A Journey to Integrated Care

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Adagio Health

adagio health

Mission

Adagio Health improves the health, wellness, and nutrition of our communities, regardless of income, with a focus on women.

Vision

Adagio Health strengthens communities by empowering individuals to lead healthier, more vibrant lives.

Medical & WIC Offices

Adagio Health owns & operates:

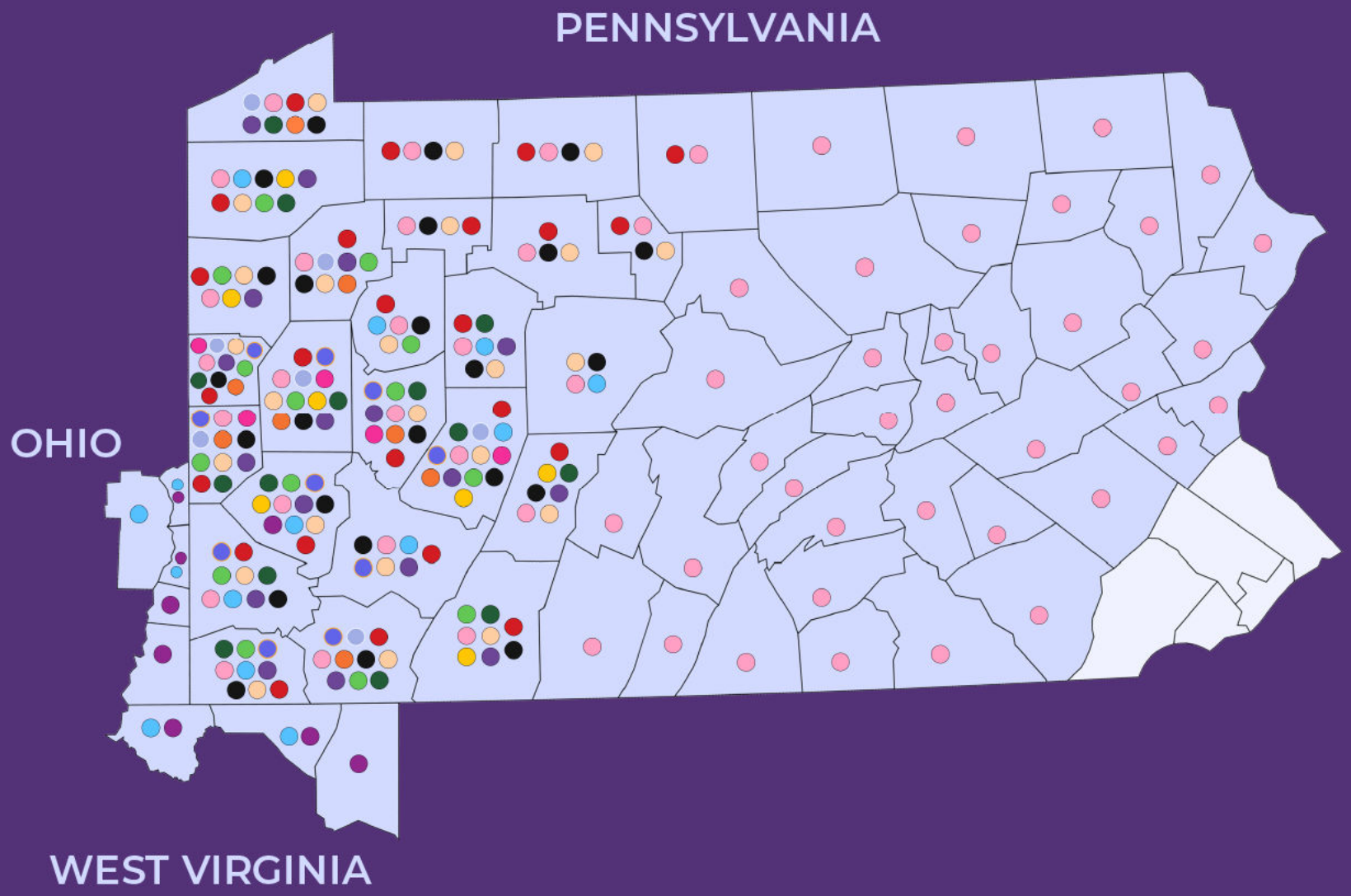
7 Medical Offices

- Beaver, Butler, Erie, Fayette, Indiana, Lawrence, and Venango counties

5 WIC Offices

- Armstrong, Beaver, Butler, Indiana, Lawrence counties

Adagio Health Service Map 2026



- Adagio Health Medical Office
- Adagio Health WIC
- Adagio Health Food Cupboard
- Behavioral Health Services
- Breast and/or Cervical Cancer Screening
- Care Navigation Services
- Diabetes Prevention Program
- Family Planning Partner
- Health Education
- **Healthy Women for Life:** Reproductive Care, Period Product Distribution, Prenatal & Postpartum Support, Preventive Screenings & More.
- Mobile Health Unit Partner
- Pennie Enrollment Program
- SNAP Education
- Tobacco Free Adagio Health

