

2022

AHA Dick Davidson

NOVA Award

Collaboration for Healthier Communities



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Each year, the American Hospital Association honors as many as five programs led by AHA-member hospitals as “bright stars of the health care field.” Winners are recognized for their work to improve community health status in collaboration with other community stakeholders.

In 2018, the AHA NOVA Award was renamed in memory of Dick Davidson, who led the Association as president and CEO from 1991 to 2007. Davidson championed the role of hospitals in improving the health of their communities and drove the creation of this award in 1994.

The AHA Dick Davidson 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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Pivoting around COVID-19 to care for children with special needs

The COVID-19 pandemic presented major challenges to the Children's Diagnostic & Treatment Center (CDTC), a 39-year-old subsidiary of Broward Health.

Working around COVID-19 was imperative for CDTC to keep serving children and youth with special health care needs. To keep its mission on track, CDTC established the Continuous Care Program.

"We had to pivot very, very fast," said Ana Calderon Randazzo, PhD, CDTC executive director. "I call COVID a silver lining, because it elevated our programs to a whole new level."

Those programs are:

- Early Steps, a provider of early interventions and family support to infants and toddlers with developmental delays and chronic conditions.
- A pediatric primary medical and dental clinic that provides high-quality, family-centered medical and dental care to children with special needs, in a way that respects a family's cultural and linguistic diversity.
- Research to develop improved treatment programs for individuals living with HIV/AIDS.
- The Comprehensive Family AIDS Program, which provides a full array of care for women, infants, children and youth living with HIV/AIDS, and for their families.

The motivation to keep these programs going drove Broward Health forward.

"As a safety net hospital, Broward Health's goal is to provide high-quality care to all those we serve, regardless of an individual's ability to pay," said Shane Strum, Broward Health presi-

dent and CEO. "The Continuous Care Program is a significant driver for the overall mission of our health care system."

One of the ways the Continuous Care Program adapted to COVID-19 was by utilizing telehealth in as many areas as possible.

"Telehealth was something we always wanted to do, but the funding wasn't there," Calderon Randazzo said. "And then, lo and behold, our federal funding agency gave us the ability to implement telehealth. Within a month, we were offering developmental evaluations to children from birth to age 3."

Calderon Randazzo said the mother of a child with autism expressed gratitude for being able to have a telehealth visit with a CDTC provider while she was with her child during dinner. "The mother said sometimes she described behaviors to the provider that the child did not exhibit during an in-person visit. But during this telehealth visit, the child had a meltdown that the provider could see remotely. That was a game changer."

CDTC continued to offer limited in-person appointments when warranted, with COVID-19 safety precautions.

In fiscal year 2020-2021, CDTC made 1,596 Early Steps telehealth visits, 840 Early Steps in-person visits, and 975 primary care telehealth visits. Through the Continuous Care Program, 87% of CDTC's most medically complex children continued to receive services identified on their family service plans.

According to the Centers for Medicare & Medicaid Services, the pandemic caused child screening services to drop by 44% nationally. At



Photo courtesy of Broward Health

BASKET BRIGADE DRIVE THRU: Volunteers stuffed and distributed more than 1,300 bags containing everything needed for a full Thanksgiving meal for families in need in the Fort Lauderdale area.

the same time, CDTC's rate declined by only 4%.

CDTC serves more than 10,000 patients with special health care needs annually, 70% of whom are economically and socially disadvantaged.

The additional financial strain of the pandemic put many CDTC families in crisis. Through the Continuous Care Program, CDTC addressed financial inequities by:

- Providing emergency client-assistance grants.
- Providing families access to an on-site food pantry.
- Donating Thanksgiving meals to 1,300 families in need.

- Providing clients with gift cards for groceries, fresh produce, nonperishable foods, back-to-school supplies and hurricane supplies as well as providing baby showers for expectant mothers.

In light of its success, CDTC plans to continue the Continuous Care Program post-COVID-19.

The program is replicable, Calderon Randazzo said. "Make it a one-stop shop and collaborate with other organizations. If you look at everything as a potential to grow and deliver services in a better and more efficient manner, then it's like a blessing." ●

This Doorway leads to help for those with substance-use disorder

New Hampshire posted the third-highest rate of opioid overdose deaths in the nation in 2018. The drug death rate in Cheshire County ranked second among the state's 10 counties, according to the New Hampshire Drug Monitoring Initiative. It was a crisis for families in many rural towns in the area and very difficult to find access to treatment even when a person was motivated to seek help.

