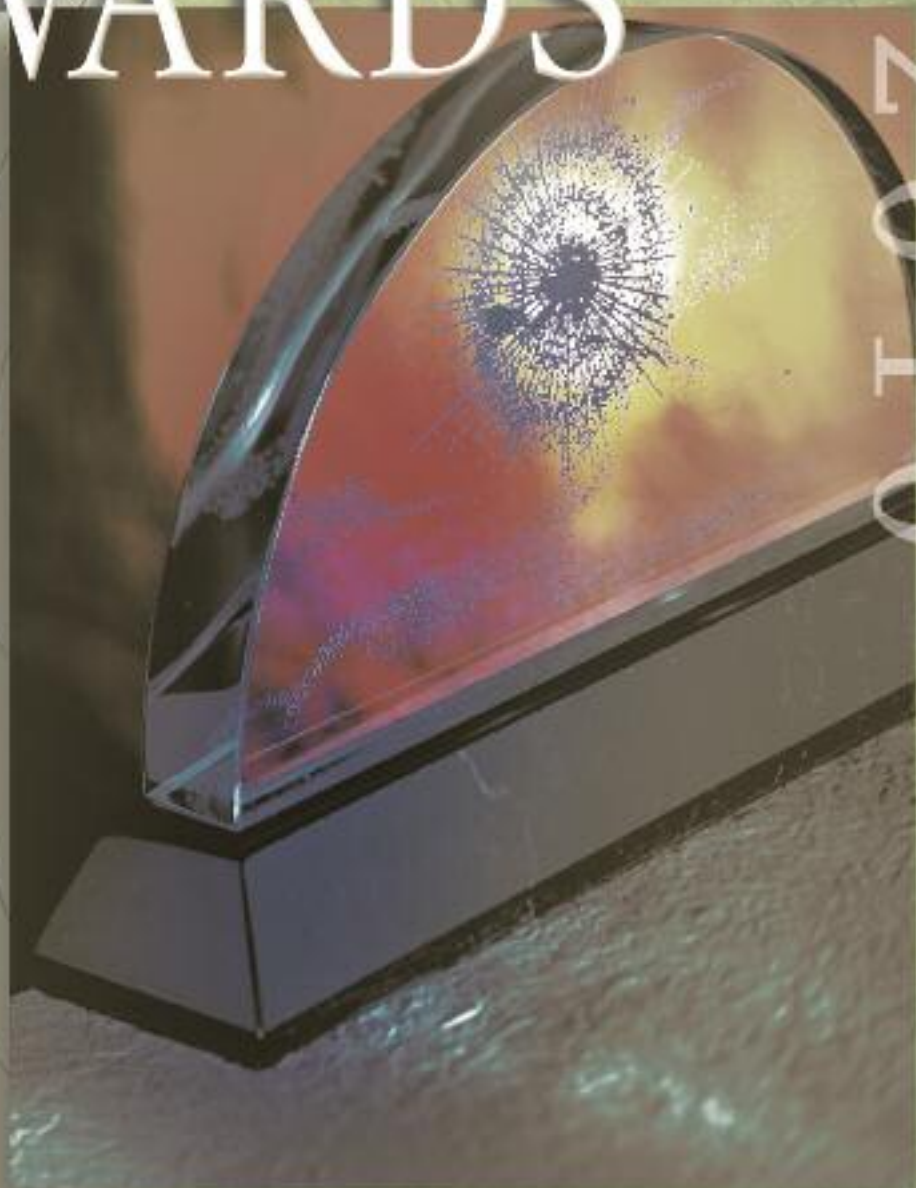


AHA
NOVA
AWARDS



2010



American Hospital
Association

THE AMERICAN
HOSPITAL ASSOCIATION
2010 NOVA AWARD WINNERS

The 2010 AHA NOVA Awards

The five winners of the 2010 AHA NOVA Awards, sponsored by the American Hospital Association and *Hospitals & Health Networks*, excel in making a difference in the lives of the most vulnerable in their communities. On the East Coast, that means developing alternatives to emergency care for behavioral health and primary care. On the West Coast, it means connecting every uninsured community resident with a primary care home and network of care. In between, health systems ensure expectant mothers and children under age 2 have a healthy beginning, no matter their income; use telemedicine to deliver high-touch care to children in schools, child care and family service agencies; and offer a pediatric asthma program to reduce the impact of the devastating disease on inner-city children. While the programs are different, one key element is the same: All employ extensive collaboration with like-minded community partners, in the spirit of the AHA NOVA Awards.

