Excellence and Innovation in Care

THE 2022 GAGE AWARDS
ABOUT AMERICA’S ESSENTIAL HOSPITALS

America’s Essential Hospitals is the leading association and champion for hospitals dedicated to equitable, high-quality care for all, including those who face social and financial barriers to care. Since 1981, America’s Essential Hospitals has advanced policies and programs that promote health, health care access, and equity. We support our more than 300 members with advocacy, policy development, research, education, and leadership development. Communities depend on essential hospitals for care across the continuum, health care workforce training, research, public health and health equity, and other services. Essential hospitals innovate and adapt to lead all of health care toward better outcomes and value.

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.

America’s Essential Hospitals acknowledges its Awards Committee members for their work to review Gage Award applications and select winners:

Parveen Chand, MHA, chair
Melinda Abrams, MS
Tangerine Brigham, MPP
Kathy Chan
Vandna Chaudhari, MHA
Paul Gorski, MPH
Stuart Guterman, MA
Amy Harris, MA
Emi Kamiya, MBA
Gavin Malcolm, LCSW, MSW
Pamela Rosenkranz, BSN, RN, MEd
Shannon Sale, MHA
Laura Sariff, DNP, RN, MBA
Anand Shah, MD, MS
Airica Steed, EdD, MRA, RN
Wendy Wilcox, MD, MBA, MPH

© 2022 America’s Essential Hospitals. All rights reserved.
Gage Awards for quality recognize activities that improve the delivery of care, enhance patient experience, and engage patients and their families, or reduce or eliminate harmful events affecting individual patients or groups of patients.
MINDFUL MOVEMENT PROGRAM FOR OPEN-HEART SURGERY PATIENTS

Following open-heart surgery, patients traditionally follow sternal precautions (SPs) that prohibit lifting and pushing with the arms. SPs, which are not evidence-based, limit function, diminish quality of life, increase chances of depression, and create hardships through loss of income. Uninsured and low-income patients, particularly elderly patients, have a greater need to enter post-acute care facilities after a median sternotomy is used to open their chest.

In March 2016, Memorial Healthcare System launched Keep Your Move in the Tube (KMIT), a mindful movement program that replaces the strict load and time restrictions of traditional SPs with safe upper-body movement with arms close to the body. KMIT training graphics depict movements in a green tube and out of a red tube to promote freedom of movement with arms close to the body while reducing force across the sternum. Patients can reach outward as they are able, limited only by changes in pain.

Memorial leaders met with KMIT’s developers at Baylor Hospital, in Dallas; introduced the program to hospital leaders; and identified nurse champions to provide culturally competent staff training. The project team developed multilingual education materials for patients and families and helped patients customize recovery goals.

“We role-play with them there, mimicking these activities and using various weights at various vectors and planes, to help simulate the activity,” says Richard Gach, PT, DPT, supervisor of the Rehab Services Department at Memorial Regional Hospital.

In the year and a half before implementing KMIT, 42 percent of cardiac surgical patients were discharged directly home, and 58 percent were discharged to a secondary facility. Following implementation, 86 percent of cardiac surgical patients were discharged directly home, and 14 percent were discharged to a secondary facility. Patients discharged home have a survivability rate of 95 percent one year after discharge, compared with a 64 percent survival rate if discharged to an inpatient rehabilitation facility and 52 percent survival rate if discharged to a skilled nursing facility. Memorial estimates a $1.5 million savings in the cost of secondary facilities.

 “[Therapists] knew that they could make their patients more independent,” says Susan Triano, ClinScD, director of rehabilitation services at Memorial Regional Hospital. “They kept telling me stories of elderly patients who had to go into nursing homes because they couldn’t use their arms to push up from a chair. As soon as we rolled this out, they were coming back with stories of independence and people going home.”

Following KMIT implementation, patients’ level of independence in bed mobility and transfers improved significantly, and wound complication and 30-day hospital readmissions did not change.

“What’s the big thing about this philosophy?” Gach says. “The big thing about this philosophy is that we are helping people get plugged back into their life as quickly as possible.”

TEAM TARGETS ROOT CAUSES OF EMERGENCY DEPARTMENT VISITS

Zuckerberg San Francisco General Hospital and Trauma Center (ZSFG) launched Social Medicine (SM) with the University of California San Francisco in 2017 to meet patients’ psychosocial needs at the point of care while reducing non-acute emergency department (ED) visits and inpatient days.

“Social medicine is a concept of taking care of a patient’s needs that impede their ability to get their medical care—so, for example, housing, or access to medications, or access to food,” says Riham Alwan, MD, a consulting clinician at ZSFG.

SM Co-Director Jenna Bilinski, RN, MBA, says the program draws on expertise from multiple disciplines. “We started in the emergency department and put a team together of clinicians, of pharmacists, some nursing staff, social workers, a health worker, a team of people who were all really eager to help people with not just what they came into the emergency department to fix, but all of these different factors that were affecting their lives,” she says.