Adagio Health Service Menu

Reproductive Care & Family Planning

- Annual Exams & Pap Tests
- Birth Control
- STI Testing & Treatment
- HIV Testing & Treatment
- PrEP & PEP
- Hepatitis C Screening & Treatment
- Prenatal Care
- Menstrual Hygiene Support

Adult Vaccinations

- Flu Shot
- COVID-19
- Hepatitis A & B
- MMR (Measles, Mumps, Rubella)
- Tetanus
- HPV

Preventive Health & Other Services

- Tobacco/Nicotine Cessation Services
- Breast & Cervical Cancer Screening
- Immunity testing (Hepatitis B, MMR)
- Tuberculosis Screening
- Diabetes & Cholesterol Screening
- Behavioral Health Services & Support
- Care Navigation
- Educational Workshops

Nutrition Services

- WIC Services & Breastfeeding Support
- Education Programs
- Nutrition Counseling
- Diabetes Prevention Program
- Food Security (on site pantry)

Adagio Health Programs

Adagio Health offers programs that provide a variety of critical services at no/low cost for all age groups.

- Family Planning Programs
- Cancer Screening Programs
- Tobacco Prevention and Control
- Special Projects: HRSA Rural Communities C.A.R.E., Veteran Care Initiative, Pennie

Adagio Health Programs

Adagio Health offers programs that provide a variety of critical services at no/low cost for all age groups.

- WIC Program
- Diabetes Prevention Program
- Education Programs
- Breastfeeding Helpline
- Nutrition Counseling
- Teaching Kitchens
- EAT Farm Fresh
- Food Security

Linking Programs, Services & Patients

Case Study: Maria’s Story

Maria’s Story

“Maria” is a 42-year-old woman living in Lawrence County. She works part-time while caring for her two grandchildren and recently lost employer-sponsored health insurance following a reduction in work hours. Maria had not received preventive healthcare in several years due to transportation barriers, financial concerns, and limited access to providers in her region.

Maria initially contacted Adagio Health after hearing about low-cost cancer screening services through a community outreach event hosted in partnership with a local food assistance organization.

Maria's Story

Screening & Assessment	Purpose & Process
• Social Determinants of Health (SDOH) screening • SBIRT • Health assessments • Insurance status • Program eligibility	• Determine eligibility • Intelichart screening

Maria's Story

Immediate Needs & Concerns Identified	Purpose & Process
• Overdue for cancer screenings • Elevated stress, anxiety, and depression symptoms • Food insecurity • Transportation challenges • Lack of primary care provider	• Eligibility determination tools • Staff program knowledge of • Clear SBIRT workflow

Maria's Story

Medical Services	Purpose & Process
• Point of care testing • Cervical cancer screening • Mammography referral • Preventive health & chronic disease risk factor education	• Program eligibility tools • Healthy Women for Life clinical testing • BCCEDP voucher • Provider education • Internal referral system • Standard operating procedures • External provider network

Maria's Story

Integrated Care	Purpose & Process
• Care Navigation (CN) • Transportation resources • On-site food pantry • Health insurance enrollment assistance	• Connect patient to services to reduce time and cost burden. • Automatic CN referral • Internal referral system • Resource guides

Maria’s Story

Program Enrollment
• Eligibility verification and enrollment across services • Reduced duplication and minimized barriers.
Technology & Workflow Integration
• Integrated referral process using internal workflows and data tracking systems. • Referral status updates, appointment completion, and follow-up activities • Data dashboards ensure referral completion, follow-up compliance, screening completion rates, and improved continuity of care.

Maria's Story

Challenges	Purpose & Process
• Differing eligibility requirements • Transportation barriers • Follow-up care • Interdepartmental communication • Program requirements and patient experience	• Patient-focused processes • Workflow assessments • Continuous staff training • Staff collaboration • Flexible workflows

Maria's Story

Within 6 months, Maria:	Purpose & Process
• Completed cancer screenings • Established primary care services • Engaged in behavioral health counseling • Accessed food and transportation assistance • Decreased stress levels • Improved appointment adherence	• Patients "connected and supported" • Follow-up, navigation, and evaluation processes monitor outcomes.

