American Hospital Association™

Advancing Health in America

Bridging the Gap: Strategies for Better Patient Transitions

Care Delivery Transformation Framework Webinar Series

November 13, 2025

Today's Speakers

Nancy Oriol
Faculty Associate Dean for Community Engagement in Medical Education at Harvard Medical School, Co-founder The Family Van

Janice Aharon-Ezer
Behavioral Health Clinical Specialist and Caregiver Navigator, Community Memorial Healthcare, Ventura, CA

Maureen Hodge
Director of Ambulatory Behavioral Health and Grants, Community Memorial Healthcare, Ventura, CA

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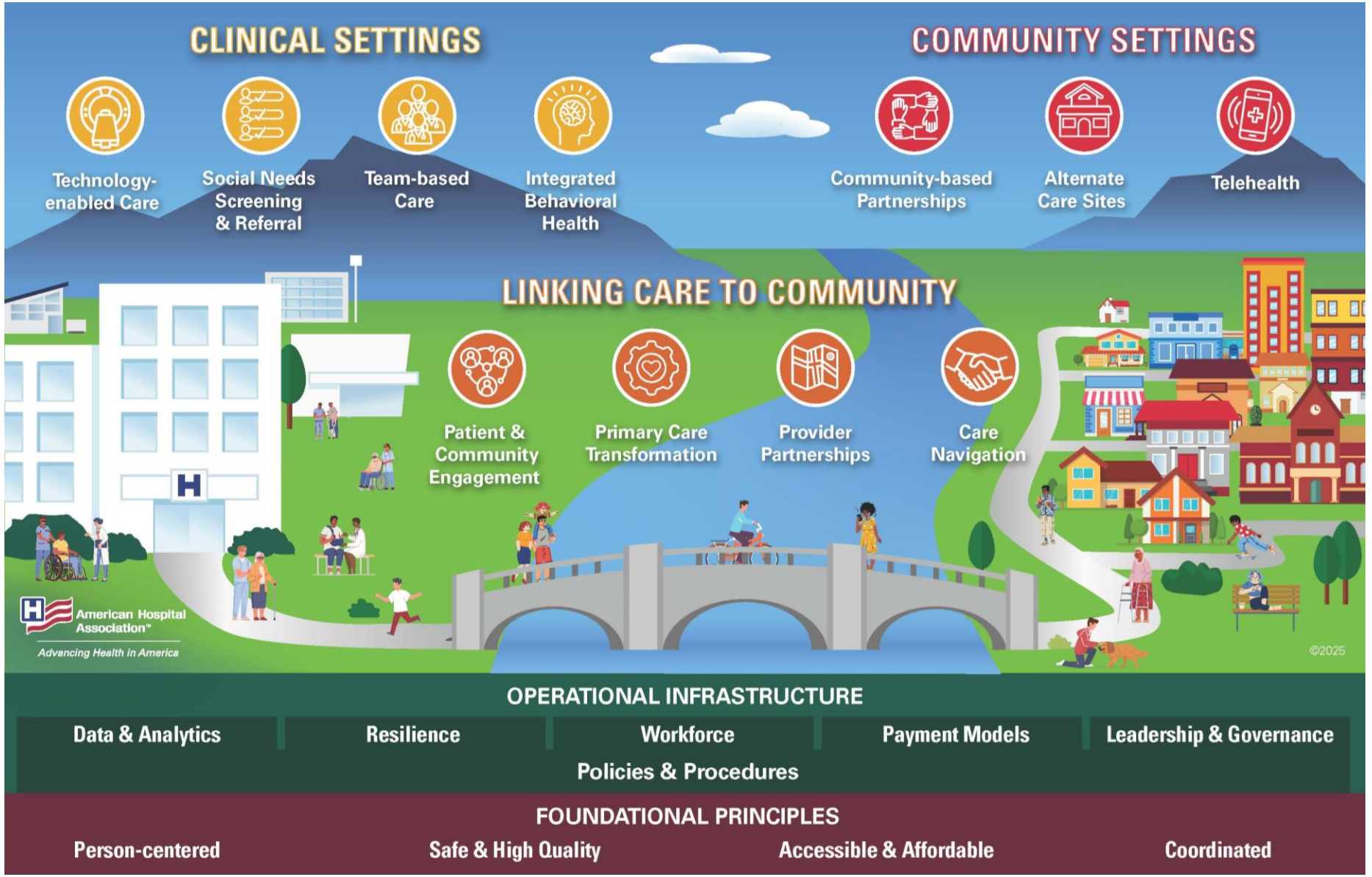
Care Delivery Transformation Framework



AHA offers curated resources in each care delivery transformation topic.