Targeting Child Asthma Sufferers

Tamika Johnson is 3 years old and suffers from asthma. She's not alone. One in four children in North Lawndale, a largely African-American community on the west side of Chicago and one of the poorest areas of the city, suffers from the disease. At 25 percent, that's one of the highest documented rates of asthma in the country.

Sinai Health System set out to change that. Sinai's emergency department historically has helped inner-city children from North Lawndale largely by treating acute symptoms. But many children didn't take the proper medications and few followed up with a clinic or physician. Other factors, such as violence, obesity and behavioral health issues, complicated the picture.

Sinai teamed with Chicago-area asthma organizations, disability advocates, community interest legal organizations and the Sinai Urban Health Institute to create Healthy Home, Healthy Child: Westside Children's Asthma Partnership, the fourth iteration of the health system's pediatric asthma intervention program. The program trains and sends into the field community health workers and lay health educators to provide individualized care and education to Tamika (not her real name) and other North Lawndale kids and families.

"The people we serve live in all these amazingly vulnerable communities," says Steve Whitman, director of the Sinai Urban Health Institute. "We decided we had to do something about it. We had to move outside the clinic to do additional good work."

Drawing on the strength of partners such as the Chicago Asthma Consortium, Health and Disability Advocates and the Metropolitan Tenant's Organization, Sinai visits children and their families in their homes to impart knowledge about asthma to the child's primary caregiver, decrease the number of triggers to which the child is exposed, improve the medical management of the child's asthma, and improve the caregiver's confidence that they can properly manage their child's condition.

Sinai and its partners' efforts have led to reductions in frequency of symptoms, reduced ED visits and hospitalizations, decreased exposure to asthma triggers in the home and fewer nighttime home asthma emergencies. The program also resulted in improved use of medications and expanded asthma-related knowledge among families and caregivers. Cost savings from the program in recent years are on the order of \$5 to \$7 for each dollar spent, says Whitman.

But Alan Channing, Sinai's CEO, doesn't measure success just in dollars. After working with Sinai experts, Tamika and her parents have made some dramatic changes. They moved from a damp basement apartment with mold-infested carpeting to an above-ground residence with hardwood floors. They switched to more natural cleaning products to lessen Tamika's problems, and with a change in masks and tubing, home asthma treatments are now more effective.

"We've tried to really understand our community's needs and help create these interventions that will make a difference," Channing says. "We've taken on the challenge of trying to speak for those folks who can't speak for themselves." ●



Don Orliveros

TAKE A DEEP BREATH: Geoni McNeal, a 14-year-old asthma sufferer, uses an aero-chamber device, which administers a metered dose inhaler. The Chicago Westside Children's Asthma Partnership trains and sends into the field community health workers and lay health educators to provide individualized care and education to kids and their families.

THE GOAL | Reduce the frequency and impact of asthma among children of African-American families; to develop and train human capital within affected communities; to select settings and methods to make the most of child and family participation.

THE PLAYERS | Among others, the Chicago Asthma Consortium, Health and Disability Advocates, Metropolitan Tenant's Organization, and the Sinai Urban Health Institute.

THE PLAN | Improve the asthma-related knowledge of the child's primary caregiver, decrease the number of triggers to which the child is exposed, improve medical management of the child's asthma; and improve the caregiver's confidence in managing their child's asthma.

THE RESULTS | 200 percent drop in frequency of symptoms, 47.6 percent drop in ED visits, 50 percent drop in hospitalizations, 63.6 percent decline in nighttime asthma symptoms.

Easy Access Telemedicine Visits

WINNER



Brad Dillsworth

WIRED FOR CARE: The Health-e-Access program uses a Web-based telemedicine system to connect children in child care, school or family service agencies to a health care professional (usually a physician or nurse practitioner). The technology relies on the Internet, videoconferencing, and special devices for patient examination, all of which allow providers to perform remote diagnosis and consultation for sick children.

THE GOAL | Increase access to quality health care for medically underserved children decrease middle-of-the-night visits to the ED and visits to urgent care centers with unfamiliar doctors, reduce parents' time off work due to child's illness.

THE PLAYERS | Child care sites (day care, child care, Head Start), elementary schools, child development centers, family service and advocacy agencies, primary care medical practices.

THE PLAN | Offer easy-to-access telemedicine visits between sick children and primary care/pediatric providers in settings that minimize or eliminate the need for parents to take time off from work during the day or make visits to the ED after hours.

