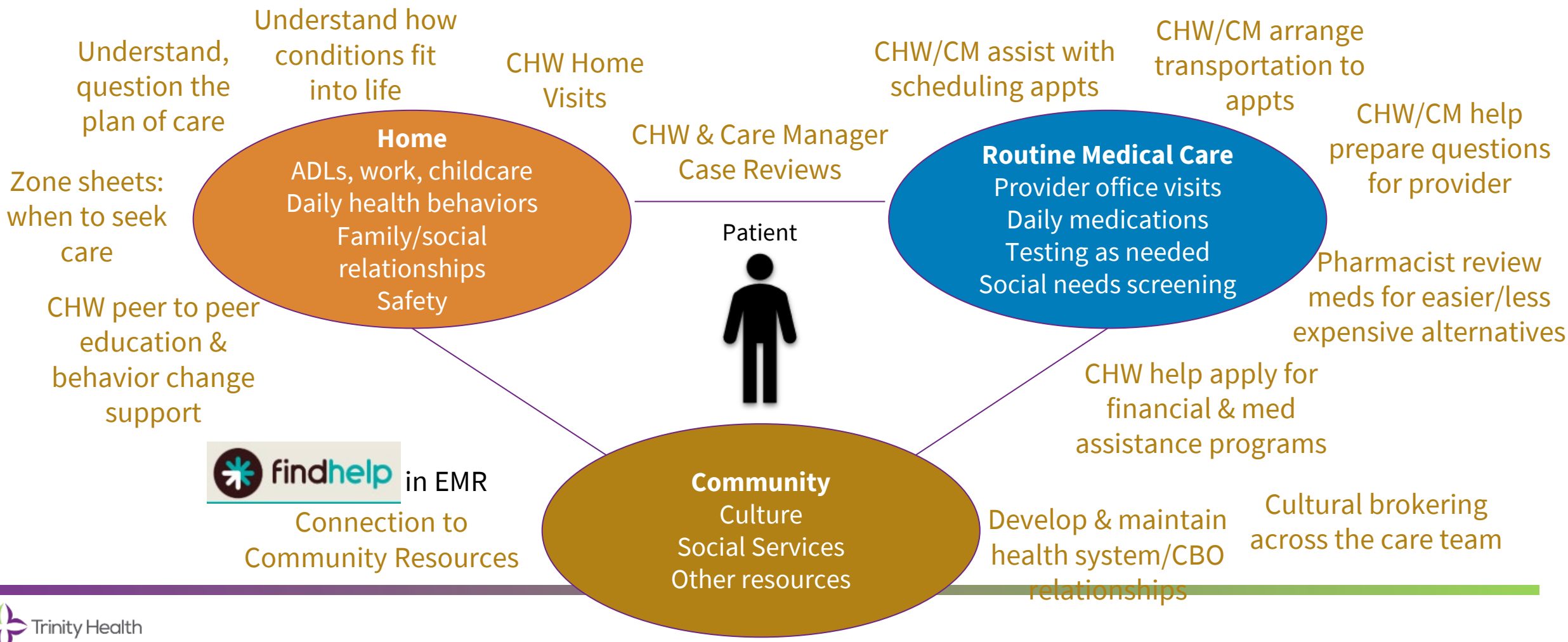
The Importance of CHWs

- Provide social support to patients experiencing hardships and barriers
- Help patients navigate care and social services
- Act as a bridge between providers and patients, the health system and community
- Build self-efficacy in patients through advocacy, empowerment, and coaching

Per research, CHWs have demonstrated success in:

- Decreased ED visits and hospital stays
- Increased primary care visits
- Improved management of chronic conditions
- Connection to food, housing, and other needed resources such as financial assistance

Hospitalizations are prevented when conditions are well-managed at home and in the outpatient setting



CHW Essential Functions

CHW Task: Social Needs Screening; draw upon lived experiences and shared background

- Increase understanding of CHWs
- Share guidance around ways to collaborate with CHWs

CHW Task: Reinforce basic health education and health promotion activities

- Expand CHW training and competencies (ex: chronic conditions and self-management)
- Co-design patient assessments and patient-facing materials like zone sheets