Learn more about the Care Delivery Transformation Framework at www.aha.org/CDT.

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Linking Care to Community

Patient & Community Engagement

Through formal and informal processes, such as community health needs assessments, patient and family advisory councils, community-based programs, hospitals receive guidance on how they can better connect with individuals of all backgrounds.

Primary Care Transformation

Health systems are transforming primary care to provide care that closes care gaps while prioritizing prevention and managing complex health and social needs across the continuum of care in alignment with new payment models.

Provider Partnerships

By fostering partnerships across providers as part of a clinically integrated network, health care organizations can better facilitate coordinated care for their patients.

Care Navigation

Care navigators can help facilitate transitions as patients – particularly those with chronic or complex diseases – move from acute care to home setting while remaining connected to needed outpatient services.

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Engage with the Care Delivery Transformation Framework

Explore

Find the most recent and relevant resources around each care delivery transformation topic.

Discuss

Talk with your team about how to advance your hospital's care delivery transformation strategies.

Share Your Story

Tell us how your hospital is transforming care delivery.

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Advancing Health in America

American Hospital Association
Care Delivery Transformation Framework

How do Mobile Clinics fit in?

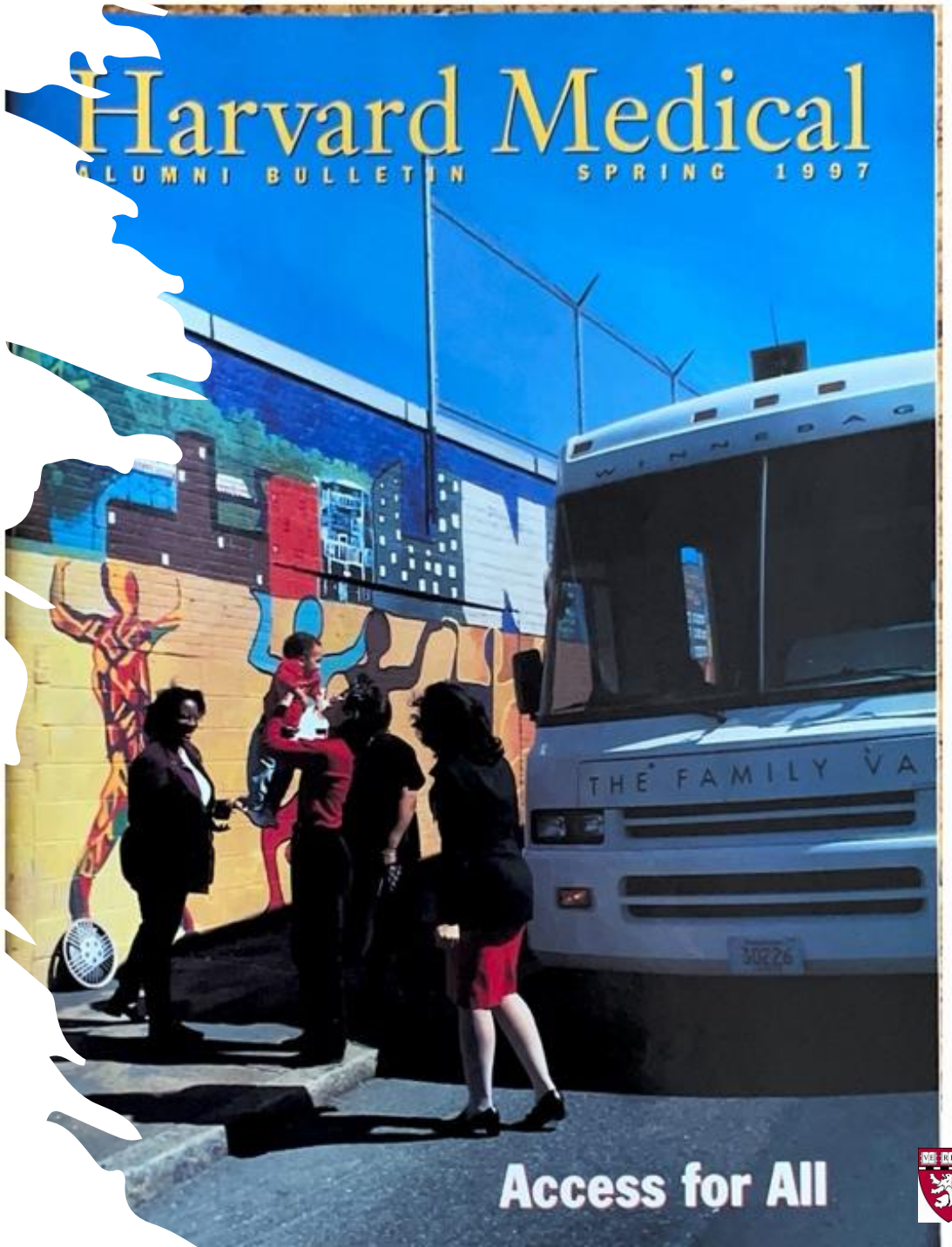
Nancy E. Oriol M.D.
Founder & President, The Family Van
Associate Dean for Community Engagement in Medical Education
Associate Professor of Anesthesiology
Lecturer, Global Health and Social Medicine
Harvard Medical School

