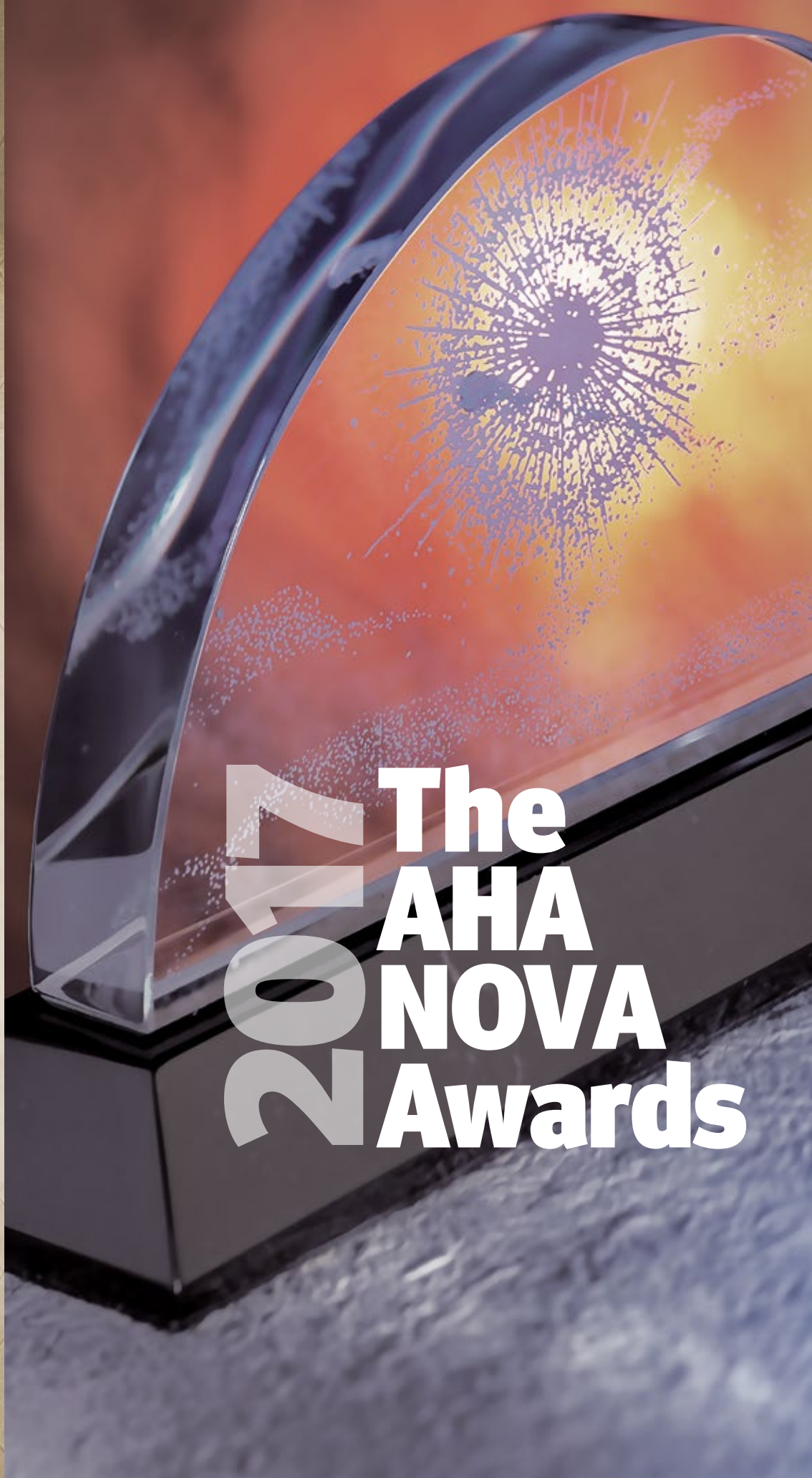
American Hospital Association



2017 The AHA NOVA Awards

ABOUT THE 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.

For more information: www.aha.org/nova

WINNER | CHI St. Gabriel's Health | Little Falls, Minn.

Rural Minnesota Health System Tackles Opioid Epidemic

In 2014, opioid addiction was just beginning to surface nationally as an epidemic, but it was already overwhelming CHI St. Gabriel's Health in Little Falls, Minn.

