

Capital Impact Council: HV-ROI Case Studies



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These case studies demonstrate examples of how the key elements of the HV-ROI Framework, HV Model and Evidence as well as HV-KPIs, are already being implemented in private investments in health care. Provided by our 2024 Capital Impact Council members committed to adopting the HV-ROI Framework, these examples highlight the Capital Impact Council's aim to develop and share resources to support alignment in investor and health system incentives, and advance the positive impacts of private investment in health care.

Through sharing and developing case examples, tools, metrics and analyses, we aim to strengthen and expand the use of effective health value assessments to increase the positive impact of private capital investments for patients, health care professionals, communities, entrepreneurs and investors and advance a repeatable, evolving model for this work.

Investor and Portfolio Company	Page
American Heart Association Ventures: Attane Health	3
American Heart Association Ventures: Pear Suite	4
American Heart Association Ventures: Simplified	5
American Heart Association Ventures: Sober Sidekick App	6
Cylinder: 7Wire Ventures	7
Echo Health Ventures: Dispatch Health	8
Echo Health Ventures: Strive Health	9
Healthier Capital: Amae Health	10
Temasek: WelbeHealth	11

Health Value Return on Investment

Attane Health

Attane Health is a patient-driven digital marketplace providing high-quality foods, nutrition coaching and data to improve food access and health outcomes for patients at risk of developing or who have already developed chronic illnesses.

attanehealth™
PERSONALIZED FOOD & NUTRITION CARE



American Heart Association
Ventures

HEALTH VALUE (HV) MODEL

Population: Currently, as many as 47% of Medicaid members experience food insecurity.² Additionally, 6 out of every 10 adults in the US have at least one chronic illnesses.¹

Patient Outcomes: Poor nutrition is a major risk factor for chronic conditions such as obesity, diabetes and hypertension.⁴

Community Impact: Improvement in outcomes for vulnerable populations through increasing access to food and healthy eating practices.⁵

Cost Impact: Improved nutrition (also known as Food as Medicine) reduces health care costs for underserved and marginalized populations.⁶

HV-KEY PERFORMANCE INDICATORS

- **Key Clinical Results:** 70% of Attane Health users with diabetes experience reduction in blood pressure.³
- **Patient Experience:** 90% of users who had health coaching reported “significantly improved” health management.³ 74% of all Attane users report reduced blood pressure.³
- **Community Well-Being:** Traction in 29 states with food delivery access in urban, suburban and rural areas working with underserved populations.³
- **Health Plan Retention:** 89% of users are likely to re-enroll in their health plans after using Attane.³

Information provided by portfolio company has not been independently verified.

Sources: 1. Centers for Disease Control and Prevention (CDC). 2020. “Economic Security During the COVID-19 Pandemic.” NIOSH Science Blog. <https://blogs.cdc.gov/niosh-science-blog/2020/06/22/economic-security-covid-19/>; 2. Springer. 2023. “Prevalence of Chronic Illness Among U.S. Adults.” Journal of General Internal Medicine. <https://link.springer.com/content/pdf/10.1186/s12912-023-01296-8.pdf>; 3. Attane Health. 2024. Internal Report on Healthcare Insights. 4. Centers for Disease Control and Prevention. 2024. “About Chronic Diseases.” <https://www.cdc.gov/chronic-disease/about/index.html>. 5. National Institute on Minority Health and Health Disparities. 2024. “Food Accessibility, Insecurity, and Health Outcomes.” <https://www.nimhd.nih.gov/resources/understanding-health-disparities/food-accessibility-insecurity-and-health-outcomes.html>; 6. National Institutes of Health. “Prescribing Healthy Foods Could Bring Cost-Effective Benefits.” NIH Research Matters, April 2, 2019. <https://www.nih.gov/news-events/nih-research-matters/prescribing-healthy-foods-could-bring-cost-effective-benefits>.