Key Takeaways

Integrated care models in community-based nonprofits can:

- Improve access to preventive care
- Address SDOH and medical needs
- Strengthen care coordination
- Reduce barriers and cost
- Improve outcomes

Maria’s story illustrates adaptable workflows, staff collaboration, and technology-supported care coordination in serving diverse and underserved populations.

Case Study: Danielle’s Story

Danielle’s Story

“Danielle” is a 27-year-old pregnant mother of two living Indiana County. She works part-time in retail and recently experienced reduced household income after her partner lost employment. Danielle learned about Adagio Health through a referral from her OB/GYN office after expressing concerns about food affordability during pregnancy.

Danielle was in her second trimester and reported:

- Difficulty consistently purchasing healthy foods
- Transportation challenges for appointments
- Increased financial stress and anxiety
- Currently smoking
- Limited awareness of community resources
- Dx with GDM and had concerns about maintaining healthy weight gain and blood glucose during pregnancy

Danielle's Story

Screening & Assessment	Purpose & Process
• WIC eligibility screening • Nutrition risk assessment • SDOH screening • Referral and resource needs assessment	• Identify primary needs • Services to meet pre/postnatal needs • Integrated intake and referral workflows.

Danielle's Story

Immediate Needs & Concerns Identified	Purpose & Process
• Food insecurity • Unstable childcare arrangements • Transportation limitations • Mild anxiety related to pregnancy and financial stress • Smoking cessation counseling • Nutrition counseling support	• Danielle qualified for WIC services • Staff documentation

Danielle's Story

WIC Services & Nutrition Support	Purpose & Process
• Enrolled in WIC and connected to nutritionist • Prenatal education • Infant feeding/breastfeeding guidance • Accessing healthy foods • Monitoring of weight gain and nutritional health • Nutrition Counseling referral with Registered Dietitian	• Participant collaboration • Staff scope determination • Motivational Interviewing • Increased contact and patient engagement

Danielle's Story

Integrated Referrals & Support Services	Purpose & Process
• Care Navigation • On-site food pantry • Behavioral health counseling • WIC/prenatal provider coordination • Healthy You Healthy Baby referral	• Informed consent and ROI • On-site services • Specialized pilot programs • Incentives • Coordinated external partner network

Danielle's Story

Technology & Workflow Integration	Purpose & Process

• **Integrated documentation and referrals allowed care team to:**
  ○ Monitor referral completion
  ○ Track service engagement
  ○ Reduce duplication of intakes
  ○ Improve communication
 	
• **Data dashboards helped leadership to monitor:**
  ○ WIC enrollment and retention
  ○ Referral outcomes
  ○ Prenatal appointment adherence
  ○ Community resource utilization
	• Agile systems
	• Jira system
	• PowerBI data dashboards

Danielle's Story

Challenges	Purpose & Process
• Limited transportation • Scheduling barriers • Navigating multiple assistance systems • Engagement across providers	• Systems to reduce patient burden and barriers • Flexible scheduling • Virtual follow-up options • Coordinated communication

Danielle's Story

By the end of her pregnancy, Danielle:	Purpose & Process
• Consistently accessed healthy foods via WIC • Attended prenatal appointments • Reported reduced stress • Connected with community-based family resources • Initiated breastfeeding • Postpartum WIC support • Registered Dietitian appointments	• Breastfeeding helpline • Having "everything in one place" made it easier to get help and stay in care during pregnancy.

Key Takeaways

Integrating WIC services into a broader framework can:

- Improve maternal and infant health outcomes
- Address food insecurity and SDOH
- Increase patient engagement
- Strengthen communication between providers
- Reduce barriers through referrals and navigation

This demonstrates the value of combining nutrition services, care navigation, community partnerships, and technology-supported workflows to support families with complex needs.

Strategies & Tips

Considerations

- Funder requirements
- Program eligibility criteria
- Program determination
- Sustainability
- Billing and credentialing
- Staff training and turnover
- Patient experience and contract requirements
- Partner network requirements
- IT/data evaluation support

Useful Tips for Implementation

Continuous staff cross-training

Consistent communication

Tools and resources

Technology

New data elements

Backend billing processes

Staff Resource Example

Adagio Health Food Bags Overview

Location	Food Bank Delivery	Avg. Monthly FI	Avg. FC Usage	Monthly Need	Threshold
Beaver	1st Tues & 3rd Friday	19	5	20	10
Butler	3rd Wednesday	23	8	15	5
Erie	As Needed (Pick Up)	52	3	10	5
Indiana	2nd Friday (Pick Up)	25	14	20	5
Lawrence	1st Thurs & 4th Wed	29	10	20	5
Venango	4th Tuesday	36	9	10	5

average numbers based on Oct 2023- June 2024 data

How Medical offices request more bags: Use the Microsoft Form available through the QR code below. As requests come in, food bags will be made by the NED team as it best fits in their schedule. There could be a delay in food bags being made if inventory is low. As a reference, delivery information is listed in the chart above. Any delays will be communicated.