The No. 1 reason patients visited the rural hospital's emergency department was to obtain narcotics for chronic pain, and in the clinic next door, family practice providers were inundated with refill requests for prescribed pain medications.

"We also started to see in our community a lot more overdoses related to opioids, and those overdoses were hitting our [ED] as well," says Lee Boyles, president and CEO.

What's more, about 60 percent of the narcotic medications prescribed by the health system's clinic were diverted by patients for illegal sales, Boyles says. "We felt, talking with law enforcement and other agencies, that we really needed to do something about this."

The next year, CHI St. Gabriel's obtained a $368,112 grant, part of a $45 million State Innovation Model cooperative agreement awarded to the Minnesota departments of Health and Human Services by the Center for Medicare and Medicaid Innovation to help implement the Minnesota Accountable Health Model. The grant required a community-integrated care model, and CHI St. Gabriel's focused on prescription drug abuse.

The grant enabled CHI St. Gabriel's to launch the Morrison County Community-Based Care Coordination project. The health system's partners in the venture are South Country Health Alliance, Morrison County Public Health and Social Services departments, and several other representatives from the Morrison County Prescription Drug Task Force.

Boyles notes that rural providers face particular challenges when dealing with drug addiction. "Physicians in a rural setting can grow to trust their patients so much they don't want to believe their patients could be diverting the drugs they're supposed to be taking," he says.

The program includes three key components: a multidisciplinary, care-centered team; a leadership team that oversees the care team; and a communitywide prescription drug task force.

The care team was designed to serve patient needs beyond the boundaries of the traditional care delivery model. The program's "physician champions," Kurt DeVine, M.D., and Heather Bell, M.D., led the effort to change prescribing practices of providers at the clinic and ED. Prescription orders were expanded to include start dates, a maximum number of pills per day and a "must last 30 days before

Minnesota Congressman Rick Nolan invited hospital leaders from CHI St. Gabriel's Health to testify at a congressional briefing on the success of their program to stem opioid abuse.

refills" provision. "Even when a patient's medication was being tapered, our goal was to provide optimum treatment. We did not want our program to be punitive," says DeVine.

In addition to prescribing, treatment is a high priority for the program. Bell recalls losing a patient to a heroin overdose one day before she received notice of her Drug Enforcement Administration certification for suboxone administration. "Losing patients to this addiction is what motivates me to do this work," she says.

Other members of the team contribute their expertise. The team's pharmacist reviews prescription histories recorded in the electronic health records, with an eye toward safely tapering patients from high narcotics doses, while the social worker considers how to address a patient's other issues, such as behavioral health history, addiction, homelessness, insurance needs and transportation.

In one instance, for example, the team helped a homeless patient with no family support system to achieve full recovery from knee surgery through physical therapy and compliance with his medication therapy. The patient also moved into a suitable apartment and returned to a quality of life that improved his relationships with his adult children.

During the first year of the program, the drug-seeking diagnosis fell off the top 20 list at the CHI St. Gabriel's ED. One local pharmacy saw a 20 percent drop in narcotics prescriptions. In a four-month period, South Country Health Alliance tabulated a $439,674 reduction in pharmacy claims compared with the same period the year before.

"We know from our own internal tracking that, as a clinic, currently we are taking over 16,000 pills off the street every single month," Boyles says. "We're making a significant difference in the amount of prescription narcotics that were being diverted and hitting the street."

Boyles says the program can be replicated wherever the need exists. "What we're doing in a rural community could be done in the inner city. You need a physician champion. It has to start with a physician who is willing to change the culture. And you need a team approach. You need to be partnering with stakeholders in your community. With the right team and the right resources, our program can be done anywhere." — JULIUS A. KARASH

