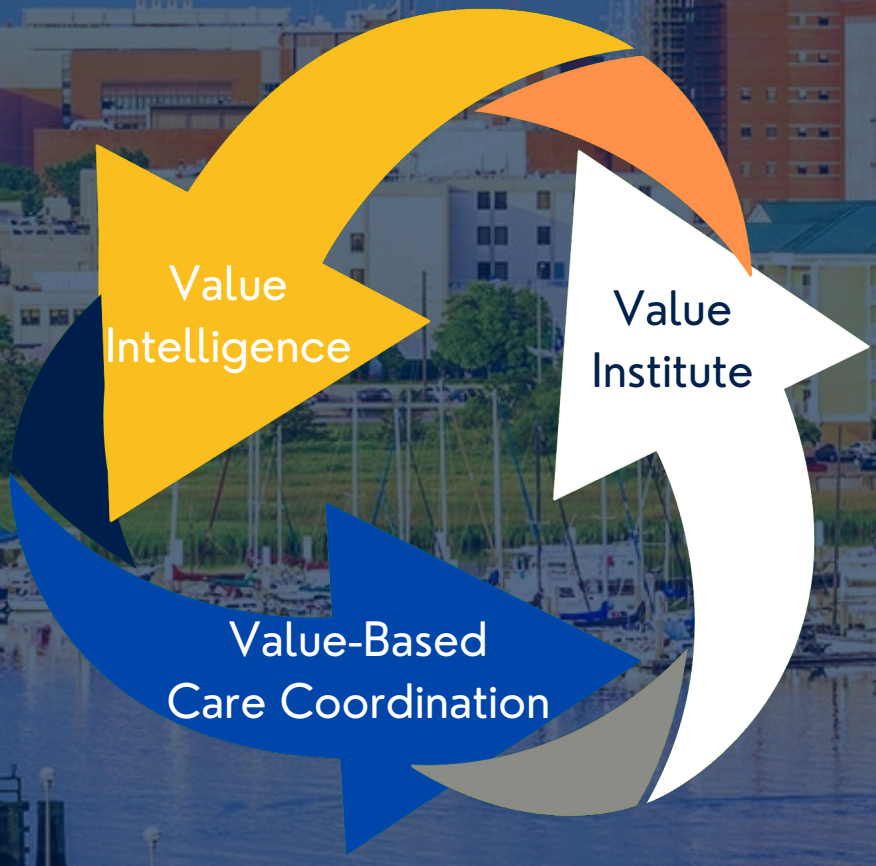
# POPULATION HEALTH

## ANNUAL REPORT 2025




MUSC Health
Medical University of South Carolina

# POPULATION HEALTH

## VISION

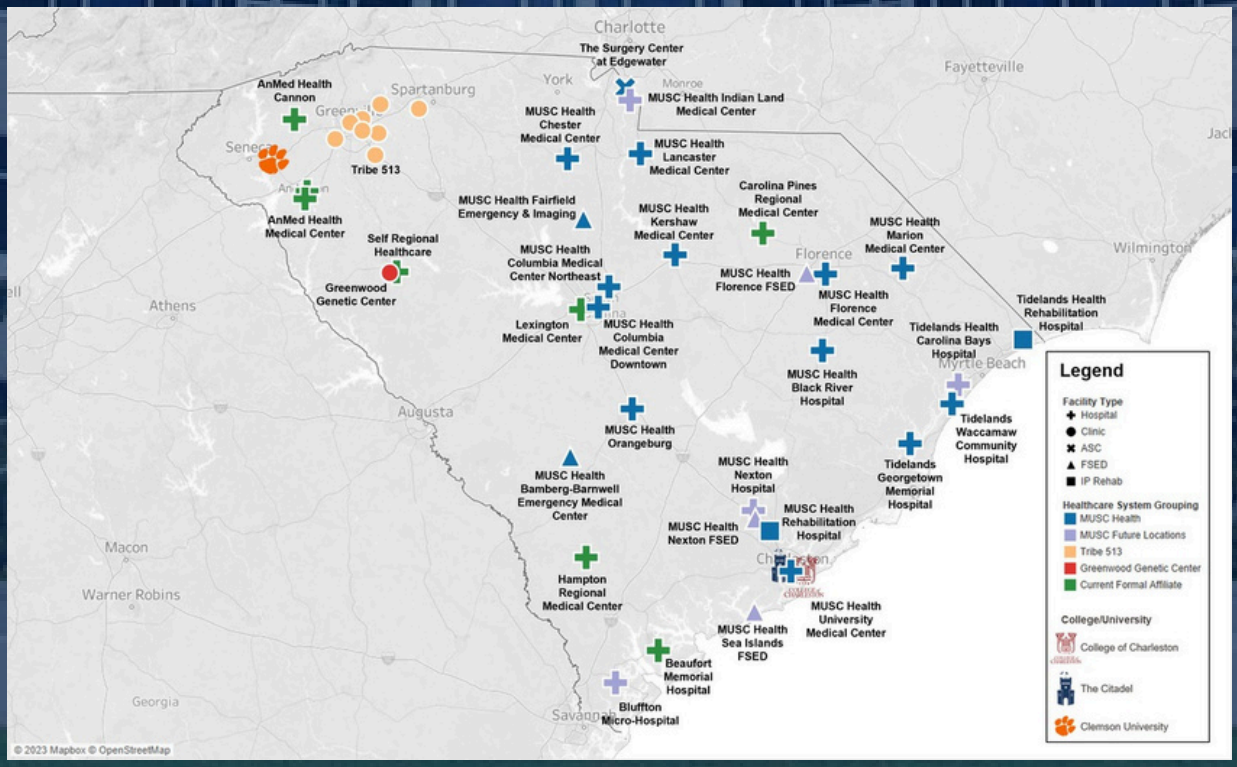
Healthy South Carolina

## MISSION

Transforming healthcare delivery to achieve better outcomes for the lives we touch.

## PROCESS

We offer health care that is consistent, sustainable, equitable, scalable, patient-centered and value-based to better serve our population.
We leverage technology, evidence-based practice, community partnerships and engagement.



# POPULATION HEALTH REIMAGINED

## *Introductory Letter*

Welcome to another report for a banner year for Population Health!