THE RESULTS | 50 percent reduction in child absences from inner-city child care centers, 25 percent drop in ED visits; and 91.2 percent of parents said a telemed visit for their child allowed them to remain at work.

It was a common scenario in Rochester. A parent is called at work to pick up his sick child from day care and told the child can't return without a letter from the doctor. Because the family doctor isn't available, the child winds up in the emergency department or an urgent care center. The parent loses time from work, the child misses time at school, and money is wasted on treatment in an inappropriate setting.

What frustrated pediatrician Kenneth McConnochie most was that the children had routine, easily treatable conditions—ear aches, sore throats, minor rashes. In McConnochie's view, it didn't make sense to take children out of child care or school to see a physician when in many cases telemedicine could resolve the problem on the spot.

So McConnochie, a professor of pediatric medicine at the University of Rochester Medical Center, co-founded Health-e-Access Telemedicine. The program uses a Web-based telemedicine system to connect children in child care, school or family service agencies to a health care professional (usually a physician or nurse practitioner). Health-e-Access staffers train personnel at the child care facilities on the equipment and in basic clinical techniques needed to transfer patient information.

The technology relies on the Internet, videoconferencing, and special devices for patient examination, all of which allow providers to perform remote diagnosis and consultation for sick children.

"The anxiety and worry, both about your child's well-being and about losing a day's pay—there's a lot of peace of mind we can offer with this program," says McConnochie.

Health-e-Access started with five inner-city child care centers, primarily serving children of families in poverty. It has since expanded across the city and county to 23 community-based sites in elementary schools, child care centers, schools for individuals with developmental disabilities, and family service and advocacy agencies. Four sites are open after hours.

"Above all, what we're providing is reassurance that the parent has done everything they can to make their child well as quickly as possible," McConnochie says.

Health-e-Access results have been impressive. The program has cut illness-related absences in inner-city child care centers by more than half, ED visits by sick kids have fallen by almost 25 percent and surveys suggest that the remote visits allow more parents to stay at work.

Collaboration among all stakeholders in the health care system is essential to the program's success, says Bradford Berk, M.D., the medical center's CEO. Key stakeholders include families, child care sites such as schools, child care and neighborhood after-hours sites, insurance companies, employers and taxpayers.

Putting together such a large collaborative effort wasn't easy, he says, but the academic medical center's prior involvement in a series of community efforts smoothed the path.

"It's a question of having worked together, trusting each other and having achieved outcomes," Berk says. "People see that it's worthwhile to invest their time when at the end of the day something actually happens that is meritorious." ●

Connecting the Uninsured with Care

On any given day at San Francisco General Hospital, 20 percent of inpatients on the medical-surgical floors are uninsured—and a good number of them came through the emergency department. The story is repeated at other hospitals as they struggle to provide care to the city's 60,000 uninsured.

"We know that the extent to which people have a usual source of care, they're not going to come to the emergency room for routine care," says Tangerine Brigham, deputy director of the San Francisco Department of Public Health, of which San Francisco General Hospital is a part.

Not content to wait for national health care reform to ease the situation, the city in 2006 created Healthy San Francisco.

The program is a public-private partnership that provides universal, comprehensive, affordable health care to uninsured adults regardless of their income, employment, immigration status or pre-existing medical conditions. It aims to connect every uninsured San Franciscan with a primary care home that serves as a gateway to a comprehensive array of services through a coordinated network of care.

"When we started, we all had a sense that we'd be doing what the rest of the country would have to do sooner or later in some form or fashion," says Roland Pickens, San Francisco General's chief operating officer.

Healthy San Francisco is unique in that it connects uninsured adults to health care services without using a health insurance model, relying instead on collaboration among existing health care providers, organized into a coordinated system of care.

The health department oversees Healthy San Francisco. Primary care medical homes are provided by the San Francisco Community Clinic Consortium, a 13-clinic partner. San Francisco General and the city's other not-for-profit hospitals provide inpatient care, and the San Francisco Health Plan provides third-party administrative services to the program.

In 2008-2009, Healthy San Francisco cost about \$126 million, paid mostly by city and county funds, federal Medicaid reimbursement and employer contributions. Individual plan participants chipped in \$3 million in co-payments. The \$298 per participant per month cost of the plan is less than the \$388 and \$618 per month that two major California health plans quoted health department officials.

