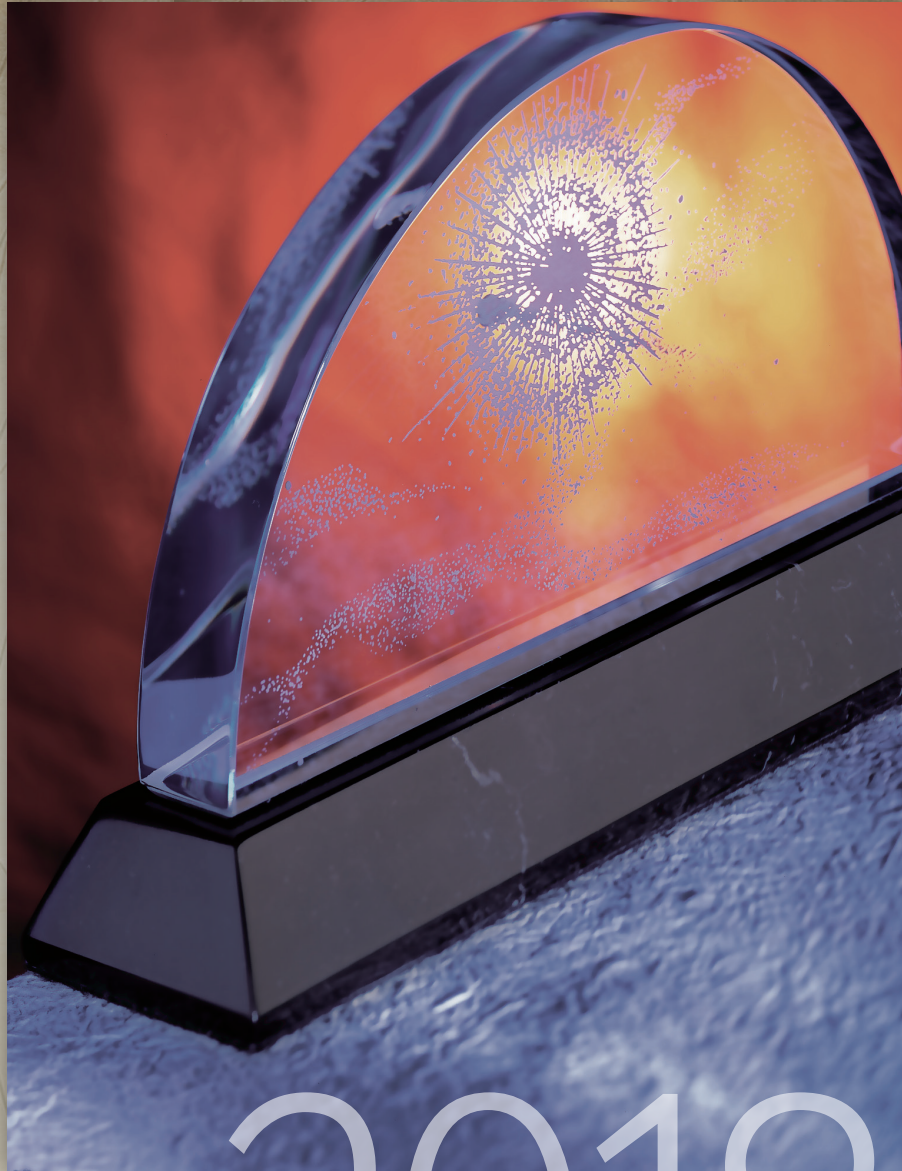




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2018

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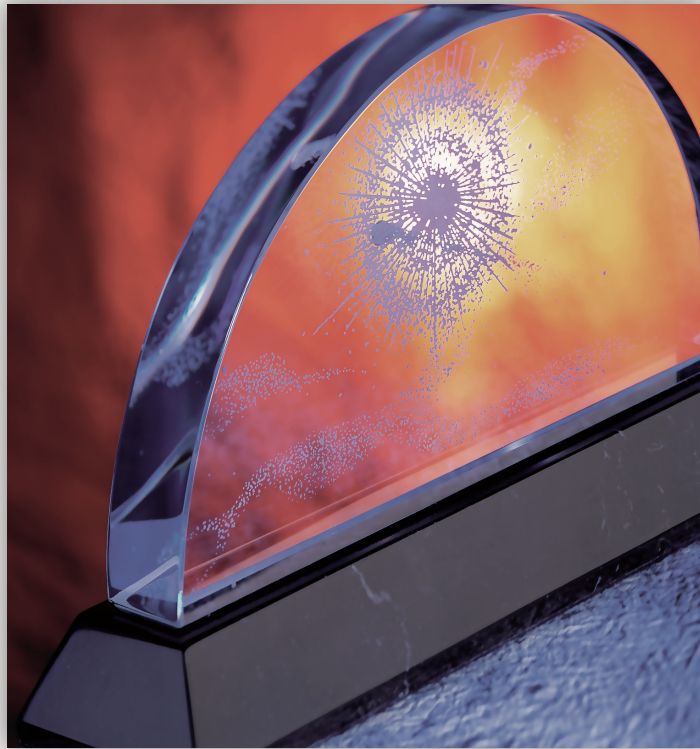
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ABOUT THE AHA NOVA AWARD



Each year, the American Hospital Association honors up to five programs led by AHA member hospitals as “bright stars of the health care field” with the AHA NOVA Award. Winners are recognized for improving community health by looking beyond patients’ physical ailments, rooting out the economic and social barriers to care, and collaborating with other community stakeholders. The AHA NOVA Award is directed and staffed by the AHA’s Office of the Secretary. Visit www.aha.org/nova for more information. ●

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ADVENTIST HEALTH • KAISER PERMANENTE • LEGACY HEALTH • OREGON HEALTH & SCIENCE UNIVERSITY

Portland health systems collaborate to meet behavioral health needs with psych center

Like many cities throughout the nation, Portland, Ore., suffered from a dysfunctional mental health system.