In response to changes to the US Healthcare System and how it is funded, MUSC Health's CEO, Dr. Patrick Cawley, asked that Population Health and our Value-Based Care Programs reimagine themselves, evolve, and become an organization centerpiece with engagement across the enterprise and with all senior executives. This report and what it is now "Population Health" captures the foundational change. Added to our portfolio are key patient care management programs that previously existed elsewhere; ambulatory social work is now part as well. These programs, which existed elsewhere in MUSC Health just 12 months ago are now aligned with Population Health to deliver a spectrum of services of varying intensity; collaboration will make it easy for patients to move up and down the programs to best match any individual patient's needs.

In the last year we have built out a state-of-the-art Epic-first claims-analytics ("Value Based Savings") that is quickly becoming the envy of academic health systems across the country. We have brought in-house claims (which is how things get paid in the US system) and can pull together clinical, claims, and demographic data to better understand quality and value.

The year ended with Population Health being the topic for MUSC's Leadership Development Institute. Leveraging our Chief Quality Officer's (Dr. Danielle Scheurer) mental model of "Think Like a Dolphin." Dolphins must be awake to breathe and in order to sleep (which is a brain reset), they must keep alternating brain halves working during sleep. Getting back to land mammals, we led nearly 1000 leaders through learning and exercises designed to connect each leader individually to how value-based care and population health tie into the work they and their teams do. The "Think-Like-a-Dolphin" paradigm is that we need to enable the other half of our brains to think in value-based care models while still being able to use the first half of our brains to think in traditional fee-for-service constructs. This reflects our current reality and the foreseeable future where fee-for-service and value-based care will co-exist and sticking to one side or the other is not a successful survival strategy.

The much larger and reorganized Population Health team is a large resource commitment for MUSC Health that is critical for future success. 2026 will see further growth – in programs, in patients attributed, and in success.

Think Like a Dolphin!

David S. Louder, M.D., MBA
System Chief, Population Health
Executive Director, MUSC Health Alliance
Clinical Associate Professor, Pediatrics

# VALUE-BASED PROGRAMS

## *Meet the team*

**Sam Guerin** MBA
Manager, Value-Based Programs

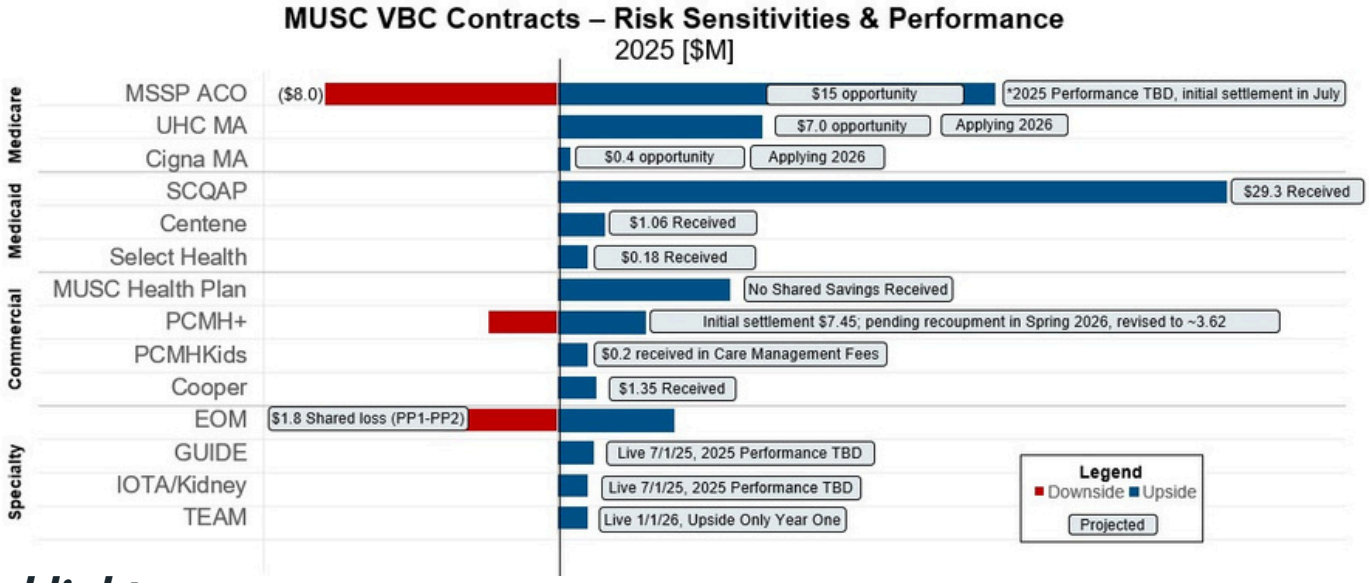
**Dr. Dave Louder** MD, MBA
System Chief, Population Health
Executive Director, MUSC Health Alliance

**Abby Stelter,** MHA
Director Value-Based Care Network

**Jaterra Mims,** MHA
Program Coordinator III

## *Program Results*

### VBC Projected Performance & Risk Sensitivities




## *Highlights*

- 225,000 and growing lives under an MUSC Value-based Care Model
- In January of 2025, MUSC entities reentered the Medicare Shared Savings Program and successfully completed performance year one
- In July of 2025, MUSC entities entered two new CMS VBC Models, Guiding an Improved Dementia Experience (GUIDE) in the first performance year & Increasing Organ Transplant Access (IOTA)
- In January of 2026, MUSC Florence entered the CMS Transforming Episode Accountability Model (TEAM) Model
- In spring of 2026, exploring applying to the CMS Advancing Chronic Care with Effective, Scalable Solutions (ACCESS) model