Healthy San Francisco has racked up impressive results. The most recent analysis of date shows that almost 49,000 uninsured residents (81 percent of the city's total) have enrolled in the program, and 78 percent of them have accessed primary care. That led to a 27 percent decrease in hospital emergency department visits in the first year of the program.

Those results may be within reach of many cities around the country, says Susan Currin, CEO of San Francisco General. "Healthy San Francisco is health care delivery reform at the local level," she says. "The impact on the patient's life is just indescribable. They really feel like they are connected to a provider who knows their health care needs." ●



Rick Gerharter

CARE FOR ALL: The Healthy San Francisco program is a public-private partnership that aims to connect every uninsured San Franciscan with a primary care home that serves as a gateway to a comprehensive array of services through a coordinated network of care.

THE GOAL | Connect every uninsured San Francisco resident with a primary care home; create a comprehensive array of services through a coordinated network of care; improve access to and satisfaction with care by uninsured residents.

THE PLAYERS | San Francisco Department of Public Health; all the city's not-for-profit hospitals; San Francisco Community Clinic Consortium; San Francisco Health Plan.

THE PLAN | Capitalize on the existing array of city health care providers, and organize them into a comprehensive and coordinated system of care; connect uninsured adults to care without using a health insurance model.

THE RESULTS | 81 percent of uninsured enrolled in Healthy San Francisco; 78 percent of enrollees accessed primary care; 27 percent decrease in ED visits.

Fresh Approach to ‘Multiple Needs’ Patients

WINNER



Jim McLaughlin

EVALUATING THE SITUATION: The Lee County Behavioral Triage Center provides law enforcement and hospital EDs with alternatives to jailing or hospitalizing people with symptoms of mental illness or intoxication. Dr. Angela Monterosso (left) a Lee Memorial Hospital psychiatric advanced practitioner evaluates a patient's chart and arrest record with Tammy Vander Kooi (center), an RN at the Triage Center, and Lt. Jay Rodriguez (right) of the Fort Myers Police Department.

THE GOAL | Provide area law enforcement and hospital EDs with alternative to jail or hospitalization for mentally ill and intoxicated patients; provide assessments and referrals to low-demand shelters, primary care, social service and case management treatment.

THE PLAYERS | Human service agencies, public health departments, law enforcement, United Way, Salvation Army, National Alliance for the Mentally Ill and more.

THE PLAN | Create a triage center to assess and refer for treatment people with symptoms of mental illness or intoxication as an alternative to jail or hospitalization; develop facilities that offer a setting for immediate intervention and longer term support.

THE RESULTS | 30 percent of clients referred to housing; 16 percent enter inpatient substance abuse treatment programs; 16 percent drop in jail time for clients with an arrest record; 160 percent increase in use of kiosks for Medicaid enrollment; 2 percent drop in use of the local food pantry.

In 2007, Lee Memorial Health System convened a community needs assessment panel that included leaders in business, education, government, faith-based organizations and health care, as well as members of the public. The goal was to create a 10-year vision of how to improve the status of community health care.

The process made clear the need to bring a wide gamut of health care and human services providers together in the community, says Sally Jackson, Lee Memorial's system director of community projects.

"People have multiple needs. If you just address one need, you're going to end up missing two or three others," she says. "Then you'll have them back as a client, patient or someone in need."

The lengthy process resulted in eight major recommendations to Lee Memorial's board of trustees, all of which the board accepted. The top two recommendations focused on behavioral health and primary care alternatives. Research showed higher than average suicide and substance abuse rates, accidental deaths, and homicide rates in the Fort Myers area. Yet the area lacked inpatient psychiatric beds, mental health providers and substance abuse treatment options.

Local government had tried for three years to obtain state funding for a triage center, but to no avail, says Jim Nathan, Lee Memorial's CEO. In the meantime, the economy collapsed and the strains on the health system grew.

"No hospital by itself is in a position to resolve these issues," says Nathan. "The visioning process brought community leaders together to become community pushers for making a positive difference and not have this be just another study that goes on the shelf."

The results are impressive:

- The Lee County Behavioral Triage Center provides law enforcement and hospital EDs with alternatives to jailing or hospitalizing people with symptoms of mental illness or intoxication. Patients are offered assessments and are given referrals to more appropriate treatment settings. Data shows that 30 percent of clients are referred to housing, 16 percent enter inpatient substance abuse treatment programs, and there's been a 16 percent reduction in jail time for clients.
- The Dunbar and East United Way Houses provide many of the services referred by the triage center, with co-located primary care, social services and case management designed to provide immediate intervention and longer term support. In its first full year, the centers saw a 23 percent increase in patients served.
- After 18 months of operation, the triage center became a model for other Florida communities, which are studying the program with an eye toward duplicating it. Already, the Dunbar House has been replicated in another Fort Myers neighborhood and a third location is being developed.

