EXCELLENCE AND INNOVATION IN CARE
The 2021 Gage Awards
About America’s Essential Hospitals

America’s Essential Hospitals is the leading champion for hospitals and health systems dedicated to high-quality care for all. We support our more than 300 members with advocacy, policy development, research, and education. Communities depend on essential hospitals to provide specialized, lifesaving services; train the health care workforce; advance public health and health equity; and coordinate care. Essential hospitals innovate and adapt to lead the way to more effective and efficient care.

About the Gage Awards

Through the Gage Awards, America’s Essential Hospitals recognizes member hospitals and health systems for successful projects to improve the quality of care and population health. The awards promote the spread of best practices and innovative programs to other organizations and support the association’s research, policy, and advocacy work by sharing member success stories with external audiences. Learn more at essentialhospitals.org/gage-awards.
Gage Awards for population health recognize programs to improve specific health outcomes for a defined population or community by addressing the social and economic factors that influence health.
High levels of parenting stress can cause poor birth outcomes, slow child development, lack of child-parent bond, and child maltreatment. Memorial Healthcare System started Mothers Overcoming Maternal Stress (MOMS) in 2008 to help mothers improve mental health and keep children healthy.

MOMS serves women who exhibit symptoms of depression or anxiety affecting daily functioning for more than two weeks, as well as mothers with additional risk factors, including low-income status, single-parent households, early or unplanned pregnancy, medical complications, and traumatic life events. Customized participant plans include in-home cognitive behavioral therapy, parenting classes, community resources, and case management services.

MOMS offers flexible hours for counseling and case management, transportation to appointments and program activities, and help applying for government assistance programs. Other benefits include:

♦ connections to the local food pantry and housing authority to mitigate food and housing insecurity;
♦ cooking classes;
♦ dollar store and supermarket tours to teach label reading and healthy shopping skills;
♦ warm handoffs to Memorial Primary Care to develop a medical home;
♦ financial assistance;
♦ employment opportunities; and
♦ quarterly family retreats to provide bonding opportunities within and among program families.

Amid the COVID-19 pandemic, MOMS provided participants smartphones with six months of prepaid service to use for telehealth services and delivered masks, diapers, gloves, cleaning supplies, and food to participants’ homes.

MOMS has served 1,532 participants since 2008. Among participants, 97 percent report improved overall family functioning and parenting skills, 96 percent report feeling more connected to the community, 94 percent report fewer depression or anxiety symptoms, 93 percent demonstrate an acceptable level or improvement of attachment and bonding with their child, and 86 percent have children that score within range of developmental milestones.
FOOD INSECURITY PROGRAM IMPROVES NUTRITION, DIABETES MANAGEMENT

Harris County, Texas, has America’s highest number of uninsured residents, and one in five patients at Harris Health System screen positive for food insecurity. The health system partnered with Houston Food Bank (HFB), the University of Texas School of Public Health, and grocery store H-E-B for a Food Rx program based on two family practice clinics.

“Our food ‘farmacies’ are unique in that we go beyond a food insecurity model. Our patients are able to select the healthy foods they want as they walk and learn with a dietitian,” said Chief Integration Officer Karen Tseng. “We also provide them with the skills and confidence to translate those raw ingredients into healthy, cost-effective, culturally appropriate meals through our culinary medicine programming.”

Food Rx served more than 650 patients in its first year. Participants improved their nutritional and community resources.

HARRIS HEALTH SYSTEM

Food Rx: A Cross-Sector Approach to Improving Health and Health Equity

HARRIS HEALTH SYSTEM
Houston

Team Members: Denise LaRue, MPH; Karen Tseng, JD; Esperanza Galvan; Thomas Porter; Craig Johnson

The health system partnered with Houston Food Bank (HFB), the University of Texas School of Public Health, and grocery store H-E-B for a Food Rx program based on two family practice clinics.

“Food Rx served more than 650 patients in its first year. Participants improved their nutritional knowledge scores, increased daily fruit and vegetable consumption, and reported increased confidence in basic cooking techniques. Program graduates decreased HbA1c levels by an average of 0.72 percentage points.”