# POPULATION HEALTH

Meet the team

## *Value Intelligence*

**Matt Jenny**
MS
Population Health
Engagement Manager

**Gail Kushner,**
PharmD
Pharmacoeconomic
Clinical Pharmacy
Specialist

**Peggy Jenny**
RN, BSN, MPHS
Director of Value
Intelligence

**Tina Walker**
RN, BSN
Senior Data Integrity
Analyst

**Jeremy Hannum**
Population Health
Engagement Manager

## *Quality Reporting and Regulatory Reporting*

**Amelia Reynoldson**
MBA
Director
Quality and Regulatory Reporting

**Patterson Burch**
MHA
Director
Quality Reporting and Improvement

**Caitlin Engelke Bullock** MSHI, MLS (ASCP)
Senior Quality and Regulatory
Reporting Analyst

## *Data Integrity*

**Rhys Adle**
Data Engineer I

**Eileen Daugherty**
MHA
Data Integrity Analyst II

**Sayaka Delaney**
Data Integrity
Analyst I

**Sarah Madgwick**
MHA
Manager
Data Integrity

**Maya Martin** MHA
Data Integrity
Analyst II

**Neema Maharjan**
MHCM, MS
Senior Data
Integrity Analyst

# VALUE INTELLIGENCE


## *Epic Value Education (EVE) Program*

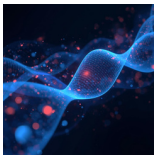
- The Population Health Engagement Manager team enhances MUSC Health care delivery through targeted workflow education.
- By optimizing Population Health tools within Epic through collaboration with IS, clinical staff, and leadership, the team equips providers to deliver high-quality care
- Engagement managers leading the EVE program are Jeremy Hannum (hannum@musc.edu) and Matt Jenny (jenny@musc.edu)

## *Guiding Principles*

- **Partner with Purpose**- Collaborate with providers to achieve shared quality and cost outcomes
- **Translate Performance Data**- Convert value-based metrics into clear, actionable practice strategies
- **Optimize Care Delivery**- Align workflows to improve quality, utilization, and patient experience
- **Focus on High**-Impact Populations- Prioritize high-risk and high opportunity patents to drive value
- **Sustain Results**- Support continuous improvement that delivers measurable, long-term performance gains

## *Kep Focus Areas*

- Across these service areas, the team is focused on partnering with clinicians and care teams to advance population health priorities across the health system
- The team helps align clinical workflows with quality, equity, and value-based care goals
- Book an appointment if you'd like to meet with an Engagement Manager



### *Clinical Variation Reduction*

Standardizes care practices leveraging evidence based practice (Agile MD and MedPearl

### *Social Drivers of Health (SDOH)*

Systematically identify and address SDOH in all care settings to reduce disparities in patient populations while generating revenue for screening

### *Quality Measure Documentation*

Increase Awareness and documentation of quality measures system-wide

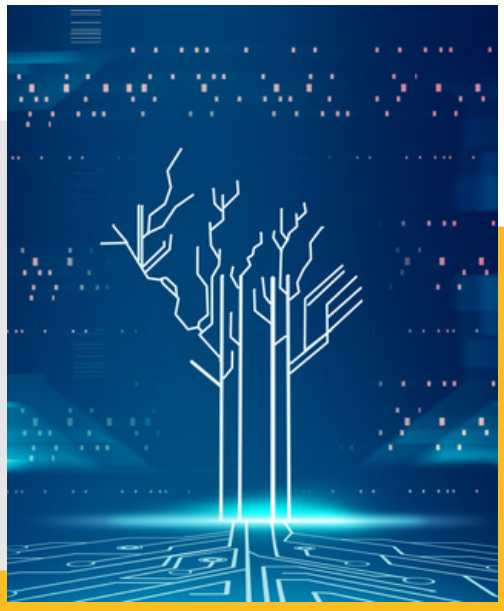

### *Risk Adjustment/Self-Service Analytics*

Accurate capture of chronic conditions to reflect patient risk and provide Slicer Dicer "how to" sessions

# VALUE INTELLIGENCE

Data Integrity

In 2025, the Data Integrity team delivered significant value through high-volume data support and robust analytics development. Major milestone accomplishments ensured operational teams had timely and accurate data for decision-making. Enhancements were developed across report configurations, rules, smartlists, and other essential build elements to strengthen analytic infrastructure.



## *Operational Wins*

The team also made notable strides in registry reporting and Epic-based analytics. A brand-new American Spine Registry was implemented, complete with custom SQL to capture all required reporting elements. Epic registry work encompassed both new builds (like the Spine registry) and maintenance of critical existing registries, including Heart Failure, Stroke, Renal Disease, and several oncology-related datasets. Meanwhile, Epic Dashboard implementation accelerated dramatically, introducing new real-time dashboards across diverse service lines—Nursing, GYN/Onc, Corrections, Transplant, ERAS, Ortho, OB, SSI, and more—while sustaining ongoing updates to dashboards for Rapid Response, Mortality, Palliative Care, and CHG Billing.

## *172 Data Report Requests*

- The Data Integrity Team has fielded 172 data report requests from users across the entire organization.
- Power BI Dashboard Development ramped up including:
  - Provider level Scorecard
  - Falls PowerBI Dashboard
  - HAPIs PowerBI Dashboard
- The team started a net new registry within the external reporting space, The American Spine Registry.
  - A SQL code was developed to capture all of the required reporting elements.

## *06 Epic Registries*

The Data Integrity team performed maintenance on six Epic registries used across the enterprise.

- KACI Cancer
- Heart Failure
- EOM Cancer
- Medtronic Diabetes
- Stroke
- Renal Disease

In addition to Epic Registries, the team implemented Epic Dashboards for access to real-time data in one centralized location.

# VALUE INTELLIGENCE

Data Integrity

## *New Dashboards for 2025*

Implementation of Epic Dashboards for access to real-time data in one place.

- New Dashboards for 2025
  - Nursing Retained Foreign Objects
  - Total Joint Replacement
  - GYN
  - GYN/Onc
  - OB
  - Department of Corrections
  - Transplant Time from DC order to DC Time
  - ERAS
    - Colo
    - GYN/Onc
    - GYN
    - Spine
    - Cesarean
    - Ortho
  - SSI Dashboard
  - Palliative Care Ambulatory
  - Pre-Op Metric
- Maintenance of existing Epic Dashboards 2025
  - Rapid Response
  - Mortality
  - Transplant Volumes
  - Palliative Care
  - CHG Bathing

## *Content Management Items Moved to Production*

The team moved 48 Tickets with a total of 1,187 items in 2025. Including:

- IDJ - Benchmark Dashboard (6)
- PAF - Columns (216)
- RPT - Reports (1)
- IDB - Dashboard Components (377)
- IDM - Dashboard Configurations (51)
- LPP - Extension (190)
- VCG - Groupers (8)
- HGP - Parameters (7)
- HFP - Properties (3)
- HFR - Registry (6)
- HRX - Report Info (162)
- CER - Rule (134)
- ELT - Smartlist (2)
- HH1 - Smartphrase (2)
- HGR (11)
- HGT (6)
- IDJ (3)
- HGL (2)

# VALUE-BASED SAVINGS

The Value-Based Savings team celebrated their one year anniversary since formation in 2024. The team has a cumulative of 30+ years of value-based experience with healthcare providers, payers, consultants, and technology vendors. In 2025, the team implemented Epic's Value-Based Performance Management Module (VBPM).