As the county's only hospital, Cheshire Medical Center saw 214 patients in its emergency department (ED) with a primary diagnosis of substance-use disorder (SUD) that year. To improve those numbers and save lives, the hospital started The Doorway at Cheshire Medical Center in 2019.

Its goals are to:

- Be the place in southwestern New Hampshire that is always available to those seeking help or information involving SUD, for oneself or a loved one.
- Provide screening and evaluation, treatment and peer-recovery support services.
- Offer prevention resources and supportive services to assist in long-term recovery.
- Advocate for treatment and services for people with SUD, and be an instrument of change in the treatment of SUD and mental health services in general.

When it was launched, The Doorway "immediately started partnering with our emergency department," said Shawn LaFrance, Cheshire Medical Center's vice president of population health. "That's where many people in crisis show up. Our team connects with the

ED, numerous community agencies, and welcomes anyone who is seeking treatment for help with an alcohol or drug addiction."

The Doorway staff go to the ED or hospital inpatient units to meet with patients interested in SUD treatment. The Doorway can initiate patients' registrations and schedule their American Society of Addiction Medicine (ASAM) assessments before discharge, and staff will provide rides from the ED to The Doorway office.

The Doorway staff also will provide information and support to someone who isn't ready to seek admission into treatment, or someone discharged early from treatment for not upholding treatment program requirements. Staffers will meet with family or friends of a person with an SUD who seek information on how to help their loved one enter or re-enter a treatment program.

A new patient who is homeless will be connected with a nearby shelter.

The Doorway provides a 24-hour hotline that allows callers to reach a clinician who can perform assessments over the phone.

The program serves anyone 16 years or older with an SUD, including those involving alcohol, regardless of a person's income, insurance status, place of residence or citizenship.

"Our patient volume has increased steadily throughout the pandemic as people find maladaptive ways to cope with stress," said Nelson Hayden, director of The Doorway. "People isolate, and it fuels their substance use because they are not having interaction with others."

A mix of contracts, grants and insur-



Photo courtesy of The Doorway at Cheshire Medical Center

THE DOOR IS ALWAYS OPEN: Staffers will meet with family or friends of a person with an SUD who seek information on how to help their loved one enter or re-enter a treatment program.

ance reimbursement financially supports the program. There is funding from federal, state and county resources; private resources; and Medicaid and commercial insurance reimbursement. Attracting patients who have commercial insurance is an important part of the program's sustainability strategy.

The Doorway has made a significant impact. In 2018, the year before it opened, Cheshire County's drug death rate was 4.14 per 10,000 persons. Two years later, the rate had dropped to 1.80 drug deaths per 10,000

persons, the second-lowest rate of any New Hampshire county, according to the initiative's 2020 drug death data.

Partners in The Doorway program include Cheshire County government. "We couldn't be more excited about the partnerships we have with The Doorway," said Christopher Coates, the county administrator. "We have helped them with grants. They operate therapeutic counseling services for our drug court. People are being served at a time when they really need support and consistency." ●

Addressing the social determinants of children's health

The vast majority of children's health outcomes depend on factors like the availability of nutritious food, adequate housing and social support services.

But obtaining these crucial resources can be particularly challenging for lower-income families, immigrant and refugee families, and communities that have been disenfranchised or excluded from the services they need.

In response, Children's Minnesota launched the Community Connect program in 2017, which identifies unmet health-related social needs, provides responsive community resources and engages in ongoing case-management services to help kids thrive.

"Only 20% of a child's overall health and well-being comes from the health care they're getting," said Jessica Block, manager of Children's Minnesota community health programs. "We know that 80% of their health is based on other factors that are impacting their lives, the social determinants of health."

The two hospital campuses of Children's Minnesota, in Minneapolis and St. Paul, serve the most diverse communities in the state. Families that come in for a well-child visit at the hospitals' primary care clinics are asked to complete a form regarding their access to health-related social needs like nutritious food, transportation services, legal assistance, housing support, early childhood education programs and employment search assistance.

Clinicians review the forms. Answers that indicate unmet needs trigger real-time referrals to a team of Community Connect resource navigators who work with the family to deter-

mine which resources may be the most helpful. Resource navigators tap into the program's network of community partners, mitigating barriers and enabling warm handoffs.