The SM team studied 70,000 ED patient records to analyze reasons for visits and proposed an interdisciplinary, team-based holistic care model to meet patients’ self-identified social needs using quality improvement methodology.
The team aimed to reduce short-stay hospitalizations related to psychosocial needs by 50 percent—20 admissions per month—by December 2018 and to increase multidisciplinary teamwork in caring for ED patients with complex needs.

After three years of meeting these goals, SM expanded in December 2020 to track patient-reported outcomes that include linkage to substance use services, referrals to permanent supportive housing, provision of patient care supplies, as well as team goals, including measures of trust and team member professional development. In January 2020, the program began including inpatient care, resulting in a 38 percent reduction in lower level of care days and an improvement in bed access. The program is supported financially by philanthropic grants and the San Francisco Health Plan, a county-managed Medicaid payer.

During the COVID-19 pandemic, SM members provided leadership in directing hotel-based isolation and quarantine for community members experiencing homelessness; established a patient care supply initiative; and provided more than 1,000 hygiene kits, food vouchers, pharmacy cards, phones, and clothing to patients during hospital encounters.

Since 2017, SM has cared for more than 6,000 patients with complex needs and provided more than 3,000 complex care consultations. The program provided 1,500 patients with discharge medications and pharmacy education at no cost and prevented more than 800 admissions and readmissions.

We deliver better care for our patients because we’re not just thinking about patients’ health from the medical model or the behavioral health model; it’s really integrated.”

– Hemal Kanzaria, MD, co-director, Social Medicine Program and medical director, Department of Care Coordination

Below: Social Medicine brings emergency department clinicians together with emergency medical services workers, social workers, and other interdisciplinary staff to coordinate care. Photo credit: Zuckerberg San Francisco General Hospital and Trauma Center.

LAC+USC Medical Center, in Los Angeles, has a 24-bed medical-surgical unit providing acute inpatient care for about 17,000 incarcerated individuals in the Los Angeles County jail system. This patient population is at high risk for concurrent medical and psychiatric issues; hospital leadership identified a high rate of patient falls in this unit compared with other medical-surgical units.

Two interventions were implemented to reduce patient falls in the jail ward: installation of antislip epoxy coating in shower areas and 15-minute nursing attendant rounds. Increased rounding allowed staff to identify patients who required assistance and engage earlier. Following the interventions, the fall rate decreased from 11.3 to 5.29 falls per 1,000 patient days.

LAC+USC MEDICAL CENTER
Los Angeles
Team Members: Shawn McGowan, MS; Michelle DeDios, RN

DECREASING PATIENT FALLS IN AN ACUTE-CARE MEDICAL-SURGICAL JAIL WARD

IMPLEMENTING INTERPROFESSIONAL HOSPITAL-BASED ADDICTION CARE

Following a community needs assessment that found quality and care gaps for patients with substance use disorder (SUD), Zuckerberg San Francisco General Hospital and Trauma Center (ZSFG) launched the Addiction Care Team to better care for patients with SUD. The hospital also surveyed staff, clinicians, and addiction consult directors and reviewed literature on addiction care models to learn how to support SUD care.

The team includes three licensed vocational nurses, three patient navigators, a nurse practitioner, an addiction fellow, and an attending doctor. They meet emergency department and hospitalized patients with SUD and develop patient-centered care plans. The program provides harm reduction; evidence-based medical and psychosocial treatment; links to care; and hospital- and communitywide advocacy, education, and systems change.

The team’s inception coincided with the launch of a local Medicaid managed care plan quality improvement program; the plan awarded ZSFG a $900,000, three-year grant to pilot the Addiction Care Team. The health system later secured funding from Kaiser and the California Health Care Foundation to increase capacity. Internal results indicate increased consults, rates of medication initiation, and discharges to a residence.

HIGHLIGHTED PROGRAM
ZUCKERBERG SAN FRANCISCO GENERAL HOSPITAL AND TRAUMA CENTER
San Francisco
Team Members: Marlene Martin, MD

HIGHLIGHTED PROGRAM
LAC+USC MEDICAL CENTER
Los Angeles
Team Members: Shawn McGowan, MS; Michelle DeDios, RN

HIGHLIGHTED PROGRAM
ZUCKERBERG SAN FRANCISCO GENERAL HOSPITAL AND TRAUMA CENTER
San Francisco
Team Members: Marlene Martin, MD
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.
The program helped me in so many ways. I felt [that] they were supporting me—they had my back. I felt safe, you could say. There was a helping hand out there to help me.”

— Francisco García, patient

HARRIS HEALTH SYSTEM

WINNER

Community Health Worker Home Visits for High-Risk Diabetes Patients

HARRIS HEALTH SYSTEM

Houston

Team Members: Ann Barnes, MD; Esperanza Galvan, PhD, MS; Denise LaRue, MPH; Maria De La Cruz, MPA; Alma Aranda

During the COVID-19 pandemic, Harris Health turned its community health worker home visit program virtual, and the number of program graduates increased by 130 percent. Photo credit: Harris Health System.