## *Mission*

To transform care delivery and optimize the patient experience by stewarding the generation of insights that make cost performance transparent.

## *Meet the team*

**Blair Shannon**
Director
Value-Based Savings

**Kelsey Ryan, PhD,**
Analyst
Value-Based Savings

**Michael Johnston, PhD,**
Analyst
Value-Based Savings

## *VBPM Milestone*

### 1 *What is VBPM?*

- A suite of analytics that sit on top of claims and enrollment data in VBC contracts

### 2 *Implementation process*

- Implementation required establishing new relationships with our payers and holding them accountable for accurate data
- Stewardship requires making configurations and gaining an understanding to drive insights

### 3 *Generate Insights*

- MUSC is pioneering the use of Epic's latest in cutting edge Population Health functionality
- The data will allow us to see what's contributing to total cost for our at-risk populations
- Predictive risk models will allow Population Health to make strategic decisions
- One of our biggest wins in this area includes working with Mary Riddle in HIM to establish an iron-clad master patient identification process so every value-based patient is accounted for in Epic

# VALUE-BASED SAVINGS

## Epic VBPM Data Integrity

· Multiple data issues were identified and resolved this year in partnership with payer data teams.
· In October, MUSC identified up to 15% of claims missing from BCBS files due to an attribution issue; BCBS issued corrected files on 10/22.
· Remaining differences related to ITS (out-of-state) claims are expected to be resolved in January following data-sharing clarification.

| | | Previous Analysis | | | | Current Analysis | | | |
|---|---|---|---|---|---|---|---|---|---|
| Year | Month | Epic - VBP Claim Payments | BCBS Actuarial Totals | Difference | % difference - Epic to BCBS Actuarial | New Epic Claim Payments | BCBS Actuarial, Medical Non-ITS | Difference | % difference - Epic to BCBS Actuarial |
| 2025 | Jan | $1,891,401 | $2,153,113 | $261,712 | 12.16% | $1,676,123 | $1,671,106 | -$5,016 | 0.30% |
| | Feb | $2,161,617 | $2,419,707 | $258,090 | 10.67% | $1,812,512 | $1,805,780 | -$6,733 | 0.37% |
| | Mar | $2,347,981 | $2,773,147 | $425,166 | 15.33% | $1,795,470 | $1,803,760 | $8,290 | 0.46% |
| | Apr | $2,792,358 | $2,820,074 | $27,716 | 0.98% | $1,758,219 | $1,737,259 | -$20,960 | 1.21% |
| | May | $3,042,235 | $3,047,990 | $5,755 | 0.19% | $2,250,103 | $2,254,192 | $4,089 | 0.18% |
| | Jun | $3,024,278 | $3,040,308 | $16,030 | 0.53% | $1,935,511 | $1,938,486 | $2,976 | 0.15% |
| | Jul | | | | | $2,100,109 | $2,105,079 | $4,970 | 0.24% |
| | Aug | | | | | $2,296,073 | $2,305,807 | $9,733 | 0.42% |
| | Sep | | | | | $1,859,208 | $1,849,175 | -$10,033 | 0.54% |
| | Oct | | | | | $1,188,412 | $1,200,057 | $11,645 | 0.97% |

## Other Wins This Year

- Blair was emcee at LDI 64
- Presented to Epic's Chief Population Health Officer Forum
- Presented at The Health Management Academy Spring VBC Summit
- Authored scientific journal article: Holcomb, L.A., Killen, E.C., Ryan, K.R. *et al.* A comparison of social drivers of health identification and intervention rates by sex among patients receiving primary care.
- Working with Dawn Aguilar and System Finance to develop financial statements per value-based program
- Partnership in standing up the Outpatient CDI program with Tracy Ferro, including measuring their potential multimillion dollar impact.
- Developed a Sickle Cell Psych Dashboard to manage this population
- Taught Biostatistics seminar in partnership with the university to MHA candidates
- The team completed Epic certifications in Epic Cogito and the Caboodle Data Model
- Emerging partnership with Compliance on identifying potential FWA in the MSSP ACO
- Developed Kidney Disease Value-Based Population Management Dashboard
- New High Risk Care Management Eligible reports

# ACADEMIC INTEGRATION

Partnerships and Collaborations

## New Funding

In 2025, MUSC's Population Health team—working in partnership with Telehealth and Psychiatry—received a **$1.1 million grant from The Duke Endowment** to strengthen **preconception health and social care**, with the ultimate goal of improving **maternal and infant health outcomes**. This investment will allow MUSC to close key social care gaps, support chronic disease management, and address behavioral health needs during the preconception period. By intervening earlier, MUSC aims to reduce preventable health care utilization and social vulnerability while improving maternal and infant clinical outcomes.

In addition, **Johnson & Johnson awarded MUSC's Care Coordination team $40,000** to support an **emergency fund for patients with urgent social needs**. This fund may be used to address immediate barriers to health and stability, including: utility assistance, transportation needs, food assistance and medical equipment access gaps.

## Continued Funding

MUSC also continued to receive funding through the Community Health Alignment Initiative (CHAI) and The Duke Endowment to sustain Population Health's Community Navigation Program. This work includes a systemwide team of embedded Community Health Workers (CHWs), as well as ongoing support for MUSC's Community Resource Library and Social Drivers of Health (SDoH) screening program.

## Scholarly Work

### 01.

Holcomb, L. A., Crabtree Killen, E., Ryan, K. R., et al. (2025). A comparison of social drivers of health identification and intervention rates by sex among patients receiving primary care. Biology of Sex Differences, 16(57).