"The program has a particular focus on families of color and Native American families who experience greater disparities," said Marayan Ibrahim, a Community Connect resource navigator. "Resource navigators are from the same backgrounds as our families. We speak a second language or come from the same neighborhoods as these families. We can advocate for them because we've gone through similar things or are going through them currently."

A robust evaluation of Community Connect data has demonstrated that addressing social determinants makes a significant difference in children's health.

Since the program started in 2017:

- Nearly 45,000 patients have been screened for health-related social needs.
- More than 8,500 families have enrolled in Community Connect, receiving essential support across a range of resource issues.
- 72% of program participants report that they have been successful and/or feel equipped to meet their needs.

Children who have participated in the program are less likely to require services in the emergency department, Block said. "They're more likely to show up for their primary care visits. We also saw better-controlled asthma."

Two years after integration of Community Connect into clinic operations, 71% of clinicians report greater satisfaction with their work. "There is nothing more disheartening for a pediatrician



COMMUNITY CONNECT: The program identifies unmet health-related social needs, provides resources and engages in ongoing case-management services to help kids thrive.

than when they can't help solve a problem for a family," said Gigi Chawla, M.D., vice president and chief of general pediatrics at Children's Minnesota. "This program has improved their experience of taking care of kids who are so fragile."

Community Connect works alongside another Children's Minnesota initiative, the Healthcare Legal Partnership. This program houses on-site, dedicated legal-aid attorneys who partner with health care teams to identify, prevent and remedy health-harming factors that are rooted in legal issues.

Individual, corporate and community

donors fund Community Connect. While they expect donor support to continue, Children's Minnesota leaders are engaged in conversations with key stakeholders, including payers, exploring shared-risk and value-based payment models to ensure sustainability.

The keys to replicating a program like Community Connect include strong leadership support and securing funding and resources, Block said.

"Providing these services and addressing folks' needs in their homes and in their day-to-day lives beyond our clinic walls makes a difference," she said. ●

Competing health systems collaborate to fight diabetes

The Salinas Valley in Monterey County, California, one of the most important agricultural areas in the United States, is a major source for healthful foods such as lettuce, broccoli, celery and spinach.

However, many of the predominantly Hispanic individuals who labor in the vegetable fields here suffer from food insecurity and a lack of fresh produce. Poor diets result in high levels of prediabetes and diabetes, which can lead to kidney disease, heart disease, strokes and amputations.

For individuals and health systems, the cost of diabetes imposes an economic burden involving inpatient care, prescription medications, diabetes supplies and physician office visits.

“When I came on board about nine years ago, I noticed that 30% to 40% of all my inpatients had some level of diabetes,” said Pete Delgado, president and CEO of Salinas Valley Memorial Healthcare System. “We were putting these folks back together and letting them go back home, and they’d wind up back in the emergency department (ED) two to four months later.”

Montage Health saw the same disturbing trend. Even though they compete against each other, the two health systems decided to join forces in the battle against diabetes.

“We compete on treating the complications of diabetes, things like cardiac surgery,” said Steven Packer, M.D., president and CEO of Montage Health. “This was an opportunity for us to see what we could do together to prevent diabetes.”

In 2018, Salinas Valley Memorial and Mon-

tage Health forged the Diabetes Collaborative of Monterey County. The goal is to transform the health of the community by reducing the level of type 2 diabetes. To make that happen, the initiative administers evidence-based and culturally engaging health initiatives, such as:

- **Blue Zones Project Monterey County.** The Blue Zones Project is part of a national initiative that supports health and well-being. Efforts include teaming up with restaurants, schools and businesses.
- **The Healthy Youth Task Force.** About one-third of American youth are overweight, a condition that is associated with the onset of type 2 diabetes. To change that trend in the community, the Healthy Youth Task Force works with schools to help youngsters learn the importance of making healthy choices.
- **The Diabetes Awareness Campaign.** This initiative, which characterizes diabetes as “The Beast,” shines a light on the dangers of type 2 diabetes and the unhealthy lifestyle choices that can feed it. Locally tailored, the campaign website includes informative articles, success stories, and programs and resources designed for diabetes prevention and management.
- **Pediatric Wellness Program and Diabetes Prevention Program for adults.** In tandem with the Healthy Youth Task Force initiative and in partnership with local pediatricians, the Pediatric Wellness Program offers free wellness coaching to kids at risk of obesity and their families. The National Diabetes Prevention Program for adults delivers diabetes prevention, management, treatment and education services.