The nonprofit advocacy group Mental Health America has ranked Oregon as one of the worst states for access to care and prevalence of mental illness. Portland mental health patients in crisis frequently wound up in jail or the city's crowded emergency departments.

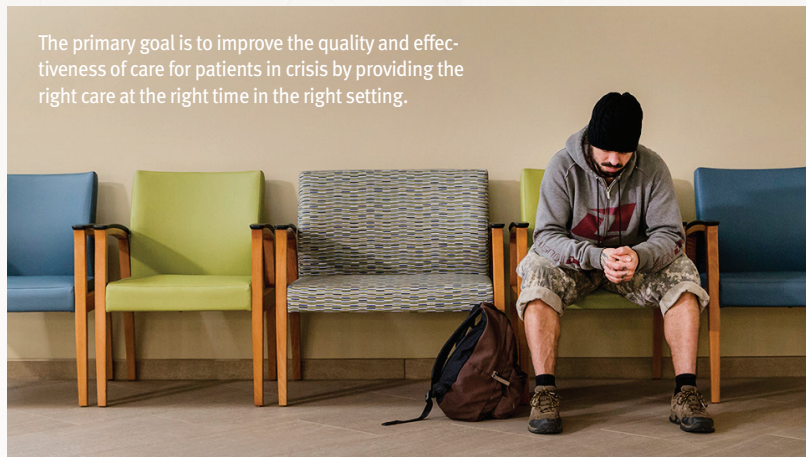
"We in Portland were struggling with the same issues that so many others across the country were struggling with," says Mike Newcomb, D.O., chief operating officer of Legacy Health. "Our mental health programs weren't coordinated, and existed as individual silos within hospitals in the metropolitan area."

George Keepers, M.D., chair of the Department of Psychiatry at Oregon Health & Science University, says mental health patients transported to EDs "were overloading those systems. Often-times, they waited for long periods of time for hospitalization, sometimes two days, in very small, cramped facilities with inadequate initial treatment, due to the limitations of regular EDs. There was a need for a larger hospital unit to take over these tasks."