Health Value Return on Investment

Pear Suite

Pear Suite is a digital platform and tech-enabled service provider that builds workflows for frontline Community Health Workers to operate more efficiently and effectively to generate long-term positive health outcomes for their payers and health systems.



HEALTH VALUE (HV) MODEL

Target Population: Pear Suite is designed to support the growing number of frontline CHWs by streamlining their workflows and improving efficiency. There are approximately 70,000 community health workers (CHWs) in the U.S. today, and their numbers are projected to grow 13% by 2033.¹

Access to Care: Improved access to care for underserved populations.

Patient Outcomes: Patients benefit from early interventions, proactive health management, and connections to resources that address SDoH.

Provider Impact: Increased provider efficiency and workforce support.

HV-KEY PERFORMANCE INDICATORS

- **Community Impact:** Impacting over 100,000 lives, collaborating with 175 community organizations and 750 CHWs.^{2,3}
- **Health Equity:** Offered in 9+ languages, across 24 states bridging gaps in care for historically underserved populations.⁴
- **Patient Engagement:** 85% engagement rates through its person-centered approach, 78% social needs addressed.³
- **CHW Key Results:** 98% partner retention rate, 3x increase in closing care gaps, 200% increase on claims.⁴

Information provided by portfolio company has not been independently verified.

Sources: 1. U.S. Bureau of Labor Statistics. "Community Health Workers." Occupational Outlook Handbook. Last modified May 2023. <https://www.bls.gov/ooh/community-and-social-service/community-health-workers.htm>; 2. Pear Suite. "Digital Health Company Pear Suite Hits 100-Customer Milestone." Pear Suite Blog, June 24, 2024. <https://www.pearsuite.com/post/digital-health-company-pear-suite-hits-100-customer-milestone/>; 3. Pear Suite. Pear Suite Webpage. Accessed March 5, 2025. <https://www.pearsuite.com/>; 4. Self-reported by Pear Suite



Health Value Return on Investment

SimpliFed

SimpliFed is a maternal health-tech company providing virtual peri- and post-natal lactation and baby feeding support alongside remote patient monitoring for high-risk conditions such as hypertension and gestational diabetes.

SimpliFed



American Heart Association
Ventures

HEALTH VALUE (HV) MODEL

Population: 70% of mothers in the U.S. will breastfeed for some period and more than 2.2M women of child-bearing age live in maternity care deserts.^{1,2}

Patient Outcomes: Improved access to quality maternity care can decrease the risk of maternal mortality for those living in maternity care deserts, women with lower-income and minority women.²

Provider Impact: It is projected by 2030 that there will be a shortage of around 5,170 obstetricians to meet demand nationally.²

HV-KEY PERFORMANCE INDICATORS

- **Key Clinical Results:** 87% of patients feed with breast milk for at least 3 months, compared to 69% national average.³
- **Patient Experience:** 96% NPS Score and 97% of SimpliFed Patients report feeling less stressed after using SimpliFed.³
- **Missed Appointment Rate:** 2% patient no-show rate.³
- **ER Utilization:** 2.6% ER utilization rate, compared to 7.6% national average.³

Information provided by portfolio company has not been independently verified.

Sources: 1. Geraghty, Sheela R., Sarah W. Riddle, and Ulfat Shaikh. "The Breastfeeding Mother and the Pediatrician." *Journal of Human Lactation* 24, no. 3 (2008): 335–339. <https://doi.org/10.1177/0890334408321091>; 2. March of Dimes. 2020 Annual Report and Financials. October 2022. https://www.marchofdimes.org/sites/default/files/2022-10/2020_Annual_Report_Financials.pdf; 3. Simplified. 2024. "Simplified." <https://www.simplified.com/>.



Health Value Return on Investment

Sober Sidekick App

Sober Sidekick (“SSK”) is a digital health engagement company for people with substance use disorder (SUD). The company powers peer-based engagement in a community-driven behavioral change model.