istock.com Clerkenwell

The Family Van, est. 1992

designed in partnership with our neighbors:

- Roxbury
- Dorchester
- Mattapan
- East Boston



- Travels a preset weekly route
  - Roxbury
  - Dorchester
  - East Boston
- Provides 3000 visits a year
  - Health screenings
  - Referrals
  - Counseling
  - Chronic disease mgt
- Staffed by
  - Community Health Workers
  - public health experts
  - nutritionist,
  - community collaborators.

Our partners

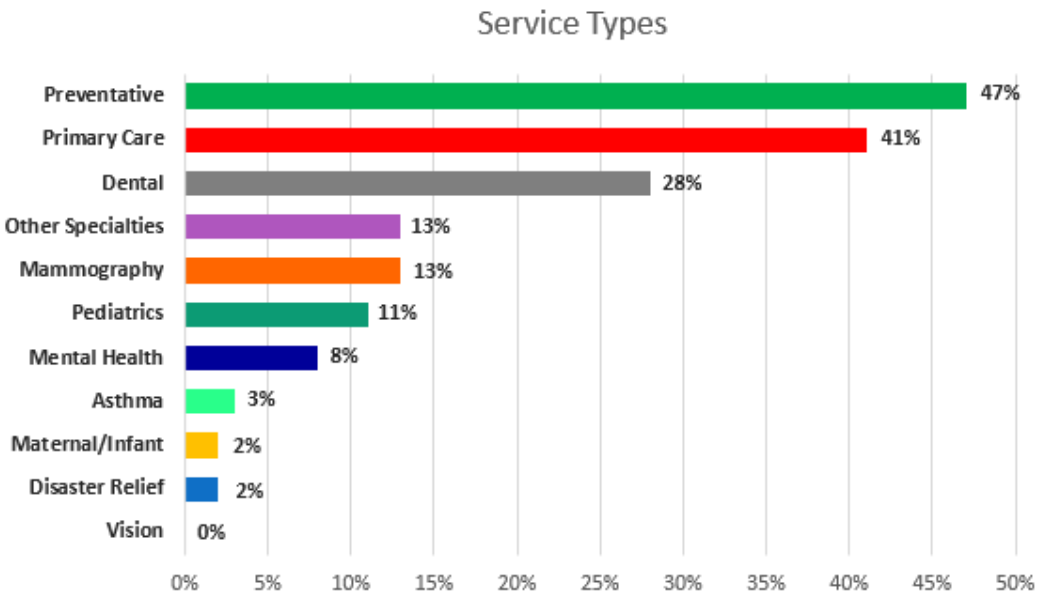
AHope - Bethel AME – Beth Israel Deaconess Medical Center - Boston Public Health Commission - Boston Medical Center - Boston Resiliency Fund - Brazilian Consulate – Brigham and Women's Hospital - Casa Myrna - Codman Square Community Health Center - Colon Cancer Coalition - Crossroads (Shelter and Food Pantry) - Daily Table - Dimock Health Center - East Boston Neighborhood Health Center - East Boston Social Center - Grace Church of All Nations - Greater Boston YMCA - Life Together – LMSA - MA Association of Portuguese Speakers (MAPS) - Mattapan Community Health Center- - Mexican Consulate – Mass General Hosital - Multicultural Aids Coalition (MAC) - Salvadoran Consulate – SNMA – StepROX - Urban Edge - Whittier Street Community Health Center - YMCA Roxbury/ Greater Boston YMCA - Stop & Shop - Grove Hall - Nubian Sy. Branch of the Boston Public Library – ABCD - Children's Advocacy Center of Suffolk County – Harvard Street Health Center - Father's Uplift - Fenway Health - Justice at Work - Lifeline Crisis Chat - Mass Families Organizing for Change - Massachusetts Commission on LGBTQ Youth - Massachusetts Department of Mental Health - Mayor's Health Line - Mobile Healthcare Association – NAMI - Neighborhood of Affordable Housing - Neighborhood PACE - New England Center and Home for Veterans - Parents Helping Parents - Project Bread - St. Ignatious Church - St. Mary's Center for Women and Children Women@Work Plus Program - St. Mary's Episcopal Church Food Pantry - Statewide Advocacy for Veterans' Empowerment (SAVE) - The Trevor Project - Upham's PACE Elder Service Plan - VA (Veterans' Affairs) Boston Healthcare System - Women, Infants and Children Supplemental Program