**If there is an emergency - anyone can use the guide below to make a food bag from the Food Cupboard. **

https://forms.office.com/r/8NB25xtcG3

Bag Contents

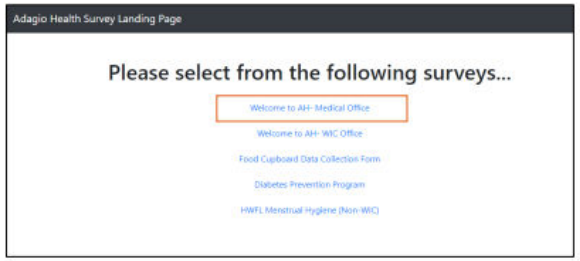
	Fruits	Vegetables	Grains	Protein	Dairy	Other
Quantity	4	5	4	4	1-2	Materials
Options	Canned; no sugar added	Canned; low/no sodium	Pasta, Rice, Cereal, Oats	Peanut Butter Tuna, Chicken, Beans	Shelf Stable Milk	Recipe Card SNAP Handout WIC Handout Food Bank List

Family Size

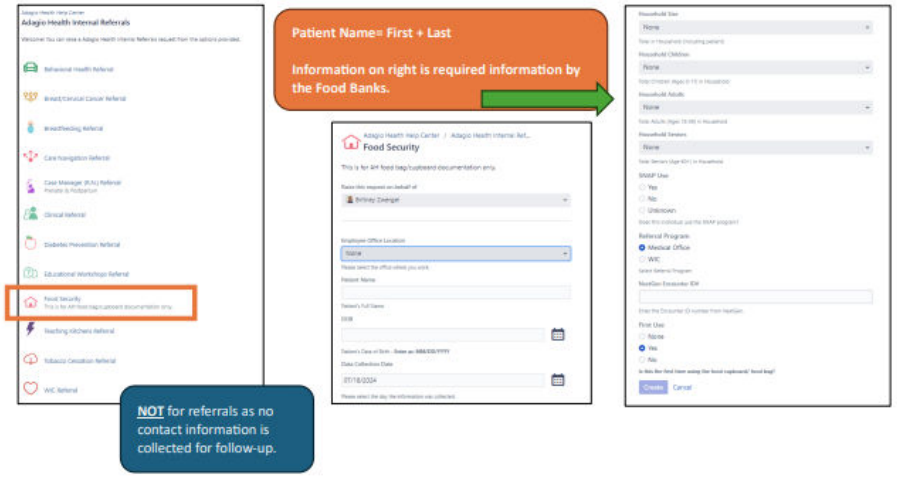
- Each bag is setup for a family of 1-3 individuals
- Families of 5+ should receive 2 bags

Medical Office Documentation

Food Insecurity Screening: Continue to use the 'Welcome to AH- Medical Office' form to screen for food insecurity. Screening should continue to be done for all participants. The 2-question screening continues that if someone answers "sometimes" or "often" to either question- that indicates a positive food insecurity screening and intervention should occur. Suggested intervention: "As part of your appointment, we have the opportunity for you to take home a pre-made bag of food or shop through our Food Cupboard today if you'd like."