The key to success of the Lee Memorial program, Nathan says, is being a strong community partner. "Many hospitals and health systems are blessed with massive leadership talent," he says. "If we can use that talent effectively in partnering in the community, we're doing our job a lot better." ●

Tracking Prenatal Through Age 2 Kids

Munson Healthcare's service area is extensive, covering seven rural counties in northeast Michigan. Not surprisingly, a community health assessment done by Munson and other community partners identified health care access as a major issue in the area—particularly for families with children through age 2 who needed prenatal and primary care services.

Research showed that in the economically challenged state, more than 50 percent of births are covered by Medicaid. To address this need, Munson Healthcare hospitals and in collaboration with area physicians and health departments developed the Healthy Futures program, with sponsorship from two local corporations.

The initial goal of Healthy Futures was to help young families access health care and other supportive services. Over time it has evolved to include a special focus on breast feeding longevity and ensuring that by age 2, children are up-to-date with recommended immunizations.

The success of Healthy Futures is due in large part to close collaboration among program partners, says Betsy Hardy, program coordinator for Healthy Futures. "Munson Healthcare is being recognized with this award, but the key is that it's a shared success," she says.

Healthy Futures is unique because there are no income or risk qualifications for targeted families. It enjoys exceptionally high participation and satisfaction rates because families are able to control the amount of information and intervention they receive. Trusting long-term relationships are built between clients and health care providers, and may exist through several pregnancies.

The program offers individualized education and support services at no charge. Based on a family's perceived need, new mothers receive as little as age-appropriate newsletters with health and developmental information, to personal contact with a public health registered nurse. Those may include phone or home visits to provide risk assessment, referral for medical care or social services, direct provision of lactation education and support, education on child development, postpartum self-care, and a wide variety of other topics.

Healthy Futures has shown impressive results. Outcomes data through late 2009 show that breast-feeding rates and immunization rates for 2 year olds are higher than national, regional and state averages. Ninety-nine percent of newborns and children have a primary health care provider. Ninety-six percent of pregnant women are connected with an obstetrician, and 87 percent receive prenatal care in the first trimester, higher than the state average.

Unlike some community health improvement initiatives, a program such as Healthy Futures would be easy to replicate, says Mary Beth Morrison, vice president of planning and operations improvement for Munson Healthcare.

Key to success, though, is not taking a hospital institutional approach, instead looking at it in a more collaborative way. "That's not what most hospitals are used to," she says. "But we can't let what is our greatest strength as hospitals overrun a different way to approach a community-based problem."—*Richard Haugh is a freelance writer in Denver.* ●



Jaqueline Southby

TOTAL CARE: Munson Healthcare's Healthy Futures program provides any expectant mother and child with access to any care needs from prenatal to children 2 years old. The program is unique because there are no income or risk qualifications for families.

THE GOAL | Ensure that every expectant mother and child under age 2 has access to everything they need for a healthy pregnancy and early life beginning.

THE PLAYERS | 100 medical providers, four district and county health departments, three hospitals, several county health departments; financial sponsors included Kohl's Corporation Cares for Kids and a local real estate agency.

THE PLAN | Offer new mothers individualized education and support services; provide phone or home visits for risk assessment, referral for care and education in lactation; ensure that children are up to date with recommended immunizations at age 2.

THE RESULTS | Breast-feeding rates and immunization rates are better than national, state and regional averages; 99 percent of newborns and children have a primary health care provider; 96 percent of pregnant women have an ob-gyn; 87 percent of women receive prenatal care in first trimester.



THE AHA NOVA AWARD

The American Hospital Association honors leadership by its member hospitals and health care systems by presenting AHA NOVA Awards annually to the bright stars of the hospital field that:

- improve community health status—whether through health care, economic or social initiatives
- are collaborative—joint efforts among health care systems or hospitals, or among hospitals and other community leaders and organizations.

Awards will be presented in July at the AHA-Health Forum Leadership Summit in San Diego, Calif. Additional information on the AHA NOVA Awards, including an application for 2011, is available at www.aha.org.



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