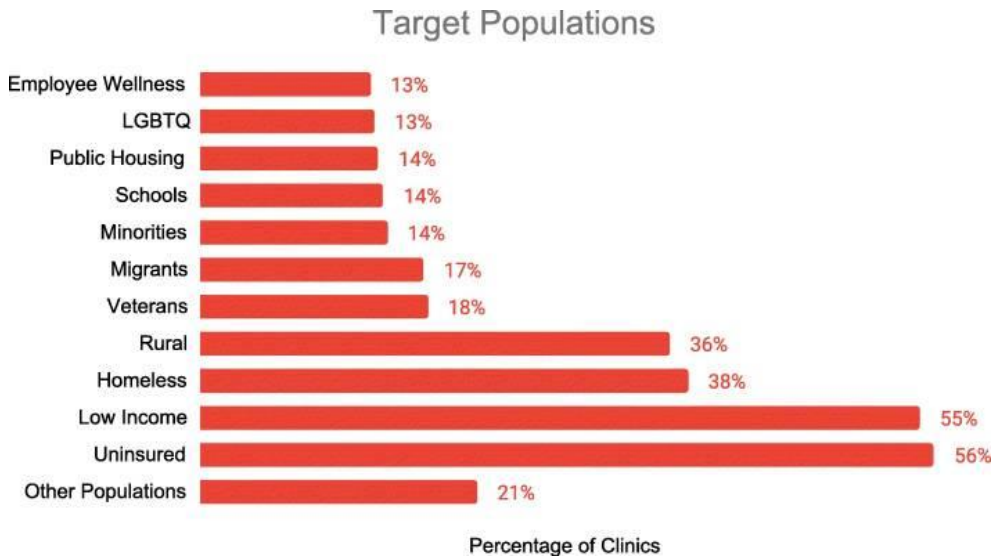
Over 3000 Mobile Health Clinics – Over 6 Million patients