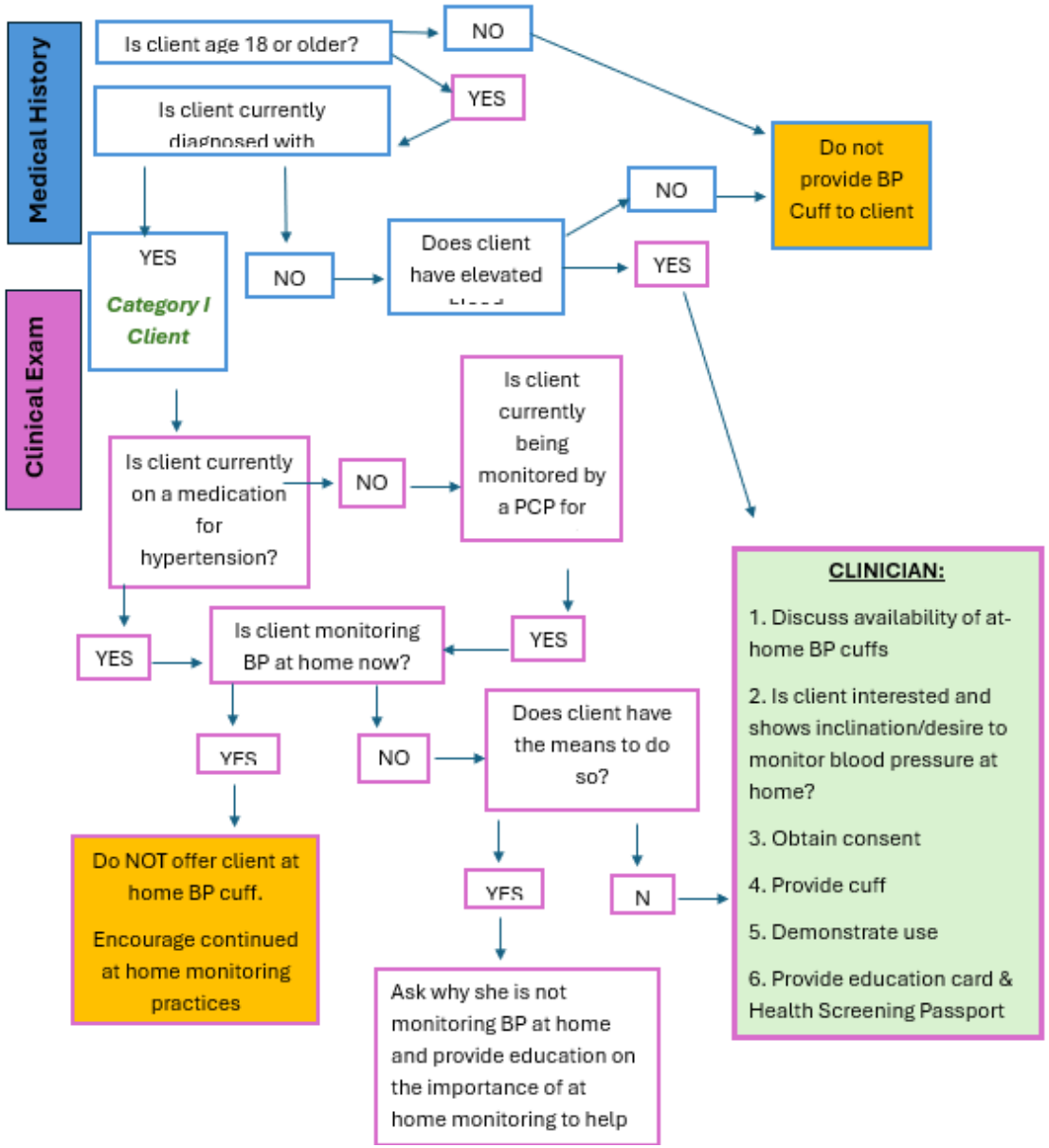


Food Bag Documentation: Discontinue the 'Food Cupboard Data Collection' forms that were entered into MS forms. Collect information on new 'Adagio Health Food Bag Data Collection' for data entry into JIRA through the Adagio Health Internal Referrals project. Information should be added to JIRA daily to ensure accurate and timely data.



Staff Resource Example

Below is an example used to train staff on distributing free blood pressure cuffs to women through Adagio Health's Healthy Women for Life Program:



Internal Referral Tracking

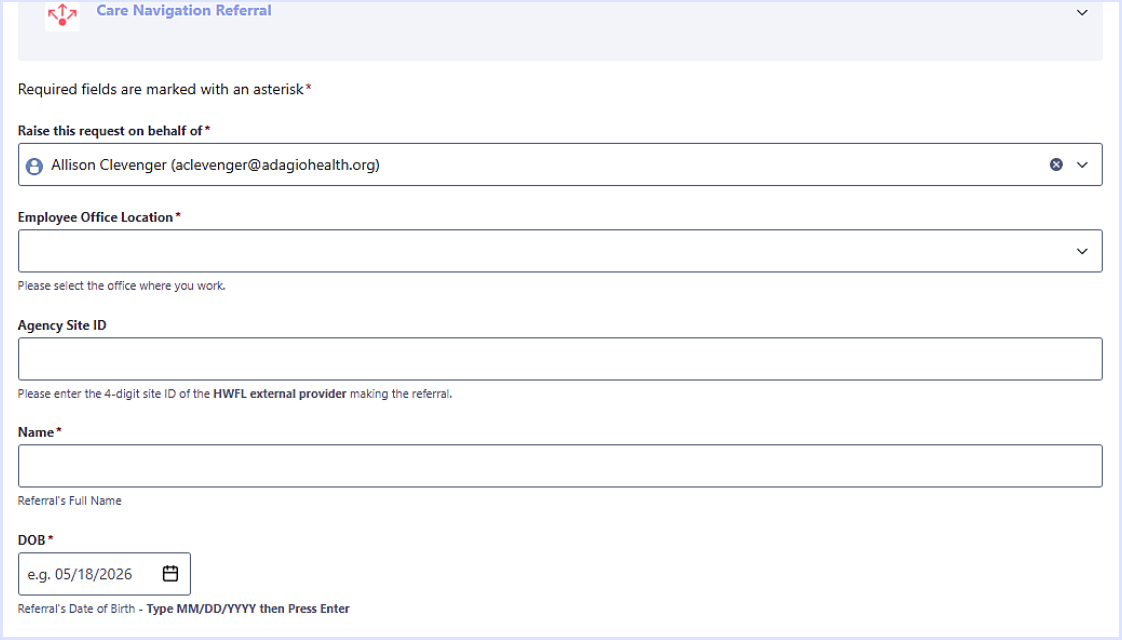
Clinical referrals

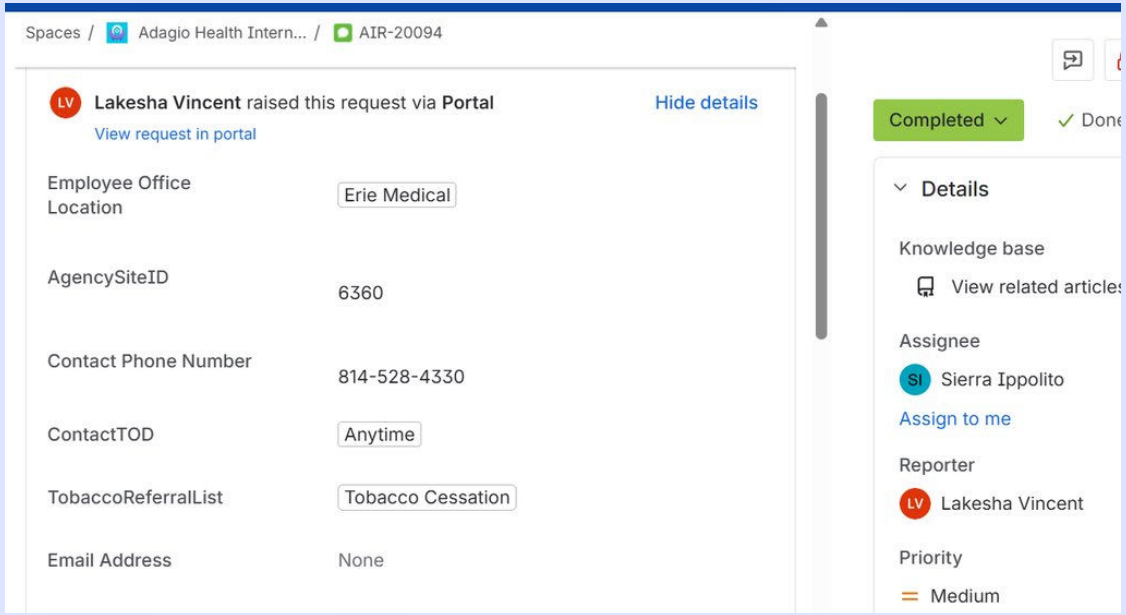
Centralized internal referrals

Warm handoff to staff

Customized data elements

Communication and tracking reduce gaps





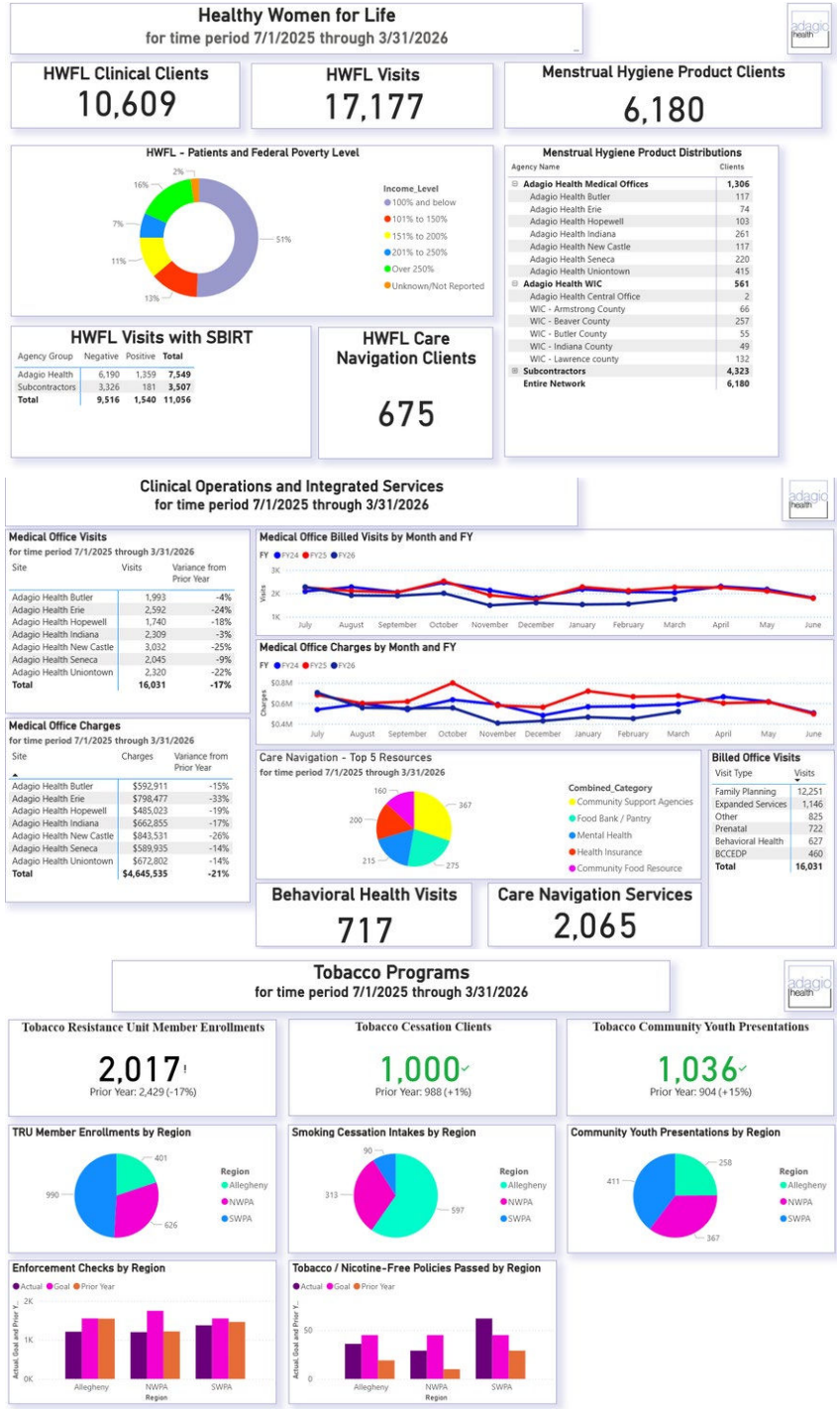
Data Warehouse

Organization-wide data warehouse

Illustrate key performance indicators

Decision-making, trends, and patient outcomes

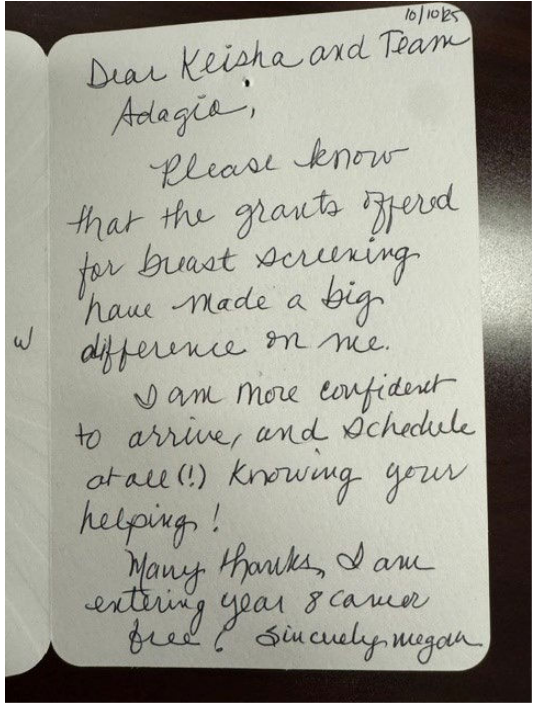
Highlights community needs and impact

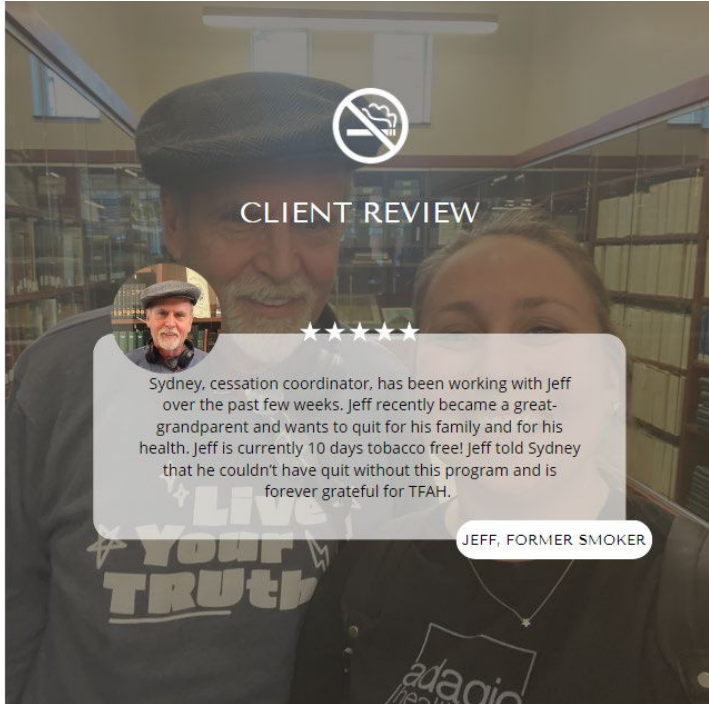


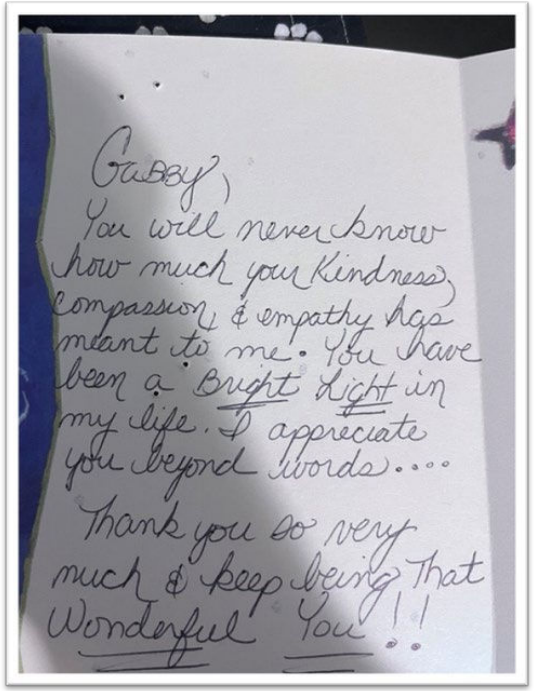
Benefits & Successes

- Improved patient outcomes
- Increased care coordination
- Reduced gaps
- Reduced financial costs
- Diversified revenue streams
- Pilot new services
- Outreach and marketing funding
- Funder relationships

Patient & Client Testimonials







Questions?

Continuing Education Information

Accreditation Statement:
In support of improving patient care, the University of Pittsburgh is jointly accredited by the Accreditation Council for Continuing Medical Education (ACCME), the Accreditation Council for Pharmacy Education (ACPE), and the American Nurses Credentialing Center (ANCC), to provide continuing education for the healthcare team.