CHW Task: Deliver culturally and linguistically appropriate services in patients' home and/or community-based settings

- Emphasize the importance of in-person, home, and community-based visits
- Provide guidance on escalation protocols and use of telehealth resources

Social Needs Screening

Social needs screening has been a Trinity Health priority since July 2022, with an initial target of 60%

81%

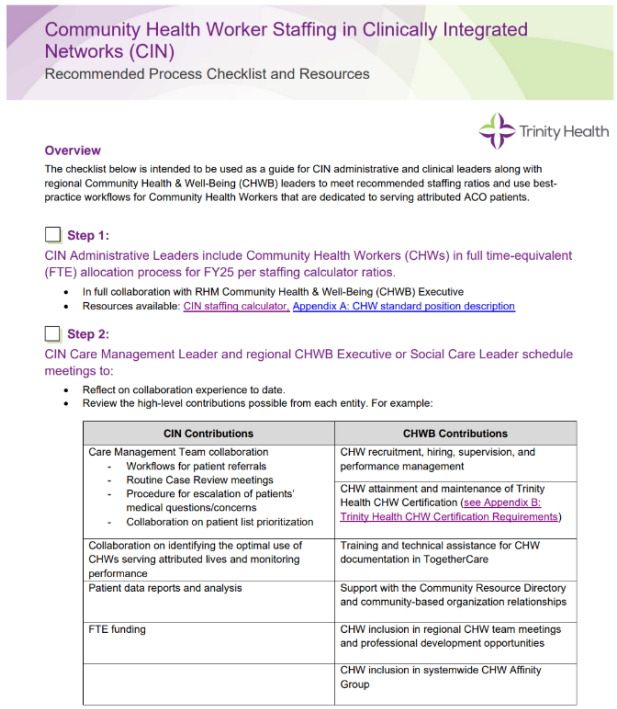
of all patients seen in the primary care are screened for at least one social need

Trinity Health launched the Community Resource Directory in 2019, as a part of our TogetherCare Epic launch across all our regions.

We developed a standard social needs screener to assess patient social needs and connect them to resources using the Findhelp Native Integration.

We have developed standard workflows for Community Health Worker, Nurse Care Manager and Social Worker documentation in Epic to track follow-up.

Co-Designed Program Materials



Community Health Worker Staffing in Clinically Integrated Networks (CIN)

Recommended Process Checklist and Resources

Trinity Health

Overview

The checklist below is intended to be used as a guide for CIN administrative and clinical leaders along with regional Community Health & Well-Being (CHWB) leaders to meet recommended staffing ratios and use best-practice workflows for Community Health Workers that are dedicated to serving attributed ACO patients.

☐ **Step 1:**

CIN Administrative Leaders include Community Health Workers (CHWs) in full time-equivalent (FTE) allocation process for FY25 per staffing calculator ratios.

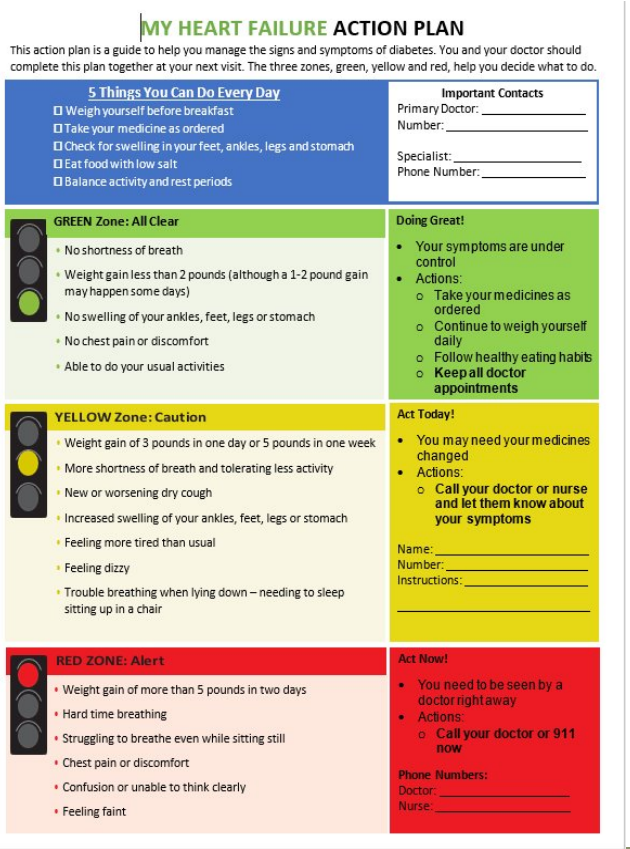
- In full collaboration with RHM Community Health & Well-Being (CHWB) Executive
- Resources available: CIN staffing calculator, Appendix A: CHW standard position description