**Elizabeth Crabtree Killen**
PhD, MPH
Administrator of
Clinical Transformation

## Office of Academic Integration

Members of the Population Health team serve as Core Faculty for Graduate Medical Education (GME) residency programs within the Regional Health Network, including participation in this year's successful site visit and resident candidate interviews.

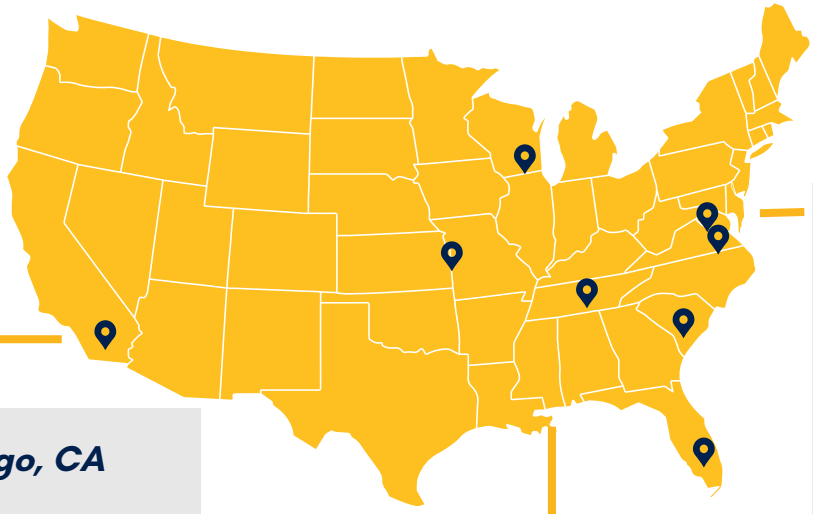
In addition, we have developed curriculum offerings focused on evidence-based practice and community health. These sessions are currently being delivered to Internal Medicine and Family Medicine residents in Florence and Lancaster, with planned expansion to the Orangeburg and Midlands residency programs in the coming months. Through this work, residents completed four evidence-based practice projects that will translate directly into measurable improvements in patient care across Regional Health Network sites.

Population Health also supports a faculty development series for residency program leadership and teaching faculty, providing lectures on research methods, biostatistics, and scholarly dissemination to strengthen academic capacity and advance a culture of continuous learning, scholarship, and quality improvement across the system.

We are proud to contribute to the training of the next generation of physicians and clinical leaders who will serve communities across South Carolina.

# ACADEMIC INTEGRATION

Presentations



### San Diego, CA

**01.** "Embedding Community Health Workers to Address Social Needs and Whole-Person Care: Two Approaches," NCQA Innovation Summit.

### Overseas

**01.** "Cigarette & E-cigarette Cessation Studies with Medical and Community Patients in an Ever-Evolving World of Tobacco Use," Research Department of Behavioral Science and Health at the University College London, December 2025.

**02.** "E-cigarette Use Prevalence and the Need to Develop Treatments: What We Know and How Treatments May Help Public Health," Royal College of Physicians, December 2025.

### Madison, WI

**01.** "Get Out & Stay Out: Utilizing a Predictive Model to Prevent Readmissions," EPIC UGM, August 2025.

### Kansas City, KS

**01.** "Cancer Prevention Research: Lung Cancer Screening, Smoking Cessation, & E-cigarettes," Grand Rounds at Kansas University, June 2025.

### Fort Lauderdale, FL

**01.** "Leveraging Technology for Smarter Value-Based Care Decisions-Epic's VBPM Module," The Health Management Academy Spring Value-Based Care Summit, May 2025.

### Washington, D.C.

**01.** "A comparison of social drivers of health identification and intervention rates by sex among patients receiving primary care," APHA Annual Meeting, October 2025.

**02** "Food is Medicine: A CHW and Nurse Care Coordinator-led Clinic-based Food Pantry to Improve Chronic Kidney Disease Outcomes," October 2025.

### Nashville, TN

**01.** "Teaching Evidence-Based Quality Improvement in Rural Residency Programs," Southern Chapter MLA meeting, October 2025.

### Richmond, VA

**01.** "Ensuring the Pipeline is Secure: Faculty Retention," Annual Meeting of the Cancer Biology Training Consortium, October 2025.

### Charleston, SC

**01.** "Clinical Pathways in the Electronic Medical Record: A Comprehensive Review and Application," ACP Fall Classic, October 2025.

# VALUE INSTITUTE

Evidence and Clinical Pathways

The Value institute has adapted over the last decade to better meet the needs of MUSC Health as it continues to grow and innovate. We strive to re-visit our Mission and Vision to better reflect our current body of work.

## *Mission*

Transforming healthcare delivery by leveraging evidence to create tools that improve value.

## *Vision*

To optimize healthcare delivery and value based on evidence.

## *Meet the team*

**Emily Brennan**
MLIS
Evidence Synthesis Librarian

**Amanda Davis**
MPH, RD, CHES Director
Value Institute

**Michelle Hannum**
MS
Project Manager Guideline Development

**Beth Johnson**
BSN, RN
Project Manager Pathway Development & Integration

**Lauren Marrozi**
MS
Manager, Pathway Implementation

**Reena Ragala**
MOTR/L
Project Manager for Guideline Development

**Heather Toeppner**
MSN, RN
Project Manager for Value Based Care

## *Team update*

Clare Valluzzo
RN
Clinical Pathway Coordinator

Clare Valluzzo joined the Value Institute as a Clinical Pathway Coordinator in December 2025. Clare brings her strong clinical background as a Registered Nurse in both acute and outpatient care settings at MUSC Health to the team. In her role as Clinical Pathway Coordinator, she is committed to advancing evidence-based practices and improving patient outcomes through standardized clinical pathways.