DON'T FEED THE BEAST! This initiative, which characterizes diabetes as “The Beast,” shines a light on the dangers of type 2 diabetes and the unhealthy lifestyle choices that can feed it.

This collaborative effort has made a demonstrable impact. Current outcomes data include a nearly 10% decline in prediabetes diagnoses in the community and a 9.5% increase in awareness of prediabetes and diabetes prevention programs in the community.

For 2021, data show that 2,160 community members completed the online diabetes risk assessment and 1,022 adults and children enrolled in diabetes prevention programs. The adult program has generated an average

weight loss of 5%, and the pediatric program showed that 60% of participants maintained or reduced body mass index.

Delgado recommends that other health care systems collaborate to improve community health. “Most health organizations have some sort of responsibility for the health of their community. I would say that if they put their time, talent and resources together, you can get a much bigger bang for your buck.” ●

Working with schools to prevent student suicides

Suicide is one of the leading causes of death among American school children. For years, many young people who attempted suicide or thought about it were sent to hospital emergency departments (EDs).

“Suicide is a devastating disease in our community,” said Hossain Marandi, M.D., president and chief of pediatrics at Spectrum Health Helen DeVos Children’s Hospital. “We saw a need to address suicide prevention outside of the health care setting.”

Spectrum’s solution was to develop the School Blue Envelope Suicide Prevention Program. Launched in 2019, the program aims to help school-aged children obtain earlier, more effective suicide-prevention services at school, without the stigma surrounding an ED visit. Participating schools use the words “blue envelope” to discreetly activate staff members to initiate suicide prevention steps.

“We wanted to find a solution for children where they spend most of their time, and that is at school,” said Subodh Jain, M.D., Spectrum Health’s chief of psychiatry. “We wanted to develop a program where suicide prevention is taken care of as it originates, right then and there.”

School Blue Envelope, a comprehensive crisis-response program, is currently being disseminated throughout a 16-county West Michigan service area. Spectrum’s goal is to establish the program with 40 school districts.

School personnel are trained to recognize opportunities for preventive conversations and early interventions before a tragedy occurs.

The program is built on “S.A.F.E.” steps, which stands for Stay with the student; Access

help; Feelings: Validate them; and Eliminate lethal risk, specifically for those moments when school personnel learn that a student has thoughts of suicide.

“Staying with the student includes dialing into them emotionally,” said Jody Sprague, LMSW, manager of behavioral health programs for Spectrum Health.

The S.A.F.E. steps goals are:

- Decrease stigma in talking about suicide.
- Boost confidence when school staff respond to students with mental health crises.
- Increase preventive interactions with school-aged youth by early identification and intervention.
- Share best practices and identify gaps and barriers in services for improvement.
- Adopt an all-hands-on-deck approach to preventing suicide, whereby strong collaboration represents the program’s motto, “Suicide prevention is EVERYONE’S responsibility.”

Suicide awareness and early intervention can prevent suicide. With treatment and resources, 70% to 90% of people with suicidal thoughts get better.

“We’re trying to change the thinking in our school systems, health care systems and communities so that it’s OK to step into that conversation with a suicidal person and walk them through S.A.F.E. steps,” Sprague said.

The program provides suicide-prevention training to everyone in a school setting who spends face time with students, from principals and teachers to bus drivers and food service workers. The first level of training teaches personnel how to respond when a student expresses



Photo by Getty Images

SCHOOL BLUE ENVELOPE SUICIDE-PREVENTION PROGRAM: The program aims to help school-aged children obtain earlier, more effective suicide-prevention services at school, not the ED.

thoughts of suicide. The second level of training goes into detail on the effective usage of nationally recognized tools and effective safety plans.

School administrators are responsible for reporting data and communicating issues/concerns to the School Blue Envelope Program leaders. Participating schools attend two clinical review meetings per academic year to review anonymized data and trends, share best practices and identify and remove barriers to safe interventions and access to care.

Spectrum Health has trained 1,600 school personnel in 35 schools across 12 school districts. Those schools reported 252 preventive

conversations and potential lives saved during the 2020-2021 school year.

Such interactions represent “opportunities to have that compassionate conversation before students take a bottle of pills or do something that might end their lives,” Sprague said.

The program is provided to schools at no cost. Funding sources include a grant from the Michigan Health Endowment Fund.

“Every person in every walk of life can be affected by behavioral health issues,” Marandi said. “The ability to replicate this program across many different continuums allows for more people to stay safe.” ●



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