HEALTH VALUE (HV) MODEL

Target Population: 48.5M U.S. patients suffered from a substance use disorder (SUD) in the past year.¹ 85% relapse rate within one year of treatment nationally.²

Patient Impact: Increased access to peer support, improved relapse prevention and better long-term outcomes.^{6,7}

Cost Impact: Lower health care costs due to reduced SUD relapse rates.⁵

HV-KEY PERFORMANCE INDICATORS

- **Key Clinical Results:** One peer-to-peer interaction cuts relapse rates by 48.2%.³
- **Patient Experience:** Half a million members; 100% peer response rate within minutes, 4.8/5 app store rating.⁴
- **Total Cost of Care:** Reduced relapse creates an est. \$7,959 savings per actively engaged member to the health system.³

Information provided by portfolio company has not been independently verified.

Sources: 1. Substance Abuse and Mental Health Services Administration. “National Survey on Drug Use and Health.” Last modified November 13, 2023. <https://www.samhsa.gov/data/>; 2. Brandon, Thomas H., Jennifer I. Vidrine, and Ellen B. Litvin. “Relapse and Relapse Prevention.” Annual Review of Clinical Psychology 3 (2007): 257–84. <https://doi.org/10.1146/annurev.clinpsy.3.022806.091455>; 3. Sobersidekick. “Sobersidekick: Your Companion in Recovery.” Accessed March 5, 2025. https://www.sobersidekick.com/_files/ugd/01129f_af3b67aaf1cc41deab4dd02d3df5d315.pdf; 4. Self-Reported by Sober Sidekick; 5. Etner, S., Huang, D., Evans, E., Ash, D. R., Hardy, M., Jourabchi, M., & Yih-Ing, H. (2006) Benefit-Cost in the California Treatment Outcome Project: Does Substance Abuse Treatment “Pay for Itself”? Health Services Research. 41(1): 192–213. doi: 10.1111/j.1475-6773.2005.00466.; 6. Tracy, Kathlene, and Samantha P. Wallace. “Benefits of Peer Support Groups in the Treatment of Addiction.” Substance Abuse and Rehabilitation 7 (2016): 143–154. <https://doi.org/10.2147/SAR.S81535>; 7. Scannell, Christian. “Voices of Hope: Substance Use Peer Support in a System of Care.” Substance Abuse: Research and Treatment 15 (2021): 11782218211050360. <https://doi.org/10.1177/11782218211050360>.



Health Value Return on Investment

Cylinder Health

Cylinder Health provides personalized gastrointestinal care, improving outcomes and reducing cost.

Cylinder



HEALTH VALUE (HV) MODEL

Target Population: 40% of individuals experience gastrointestinal issues daily, including conditions such as Crohn's disease, Ulcerative Colitis, Irritable Bowel Syndrome, Celiac Disease, and acid reflux (GERD).¹

Community Impact: Socially vulnerable populations, including those with lower socioeconomic status and minority groups, typically have less access to quality GI care.^{2,3}

Patient Outcomes: Improvement in GI symptoms, member satisfaction, medication adherence and decreased absenteeism.¹

Provider Impact: Improvement in care team coordination and satisfaction, the prevalence of burnout in dietitians and nutritionists is 40% as well as 37% of gastroenterologists reported burnout.^{4,5}

Cost Impact: Reduction in total health care spend, including reduced ER admits, inpatient admissions and duplicative doctor visits.¹

HV-KEY PERFORMANCE INDICATORS

- **Patient Experience:** 83% of users reported feeling more in control of their health, with African American users (92%) and women (86%) reporting the highest improvement¹
 - 76% of users reported feeling happier¹
- **Key Clinical Results: 91% of patients report improved GI symptoms¹**
 - 83% of users reported better symptom management¹
 - Severe symptom prevalence decreased from 80% to 48% post intervention²
- **Provider/Patient Engagement:** ~18% increase in dietitian / patient interactions compared to a typical practice¹
- **Provider Experience:** 89% care team satisfaction¹
- **Employee Engagement:** 13% of employees reached (vs 5% with other chronic care services)¹
- **Employer Savings:** 65%+ decrease in ER costs¹
 - \$2,000 PMPY medical savings¹
 - 5:1 ROI¹