The Scope of Mobile Healthcare in USA

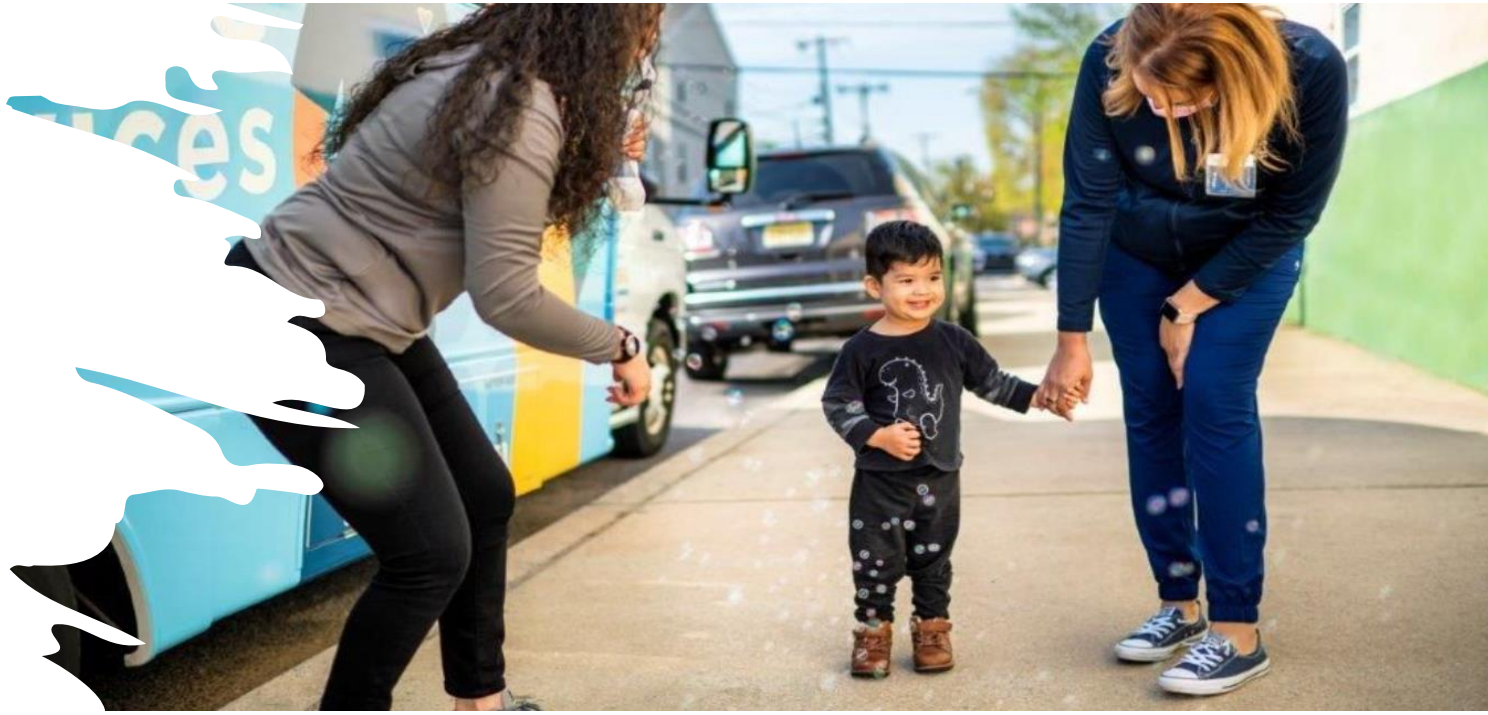
Source: www.MobileHealthMap.org

Who uses mobile clinics?





Mobile clinics are now
everywhere
but we need to
prove our value



MobileHealthMap.org

- Mapped mobile clinics
- Measured their value (ROI 19:1)
- Showed how many people they served
- And who they serve

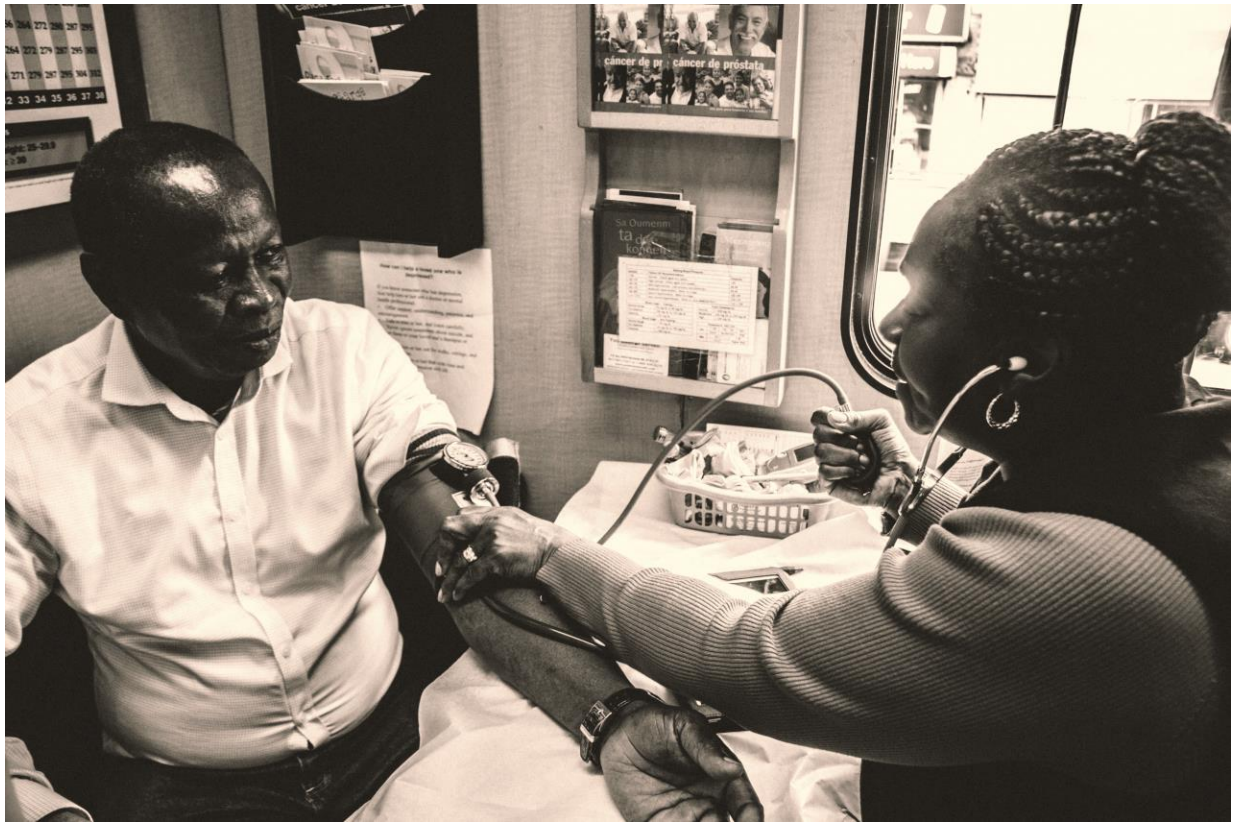
Where mobile fits in the Healthcare Delivery Transformation Framework