That need was addressed head-on with the February 2017 opening of the Unity Center for Behavioral Health, a collaborative venture of Legacy Health, OHSU, Adventist Health and Kaiser Permanente. It is Portland's first comprehensive behavioral health care center and the first psychiatric center in the country formed by four competing health systems.

"That is a huge shift," Newcomb says. "The thought was to go to some of our competitors in the community and see if they'd be interested in combining our inpatient mental health facilities. I got immediate responses of 'yes, we're

The primary goal is to improve the quality and effectiveness of care for patients in crisis by providing the right care at the right time in the right setting.



interested, let's see what we can do.' Kaiser Northwest didn't have an inpatient mental health facility, so they were very interested."

The proposal was not easy to implement, Keepers recalls. "The development of a joint operating agreement required a long period of development and negotiation. And then the planning process itself took a long time because of the involvement of so much of the community."

Unity Center was established in a building owned by Legacy Health where more than 80,000 square feet of space became available. The center includes a psychiatric emergency room for adults and a 107-bed inpatient facility for adults and adolescents.

OHSU provides the psychiatric medical staff, residents and fellows.

All four health systems share in the costs of operating Unity Center, which also receives philanthropic support through grants and contributions.

Collaborative partners in the program include area police and emergency services, health and justice departments, accountable care organizations and community-based, mental health programs.

The primary goal is to improve the

quality and effectiveness of care for patients in crisis by providing the right care at the right time in the right setting. Other key goals include reducing the amount of time area hospital EDs are on divert due to large volumes of behavioral health patients, reducing the number of short-term (less than 48 hours) behavioral health inpatient stays and improving outcomes for behavioral health patients through enhanced access to community-based services.

Early results showed that Unity Center was discharging 77 percent of patients, on average, after 20 hours of stabilization, mental health crisis intervention and discharge planning. Only 23 percent of the patients who enter Unity Center are admitted as inpatients, thereby eliminating unnecessary hospitalizations. Of those who are hospitalized, more than 89 percent attend their scheduled follow-up visit with a community-based provider within seven days, compared with the Oregon state goal of 80 percent.

Since Unity Center opened, Legacy Health has seen a 70 percent drop in ED divert hours, while Adventist Health has experienced a 37 percent reduction. ●

ANNE ARUNDEL MEDICAL CENTER

Maryland hospital establishes primary care practice in public housing apartment building

Anne Arundel Medical Center in Annapolis, Md., discovered a "hot spot" during a 2012 examination of readmission data: the Morris Blum Senior Apartment Building operated by the city's public housing authority.

Located just blocks away from the Maryland State House and upscale neighborhoods, Morris Blum and the surrounding vicinity are home to a medically underserved population. To bring better care to this population, AAMC worked with the housing authority to develop the Annapolis Community Health Partnership.

"It's well-aligned with our mission, our vision and our values," says Victoria Bayless, president and CEO of AAMC. "Our strategic plan for this decade, called Living Healthier Together, describes a system of care that goes outside the walls of the traditional hospital and health system, and that focuses on the patients and their families. It is driven by evidence and data, and it is accomplished through partnerships in the community, in a financially responsible way."

Bayless says AAMC determined that residents of the Morris Blum building had not been accessing health care in the best way, even though many were eligible for both Medicare and Medicaid.

The program's goals are to prevent, screen for, diagnose and treat disease, in order to reduce preventable complications of hypertension, mental illness, substance abuse, diabetes, lung disease, heart disease and cancer.

Patricia Czapp, M.D., AAMC's chair of clinical integration, says the hospital didn't want to "plunk a traditional primary care practice down in public housing. In fact, we knew that many of these folks had access to primary care, but it didn't seem to work for them. They kept coming to the emergency department and the hospital, sometimes



Residents of the Morris Blum Senior Apartment Building had not been accessing health care in the best way.

for medical reasons and sometimes for nonmedical reasons."