PATHWAYS TO SUCCESS FOR SENIORS

The geriatric emergency department (GED) at St. Joseph’s Medical Center, in partnership with the Health Coalition of Passaic County, created a program to proactively help vulnerable Paterson, N.J., seniors remain healthy and independent. The Pathways to Success for Seniors program was forged to expand home-based follow-up care for seniors—especially those at risk of falling—and address social determinants of health to improve health outcomes for vulnerable populations in a rapidly growing senior community. The program integrates the evidence-based Pathways Community HUB model with the NowPow community referral platform and provides direct client care coordination through a dedicated community health worker.

“Medicaid patients are often unaware of community resources that can help them. I see seniors in the emergency department who are not talking about their social determinants of health. The Pathways team is proactive and leverages all community resources to address these needs,” said Dr. Jennifer Fleming, St. Joseph’s Medical Center’s director of the Pathways to Success for Seniors program.

The hospital collaborated with community partners to connect the needs of seniors to existing community resources. A community health worker assesses unmet medical, environmental, and social service needs and initiates applicable pathways for each client to address these needs. Each pathway was monitored and tracked to completion. Thirty-one vulnerable seniors have enrolled in the program, resulting in more than 630 referrals to community partners and 150 completed pathways, indicating a specific risk factor was mitigated.

STREETCRED

Boston Medical Center (BMC) launched StreetCred—one of the first hospital-based financial stability programs in the nation—to increase access to federal, state, and community financial resources for families receiving pediatric care. The program provides families eligible to receive the earned income tax credit (EITC) and child tax credit with clinic-based tax preparation, enrollment in college savings accounts, and financial coaching to advance economic equity.

BMC’s pediatric department recognized families’ difficulties in completing taxes, as well as the impact poverty has on children, noting patients were spending hundreds of dollars to get their taxes done by for-profit companies. The EITC and other financial resources are offered to mitigate the effects of financial instability on families; by helping families receive appropriate tax credits and refunds, the program aims to improve the overall health and well-being of family members through poverty reduction. By achieving greater financial stability, families and their children have higher participation in their pediatric care and lower toxic stress.

Focusing on increasing uptake of underused financial resources, BMC scaled this model by building a Medical Tax Collaborative, a network of more than 20 hospitals and health centers across 14 states. Since its inception, StreetCred has returned more than $7.3 million in tax refunds to families across the country.

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CO-CREATED MESSAGING TO PROMOTE VACCINE UPTAKE IN HIGH-RISK ZIP CODES

South Dallas’ mortality rate due to influenza remains more than twice the age-adjusted mortality rate of areas in north Dallas. Parkland Health & Hospital System’s Center for Innovation and Value implemented a community-based approach to promote flu vaccinations among a population challenged by high morbidity and mortality from flu and pneumonia. Local high school students initially were educated about flu infections, vaccination, and the disproportionate mortality rates of their community. Serving as health ambassadors and trusted sources in their community, they were asked to deliver the culturally designed messages and encourage people to attend the flu vaccine drive at the school, the neighboring Catholic church, and surrounding community.

The health ambassador–led event resulted in the largest turnout for a single flu vaccination event by Dallas County Health and Human Services for their zip code in the 2019–2020 influenza season, with 394 individuals vaccinated in four hours. Amid the COVID-19 pandemic, Parkland recognized the increased importance to boost flu vaccinations and expanded the pilot program to other neighboring zip codes with disproportionate rates of influenza mortality. In addition, the center held community-level focus groups for input on how to ensure community participation in the drives while observing COVID-19 precautions.
Quality

Gage Awards for quality recognize activities that improve the quality of care delivered, improve patient experience, engage patients and their families, or reduce or eliminate harmful events affecting individual patients or groups of patients.
A Hennepin Healthcare analysis showed that housing instability was the second-highest contributing factor to 30-day readmissions, affecting 75 percent of patient charts reviewed. The health system partnered with Hennepin Health, a county-based accountable care organization (ACO), to proactively identify and respond to social determinants of health to reduce readmissions in the ACO population experiencing homelessness.

The initiative placed community-based care managers in the inpatient setting to build rapport, promote care continuity, and connect patients experiencing homelessness to social services. Hennepin Healthcare developed a novel analytics tool to identify risk factors indicating housing insecurity—such as patient address corresponding with a shelter, drop-in center, or mail pick-up location—and in January 2019 began screening adult patients in the ACO’s prepaid medical assistance program. A care manager visited these patients while they were hospitalized to invite them to outpatient, community-based care management. Patients were connected to primary care, transportation resources, cash assistance, food benefits, and housing resources.