Sources: 1. Cylinder. n.d. Cylinder Website & Cylinder Case Studies. <https://cylinderhealth.com/>; 2. Agency for Toxic Substances and Disease Registry. 2023. "Overall Social Vulnerability." Agency for Toxic Substances and Disease Registry. Accessed February 28, 2025. <https://www.atsdr.cdc.gov/placeandhealth/svi/overall-social-vulnerability.html>; 3. BMJ Open Gastroenterology. 2024. "BMJ Open Gastroenterology 11, e001463." <https://doi.org/10.1136/bmjgast-2024-001463>; 4. National Library of Medicine. n.d. "Article from PMC11667849." Accessed February 28, 2025. <https://pmc.ncbi.nlm.nih.gov/articles/PMC11667849/>; 5. National Library of Medicine. n.d. "Article from PMC7435002." Accessed February 28, 2025. <https://pmc.ncbi.nlm.nih.gov/articles/PMC7435002/>.



Health Value Return on Investment

dispatchhealth

DispatchHealth

Dispatch delivers on-demand health care to patients in the comfort of their own home, reducing unnecessary ER visits and hospital readmissions. Dispatch's system of care includes in-home ER-level medical care, advanced/hospital alternative care, and recovery/bridge care.



HEALTH VALUE (HV) MODEL

Population: Medically complex patients, frequent ER/hospital utilizers; often Medicare or MA eligible; over half are typically homebound. In 2019, >800k Medicare hospitalizations could have qualified for hospital-at-home.¹

Patient Impact: In-home services lower mortality rates, fall risk, and the onset of delirium.^{1,2} The Dispatch system of care allows members to remain in their homes, avoid hospitalizations that may come with complications, and maintain quality of life as defined by member goals.

Payer Impact: Shifting site of service enables patients to remain in their homes, even for acute and inpatient interventions, which would traditionally be delivered in the ER or inpatient setting. This reduces health care spend for payers.³

HV-KEY PERFORMANCE INDICATORS

- **Member Satisfaction/Net Promoter Score (NPS)** (scale of 100): Across markets, Dispatch achieves a typical NPS of 97-98.⁴ Results from Dispatch's work with a regional Blue plan showed an NPS of 95 among members who received acute care and 97 among those who received Recovery Care.⁴
- **Hospital Readmission Rate:** A regional Blue plan saw a 49% reduction in readmission rate and 53% improvement in 30-day hospital readmissions among members who received Dispatch's Recovery/Bridge Care solution.⁵
- **ER, Ambulance, and Hospital Diversion Rate:** Across markets, Dispatch Acute Care visits divert patients from the ER 58% of time, from an ambulance 20% of time, and hospital admission 3% of time.⁵ Advanced Care visits lead to a 30-day hospital readmit rate of 8.5% (the national average is 20%).⁵
- **Savings per Diverted ER Visit and Hospital Readmissions:** Across markets, Dispatch sees medical cost savings of \$1,625 per Acute Care visit and \$5-7k per Advanced Care visit. Total Acute Care and Advanced Care savings amount to \$1.5B across all markets.⁴ Dispatch's work with a regional Blue plan saved \$1,700 per diverted ER visit and \$30,000 per avoided hospital readmission, or ~\$3M in total savings.⁵

**Echo Health Ventures uses a strategic engagement model to establish and improve partnerships between its health plan stakeholders and portfolio companies. Echo believes its involvement in expanding Dispatch's contract with the regional Blue plan mentioned above helped contribute to the KPI results and Dispatch's overall impact.*