In light of that, the program adheres to a nontraditional primary care practice model. Patients are welcomed, even when they show up late or without an appointment, and their needs are always addressed.

They are greeted by staff members who are recruited from the local community. Staff members are trained in national CLAS (Culturally and Linguistically Appropriate Services) standards, as well as how to maintain a calm, non-judgmental, welcoming attitude.

Since implementation of the Annapolis Community Health Partnership, residents of Morris Blum and the surrounding community have generated fewer ED visits, avoidable hospitalizations and medical 911 calls, along with a 25 percent decline in hospital readmissions between fiscal years 2013 and 2017.

Quality measures also have shown improvements in diabetes control, hypertension control, BMI screening/

follow up, colorectal cancer screening and mammography.

"In this population, with challenges involving physical activity and nutrition, we expected a lot of poorly controlled diabetics and we certainly found them," Czapp says. "Thirty-six percent of ours were poorly controlled. We were able to get that down to 28 percent in a year. We were able to engage folks in a medical regimen that made sense to them, and tie that to nutrition and physical activity, because you need all three to treat diabetes effectively. They made differences in their lifestyle that were enduring."

The program represents an "investment in the community's health," Bayless says. "If you look at the clinic on a profit-and-loss basis, we lose money on it. But if you look at broader population health and what we're trying to achieve in terms of reduced utilization of hospitals and EDs, and bring the most appropriate level of care to the right setting, we know we're doing the right thing." ●

HSHS ST. JOHN'S HOSPITAL • MEMORIAL MEDICAL CENTER

Community health worker program earns trust to address health challenges and other needs

The Enos Park neighborhood in Springfield, Ill., drew the attention of HSHS St. John's Hospital and Memorial Medical Center when they forged a collaborative community health needs assessment in 2015.

"Access to care was identified as one of the most significant issues in our community, and Memorial and HSHS St. John's Hospital decided to take a deep dive into one geographic neighborhood to identify and address issues that prevent residents from getting the care they need to live healthy lives," says Ed Curtis, Memorial's president and CEO.

That resolve led to the creation of the Enos Park Access to Care Collaborative, a three-year program launched in 2015. The Enos Park neighborhood ranked high in unmanaged chronic conditions such as diabetes, heart disease, mental health and pediatric asthma. Nearly half of the roughly 2,300 residents were below the federal poverty level.

Yet, Memorial stands on the southwest corner of Enos Park, and St. John's overlooks the southeast corner of the neighborhood. Close by is the Southern Illinois University School of Medicine's Center for Family Medicine, a federally qualified health center.

"If we can't do something for our own neighbors, what can we do across town or in another city?" asks Tracey Smith, director of the program.

The primary goals of the program are to improve access to health care through the efforts of community health workers, and increase access to pediatric mental health services through screening, intervention and education.

Other goals include reducing emergency department visits for non-emergent health issues and improving self-sufficiency for program participants.

"We conducted focus groups in the



Summer clubs for children aged nine to 14 include a bicycle club led by neighborhood police officers.

neighborhood," says Kim Luz, director of community outreach for HSHS St. John's and the HSHS Central Illinois Division. "We worked with the Enos Park Neighborhood Improvement Association to address identified needs."

Focus group participants said the neighborhood needed a trusted individual who could help identify health care needs and guide residents through the health care system in areas such as accessing insurance and a primary care physician.

"We established the community health worker program to go in the neighborhood and meet people in their homes, to identify not only health care needs, but also basic needs that weren't being met," Luz says.

Smith says "education or degrees are not the most important aspects of someone who is a good community health worker. The key is to find someone whose heart is in the right place."

The program reached 1,095 residents in Years 1 and 2, including 300 clients enrolled in the community health

worker program. All of those 300 clients selected a primary care home through the program. Clients needing mental health services completed 172 appointments, and there was a 22 percent reduction in unnecessary ED visits.

Overall, 38 percent of Enos Park residents had obtained greater access to care in the second year of the program.