“We don’t wait for referrals to come in to us with the use of the homelessness indicator. We actually go and visit people who are identified with that, while they’re inpatient. So we have a captive audience and we also have an easy way to get in touch with them,” said Complex Care Coordinator Molly Hoff, RN, PHN, MPH.

From January through December 2019, 93 eligible patients were visited by a care manager while receiving inpatient care and 73 engaged with the program outside of the hospital. Readmissions in the total ACO population decreased from 16.7 percent to 13 percent as a result of this intervention. The intervention group readmission rate decreased to 5.6 percent. While housing was not the program’s primary focus, 12 percent of program participants were housed during the pilot.

**Winner QUALITY**

**PROACTIVE INTERVENTION HELPS HOMELESS COMMUNITY REACH SOCIAL SERVICES**

**Reducing 30-Day Readmissions in a Population Experiencing Homelessness**

**HENNEPIN HEALTHCARE**

**Minneapolis**

**Team Members:** Heather Rhodes, Danielle Robertshaw, Heather Simon, Dawn Strief, Hillary Hume, Christy Barich, Molly Hoff, Justin Dempsey, Yang Chan, Lori Johnson, Dan Hoody, Alex Knutson

“Get curious about the problem. You might be surprised what you learn and you might be surprised how many things are truly actionable.”

— HEATHER SIMON, PERFORMANCE IMPROVEMENT ADVISOR II, HENNEPIN HEALTHCARE
‘CHOOSING WISELY’ TO REDUCE PATIENT HARM

NYC Health + Hospitals (NYC H+H) developed the High-Value Care Initiative to reduce unnecessary testing and treatment that result in patient harm. Leaders recognized that unnecessary follow-up appointments or blood tests can be a burden for patients in underserved communities and administration of certain procedures at night can disrupt patients. The health system targeted eight low-value services in the inpatient setting:

- creatine-kinase-MB (CK-MB);
- Docusate use;
- amylase;
- fecal occult blood test (FOBT);
- folate (serum and red blood cell);
- prealbumin;
- evening furosemide; and
- vitals at night.

An interdisciplinary High-Value Care Council, led by system and site leadership, engaged front-line staff in reducing use of low-value services by creating “Choosing Wisely” recommendations. Leaders built nonintrusive advisories and other “nudges” into the electronic health record to influence provider behavior. One year post-intervention, the health system eliminated CK-MB testing and Docusate use in the inpatient setting. During this time, NYC H+H also reduced weekly orders of:

- amylase from 242 to 81;
- FOBT from 57 to 46;
- folate from 227 to 46;
- prealbumin from 34 to 24;
- vitals at night from 34 to 25; and
- evening furosemide from 156 to 48.

These interventions saved an estimated $3.5 million.

CREATING A NEW POSITION TO MEET THE NEEDS OF IMMIGRANT, REFUGEE PATIENTS

Truman Medical Centers/University Health saw more than 165,000 interpreter requests per year and frequent traffic to a resource table set up near the hospital entrance to assist patients with limited English proficiency (LEP). Of the patients whom interpreters screened for social determinants of health needs, 89 percent had an unmet need.

The health system developed a hybrid cultural health navigator (CHN) position to improve social determinants of health screening and assistance for immigrant, refugee, and non–English speaking populations. The position provides more than medical interpretation to patients, bridging the gap of understanding the cultural nuances that often complicate cross-cultural communication, as well as provides culturally appropriate patient navigation services. Four individuals now serve as CHNs, including two Spanish speakers, one Arabic speaker, and one Somali speaker.

“When you know what it’s like to be new to a country, unable to speak the language, and experiencing difficulty navigating the health care system, you work hard to empower others to access all the health services and resources they require to live a healthy life,” said Clara Zambrano, a cultural health navigator.

In two years, the program provided more than 35,000 navigation contacts and 22,000 interpretation contacts, where contact is defined as a 15-minute interval. More than 6,500 unique patients accessed these interpretation and navigation services. Ninety-seven percent of LEP patients screening positive have followed through with a referral or link to community resources.
REducing Workplace Violence Using a Risk Assessment Tool

To reduce workplace violence and violence-related injuries, Hennepin Healthcare implemented a violence risk assessment and interventions package, known as MIAHTAPS—an acronym for the assessment elements: altered Mental status, Irritable, Agitated, History of violence, Threatening, Attacking objects, Pacing or Staring. The tool is largely based on the Broset Violence Checklist but incorporates history of violence into the scoring and prescribes interventions for each risk range. The approach was rooted in improvement science and plan-do-study-act (PDSA) methodology. Through PDSA, the MIAHTAPS package was tested in psychiatric intensive care units to confirm cause and effect and subsequently spread to the rest of the services. To define and analyze the Workplace Violence problem on inpatient psychiatry, a group of front-line staff, mid-level leaders, medical providers, and senior leaders reviewed data, interviewed staff, and observed processes during two three-day planning events. The planning events identified the root cause: no standard proactive approach existed to recognize and address escalating patient behavior. Use of the MIAHTAPS tool resulted in a 36 percent reduction in patient-to-staff assaults.