Physician (CME)
The University of Pittsburgh School designates this live activity for a maximum of 6.75 AMA PRA Category 1 Credits . Physicians should claim only the credit commensurate with the extent of their participation in the activity.

Nursing (CNE)
The maximum number of hours awarded for this Continuing Nursing Education activity is 6.75 contact hours.

Social Work (ASWB)
As a Jointly Accredited Organization, University of Pittsburgh is approved to offer social work continuing education by the Association of Social Work Boards (ASWB) Approved Continuing Education (ACE) program. Organizations, not individual courses, are approved under this program. State and provincial regulatory boards have the final authority to determine whether an individual course may be accepted for continuing education credit. University of Pittsburgh maintains responsibility for this course. Social workers completing this course receive 6.75 continuing education credits.

Physician Assistant (AAPA)
The University of Pittsburgh has been authorized by the American Academy of PAs (AAPA) to award AAPA Category 1 CME credit for activities planned in accordance with AAPA CME Criteria. This activity is designated for 6.75 AAPA Category 1 CME credits. PAs should only claim credit commensurate with the extent of their participation.

Psychologist (APA)
Continuing Education (CE) credits for psychologists are provided through the co-sponsorship of the American Psychological Association (APA) Office of Continuing Education in Psychology (CEP). The APA CEP Office maintains responsibility for the content of the programs.

Other health care professionals: Other health care professionals will receive a certificate of attendance confirming the number of contact hours commensurate with the extent of participation in this activity.

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No planners, members of the planning committee, speakers, presenters, authors, content reviewers and/or anyone else in a position to control the content of this education activity have relevant financial relationships to disclose.

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