Sources: 1. Laurila, Jaakko V., Raimo O. Pitkala, Harriet Strandberg, and Timo E. Tilvis. 2009. "Delirium in Elderly Home-Treated Patients: A Prospective Study with 6-Month Follow-Up." *BMC Geriatrics*. <https://pmc.ncbi.nlm.nih.gov/articles/PMC2693729/>; 2. Stuck, Andreas E., Juerg C. Egger, Gerhard Hammer, Christa M. Minder, and John C. Beck. 2015. "Preventive Home Visits for Mortality, Morbidity, and Institutionalization in Older Adults: A Systematic Review." *BMC Public Health*. <https://pmc.ncbi.nlm.nih.gov/articles/PMC3951196/>; 3. Smith, Adam C., and Jonathan P. Jones. 2017. "Innovative Home Visit Model Associated with Reduction in Costs, Hospitalizations, and ED Use." *Journal of the American Geriatrics Society*. <https://pubmed.ncbi.nlm.nih.gov/28264943/>; 4. Dispatch Analytics Department. 2024. Internal Report on Home Healthcare Data; 5. Regional Blue Health Plan. 2024. Health Plan Data Report.



Health Value Return on Investment

Strive Health

Strive is a leading provider of value-based kidney care. It aims to improve outcomes for patients with chronic kidney disease (CKD) and end-stage kidney disease (ESKD) by lowering the total cost of care through its high touch, technology-enabled care model that addresses comorbidities and delays disease progression.

strive



HEALTH VALUE (HV) MODEL

Target Population: Kidney disease affects ~37M people in the U.S. and is more common in people >65 years and those with diabetes and high blood pressure, which cause 45% and 28%, respectively, of kidney disease cases.^{1,6}

Patient Impact: About 90% of people with CKD do not realize they have the disease until the condition reaches late-stage or end-stage kidney disease (ESKD), and those with CKD or ESKD carry a disproportionate burden of cardiovascular morbidity/mortality, and health care utilization and costs.^{1,2}

Strive Health's care model engages and educates patients at the highest risk, brings care to preferred settings, and manages the care continuum. Strive treats the whole person and keeps patients on the ideal care journey, while slowing down overall kidney disease progression.

Payer Impact: Over \$100B in annual Medicare spend on kidney disease patients, with costs to U.S. health plans increasing exponentially as CKD progresses.^{3,4,8} Strive saves money for payers by lowering the total cost of care (TCOC) via overall improved quality of care, a reduction in hospital admissions and an increase in optimal dialysis starts.

HV-KEY PERFORMANCE INDICATORS

- **Member Satisfaction/Net Promoter Score (scale of 100):** Strive's average patient satisfaction score is 94%.⁷
- **Optimal Start Rate:** 67% increase in rate of optimal starts (includes preemptive kidney transplant or initiation of dialysis), compared to unenrolled patients in Strive markets.⁵
- **30-day Hospital Readmission Rate:** 36% reduction in Strive patient readmission rate, compared to historical benchmark.⁵
- **Hospitalization Rate:** 49% reduction in hospitalizations among high-risk Strive patients, compared to historical benchmark.⁵
- **ER Diversion Rate:** 10% reduction in ED visits, compared to initial baseline.⁷
- **Nephrology Visits:** 31% increase in visits, compared to initial baseline.⁷
- **Total Cost of Care:** Strive national results show a reduction in Total Cost of Care by 20%.⁵

* Echo Health Ventures uses a strategic engagement model to establish and improve partnerships between its health plan stakeholders and portfolio companies. In addition to supporting Strive's partnerships with regional Blue plans in our Alliance, Echo was at the table to support the creation of Strive in 2018. We partnered with the founders to transform the company from a concept to a leading kidney care solutions company.