Zero Suicide: A Novel Approach

To save lives and transform the health care system, University Health launched the Zero Suicide program, a five-year, $1.9 million initiative funded through a Substance Abuse and Mental Health Services Administration (SAMHSA) grant. The initiative aims to improve outcomes for patients at risk for suicide by building organizational capacity through provider education and medical record system enhancement. Under the framework of the seven essential elements of the Zero Suicide model, University Health has raised awareness, established referral processes, and improved care and outcomes for patients at risk for suicide. To ensure successful transformation, the implementation team—including survivors of suicide—implemented a violence risk assessment and interventions package, known as MIAHTAPS—an acronym for the assessment elements: altered Mental status, Irritable, Agitated, History of violence, Threatening, Attacking objects, Pacing or Staring. The tool is largely based on the Broset Violence Checklist but incorporates history of violence into the scoring and prescribes interventions for each risk range. Zero Suicide aims to proactively identify and engage patients at risk for suicide by increasing screenings, assessments, and safety planning. Additionally, University Health ensures continuity of care by increasing formal agreements with community behavioral health organizations for referrals, providing rapid follow-up and seamless transitions of care. By September 2020, 19,560 patients were screened for suicide risk during primary care visits, representing a 66.2 percent increase in screening rates compared with those screened through March 2020. Of those screened, 346 (1.7 percent) reported suicidal thoughts. Further, more than 100 seamless transitions of care. By September 2020, 19,560 patients were screened for suicide risk during primary care visits, representing a 66.2 percent increase in screening rates compared with those screened through March 2020. Of those screened, 346 (1.7 percent) reported suicidal thoughts. Further, more than 100

Essential Hospital Resources

America’s Essential Hospitals regularly compiles resource pages to inform our members and other stakeholders about timely issues. Explore the resource libraries at essentialhospitals.org/resources.

Infectious Disease Resources for Essential Hospitals

Essential hospitals provide a significant volume of public health and emergency preparedness services and stand ready to support the nation’s response to pandemic threats, including Zika virus and Ebola. America’s Essential Hospitals developed a resource library specific to COVID-19; see page 23 for details and a link.

Disaster Response Resources for Essential Hospitals

This resource list includes links to various tools and information to help essential hospitals prepare for a natural disaster or other emergency situation.

Support for Patients and Communities Act—Grant and Demonstration Opportunity Tracker

America’s Essential Hospitals created this tracker to focus on opportunities available to essential hospitals or state projects that could include essential hospitals.

Opioid Resources for Essential Hospitals

Essential hospitals play a key role in the prevention and intervention of opioid use disorder. America’s Essential Hospitals has compiled relevant federal resources on this evolving health crisis.

Immigration and Health Care: Resources for Essential Hospitals

This library includes relevant resources to inform essential hospitals about the rights of patients and providers.

IT Security Resources for Essential Hospitals

As hospitals increasingly rely on health information technology (IT), the risk of cybersecurity breaches also increases. This resource page includes cybersecurity resources that focus on preventing and responding to IT attacks.

Physician Payment Program Resources for Essential Hospitals

This page contains infographics and resources to help essential hospitals navigate the Quality Payment Program.

Resources on Sociodemographic Factors and Health Outcomes

This periodically updated list of research and other resources covers the need to risk adjust performance measures for sociodemographic and socioeconomic factors that can influence health outcomes.
COVID-19 Innovations

Gage Awards for COVID-19 Innovations recognize innovative practices, projects, and programs related to the pandemic. This temporary category captures creative solutions within the hospital or in its community for the current or potential future pandemics.
COVID-19 PANDEMIC INNOVATIONS FOR DALLAS COUNTY

As COVID-19 spread across Texas, Parkland Health & Hospital System, in Dallas, initiated multiple responses to target underserved communities and populations at elevated risk of contracting the novel coronavirus. Parkland provided half of testing in Dallas County and leveraged COVID-19 testing services for flu vaccine administration. The health system also developed analytic tools to monitor and respond to confirmed cases; used widespread media and messaging campaigns, as well as texting, email, patient portals, and other person-centric technology, to inform patients; expanded virtual health services; and provided remote pulse oximetry home monitoring kits for emergency department discharges.