But not all the improvements directly involve health care. For example, the Springfield Police Department reported a 22 percent reduction in Enos Park police calls in Years 1 and 2 of the program, and an 11 percent reduction in crime rates.

The program also developed summer clubs for children aged 9 to 14, including a bicycle club led by neighborhood police officers.

"The outcomes demonstrate that if you provide access to the right type of health care in the right place at the right time, it's going to contribute to wellness and a better living standard," says Charles Lucore, M.D., president and CEO of HSHS St. John's. ●

MEDICAL CITY HEALTHCARE

Collaboration with school districts, restaurants and employers encourages healthy snacking

Snack time often is poor nutrition time for kids. High-fat snacks contribute to childhood obesity, which can lead to lifelong health problems.

Medical City Children's Hospital in Dallas, part of Medical City Healthcare, took a novel approach to this problem when it created the Kids Teaching Kids program in 2010. The initiative includes high school culinary students creating healthy snack recipe books for elementary school kids throughout North Texas.

"Our program is about nutrition education," says Ryan Eason, Kids Teaching Kids program director and Medical City Healthcare community relations manager. "We noticed that many children with obesity get many of their calories through snacking. We worked with high school culinary students and got them to come up with healthier snacks that elementary school kids can make themselves."

Erol Akdamar, president of Medical City Healthcare, says Kids Teaching Kids is "an innovative program designed to help children develop lifelong healthy eating habits. As an organization, we are committed to the care and improvement of human life — and this program personifies that mission."

The recipe books feature snacks made with "all kinds of fruits and vegetables," Eason says. "We want to get kids to not only eat more fruits and vegetables, but try more fruits and vegetables."

Eason cites banana sushi, "which a student named Alan created years ago. You take a piece of banana and roll it in Greek yogurt, and roll that in Rice Krispies cereal."

Medical City Healthcare, which is part of HCA Healthcare, collaborates with partners such as school districts, private companies, the Greater Dallas Restaurant Association and Texas Pro-



Kids talk to local student chefs about nutrition and healthy eating.

Start, a program that prepares students for careers in the restaurant and food service industry.

One of the cornerstones of the program is the 21-Day Challenge. Elementary school kids are given recipe books featuring healthy snacks and challenged to make their own healthy snacks for 21 straight days.

"That's where learning happens," Eason says.

Nearly 36,000 elementary school kids signed up for the 21-Day Challenge from April 2016 to April 2017, and 9,527 completed the challenge. Those who completed the challenge demonstrated these improvements during their snack times:

- 19.8 percent reduction in chips consumption.
- 21.4 percent reduction in cookie consumption.
- 5.3 percent reduction in soda consumption.
- 14.6 percent increase in fruit and vegetable consumption.
- 61.3 percent of kids who tried a

new fruit or vegetable.

A total of 143,000 kids have participated in the 21-Day Challenge since its inception. It will be offered in 14 North Texas area school districts in the coming school year, Eason says. "Those districts contain 500 elementary schools and about 300,000 kids."

Another facet of Kids Teaching Kids is a Kids Fit Menu that's offered in participating restaurants. Each meal includes at least two servings of fruits and vegetables.

"Here in the Dallas-Fort Worth area, in four years, there have been over 285,000 orders of these meals at our participating restaurant partners," Eason says.

Akdamar says Medical City Healthcare takes great pride in the Kids Teaching Kids initiatives. "Driven with passion and strong leadership, it has taken hold in the market and continues to grow. The program may expand to other HCA markets in the future — to encourage healthier communities across the country." ●

ST. LOUIS CHILDREN'S HOSPITAL

Healthy Kids Express sends van to schools to teach kids how to manage their asthma

One of the biggest health challenges facing America's urban communities is pediatric asthma, and St. Louis is no exception.

"It's the No. 1 diagnosis in the St. Louis public school district," says Lisa Henry, a pediatric nurse practitioner. "It's the No. 1 reason for missing school."