WINNER | Children's Health | Dallas

Provider Leads Campaign to Fight Childhood Asthma

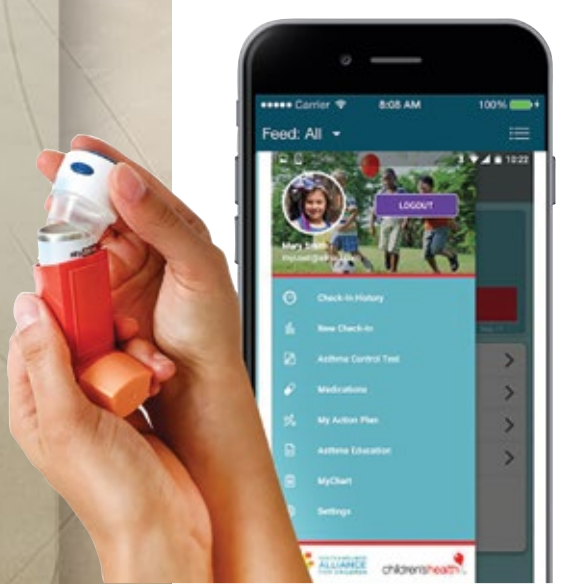
Dallas is known for its gleaming office towers, sparkling entertainment venues and booming economy. But it's not all glitz in Dallas. The city has pockets of poverty along with the health challenges they bring. One such challenge is childhood asthma, which affects more than 60,000 children in Dallas County alone. The direct medical costs and indirect costs to county taxpayers exceed $60 million annually.

"One in 10 children in Dallas County has asthma," says Matt Moore, vice president of government relations and public policy for Children's Health. "Looking at our own data, we realized that asthma was among the top five reasons that kiddos came to our [emergency department]."

Moore says the data convinced Children's Health that it needed to "do more in the clinical pathways and treatments provided to the kids who have asthma in our region, and more reaching out to other community partners to address kids' health and wellness before they become sick."

To that end, in 2012 Children's Health organized the Health and Wellness Alliance for Children. The alliance comprises a broad coalition of stakeholders, including local health systems, health insurers, school districts, the Environmental Protection Agency, local health departments, faith-based organizations, and organizations such as the YMCA, United Way and the American Heart Association.

As its first area of focus, the alliance established the Childhood Asthma Program. The program was designed with a "collective



My Asthma Pal is a smartphone app that enables children and their parents to customize an asthma action plan, and a Bluetooth device fits on an inhaler to monitor use.

impact" approach, which calls for organizations to align around difficult social problems.

Through its various work groups, the alliance addresses asthma wellness issues, such as clinical care access and delivery. One work group evaluated ways to decrease asthma triggers in the air and in the built environment. Another focused on education to better equip children, families and other caregivers in asthma self-management.

Children's Health effectively used technology as part of its program, establishing a school-based telemedicine program that links its physicians with 100 school nurses throughout North Texas. "In that way we're able to treat symptoms of asthma before they become emergency conditions," Moore says. It also distributed My Asthma Pal, a smartphone app that enables children and their parents to customize an asthma action plan. In addition, participants are encouraged to use a Bluetooth device that fits on top of an asthma inhaler to track whether, when and how kids are using their inhalers.

"If they're overusing it, the physician can call the family and make sure everything is OK," Moore says. "If they're not using it enough, the physician can call the family and make sure everything is OK. It's about managing the population health for the kiddos who are coming through our system, as opposed to sitting back and waiting for them to get sick and show up in the [ED]."

Recognizing that changes to Dallas city housing codes were essential to changing the physical environments of children with asthma, the alliance successfully advocated to upgrade city housing standards to decrease common triggers such as mold, cockroaches and extreme temperatures.

The clinical, community and technological initiatives together nearly cut in half the number of unique patients visiting the Children's Health ED with a primary diagnosis of asthma between 2012 and 2016.

"That's a testament to what a population-based community strategy can do," Moore says. "If you want to improve population health in a community, a health care provider simply can't do it alone. You have to partner with community organizations. You have to reach kids where they live and where they learn and where they play." — JULIUS A. KARASH

WINNER | Memorial Healthcare System | Hollywood, Fla.

Health System Takes Holistic Approach to Helping Youth

How many 18-year-olds are capable of living on their own? Not many. And yet that was the expectation in Florida, which in 2001 determined that 18-year-olds in foster care could be considered adults, able to leave the only stable homes they'd ever known and live on their own.

To help these young people have productive and rewarding young adulthoods, Memorial Healthcare System launched the Healthy Youth Transitions program in 2010. With a combination of evidence-based prevention and early intervention, the program serves at-risk youth ages 15-22 who are aging out of foster care.

Part of Memorial Healthcare's Community Youth Services initiative, Healthy Youth Transitions is funded by a grant from the health system and the Children's Services Council of Broward County.