Sources: 1. American Heart Association. 2020. "Cardiovascular Disease in Chronic Kidney Disease." *Circulation*. <https://www.ahajournals.org/doi/10.1161/CIRCULATIONAHA.120.050686>; 2. Jha, Vivekanand, and Geoffrey A. Block. 2023. "Global Economic Burden Associated with Chronic Kidney Disease." *International Journal of Nephrology and Renovascular Disease*. <https://pmc.ncbi.nlm.nih.gov/articles/PMC10499937/>; 3. American Journal of Managed Care. 2023. "Medical Costs for Managing Chronic Kidney Disease and Related Complications in Patients with Chronic Kidney Disease and Type 2 Diabetes." *AJMC*. <https://www.ajmc.com/view/medical-costs-for-managing-chronic-kidney-disease-and-related-complications-in-patients-with-chronic-kidney-disease-and-type-2-diabetes>; 4. National Kidney Foundation. 2023. "Federal Investment in Kidney Disease Research and Care." National Kidney Foundation. <https://www.kidney.org/get-involved/advocate/legislative-priorities/federal-investment>; 5. Strive Health. "Strive Metrics: Analysis Details." Strive Health. Accessed March 5, 2025. <https://strivehealth.com/strive-metrics/>; 6. National Kidney Foundation. "Diabetes and Chronic Kidney Disease." National Institute of Diabetes and Digestive and Kidney Diseases. "Kidney Disease Statistics for the United States." National Institute of Diabetes and Digestive and Kidney Diseases. Accessed March 5, 2025. <https://www.niddk.nih.gov/health-information/health-statistics/kidney-disease>; 7. Strive Health. "Strive Media Kit" Strive Health. Accessed March 11, 2025. https://strivehealth.com/wp-content/uploads/2024/10/MediaKit_Q42024_v2.pdf; 8. CDC. "Chronic Kidney Disease: Common, Serious, and Costly." CDC.gov. Accessed March 11, 2025. <https://www.cdc.gov/kidney-disease/ckd-facts/index.html>.



Health Value Return on Investment

Amae Health

Amae Health, a psychiatry-led integrated care provider of outpatient physical and behavioral health services for people living with a severe mental illness (SMI). Amae Health's mission is to create the center of excellence for patients with severe mental illness.



HEALTH VALUE (HV) MODEL

Population: 15M adults in the US suffer from Severe Mental Illness (SMI)¹. These individuals have a 10-20 year reduction in life expectancy and 50% of people with SMI suffer from substance abuse.^{2,4}

Patient Impact: Current standard of care for SMI leads to 23% 30-day ER readmissions, 15-day average length of stay (LOS) post readmission, and only 53% medication adherence.

Cost Impact: SMI accounts for over \$300Bn in costs in the US annually.²

HV-KEY PERFORMANCE INDICATORS

- **Patient Engagement:** Amae Health's clinical model delivers intensive outpatient SMI care under an integrated model with psychiatric, medical, social and medication needs addressed cohesively. Patients have an 80% engagement with Amae, compared to the standard of care of 30%.³
- **ER Readmissions:** Amae's model enables up to 83% reductions in 30-day ER readmission. Amae's in-network model (inclusive of Medicaid plans) model has proven to reduce 30-day ER readmissions from 23% down to 4%, leading to Total Cost of Care reductions.³
- **Key Clinical Results:** 60% increase in medication adherence and 50% reduction in key SMI symptoms—including 49% reduction in suicidality, 61% reduction in psychosis, and 76% reduction in mania over 24 weeks.³

Sources: 1. National Institute of Mental Health. "Mental Illness." National Institute of Mental Health. Accessed March 5, 2025. <https://www.nimh.nih.gov/health/statistics/mental-illness>. 2. American Addiction Centers. "The Long-Term Effects of Drug Abuse." American Addiction Centers. Accessed March 5, 2025. <https://americanaddictioncenters.org/blog/long-term-effects-drug-abuse>. 3. Amae Health Internal Data. 4. Drake, Robert E., Kim T. Mueser, and Mary F. Brunette. "Management of Persons with Co-Occurring Severe Mental Illness and Substance Use Disorder: Program Implications." *World Psychiatry* 6, no. 3 (2007): 131–136. <https://pmc.ncbi.nlm.nih.gov/articles/PMC2174596/>.