Henry works with the Healthy Kids Express Asthma Program operated by St. Louis Children's Hospital. Designed to help kids better manage their asthma, the program periodically sends a 40-foot mobile health unit to 14 underserved schools in five school districts.

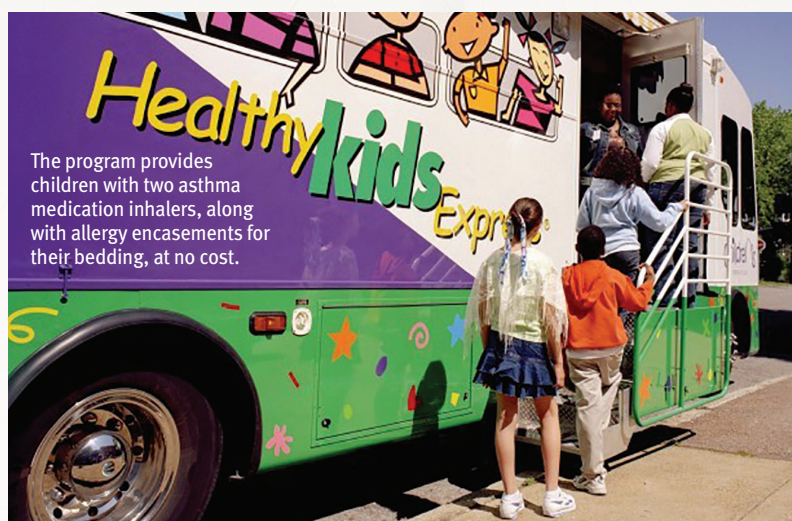
Healthy Kids Express, which was launched in 2009, helps children manage their asthma by increasing their knowledge of signs and symptoms of the disease, improving their ability to use medications correctly and following an asthma action plan.

Goals include increasing physician visits, improving school attendance and decreasing emergency department visits and hospitalizations due to asthma.

"We already had really good relationships with the schools," Henry says. "We had gone there with other programs, doing health screenings in areas such as vision and hearing. So we were able to leverage those good relationships to start the asthma program."

A multidisciplinary team creates goals and develops services that address social determinants of health, including access and health disparities. Washington University allergists and immunologists provide medical guidance for the program, which shares information with important partners such as the child's doctor, school and pharmacist.

When the program first began, students were seen inside their school buildings. "One of the challenges was finding space within the schools to see



The program provides children with two asthma medication inhalers, along with allergy encasements for their bedding, at no cost.

the children," Henry recalls. "And we wouldn't always have the best privacy in which to see these children."

With funding from the St. Louis Children's Hospital Foundation, the program acquired a mobile health unit in which to see the children, thereby solving the problem of finding an appropriate space.

"The schools have agreed to let us come and park outside their school," Henry says. "The children we see on the van have been consented for our program. They're already diagnosed with asthma. We help them manage their asthma. We help them with education and supplies. We're able to do lung function testing on the van."

Henry says parents are welcome to come to school and join their kids on the van, but the parents' presence is not required. "If the parents can't take off work, we're able to see their children on the van by themselves."

The main avenue of communication with parents is over the phone. In addition, Henry says, "We make sure we're always in communication with primary care providers, so we're on

the same page."

The program provides children with two aerochambers to use with their inhaled medications, along with allergy encasements for their bedding, at no cost.

Asthma coaches assist with a subset of patients considered high-risk, including those with uncontrolled asthma who may be fatality-prone. Families are paired with a social worker as an additional level of support when needed.

In 2016, students who had been enrolled in the program for at least two years demonstrated a 13 percent reduction in school absenteeism from the previous year. The program also has helped lower pediatric ED visits and inpatient admissions due to asthma.

"I've seen kids who at the beginning of the program couldn't do what they wanted to do, and by the end of the program they were able to play in the band or play on the football field," Henry says. "I've had parents thank me for being able to sleep all night for the first time since their 6-year-old child was born. I feel so lucky to be able to do this." ●