"Memorial Healthcare System worked with these kids before," says Aurelio Fernandez III, president and CEO of the Hollywood, Fla.-based health system. "But we just worked on the medical piece. That's a hospital's role. We took it upon ourselves to say, 'What more can we do?'"

Each year, 175 young people go through the program, which pro-

HYT teens are educated in infant stimulation, mother-baby bonding and are always reading aloud to their infants and newborns.

vides each young person with a life coach, typically a bachelor's degree-level social worker who guides participants through various aspects of responsible adult living, including:

- Planning and making nutritious meals, shopping for groceries, reading food labels and keeping house.
- Applying for a driver's license and buying a car.
- Obtaining personal documents, such as birth certificates and Social Security cards.
- Finding a medical home for preventive care and learning the ins and outs of health care coverage.
- Linking up with resources that provide guidance in social relationships, such as making good decisions about sexuality.
- Transitioning from old environments and neighborhoods to new and better ones.
- Obtaining more education.
- Learning to manage money.
- Writing a resume and applying for a job.

"Nobody ever taught these youth those sorts of things," says Tim Curtin, Memorial Healthcare's administrative director of community services. "They really didn't have parents growing up. They were bouncing from group home to group home, and when they ran away from a group home they would couch surf at a friend's house. Nearly half the girls have been impregnated. We're trying to break that cycle, so they can be acceptable, responsible, productive young adults."

In addition to its grant, Memorial Healthcare provides other resources. "We have four SUVs. Our staff picks the kids up, takes them to the doctor, takes their babies for immunizations — whatever is needed for the youth to continue to aspire and thrive," says Curtin.

Since its inception, Healthy Youth Transitions has served 831 youths and young adults. The Children's Services Council's 2015-16 Performance Measurement Summary Report enumerated the following outcomes:

- 96 percent of participating youth had no new pregnancies.
- 98 percent had no new law violations.
- 98 percent demonstrated proficiency in employability and job-retention skills.
- 86 percent made progress in school or postsecondary education, graduated or obtained a GED certificate, or found employment.
- 89 percent obtained stable housing.

To replicate Healthy Youth Transitions in other cities, Memorial Healthcare recommends that a founding organization be well established in the community and that the program have reliable, continuous financial support.

"Whoever adopts this program has to have a mission statement that gives back to the community," Fernandez says. "The youth that are going to be the future of this community — if they start off on the wrong side of the fence, how can they get back? They can't. Why don't we help them get straightened out from the beginning?" — JULIUS A. KARASH

WINNER | Norwegian American Hospital | Chicago

Bringing Care to Children Facing Health Disparities

Norwegian American Hospital serves some of Chicago's neediest ZIP codes. The average per capita income in its core service neighborhood is $13,391, while the unemployment rate stands at 12 percent.

Those numbers translate into health problems, such as childhood asthma, elevated blood lead levels and high rates of childhood obesity and teen pregnancy. Because they lack regular medical care, many children in the community can't meet the vaccine requirements for public school registration.

"We are a community hospital in a disadvantaged community, where many of our residents are minorities as well as immigrants," says Jose R. Sanchez, Norwegian American president and CEO. "One of our critical concerns is to keep children healthy in our community."

In an effort to meet that concern, Norwegian American launched its Care-A-Van program in 2008,

featuring a fully equipped mobile medical clinic in a van that provides preventive medical care to low-income children at school in Chicago's disadvantaged West Side communities.

Care-A-Van provides such preventive care as physicals, immunizations and screenings for lead, hemoglobin, hearing and vision.

"We have a team of professionals, clinicians from the hospital, that are fully dedicated to the success of this program," Sanchez says. "We have nurses, community workers, drivers."

The program is structured to work in partnership with the Chicago Public Schools system. Schools must obtain signed parental consent forms before scheduling a van visit, where 25 or more children may be seen in a single day. If the van completes a school visit ahead of schedule, it can return to a school that has additional need and see the remaining, otherwise unserved students.

Care-A-Van services include sports physicals for high school athletic teams, youth sports leagues and Special Olympics programs.

Outside of school hours, the van serves day care centers, community organizations and health fairs to reach younger children and others not able to access services through schools.

About two years ago, the program added a van for dental care.

Demand for the Care-A-Van program is high. The van is booked months in advance and has a waiting list in case of a cancellation.