By late December 2020, Parkland identified more than 34,500 positive COVID-19 cases and flagged more than 10,000 patients as high risk to initiate care and outreach. More than 200,000 COVID-19 tests were administered at Parkland’s drive-through and walk-up locations, including through mobile outreach at nursing homes and homeless shelters.

STOPPING THE SPREAD: COVID-19 COMMUNITY INTERVENTION

UMass Memorial Medical Center developed and implemented a multipronged, community-based approach to target populations at high risk of contracting COVID-19. The hospital deployed mobile care staff to educate residents and answer COVID-19 questions in multiple languages. The intervention also distributed face masks, sanitizer, and information on critical social resources. In August, the hospital began leading Massachusetts Stop the Spread testing in areas of Worcester, Mass., with high rates of COVID-19. The hospital developed and implemented a testing operation able to:

♦ function effectively outdoors or indoors, as weather permitted;
♦ rotate into various hot-spot neighborhoods of color and vulnerability, based on data;
♦ provide same-day set-up and function with minimal or no power; and
♦ manage unpredictable volumes while meeting the language needs of Worcester’s diverse population.

In November, the program moved indoors to a central location with easy access to minimize transportation barriers. Using lean best practices, the project was scaled to successfully test up to 340 people per hour. By identifying cases earlier, the initiative helped reduce the spread and minimize emergency department and intensive care unit use, as well as preventable deaths.

The Massachusetts Department of Public Health reimburses UMass Memorial $140 per completed test, resulting in a gross revenue of more than $4.1 million through Dec. 29, 2020. The program’s events relied heavily on volunteers and partnerships with the City of Worcester, Worcester Interfaith, Latino Education Institute, and other local groups.

COVID-19 Resources for Essential Hospitals

The COVID-19 pandemic has highlighted the role essential hospitals play in emergency response efforts nationwide. America’s Essential Hospitals launched a COVID-19 resource library with a rich and growing collection of general and topical resources to help hospitals prepare for and respond to this crisis. Visit essentialhospitals.org/COVID19 to explore topics related to COVID-19, including a look back at how essential hospitals dealt with the first year of the pandemic.
Research shows that family visitation during hospital recovery is key to the outcomes for critically ill COVID-19 patients. As restrictions eased and case rates declined, University Medical Center of El Paso piloted a program allowing adult family members to visit hospitalized patients once per week for two hours. Qualifying patients had to be hospitalized for 20 days or longer; family members had to be screened at entry and could not be in the self-quarantine window for a positive COVID-19 test. Visitors were required to use hospital-provided personal protective equipment and a power air-purifying respirator, at a cost of $250 each—the hospital’s only expense related to the program.

The program has enhanced patients’ feeling of safety and initial results point toward improved recovery rates for critically ill COVID-19 patients. Aside from patient success stories, other results also are promising. Since the program kicked off, the hospital has seen a reduction, by nearly half, in the number of Code Blue medical emergency activations and Rapid Response critical care activations. The hospital is establishing a study and hopes to publish findings as the program grows and additional data is evaluated.

FAMILY VISITATION AT UMC EL PASO’S COVID-19 ICU

UCSHEALTH.COM/ELPASO

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COLLABORATIVE RESPONSE TO THE PANDEMIC AMONG UNDERSERVED POPULATIONS

Led by the director of population health, San Joaquin General Hospital (SJGH) played a key role in planning the initial communitywide response to COVID-19 led by the county human services agency. In collaboration with San Joaquin County Clinics (SJCC) and with funding from the United Way, SJGH in March 2020 quickly transitioned to a community-based model of using pop-up testing sites in areas with high populations of people experiencing homelessness, homeless shelters, and communities with large populations of migrant and seasonal agricultural workers. SJGH and SJCC played a primary role in establishing two isolation facilities at a local homeless shelter for up to 48 patients with COVID-19 or who were exposed to the disease.

