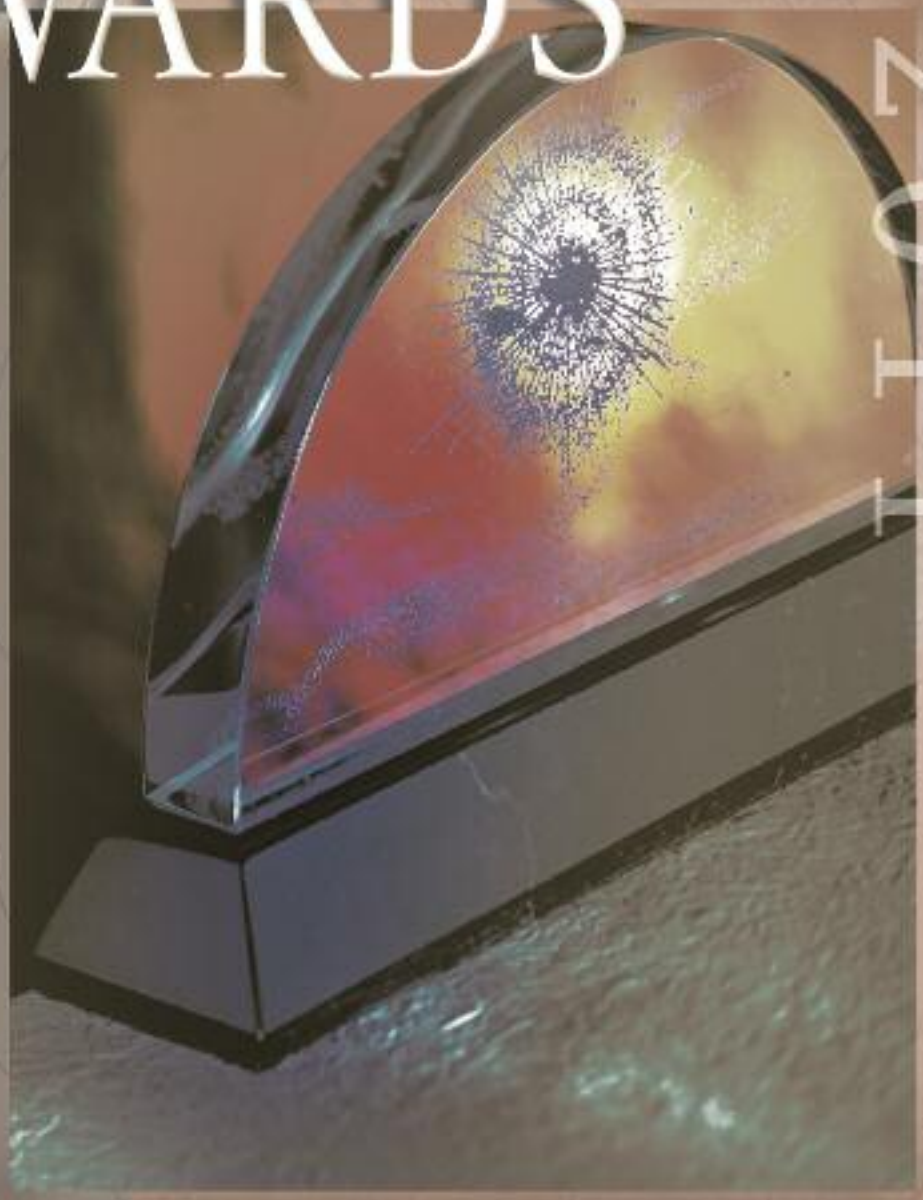
AHA

NOVA AWARDS

2011



American Hospital Association

THE AMERICAN HOSPITAL ASSOCIATION 2011 NOVA AWARD WINNERS

The 2011 AHA NOVA Awards

From helping patients manage Type 2 diabetes to ensuring teen victims of violence keep out of harm's way, the five winners of the 2011 AHA NOVA Awards demonstrate every day how working with partners in the community can improve quality of care and save lives.