☐ **Step 2:**

CIN Care Management Leader and regional CHWB Executive or Social Care Leader schedule meetings to:

- Reflect on collaboration experience to date.
- Review the high-level contributions possible from each entity. For example:

CIN Contributions	CHWB Contributions
Care Management Team collaboration - Workflows for patient referrals - Routine Case Review meetings - Procedure for escalation of patients' medical questions/concerns - Collaboration on patient list prioritization	CHW recruitment, hiring, supervision, and performance management
	CHW attainment and maintenance of Trinity Health CHW Certification (see Appendix B: Trinity Health CHW Certification Requirements)
Collaboration on identifying the optimal use of CHWs serving attributed lives and monitoring performance	Training and technical assistance for CHW documentation in TogetherCare
Patient data reports and analysis	Support with the Community Resource Directory and community-based organization relationships
FTE funding	CHW inclusion in regional CHW team meetings and professional development opportunities
	CHW inclusion in systemwide CHW Affinity Group



MY HEART FAILURE ACTION PLAN

This action plan is a guide to help you manage the signs and symptoms of diabetes. You and your doctor should complete this plan together at your next visit. The three zones, green, yellow and red, help you decide what to do.

5 Things You Can Do Every Day

- ☐ Weigh yourself before breakfast
- ☐ Take your medicine as ordered
- ☐ Check for swelling in your feet, ankles, legs and stomach
- ☐ Eat food with low salt
- ☐ Balance activity and rest periods

Important Contacts

Primary Doctor: _____
Number: _____

Specialist: _____
Phone Number: _____

GREEN Zone: All Clear

- No shortness of breath
- Weight gain less than 2 pounds (although a 1-2 pound gain may happen some days)
- No swelling of your ankles, feet, legs or stomach
- No chest pain or discomfort
- Able to do your usual activities

Doing Great!

- Your symptoms are under control
- Actions:
  - Take your medicines as ordered
  - Continue to weigh yourself daily
  - Follow healthy eating habits
  - **Keep all doctor appointments**

YELLOW Zone: Caution

- Weight gain of 3 pounds in one day or 5 pounds in one week
- More shortness of breath and tolerating less activity
- New or worsening dry cough
- Increased swelling of your ankles, feet, legs or stomach
- Feeling more tired than usual
- Feeling dizzy
- Trouble breathing when lying down – needing to sleep sitting up in a chair

Act Today!

- You may need your medicines changed
- Actions:
  - **Call your doctor or nurse and let them know about your symptoms**

Name: _____
Number: _____
Instructions: _____

RED ZONE: Alert

- Weight gain of more than 5 pounds in two days
- Hard time breathing
- Struggling to breathe even while sitting still
- Chest pain or discomfort
- Confusion or unable to think clearly
- Feeling faint

Act Now!

- You need to be seen by a doctor right away
- Actions:
  - **Call your doctor or 911 now**

Phone Numbers:
Doctor: _____
Nurse: _____

Teach back Questions for Community Health Workers - Heart Failure

Supplies:		
Does pt. own a functional scale	Y	N
Does the pt. use their scale	Y	N
When does the pt. weigh themselves?	Y	N
Does pt. own a blood pressure machine at home?	Y	N
Pt can state the importance of keeping a blood pressure log	Y	N
Medications:		
Pt has problems getting or taking meds	Y	N
Pt can describe when they take their water pill	Y	N
Pt verbalizes the importance of taking the meds	Y	N
Healthy Eating & Physical Activity:		
Pt can describe if they have salt or fluid restriction	Y	N
Pt can verbalize what foods to avoid that make their heart failure worse	Y	N
Pt can state how to reference a food label and foods high in salt	Y	N
Pt can verbalize the importance of having an activity routine	Y	N
Symptom Management:		
Pt can describe symptoms of heart failure including fatigue, weight gain, swelling hands/abdomen/feet, and/or shortness of breath, at rest or with activity	Y	N
Pt can say when to call their doctor (2-3 lbs./day or 5 lbs. in a week)	Y	N
Does the pt. know which doctor to contact based on symptoms (PCP/IM or Cardiology)	Y	N
Care Guidelines:		