As of Jan. 4, the initiative conducted more than 4,200 COVID-19 tests through these pop-up sites, as well as in areas where populations lack transportation and face other barriers to testing. The project has prevented potential outbreaks among individuals without homes and among low-income agricultural workers. For example, one testing site recently had a positive rate of 19 percent among a single agricultural employer; these results triggered a quick response to address isolation and retest at the location after seven days.

NATIONAL OUTREACH OF TELEPALLIATIVE MEDICINE VOLUNTEERS

Despite being the largest public health system in the United States, NYC Health + Hospitals’ (NYC H+H) palliative care resources are limited, with just two or fewer full-time palliative care employees at most of its acute care facilities. During the first COVID-19 surge, these numbers were further depleted when some palliative care staff were redeployed to fill staffing shortages. In response, NYC H+H recruited more than 400 telepalliative medicine volunteers—including medical professionals, social workers, medical students, and chaplains—through a national social media campaign. Of those, 64 physicians, nurse practitioners, and physician assistants completed expedited credentialing and assisted with remote care consultations at five of the health system’s acute care hospitals.

During a two-week pilot period in April 2020, 109 consultations were performed. The project continued through June 2020, when it was shifted to post-acute care facilities as the first wave of COVID-19 subsided.

This project had no associated funding, but team members are seeking grant funding to expand on lessons learned. The project was coordinated by the systemwide quality and safety office, and every participating hospital had a palliative care or hospitalist liaison to help coordinate volunteer assignments.
PROACTIVE OUTREACH TO HIGH-RISK PATIENTS DURING COVID-19

Many patients lacked customary access to the critical health care and social resources they need amid the COVID-19 pandemic. A team, led and organized by student volunteers, developed a proactive outreach call program to screen patients for COVID-19 at Grady Health System. The program also provides COVID-19 prevention education, helps patients get connected to virtual appointments and sign up for mail-order pharmacy services, and identifies and mitigates health-related social needs.

This program provided medical and physician assistant students from the Emory University and Morehouse School of Medicine meaningful patient engagement experience and filled a communication gap at a time when patients needed support the most. At no cost to Grady, an existing prescriptive analytics company partner used artificial intelligence to identify patients at highest risk of poor outcomes if they were to contract the coronavirus. Students called these patients using a custom form that served as both a call script and data collection tool. Based on patient responses, the form prompted tailored reminders and connections to medical and social resources.

In 2020, students in the program made more than 4,600 calls to patients. More than half of answered calls identified at least one health care need that required action and 20 percent had social needs, such as food insecurity, that required action.

SAFE @ HOME O2: AMBULATORY MANAGEMENT OF SUPPLEMENTARY OXYGEN FOR COVID-19

To optimize patient outcomes and preserve critical acute care access during the COVID-19 pandemic, LAC+USC Medical Center spearheaded design and implementation of the SAFE @ Home O2 program. The initiative enabled patients requiring low levels of oxygen support to be managed at home.

Mortality and readmission outcomes were evaluated rigorously and the program was found to be both safe and effective, as demonstrated by low rates of all-cause mortality and return admissions. The analysis was published in JAMA Network Open.

Over the past year, LAC+USC Medical Center has discharged more than 1,600 patients with COVID-19 on home oxygen, delivering the right care at the right time and place for patients with pneumonia related to the disease and preserving access to acute care services for all patients during the pandemic.

BMC PEDIATRICS MOBILE OUTREACH PROGRAM

When COVID-19 cases began to surge at Boston Medical Center (BMC), in-person pediatric visits dropped 90 percent. Many families were unable to come to BMC for routine clinical care and wraparound services, and while providers and staff shifted to telehealth, they were still unable to provide routine vaccinations and critical in-person care.

To continue meeting the needs of more than 14,000 pediatric patients, a team of providers and staff from the department of pediatrics launched the BMC Pediatrics Mobile Outreach Program in early April 2020. The program conducts home visits in which the team provides vaccinations, mental health care, child care support, domestic violence assistance, and neonatal care while also addressing patients’ unmet social needs.

The program serves more than 200 families each week, providing more than 2,700 vaccinations to date. Providers have referred 100 participants to mental health services and connected more than 200 families with housing assistance programs. Staff made more than 230 emergency same-day food deliveries to families experiencing food insecurity and continued biweekly food delivery to at least 100 families. In addition, the program distributed grocery gift cards totaling $200,000 to families, as well as $30,000 worth of diapers, formula, and other necessities.