The AHA NOVA Awards, sponsored by the American Hospital Association and *Hospitals & Health Networks*, honor effective, collaborative programs focused on improving community health status.

In Milwaukee, five hospitals came together to expand primary care services and increase access to affordable medications. In Olympia, Wash., hospitals reduced inappropriate emergency department visits while improving the health status of those previous "frequent flyers." A wide-ranging collaboration in Fort Wayne, Ind., targets the health needs of low-income and medically underserved residents. A Chicago initiative teaches African-Americans and Hispanics how to manage their diabetes. And in Rochester, N.Y., a program to keep teenagers from becoming repeat victims of gunshot or knife wounds has had impressive results.

Working together is the key to success. As Froedtert Health President and CEO William Petasnick says, "A single health system can't do it alone."

For more information about the AHA NOVA Awards, go to www.aha.org/aha/news-center/awards/NOVA.html.

American Hospital Association

Dealing with Diabetes

WINNER

Managing diabetes is much easier for patients in two Chicago communities, thanks to the Diabetes Collaborative launched by Northwestern Memorial Hospital in 2006.

The program grew out of a critical need for assistance to deal with the health problems associated with diabetes in two of Chicago's underserved and uninsured neighborhoods. One is a largely African-American community, and the other comprises predominantly Hispanic residents. Death rates for people with diabetes are 27 percent higher for African-Americans compared with those of whites; Hispanic residents are almost twice as likely to die from the disease as are non-Hispanic whites.

The collaborative is a partnership among Northwestern Memorial Hospital, two federally qualified health centers, and Northwestern University's Feinberg School of Medicine. It identifies and teaches adult patients with Type 2 diabetes how to manage their disease, focusing on patient education and self-management.

The aim is to be responsive to community health needs, says Daniel Derman, M.D., vice president of operations and president of Northwestern Memorial Physicians Group. "Instead of saying, 'Let us tell you what we can do for you,' we ask, 'What are your specific needs?' and translate them into a sustainable program that fits," he says. In this case, the two neighborhoods requested help with the growing health problems associated with diabetes.

In addition to the Food Oasis program, which provides patients with prescriptions to buy fresh fruits and vegetables and other healthy food items at Walgreens stores, the medical school developed seven culturally sensitive bilingual education videos and print materials to help patients of all educational levels gain a better understanding of diabetes. "The self-management education component is really what sets this apart from other efforts," says Derman.

The collaborative also uses chronic care teams to review patient information and improve care. Northwestern Memorial provided technical assistance to the two community health centers to implement electronic medical record systems. Access to specialists through the academic medical center and the medical school is a major strength of the program.

To gauge its success, the collaborative focuses on eight key outcome measures, including hemoglobin A1C, annual foot and eye exams, and cholesterol screening. From 2006 to 2011, improvements have been realized in all measures. Blood-sugar levels have decreased, a good indication that patients are doing a better job of managing their disease.

"The collaborative has helped make a measurable difference in the community by bringing the minds of a lot of people to bear on the problems associated with diabetes," says Northwestern Memorial HealthCare's President and CEO Dean M. Harrison. "It also represents what Northwestern hopes will be the start of additional initiatives to deal with other chronic diseases in our communities."●

Photo courtesy of Northwestern Memorial Hospital

REACHING OUT: David W Baker, M.D., an internist on the medical staff of Northwestern Memorial Hospital and chief of the division of general internal medicine at Northwestern University's Feinberg School of Medicine, and his team developed a replicable patient education program for the collaborative that recognizes educational and cultural differences.

THE GOAL | Create a comprehensive, sustainable, evidence-based model of care, which can be replicated by other hospitals and community-based health centers to combat diabetes and other chronic diseases.