- Rebuilding trust in the health care system
- Supporting healthy lives with prevention and education
- Navigating and Connecting to clinics and hospitals
- Supporting transitions with knowledge and counseling
- Navigating and Connecting to community resources
- Building self-confidence and community efficacy

The right place for the right care

Creating new models of care

"In the end, we can have the best therapies and most effective medications, but nothing will result in positive long-term outcomes if we don't create models of care that focus on the individual and how they manage their life."



Care that connects

"Care that includes the space between clinical and community, rerouting the disconnected circuitry of the health care system."

As one student explained:

"The new frontier here is to develop models of care that not only include Hospitals and community health centers, but all the other important assets like shelters, churches, schoo food pantries, and others in the community, that enrich the lives of the people living there."

Radical Listening

“Learning how to listen without judgment. How to listen, blind to the external appearances of your speaker, so your prejudices are not activated,

yet open-hearted

to their appearances

so you can begin

to see the road

they have traveled.”

The Family Van,
a model of care based on

listening, connecting, and building self-confidence.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EXAMEN DEL COLESTEROL
FAST · FREE · FRIENDLY
AMILYVA
CLOSED
Thank you

Looking Through a New Lens- Strengthening Patient and Family Caregiver Health Outcomes

Caregiver Navigation Program By Community Memorial Healthcare

Maureen Hodge, LCSW, Director of Behavioral Health and Grants

Janice Aharon-Ezer, LMFT, Behavioral Health Clinical Specialist/Caregiver Navigator

WHY IS TALKING ABOUT CAREGIVING AND CAREGIVERS SO IMPORTANT?

The Many Faces of Caregiving…

WHO IS A CAREGIVER

- Caregivers come from all backgrounds, ages and cultures and assist others who might be neighbors, family or friends with medical, psychological, substance abuse, developmental disabilities or dementia

- A caregiver is a paid or unpaid person who provides care and support to another person/s who need help due to illness, injury, disability or age.

National Alliance for Caregiving- Caregiving in the US 2025 Report

- **63 Million Americans-** Nearly 1 in 4 Americans is a family caregiver—a staggering 45% increase from 2015
- Most care recipients are older adults; nearly half are 75+ and most face multiple chronic health conditions
- Caregivers spend an average of 27 hours per week providing care, and 24% provide 40 or more hours a week
- Half of all working caregivers experience impacts on their employment
- Nearly half of caregivers report at least one negative financial impact from their caregiving responsibilities, including taking on debt, not saving money, and using up short-term savings

Caregiver Numbers will Rise

By 2030, 77 million Americans will have reached age 65 and will face growing risks of chronic ailments that make it harder to live independently (AARP)

20% of adults 45-64 expect to become family-based caregivers during their lifetime (CDC)

MENTAL AND EMOTIONAL COSTS

- **High Emotional Stress:** Around 64% of caregivers report high emotional stress, with nearly half (47%) reporting issues with anxiety, depression, and other mental health challenges.