## *MUSC Ideal Care Plans:*

- ***Mar 2025*** — Hypoglycemia Management in Hospitalized Patients *New*
- ***Oct 2025*** — Treatment Resistant Depression in Adults *New*
- ***Nov 2025*** — Atrial Fibrillation Management *New*
- ***Coming Soon*** — Subarachnoid Hemorrhage *New*
- Low Back Pain in Adults *New*

# VALUE INSTITUTE

E-learning and Evidence

## EBP for Healthcare Professionals Education

### 04 Final Presentations of the inaugural cohort of Evidence-based Quality Improvement (EBQI) Course

- Reducing Chemotherapy-Induced Nausea & Vomiting (CINV) Rates in Inpatient Setting by Ilias Jerrar, MD and Danny Aboujamra, MD
- Reducing Daily Chest Radiographs in ICU Patients by FNU Karishma, MBBS and Sabzada Mamoon Rasool, MBBS
- Implementing the Utilization of Khorana Scope to Assess VTE Risk in Oncology Patients by Rayan Borji, MD and Chinenye Okafor, MBBS
- Implementing Quadruple GDMT on Hospitalized Heart Failure Patients by Piyush Sharma, MD and Shreeram Paudel, MBBS

### ++ Next steps

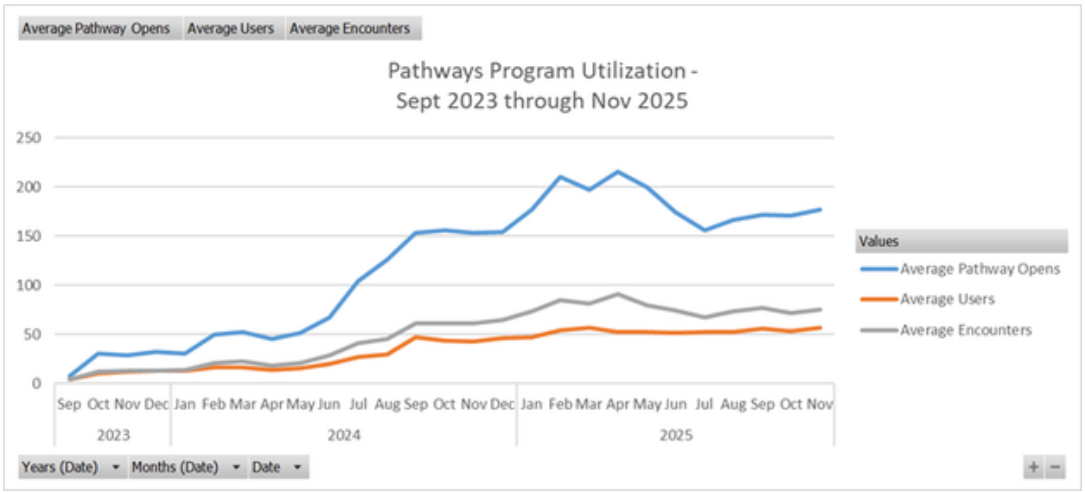
- We look forward to mentoring 24 new PY1's from all three Regional Network GME programs through the EBQI course in 2026!
- Nurses spoke - we listened! During the summer of 2025, the Value Institute re-designed our EBP for Healthcare Professionals course to better meet the needs of nurses systemwide.
- To learn more visit: Evidence-based Practice Lessons in OurDay and Self-paced EBP for Healthcare Professionals course.

## Evidence Briefs & Program Growth

### 18 Value Institute Requests

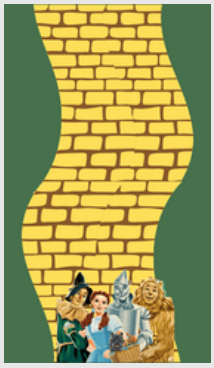
- Triaged with literature searches performed from stakeholders across MUSC Health

### 12 New Evidence Briefs completed



# VALUE INSTITUTE

Pathways in Epic via AgileMD



**Follow the Yellow Brick Pathway Campaign**

## New Pathways in Epic

We hit our stride towards our "Pathway to 300" milestone in 2025 – increasing our library of Pathways in Epic (n = 213) to meet the upcoming needs of hospitalists systemwide in addition to surgical teams as part of the new 2026 Transforming Episode Accountability Model (TEAM) requirements for the Florence market. We also vastly expanded our Pediatric pathways library through our collaboration with the SJCH ED's Peds Readiness program for the RHN. New Pathway Ideal Care Plan-related releases during 2025 included:

- Pediatric Populations
- Asthma
- Pneumonia
- Psoriasis
- Adult Populations
- VTE Diagnosis & Treatment
- Cardiac Surgery ERAS
- Psoriasis
- Total Shoulder Replacement
- Expansion of Spine Surgery ERAS Pathways to RHN
- Spine/Ortho Bowel Management – Nursing

## Pathways Program Update

- We began our Pathway Request program at the end of 2024 and have received and garnered senior leadership approval for 15 front line requests to date. This program allows the Pathways program to meet the needs of end users in Epic for requests that are "by them, for them."
- A key focus for the Value Institute's Pathways program in 2025 was collecting feedback from end users and using that feedback to "meet people where they are" in Epic. This resulted the ability to order Pathways in the Managed Orders activity, addition of Pathway links in Navigators and Flowsheets, and multiple optimizations of existing Pathways (Hip Fracture, Heart Failure, GI Bleeding, Adult Sickle Cell Disease, Stroke, Peds DKA, and AM-PAC Mobility Decision Tree) and served to strengthen our collaborative efforts with System Quality – especially for Nursing Standard Work Pathways. We want to thank Kristine Harper, Haley Dorr, and Kim Munto for their tireless efforts to promote Nursing Standard Work Pathways focused on minimizing hospital-acquired infections and promoting safe patient restraint practices.
- We would like to recognize the following Sustainability Partners for their Exemplary Pathway Performance during 2025:
  - Charleston Spine Surgery ERAS: **72.3%**
  - SJCH – Peds Pathways: **58.2%**
- We would also like to recognize the winner of the 2025 Value Institute Partner award (Dr. Maggie Thomas, Associate Chief Quality Officer for Inpatient Medicine and Clerkship Director for Internal Medicine in Charleston Division) and our 2025 Pathway MVPs (Dr. Adarsh Kuma Srivastava from Lancaster and Yulia Romazanova, RN from Charleston) for their support and dedication to evidence-based patient care. We also had 21 Care Team Members make it into our "Pathway to 200 Club" for 2025 – almost doubling our high utilizer cohort from last year!

# CARE TRANSITIONS

## Meet the Team

**Amanda Biondi**
System Executive Director
Care Transitions

**Kendra Wickline**
Manager, TCM Care
Transitions

**Stephanie Hester**
Manager, System Case
Management

## Transitional Care Management

The Transitions of Care Management (TCM) Team is a dedicated, multidisciplinary group focused on supporting safe, timely, and effective transitions from inpatient settings to outpatient care.