THE PLAYERS | Near North Health Service Corp., Erie Family Health Centers, Northwestern University's Feinberg School of Medicine's Department of Medicine, Northwestern Medical Faculty Foundation and Northwestern Memorial Foundation.

THE PLAN | Identify and teach adult patients with Type 2 diabetes how to manage their chronic disease better through patient education and self-management skills training. Evidence-based, clinical practice guidelines and provider education are provided, as well as clinical information systems like electronic reminders to help providers comply with practice guidelines.

THE RESULTS | Over a five-year period, eight key measures at each health center show a positive impact on the health of diabetic patients at all levels. Videos and print materials have improved patients' understanding of proper diabetes diagnosis and treatment.

WINNER

EMERGENCY DEPARTMENT CONSISTENT CARE PROGRAM | PROVIDENCE ST. PETER HOSPITAL/ CHOICE REGIONAL HEALTH NETWORK, OLYMPIA, WASH.

A Care Plan to Reduce ED Use

Steven Herppich

IN TANDEM: Doug Burt, left, health resource coordinator in the CHOICE Regional Health Network, and Joseph Pellicer, M.D., medical director of Providence St. Peter Hospital emergency center, meet with a patient in the Consistent Care program.

THE GOAL | To guide treatment decisions for patients with complex health needs. The majority of the patients have severe mental health or drug-addiction issues. The aim is to reduce the inappropriate use of the emergency center, improve the health status of those in the program, and improve the capacity and integration of the safety net.

THE PLAYERS | Community health clinics and collaboratives, emergency departments, private physicians, providers of mental health and chemical-dependency services, and insurance payers, including state Medicaid.

THE PLAN | To set up a widespread community collaboration that allows medical and nonmedical providers to come together and operate services in a coordinated way for vulnerable and chronically ill patients. Community organizations work together to guide treatment decisions, share plans of care and help patients reshape their lives.

THE RESULTS | Visits to the ED have fallen by more than 50 percent, with an average annual savings of $9,000 per patient, and an estimated $5.6 million in cumulative combined charges saved at Providence St. Peter. The program has increased its capacity and now can serve approximately 150 new clients a year.

Providence St. Peter Hospital was seeing a common occurrence in its emergency department. Patients with chronic conditions and an addiction to pain medication showed up frequently for treatment. Abuse of other types of drugs also was climbing in the area, which equals or exceeds all regions in the state with regard to drug and substance abuse.

Providence St. Peter launched Consistent Care in 2003 to respond to the crisis. The hospital works in collaboration with CHOICE Regional Health Network, a nonprofit coalition of rural and urban hospitals, practitioners, public health clinics, community health centers and others in a five-county service area.

Seven years later the results are impressive. Visits to the ED by patients enrolled in the program have fallen by more than 50 percent, with an average annual savings of $9,000 per patient. Consistent Care also has improved the health status of participating patients, and increased the capacity and integration of safety-net services in the community. The program has helped patients become more emotionally stable and resilient, reconnect with family and friends, and improve life-sustaining skills.

Consistent Care serves as an excellent example of a community collaboration, bringing medical and nonmedical providers together to offer coordinated services for some of the area's most vulnerable and chronically ill patients. "One of the most significant results is that the program provides the most vulnerable with hope and helps them help themselves" says Medrice Coluccio, CEO of Providence St. Peter.

Consistent Care also shifted the way treatment is delivered in the ED. "Patients no longer come to the ED and get a script for pain medication. Instead, the program provides them with a care plan that may include a referral to a chemical-dependency or other appropriate community health care program," says Kara Elliott, R.N., the program's administrative coordinator.

Consistent Care has served 633 people and approximately 50 percent were drug-seeking. Most did not have regular contact with a primary care provider. About a third had mental health problems, more than a fifth had migraine, dental or back pain, and about 30 percent had other chronic or acute conditions. The program has expanded to include four other hospitals in the region.