Health Value Return on Investment



WelbeHealth

WelbeHealth, a Temasek portfolio company, provides full-service healthcare and personalized support to help seniors age at home and in their communities through the Program for All-inclusive Care for the Elderly (PACE). PACE provides fully integrated, community-based care for medically complex adults 55 and older who need nursing home level care.

HEALTH VALUE (HV) MODEL

Population: ~1.4M seniors in CA are eligible for a PACE program.¹ PACE enrollment has increased by 50% since 2019.² Californians make up 30% of national PACE enrollment as of June 2024 and the largest growth in PACE is in CA where Welbe is headquartered.² In 2023, Los Angeles had the largest PACE population of any county in the US.³

Patient Impact: Despite high care needs, over 90% of PACE participants continue to live in their community with a good quality of life for up to 4 years.⁴ PACE is associated with lower hospitalization rates, shorter lengths of stay in hospitals (<6 days), reduced caregiver burden, and a higher quality of life compared to other programs.⁴ Data also shows that PACE participants are significantly less likely to use emergency department care or be institutionalized than Medicare Advantage enrollees.⁵

Financial Impact: PACE is lower cost compared to nursing home care. PACE organizations like WelbeHealth reduce preventable hospitalizations and save money compared to costly long-term nursing care and comparable government funded programs (Medicare/Medicaid). The average cost for a PACE program is 12% percent less/person/month than the costs the state Medicaid programs otherwise would incur.⁶ In 2024, CA paid approximately \$370M less than it would have if all PACE participants were served outside of PACE.⁷ We can assume Welbe is a significant portion of those savings as the 2nd largest PACE Organization in CA.

HV-KEY PERFORMANCE INDICATORS

- **Member Satisfaction:** PACE participants are highly satisfied and feel uniquely cared for. 92% of PACE participants are very satisfied with their care and would recommend PACE to friends/relatives, and 95% of caregivers would recommend PACE.⁷ In 2024, 94% of Welbe participants report improved quality of life under Welbe's care, according to 3rd party survey (I-SAT) data.⁹
- **Hospital Readmission Rate:** Welbe's care model effectively reduces avoidable emergency room visits and inpatient admissions. In 2024, admissions per thousand improved by 9%, while ER visits per thousand saw a 14% improvement.⁹
- **Health Outcomes:** In 2024, 82% of Welbe participants with diabetes had a most recent HbA1c level of $\leq 9\%$, achieving a performance level equivalent to a Medicare Advantage 4-star rating.⁸ 73% of Welbe participants maintained or improved their frailty status in 2024, demonstrating success in preserving functional independence.⁹
- **Advanced Care Planning:** Ensuring that participants' medical decisions align with their personal goals is a priority. In 2024, 99% of Welbe participants engaged in an advance care planning discussion, and 96% had a completed POLST or Advanced Directive.⁹

Sources: 1. California Department of Health Care Services, "Program of All-Inclusive Care for the Elderly (PACE)," 2. ATI Advisory, "A Look at PACE Growth by the Numbers: States, Organizations, and Enrollment," July 2024. 3. Skopec, Laura, "The Program of All-Inclusive Care for the Elderly (PACE) Payment System," Urban Institute, June 2024; 4 National Library of Medicine, Program of All-Inclusive Care for the Elderly (PACE), StatPearls, accessed March 12, 2025; 5 Harootunian, Lisa, Allison Buffett, Brian O'Gara, Kamryn Perry, Marilyn Werber Serafini, and G. William Hoagland, "Improving Access to and Enrollment in Programs of All-Inclusive Care for the Elderly (PACE)," Bipartisan Policy Center, October 4, 2022. Accessed March 12, 2025. <https://bipartisanpolicy.org/report/improving-pace/>; 6. National PACE Association, "2023 PACE Rates and Trends in Medicaid Payments," December 6, 2023; 7. California PACE Association, "Home Care Assistance & Senior Care Services," <https://calpace.org/>. 8. Centers for Medicare & Medicaid Services, "Quality ID #1 (CBE 0059): Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9%)." December 2023. 9. Reported by Welbe Health