# CARE TRANSITIONS

## 2025 Highlights

- **Workforce Stability and Organizational Alignment**: All 16 TCM are fully staffed, ensuring continuity of operations and consistent patient coverage. Additionally, the TCM team transitioned under Population Health leadership, strengthening alignment with system-wide population health strategies and initiatives.
- **Data Expansion and Registry Enhancements**: The expansion of the Bamboo registry provided the TCM team with increased visibility into external hospital discharges.
- **Performance and Productivity Milestones:** In October 2025, the TCM team achieved a record-breaking milestone by completing 2,180 TCM encounters in a single month.
- **Service Expansion Without Additional FTEs:** The TCM team assumed responsibility for additional Pediatrics and Primary Care offices without requesting additional FTEs, demonstrating efficient resource utilization.
- **Technology, Innovation, and Process Optimization:** The team continues to leverage EHR tools, registry enhancements, and standardized workflows to improve efficiency and data accuracy. Improved visibility into discharge data supports proactive outreach and better prioritization of high-risk patients.

## *Program Management Team*

Care Transitions is a multidisciplinary group dedicated to improving patient movement across care settings, minimizing hospital readmissions, and enhancing overall patient outcomes.

# AMBULATORY CARE MANAGEMENT

***Our Mission*** *is "to transform lives for the diverse communities we serve through advocacy, collaboration, patient-centered, cost-effective care and advancement of health equity"*

## Meet the Team

**Rita Aidoo** LMSW MHFA
System Manager Community Navigation; Affiliate Associate, Department of Public Health Sciences

**Mark Clair** MSN, RN, FAACVPR System Manager, Value-Based Care Coordination

**Katie Hampton,** MSW, LISW-CP/S, ACM-SW
System Manager Ambulatory Social Work

**Stacey Seipel,** MSN, RN
System Executive Director; Affiliate Associate, Department of Public Health Sciences

# AMBULATORY CARE MANAGEMENT

## Community Health Work (CHW)

### Highlights

- Expanded MUSC's Community Resource Library to more than 2,000 statewide resources, enhancing access to comprehensive community supports.
- Participated in 40+ health fairs, volunteer initiatives, and community events statewide, strengthening outreach, partnerships, and community engagement.
- Represented MUSC for the third consecutive year at Trident Technical College's Annual High School Career Fair, promoting awareness of the Community Health Worker (CHW) profession and workforce development.
- Participated in the Center for Community Health Alignment Partners meeting to support cross-sector collaboration and alignment.
- Engaged community members at the Charleston County Employee Health Event and Senior Expo, increasing awareness of available health resources and services.
- Hired and onboarded disease-specific Community Health Workers, expanding program capacity in Maternal Health, Palliative and Geriatric Care, and Digital Navigation.
- Provided ongoing support and care coordination for more than 1,300 active cases, contributing to improved access to services and continuity of care.
- Leveraging CMS's Community Health Integration (CHI) initiative by working to addressing health related social needs of Medicare and Medicare Advantage patients.

### Patient Letters

- "(Dear CHW), Here are some bills that were paid by MUSC Charity. I'm tremendously thankful for your assistance signing me up for help and for walking me through the assistance that is available. You're truly what I needed during this time."
- "I am writing this email as I hope your employer will get to see how truly wonderful you are. You take the time to listen to me. You really care about me. You will go above and beyond the call of duty. You have helped me during a very dark period. I personally again want to thank you and let you know you're great. Never stop doing what you're doing. You do help people. I am sure you have changed more than just my darker spots throughout you're career, so never stop. Thank you deeply from the bottom of my heart."

### CHWs in the Community


# AMBULATORY SOCIAL WORK

CHW 2025 Highlights

- Processed nearly **4,500** referrals from more than **60 clinics** across the Tricounty area
- Expanded staffing to include adding a new social worker to both the **Bronchiectasis/Nontuberculous Mycobacteria Clinic** and the **Rena N. Grant Sickle Cell Clinic**. Also, expanded coverage for other **Charleston Division Pediatric Primary Care clinics** and the **Charleston Division Internal Medicine clinics**
- Strengthened partnerships with numerous community-based organizations, to include **Trident United Way, Perinatal Awareness for Successful Outcomes (PASOS), the Beloved Early Education (BEE) and Care Collective, the National Multiple Sclerosis Society, the Ronald McDonald House, Cover SC, Charleston Area Regional Transportation Authority (CARTA), Family Connection of SC, Palmetto Community Action Partnership, Optum, and Charleston County Probate Court**
- Engaged in recruitment and student outreach at the **University of South Carolina's College of Social Work Field and Job Fairs** in Columbia and Charleston
- Organized a **canned food drive for the community during the federal government shutdown**

## Ambulatory Social Worker Team

Antoinaya Grant
LMSW

Bre Brown
LMSW

Candance Harper
LISW-CP

Casey Manya
LMSW

Chandler Soloway
LMSW

Jess Beanard
LMSW

Paula Pompey
LMSW

Suzanne Mondello
LMSW

Taylor Wilkins
LMSW

Tiombe Plair
LMSW

# AMBULATORY CARE MANAGEMENT

Chronic Care Management

## *Impact*

- What Is Chronic Care Management (CCM)? Chronic Care Management is a vital healthcare service for Medicare patients living with two or more chronic conditions expected to last at least 12 months. These conditions place patients at increased risk for declining health, hospitalization, and functional loss.
- Our Care Managers provide proactive, monthly telephone outreach, ensuring patients receive ongoing support between clinic visits.
- 1,650+ patients currently enrolled in the CCM program with our potential to be +1800 by end of January 2026 and +2200 by the end of April. The team will also add an APCM panel!