Now funded by participating hospitals, initial start-up funds were provided by Providence St. Peter Foundation. Ken Anderson, the foundation's board president, says, "We are proud that charitable gifts made a difference in changing health care." ●

Integrating Resources for Better Care

WINNER

Alfred McGinnis, a 48-year-old asthma patient in Fort Wayne, Ind., says the help he received from the Integrated Community Nursing Program at Parkview Health saved his life. He has suffered from asthma since age 12.

Before enrolling in the program, McGinnis was a frequent patient at Parkview's emergency department. He had daily symptoms and woke several times each night with breathing difficulties. He was using his reliever medicine four to 10 times a day and was unable to pay for any type of controller medication.

Once in the program, McGinnis qualified for medication assistance and now receives his medication by mail. Thanks to the program's one-on-one educational effort, he also made changes in his living environment to reduce asthma triggers. McGinnis has not visited the ED for asthma-related problems in a year.

This case is just one of many success stories. The program's collaboration with a variety of community agencies provides low-income and medically underserved patients with a wide array of resources to meet their health needs.

Of the 14 nurses employed by the program, five are located in 10 school buildings so they can provide clinic services, screenings and opportunities for classroom education on hygiene, diabetes, asthma and smoking. It is also a communitywide program."The nurses touch so many parts of our community that they help the adults as much as the children," says Sue Ehinger, Parkview's chief operating officer.

In addition to asthma, the program provides other health care assistance. For example, there is a diabetes education and management program, an in-school FluMist program for the area's most impoverished schools, a vision-screening program in 49 schools and a safe-slumber program designed to avoid infant suffocation.

The FluMist and safe-slumber programs have demonstrated the most significant results, says Connie Kerrigan, manager of community nursing. A total of 30,000 FluMist doses resulted in improved health and increased school attendance. Families who attended the safe-slumber program have not experienced any infant deaths due to suffocation.

Once enrolled in the program, patients receive follow-up and follow-through to make sure connections are made and necessary health care education and services are provided. One of the program's most important aspects is the ability of the community nurses to locate the necessary resources to help the medically underserved. "The community nurses tie the pieces together. Integrating services is key to the program's success," says Ehinger. ●

Paul VanCamp, Parkview Media Services

ONE-ON-ONE CARE: Patient Alfred McGinnis learns how to manage his asthma from Jan Moore, left, and Deborah Lulling, nurses in the Integrated Community Nursing Program at Parkview Health.

THE GOAL | Provide comprehensive and accessible health care options to the most disadvantaged in the community by bringing together schools, nonprofit social-service agencies, foundations, government agencies and programs to identify health issues and needs specific to the community and provide an integrated web of services to meet those needs.

THE PLAYERS | Among others, the Fort Wayne–Allen County Board of Health, the Allen County Child Death Review Team, Stop Child Abuse and Neglect, area school districts, the YMCA, the federal Head Start program and community health clinics, and social service organizations.

THE PLAN | By collaborating with a variety of community agencies, the program provides health resources to meet identified community health needs, especially for the underserved and low-income populations. Services include health screening, immunizations, referrals, home visits, follow-up and connection to a medical home.

THE RESULTS | There were 38 fewer ED asthma-related visits and nine fewer hospitalizations for a total savings of $605,980 at the end of the program's first year. Some 7,852 children in 49 area schools are screened each year in the vision program, resulting in 1,261 children identified as having some type of visual concern and referred to an eye doctor for treatment.

WINNER

MILWAUKEE HEALTH CARE PARTNERSHIP | AURORA HEALTH CARE, CHILDREN'S HOSPITAL & HEALTH SYSTEM INC., COLUMBIA ST. MARY'S, FROEDTERT HEALTH, ALL OF MILWAUKEE; WHEATON FRANCISCAN HEALTHCARE, GLENDALE, WIS.

United to Improve Access and Care

Jake Utech, Ricco Photography

PRIMARY ACCESS: Paul Corgan, M.D., and Christine Hutchinson, case manager, consult with a patient as part of the Milwaukee Health Care Partnership.