- **Burnout and Sleep Loss:** Ninety percent of caregivers reported losing sleep due to their responsibilities, and the same percentage felt burnt out in a 2025 survey.

- **Isolation and Dread:** Many caregivers report feeling a sense of dread (75%) and isolation (nearly one in four).

- **Severe Impacts:** Alarmingly, 29% of parents who are also caregivers reported they had considered suicide or self-harm due to the overwhelming stress.

PHYSICAL COSTS TO CAREGIVERS

- **Poor Health Ratings:** One in five caregivers report their own health as only "fair" or "poor," and nearly a quarter say they have difficulty caring for themselves while focused on their care recipient's needs.

- **Physical Strain:** Many caregivers experience moderate to high physical strain (45%) from tasks like lifting, bathing, and assisting with mobility.

- **Increased Health Risks:** Caregiving-induced declines in health are linked to an estimated **$28.3 billion annually** in additional healthcare costs nationally. Caregivers often have higher rates of chronic conditions like hypertension, diabetes, and heart disease.

Ventura County Caregiver Navigator Pilot Program

Funded by Ventura County Community Foundation (VCCF)

CAREGIVER NAVIGATOR PROGRAM

VCCF funded three acute care hospitals between 2020-2023 to implement an innovative program in order to:

- Reduce hospital and emergency room readmissions for both caregiver and care recipient
- Reduce depression and anxiety among caregivers
- Reduce level of caregiver burden experienced by caregivers
- Increase caregiver resiliency and confidence in their role as caregiver
- Integrate family caregivers into the care team in collaboration with primary care physicians

Caregiver Navigators provide the following:

- Assessment/Intake with caregiver (s)
- Assist in communication and coordination with healthcare providers
- Emotional support and help to establish plan for caregiver's self care
- Ongoing contact for a minimum of 3 months
- Brief supportive counseling
- Support linkages to other resources within the hospital setting or outside services

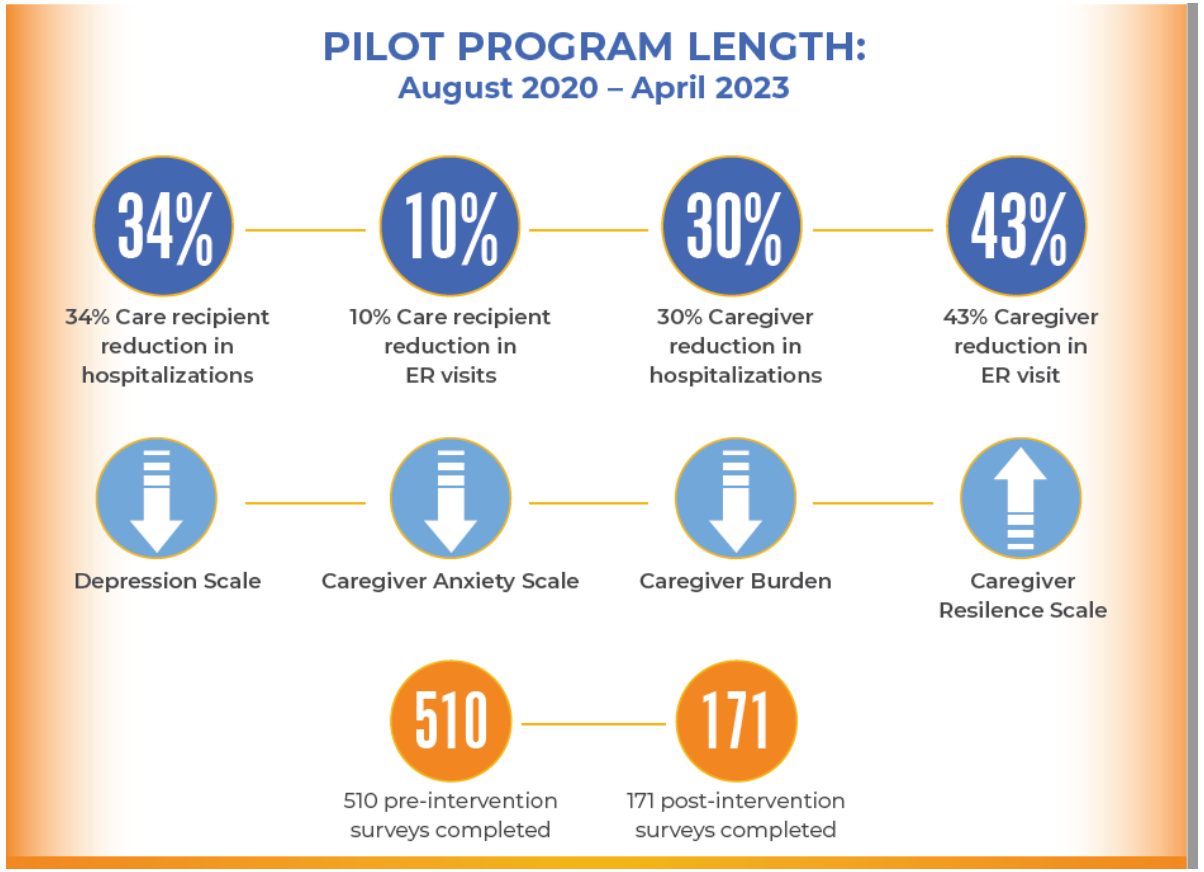
Supporting the caregiver leads to *better health* outcomes for both the patient and the caregiver