The program relies on philanthropy, primarily from the Children's Care Foundation, but Norwegian American has been diversifying Care-A-Van's funding in recent years. Awards and grant support have come from Northern Trust Co. Charitable Trust, the Col. Stanley McNeil Foundation and the Illinois Association of Free and Charitable Clinics.

In addition to partnering with Chicago Public Schools, Norwegian American collaborates in the Care-A-Van program with public health agencies, Korean American Community Services, the Night Ministry, Casa Central and New Life Covenant Church.

Care-A-Van has been effective at increasing access to care. It serves more than 3,000 children a year at 80 schools. Between fiscal 2013 and fiscal 2015, the program doubled the number of patients seen and tripled the number of services provided while maintaining the same operating budget in 2016.

Norwegian American says hospitals wishing to replicate its mobile pediatric services should use a clinical/manager staffing model within a defined geographic area integrate the program with hospital infrastructure; and proactively coordinate referrals, all of which helps families to establish a medical home for ongoing care.

Sanchez recommends that hospitals serving inner-city communities create similar programs. "It's a comprehensive approach to deliver care to children in the inner city who otherwise would not have access to immunizations or dental care." — JULIUS A. KARASH

Norwegian's Care-A-Van serves more than 3,000 children a year.

WINNER | **Palmetto Health** | Columbia, S.C.

South Carolina Health System Drives Dental Care Expansion

A lack of dental insurance means a lack of oral health care (and an abundance of pain) for many people. Left untreated, dental issues can hurt job performance and exacerbate related medical problems, among other negative impacts.

When adult dental care was cut from South Carolina's Medicaid program in 2009, Palmetto Health in Columbia, S.C., saw a rise in dental-related emergency department visits. But EDs are equipped to treat the pain, not the underlying the problem.

"When you have dental pain, you've got to get to the root of the problem — literally," says Charles D. Beaman Jr., Palmetto Health CEO. "Out of that came the idea of forming a more comprehensive approach to meet the needs of patients who had dental pain."

In 2012, Palmetto Health and its partners in the Midlands Dental Initiative decided to provide exams, extractions, fillings and surgeries for the uninsured in need. The program redirected patients from the ED to privately contracted dental practices at no cost to the patient. Rather, Palmetto Health reimbursed providers at the Medicaid rate.

The number of patients referred by the program rose from 743 in 2012 to 1,281 in 2014, but the number of ED dental visits declined only slightly. In 2013, Palmetto Health's annual community needs assessment found that there remained a lack of dental care for families and high-risk populations.

WellPartners is a dental and vision clinic that provides emergency and preventive dental care to uninsured area residents.

Palmetto and its community partners decided to build on and augment the success of the Midlands Dental Initiative. To that end, in 2016 they created WellPartners, a dental and vision clinic that provides emergency and preventive dental care to uninsured area residents.

"The Midlands Dental Initiative morphed into WellPartners," says Vince Ford, Palmetto Health's chief community health services officer. "We now have a permanent home for dental care five days a week."

The clinic operates in newly renovated space in the Richland County Health Department. A full-time dentist runs the dental segment of the clinic, and other dentists rotate through the facility. A part-time optometrist and volunteers operate the vision-related portion of the clinic, which is on a bus line and within walking distance of other facilities that serve as patient medical homes.

"We found dentists who were willing to see these patients for a Medicaid rate," Beaman says. "If you're a dentist and you have two slots a week available, or three a month, you could be happy to do this as a community service and get some reimbursement for it."

Funding for WellPartners came from several organizations, including BlueCross BlueShield of South Carolina and Richland County, which provided an in-kind donation for space and infrastructure. Palmetto Health provided $220,000 for services and $100,000 for infrastructure in 2016.

Other partners in the program include Lexington Medical Center, United Way of the Midlands, Richland County and the South Carolina Department of Health and Environmental Control.

As of October 2016, WellPartners reported that nearly $1.3 million worth of treatment had been performed at the clinic, which translates to more than 3,300 service hours from providers. Palmetto Health provided nearly 100 referrals from its ED. "If you have dental pain and don't have insurance or resources, Columbia, S.C., is a pretty good place to be," Beaman says.

Similar programs can be established in other communities, Beaman says, "if you've got partners who are willing to invest and you can do it collectively. If everybody does their fair share, you'd be amazed at what can be done." — JULIUS A. KARASH

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