THE GOAL | Expand adequate and affordable insurance coverage for low-income individuals; improve access to primary, specialty, dental and behavioral health services; provide affordable medications; enhance care coordination between emergency departments and primary care medical homes; improve outcomes while reducing the cost of care.

THE PLAYERS | The five Milwaukee-based health systems plus Health Care for the Homeless of Milwaukee, Milwaukee Health Services Inc., Sixteenth Street Community Health Center, Westside Healthcare Association, Medical College of Wisconsin, City of Milwaukee Health Department, Milwaukee County Department of Health & Human Services and Wisconsin Department of Health Services.

THE PLAN | Implement a communitywide plan and policy agenda; serve as a clearinghouse for existing and new initiatives; facilitate communication among stakeholders; secure public and private funding for high-leverage initiatives; measure progress and overall community performance; support efforts to improve effectiveness; and reduce cost and duplication.

THE RESULTS | Government-funded insurance coverage for low-income individuals has been expanded. The four FQHCs recruited 20 new providers and saw a 13 percent increase in utilization by patients who are uninsured or enrolled in a Medicaid program. Referrals from the 10 hospital EDs to the medical home have grown from 78 in the first month to nearly 550 per month.

In 2006, the five Milwaukee health systems put competition aside and decided to work together to expand coverage, access and care coordination for the county's most vulnerable populations. Increasing numbers of uninsured and Medicaid patients fueled gaps in access to primary care. Inappropriate and overuse of the emergency department also was becoming a problem. Nearly half of the avoidable ED visits in the county were made by Medicaid or uninsured patients for conditions that could have been dealt with in a primary care setting.

The collaboration resulted in the creation of the Milwaukee Health Care Partnership, a public-private consortium. It set out to expand primary care services through community health centers, increase access to affordable medications, and provide a coordinated specialty access network for the uninsured. Milwaukee's four federally qualified health centers, the Medical College of Wisconsin, and state and local government health agencies also are members.

With only one paid staff member, a key success has been the significant contributions of its members' in-kind services and expertise. In four years, the partnership also has secured more than $8 million in new public and private funding for an aligned communitywide health improvement plan.

On the patient level, Westside Healthcare Association Inc., an FQHC and one of the partnership members, reports significant progress to date. The center has increased its capacity by expanding operating hours and hiring more providers. Westside provides primary care services to Milwaukee's most underserved.

One of the best examples of the partnership's work is the ED Care Coordination Program, says Westside's CEO Jenni Sevenich. Patients who arrive at the ED without primary care homes are linked with an FQHC. Hospital staff schedule patient appointments right in the ED, and subsidize additional case-management resources at the health center medical home. Referrals from the ED to the medical home have grown dramatically and "show" rates for appointments have increased from 25 to 44 percent.

The partnership demonstrates that working together is essential, says William D. Petasnick, president and CEO of Froedtert Health. Members understand that all stakeholders must be at the table if the complexities of these issues are to be addressed successfully. "A single health system can't do it alone," says Petasnick. ●

WINNER

Empowering Youths to Avoid Violence

All too often teenagers with gunshot and knife wounds were arriving at the University of Rochester (N.Y.) Medical Center's Kessler Burn & Trauma Center for treatment, only to return weeks or months later with more serious or even fatal injuries. Statistics show that once a child has been shot or stabbed, his or her chances of being injured again or killed as a result of violence greatly increase. A multidisciplinary team from URMC developed the Rochester Youth Violence Partnership to address this serious problem.

RYVP is a hospital-based violence intervention program designed to identify at-risk youths immediately after they have been injured and protect them from further injury. Once in the program, the RYVP provides teenagers and their families with a wide range of targeted services designed to address identified risk factors and prevent additional injuries due to violence.