*Patient quote: ""I know I can depend on you."*

*Patient quote: "I don't know if I would ever be able to handle everything I go through without you and Dr. Diaz."*

## Population Health CCM Team

SHARON MARALIT, MANAGER

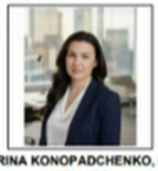
MONA BAYLOCK, LPN
CHARLESTON

CRYSTAL COLE, LPN
CATAWBA

SHERRY DAVIS, RN
ORANGEBURG

LINDSEY GRAHAM, CMA
ORANGEBURG

CHRISTINA HUTCHENS, LPN
CHARLESTON



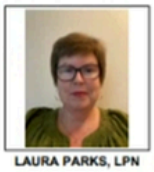
MARINA KONOPADCHENKO, LPN
MIDLANDS

LAUREN LEGRAND, RN
MIDLANDS

BRIDGETT MCELVEEN, RN
PEE DEE

DENISE MIDDLETON, LPN
CHARLESTON/UIM

KAREN MOSKOS, RN
CHARLESTON/DFM



LAURA PARKS, LPN
CHARLESTON/UIM

SUSAN TILLEY, RN
CHARLESTON/DFM

ISABEL WORIAX, RN
BEAUFORT

# AMBULATORY CARE MANAGEMENT

Value-Based Care Coordination

## *Highlights*

- In 2025, we welcomed 2 new Care Team members:
  - Raven Carraway, LMSW – Enhancing Oncology Model (EOM) Social Worker for the Kershaw Oncology Clinic
  - Robin Zinser, MSN, RN – High-Risk Care Manager (CHS)
- Congratulations on achieving the Lean Six Sigma Yellow Belt:
  - Jennifer Newbury
  - Raven Carraway
  - Tina Brantley
  - Amber Marflak
- Jennifer Newbury, BSN, RN: The Nourish to Flourish Food Pantries (RT8 and HW) served 268 families in 2025!
- Enhancing Oncology Model:
  - CBS PMPM increased from $70 to $200 thanks to the efforts of our CTMs
  - Logan Burroughs, MSW, LCSW-A appointed to the Board of Directors for Neighbor to Neighbor (a non-profit organization whose mission is to provide access to the community for adults with disabilities, older adults, and veterans through transportation, pantry delivery, and connectedness.
  - Tina Brantley, RN, CRNI – In the Orangeburg Oncology clinic, staging of EOM patients increased from 18.2% to 57.1% in 2025 thanks to Tina's efforts in provider engagement!

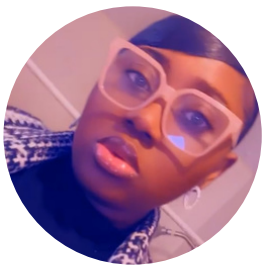
**Tina Brantley,** RN, CRNI
EOM RN Care Coordinator-Orangeburg

**Logan Burroughs,** LCSW-A
EOM Social Worker-Florence

**Robin Zinser**, MSN, RN
High Risk Nurse Care Manager

**Amber Marflak** BSN, RN
Care Coordinator-Heart Failure

**Jennifer Newbury** BSN, RN-CNN
RN Kidney Care Coordinator



**Raven Carraway,** LMSW
EOM Social Worker-Florence

# WELLNESS PROGRAMS

Tobacco Cessation and Diabetes Prevention Program

**Stephanie Stansell**
PhD, MPH, NCTTP
Training Director
Tobacco Treatment Specialist

**Ben Toll**
PhD
Clinical Psychologist
Cancer/ Smoking Cessation

## Tobacco Treatment Program

### Highlights

- The Tobacco Treatment Program (TTP) is thrilled to be joined this year by two new outpatient clinical pharmacists, Dr. Amanda Forrest (Charleston) and Dr. Catie Tuori (Midlands). Their addition to the Program will assist with providing state-wide outpatient care to MUSC Health patients.
- After several years of bi-annual Tobacco Treatment Specialist trainings, the TTP has now trained 96 healthcare workers from all over the state of South Carolina, again assisting with provision of state-wide tobacco treatment. Some of these trainees have come from outside of the state and bring these special skills to their own catchment areas.
- The TTP recently created a new video training for lung cancer screening that provides Continuing Medical Education credits for all healthcare workers who engage in the training. This training assists with integration between MUSC's Tobacco Treatment and Lung Cancer Screening Programs.
- Dr's Stansell and Ware are now nationally certified as Tobacco Treatment Specialists.

## Diabetes Prevention Program

### Highlights

- The SHINE (Supporting Health Improvement, Nutrition and Exercise) Diabetes Prevention Program (DPP) completed three year-long cohorts in 2025.
- Participant health outcomes continue to demonstrate a decrease in type 2 diabetes risk, as evidenced by an average weight loss of 5 % from baseline.
- DPP received a supplemental grant from HabitNu (Prana Diabetes) to train additional DPP lifestyle coaches for DPP and partner to deliver subsequent distance education and online cohorts available to patients across SC.

**Sarah Hales**
MSW, PhD
Department of Psychiatry and Behavioral Sciences

# 2025 AWARDS

Population Health, Value Institute, Value Intelligence

## *Winners*

- **Value Institute Partner**: Dr. Maggie Thomas; CHS Clerkship Director, Department of Medicine Associate Program Director
- **Pathway MVP**: Yulia Romazanova, RN; CHS Spine Nurse Navigator
- **Pathway MVP**: Dr. Adarsh Kumar Srivastava; Lancaster Pulmonary Medicine
- **Community Partner Award Charleston Division**: Lowcountry Food Bank
- **Community Partner Award Pee Dee Division**: Sassy Tugwell from Good Friends of Georgetown County
- **Community Partner Award Midlands Division**: Melanie Dalton at Feonix Mobility
- **Community Partner Award Catawba Division**: HOPE in Lancaster
- **SDOH Champion**: Vergelia Davis, Application Analyst, Clinical Applications
- **Population Health Most Valuable Partner**: Carmen Rice, Corporate Health System Finance
- **Population Health Provider Partner**: Dr. Amanda Overstreet, Geriatrics
- **Population Health Provider Partner:** Dr. Chak Inampudi, Heart Failure
- **Value Intelligence Most Valuable Partner Award:** Shelia Diaz, Coordinator, Hospital Patient Accounting
- **Value-based Savings Team Most Valuable Partner Award:** Adam Hamilton, Director, Data Management
- **Population Health Care Coordination Partner**: Nadezda Piliavec-Swimm

## *Theme: Groovy 1970's*

Population Health Provider Partner Award: Dr. Amanda Overstreet

Community Partner Award Charleston Division: Lowcountry Food Bank

Community Partner Award, Presentation


Health Equity Award Presentation