Social Care for Congestive Heart Failure (CHF) Spotlight

Miguel's Background

- 49-year old male with Medicare and Medicaid
- New CHF diagnosis
- Lives alone, relies on mother (who lives out of state) to understand his health

Current Situation:

- Did not fully understand his new diagnosis
- Struggling to manage his CHF on his own

CHW Intervention:

- Monthly check-ins and home visits
- Provide weight scale, pill box, blood pressure cuff, and patient education

Outcomes:

- 90% reduction in missed appointments, cardiac rehab, and nutrition education classes
- Heart-healthy meal delivery and housekeeping services

CHWs Addressing Top Social Needs

Food Insecurity

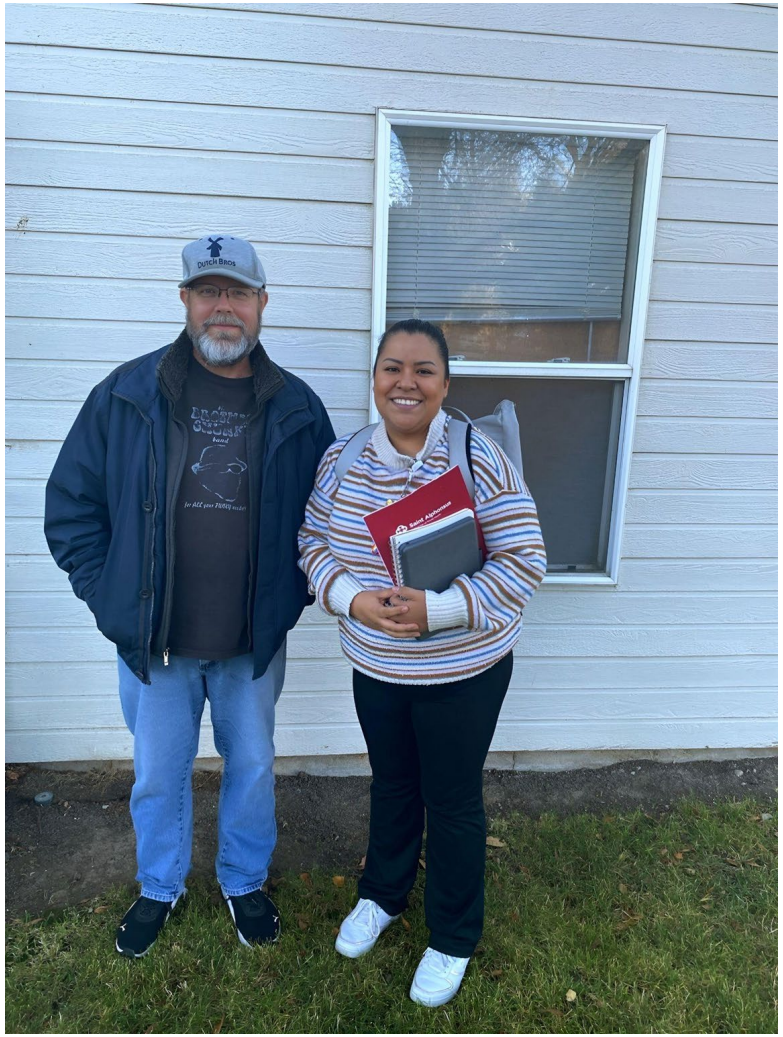
- Fresh produce box delivery/pick-up
- Apply for public assistance benefits like WIC or SNAP