After a victim is stabilized and injuries treated, a standardized, social-work assessment is performed to identify risk factors that might have led to the injury. This allows interventions to be targeted toward identified needs and risk factors. All patients view a video designed for victims and their families while they are still hospitalized. The video, titled "Voices of Violence: Your Chance to Change," encourages the victim and family to become engaged in the process and capitalizes on the "teachable moment" the current hospitalization provides. The assessment allows the team to develop a safe discharge plan for each teenager linked to follow-up services.

"Each case involves different circumstances and each patient is different," says Mark Gestring, M.D., medical director of the trauma center and one of the originators of the RYVP. "The goal of this program is to help patients and their families understand [that] the majority of these injuries are not random and actions can be taken to avoid further injury," he says.

The program's impact has been nothing short of astonishing, says James R. McCauley Jr., director of operations for Camp Good Days and Special Times Inc., an RYVP member. In 2007, nine youths previously injured by violence returned as a result of violence. In the three years since then, not one has returned. The "wake-up" intervention video also is making a difference.

"This program required a significant culture change within our institution," Gestring says. "With the resources of our community partners and the support of our institutional leadership, this program plays an important role in the prevention of further injury in a very high-risk population of young people." ●

Photo courtesy of the University of Rochester Medical Center

FOR KIDS' SAKE: Among the leaders of the Rochester Youth Violence Partnership are, from left: Michael Scharf, M.D., assistant professor in psychiatry and pediatrics; Jeffrey Rideout, pediatric social worker; and Mark L. Gestring, M.D., medical director of the Strong Regional Trauma Program and Partnership director.

THE GOAL | Identify at-risk youths following violent injury and intervene actively to prevent further injury due to violence.

THE PLAYERS | The University of Rochester Medical Center enlisted support from hospitals such as Rochester General Hospital, and community agencies such as Pathways to Peace, Rochester Police Department, Project Exile Advisory Board, Rochester City School District, Rochester Institute of Technology, community support groups, Center for Restorative Justice, Center for Public Safety Initiatives, the U.S. Attorney's Office, Monroe County District Attorney's Office and Monroe County Child Protective Services.

THE PLAN | The Rochester Youth Violence Partnership is a hospital-based violence intervention program that was designed to identify at-risk youth immediately after they have been injured and protect them from further injury. At-risk teenagers and their families are provided with access to a wide range of targeted services designed to address identified risk factors and to prevent additional injury due to violence.

THE RESULTS | To date, 219 youths have been enrolled in this program. The percentage of those admitted for the intervention increased steadily over a four-year period and the recidivism rate has steadily decreased over the same period.

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. Additional information on the AHA NOVA Awards, including an application for 2011, is available at www.aha.org.

American Hospital Association

2011 AHA NOVA AWARDS COMMITTEE

Ron J. Anderson, M.D., president and CEO, Parkland Health and Hospital System, Dallas

Eileen Barsi, director, community benefit, Catholic Healthcare West, San Francisco

Richard C. Breon (Chairman), president and chief executive officer, Spectrum Health, Grand Rapids, Mich.

Jeff Dye, president and chief executive officer, New Mexico Hospital Association, Albuquerque

Lorraine C. Pruitt, trustee, Abington (Pa.) Memorial Hospital

Chandler M. Ralph, president/CEO, Adirondack Medical Center, Saranac Lake, N.Y.

Drew Sones, chair, Presbyterian Intercommunity Hospital, Whittier, Calif.

Editorial Director: *Mary Grayson*
Managing Editor: *Bill Santamour*
Senior Editor: *Matthew Weinstock*
Writer: *Joan Szabo*
Proofreader: *Susan Edge-Gumbel*
Senior Designer: *Jennifer Linton*
Production: *Heather Yang*
Cover Photographer: *Blair Jenson*

2011 NOVA Awards is published by Health Forum, an American Hospital Association company. The American Hospital Association sponsors the AHA NOVA Award program, along with *Hospitals & Health Networks.*