CMH worked with Channel Islands State University to provide data collection to measure the following:

- Zarit Caregiver Burden Scale
- Depression (PHQ-9)
- Anxiety (GAD7)
- Connor Resiliency Scale
- 30 day hospital readmission either from ER or inpatient

CMH and its partners are committed to creating an evidence based Caregiver Navigator Program

Pilot Program Outcomes



- Level of caregiver burden was significantly reduced
- 30 day readmissions for both inpatient and ER were reduced for both the caregiver and the patient
- Level of caregiver resilience increased once they began meeting with a Caregiver Navigator and interventions were provided
- Depression and anxiety both decreased significantly for the caregiver

Ventura County Caregiver Coalition (VCCC)

MISSION STATEMENT

The Ventura County Caregiver Coalition advocates for and empowers caregivers by ensuring that accessible, supportive services are available to all that care for their loved ones.

"If you provide care for someone you love, you ARE a caregiver"

Ventura County Caregiver Coalition

VCCC Members:

Adult Protective Services; Alzheimer's Association; Area Agency on Aging; Community Caregivers; Coast Caregiver Resource Center; Compassionate Care Faith Community Coalition; Community Memorial Healthcare; Camarillo Healthcare District; Oxnard Family Circle; Promotoras y Promotores; Senior Concerns; Ventura County Community Foundation; Ventura County Medical Resource Association

How has CMH Funded the CGN Program?

- Out of the Community Health Needs Assessment, VCCF funded the program for three years at three hospitals and one CBO for caregiver training
- As the leader of this movement, CMH pursued ongoing funding with VCCF through 2025 and is awaiting another three year grant
- CMH leadership is fully committed to this program as a Community Benefit Program
- CGN is fully embedded in two hospitals and 26 outpatient clinics
- The CGN has impacted the lives of over 600 families
- Master Level Social Work Interns receive training and carry a small CGN caseload
- CGN receives referrals from within our health system, but also from Adult Protective Services, Area Agency on Aging, CBO's, non-profits and more
- CGN drops a caregiver navigator assessment code (CPT 96161)

CMH in the News and Podcasts

- **Journal for Social Work in Public Health**. Click the following: Family Caregiver Support Interventions' Effectiveness Before and During the COVID-19 Pandemic
- **VCCF Caregiver Video** https://vimeo.com/857694981?share=copy - the password is VCCF Podcast for our local CMH Social Media Channel https://support.doctorpodcasting.com/client/cmhs/item/49004-caregiver-navigators-uniquesupport-for-caregivers-right-here-in-ventura
- **Ebook by AHA and CMH** https://indd.adobe.com/view/4689d5cd-4988-4563-8b84-25dc743a9ba7
- **Four Part Podcast series for AHA** Episode #1- https://www.aha.org/advancing-health-podcast/2022-12-14-caring-family-caregivers-part-1understanding-role-caregiver

  Episode #2- https://www.youtube.com/watch?v=EAvjBQuPVo8

  Episode #3- https://www.aha.org/advancing-health-podcast/2023-01-11-caring-family-caregivers-part-3navigating-caregiving-relationships

  Episode #4- https://www.aha.org/advancing-health-podcast/2023-01-13-caring-family-caregivers-part-4future-family-caregiving

Community Memorial HEALTHCARE

THANK YOU!

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