Social Isolation

- Link older adults to technology resource
- Free virtual counseling resources

Access to Health Care

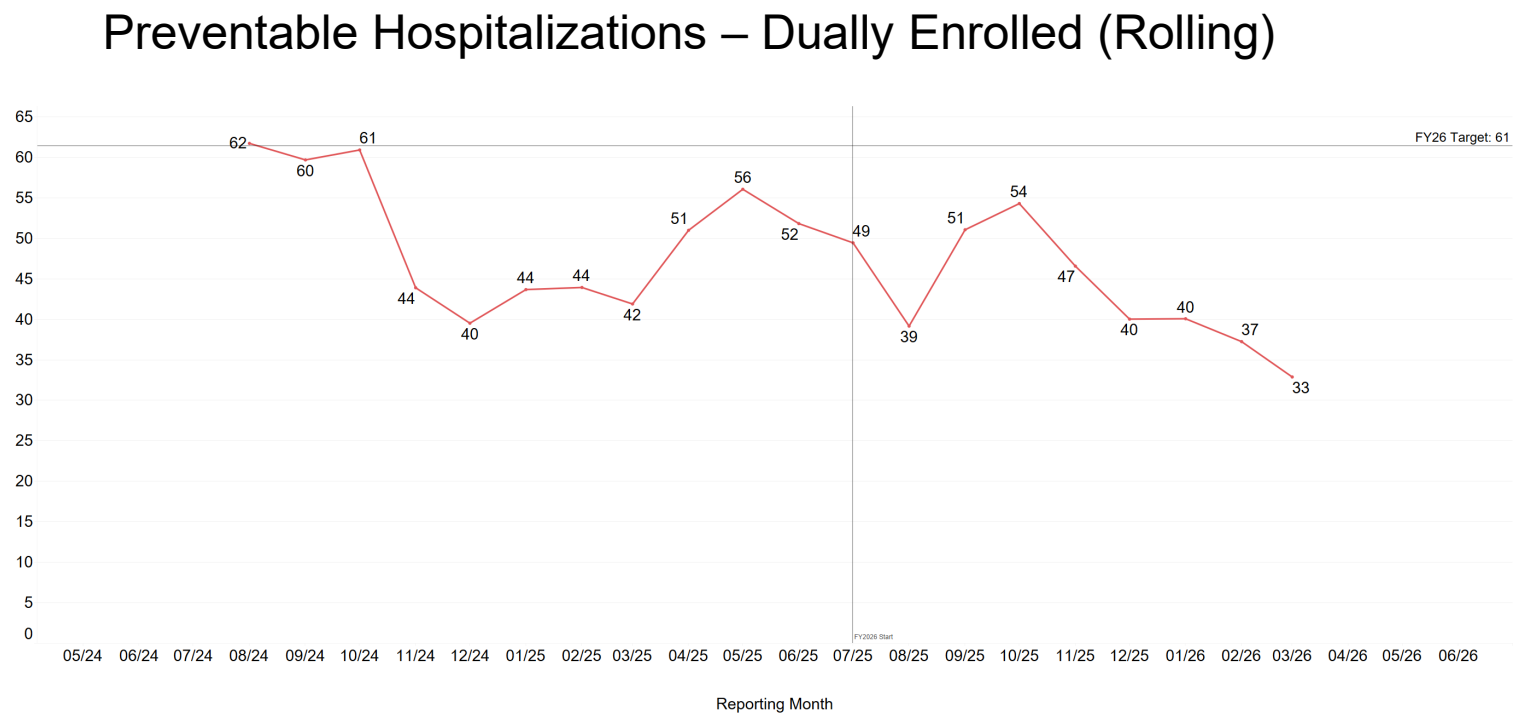
- (Re)connect to primary care
- Apply for prescription/financial assistance, health coverage



Miguel and Marielena, CHW

Results and Lessons Learned

Demonstrating results of targeted interventions with CHWs



Lessons Learned: Strategies to Integrate CHWs and Build Stronger Collaboration

Raise Visibility of CHW Role

CHW training & education

CHW staffing guidance

Implementation guidance

Emphasize unique contribution

Increase Communication and Connectivity

Use of EHR, messaging, & telehealth

Care team case reviews

Participate in virtual/on-site team meetings

Identify Shared Goals

Patient prioritization (ex: high needs, high cost)

Increase patient health outcomes and experience

Team-based approach

Trinity Health