Harris Health System, in Houston, serves a largely low-income and uninsured or underinsured patient population, of which nearly 90 percent are people of color. These communities experience a disproportionate prevalence of diabetes, and Type 2 diabetes ranks among the most prevalent and costly outpatient diagnoses.

Spurred in part by a Medicaid Section 1115 waiver, the health system developed a diabetes registry that identified nearly 40,000 diagnosed patients, including about one-third who had uncontrolled diabetes with HbA1c levels greater than 9. In 2017, Harris Health then designed a community health worker (CHW) home visit pilot program that uses a hub-and-spoke, community-focused model to work with disengaged patients with diabetes.

“Our teams of community health workers live or are intimately familiar with the neighborhoods they serve,” says Esperanza “Hope” Galvan, PhD, MS. “This is key in being able to build trust and interpersonal connections with our patients.”

Through the program, CHWs capture a comprehensive picture of patients’ health-related social needs, diabetes knowledge, and self-management behaviors. The four-month program extends the health system’s reach outside its walls to better understand barriers to good health and offer point-of-care navigation. CHWs launch a care plan that can include establishing eligibility for charity care, making appointments with interdisciplinary teams, applying for rental assistance, providing education on public transportation, and more. Since its inception, the program has grown to 14 clinics.

“With in-home visits being temporarily paused because of the pandemic, the program shifted to teaching patients about technology platforms for virtual care,” says Denise LaRue, MPH, director of care integration for Harris Health System. “This included the use of our online health portal to complete visits virtually, communicate with their care teams, and place home delivery prescription refills.”

Before the start of the pandemic, 181 program participants reported an average decrease of 2.2 percentage points in HbA1c levels and increased knowledge of their condition and appropriate treatment. The program sustained these outcomes amid the pandemic and increased the number of program graduates by 130 percent, with 417 patients completing the program from November 2020 to October 2021.
A decade ago, Cleveland public schools were plagued with chronic absenteeism and stagnant academic achievement, with a graduation rate of just 52.2 percent. At the same time, The MetroHealth System noticed declining pediatric primary care visits, increasing emergency department use, and gaps in children's health outcomes.

“We know that healthy kids learn better,” says Katie Davis Bellamy, RN, MSN, director of the Center for Health Outreach, Access & Prevention at The MetroHealth System. “The outcomes and the research show, if you have access to health care, you’re going to actually most likely graduate high school and have [a] higher chance of grade promotion.”

In 2013, MetroHealth opened the first Institute for H.O.P.E. school health program clinic in a converted classroom at an elementary school. Today, the program has expanded to more than two dozen sites and mobile units, selected based on assessed need.

In addition to traditional medical care, the Institute for H.O.P.E. provides mental and behavioral health support through an arts-based program.

“The program also helps mitigate social determinants of health by helping students and their families sign up for insurance; recognize lead exposure; and connect with community partners to find housing, pay rent, and more. The program also provides coats, toothbrushes, backpacks, and school supplies to students.

The program is funded through philanthropic support, Medicaid billing, and the health system’s general operations budget; its annual budget is on pace to exceed $1 million for 2022.

Compared with a baseline, program enrollees were 64 percent more likely to be up to date on immunizations, 38 percent more likely to have attended one or more primary care visits, and 22 percent more likely to have had an annual well-child exam. At the first participating high school, attendance rates exceeded 99 percent and enrollees had eight fewer absences on average and a grade-point average 0.41 higher than other students.

“I found it so convenient for the bus to be here at our school because when you have more than one kid, it’s hard to make a lot of different appointments,” says Kanika Williams, whose children receive care through the School Health Program. “Having the Metro bus here, and having the staff, just reassures me that they’re going to be taken care of.”

Lisa Ramirez, PhD, meets with students as part of The MetroHealth System’s School Health Program, which provides primary care and mental and behavioral health support at more than two dozen school sites. Photo credit: The MetroHealth System
FAMILY CONNECTS: A POPULATION HEALTH APPROACH TO HOME VISITING

Hennepin Health serves a diverse population disproportionately at risk for adverse birth outcomes. In 2017, 55 percent of births in Minneapolis were to people of color. After a community health needs assessment identified maternal child health as a key focus area, Hennepin in 2019 launched the Family Connects home visiting program in partnership with the Minneapolis Health Department.

In this evidence-based model, public health nurses conduct up to three home visits to support newborns and their families in a set geographic service area and complete the Family Support Matrix to identify social risk factors. A community advisory board of team members, clinicians, and community partners provides program updates, seeks community feedback, and shares resources.

Overall, 78 percent of all families participating in the program have needed one or more referrals for social services. Since implementation, the program has reached 66 percent of the eligible population—births that took place at Hennepin and have a home address within Minneapolis city limits. The program later was expanded to Hennepin Healthcare births with home addresses in suburban Hennepin County. The Family Connects team has made 2,422 referrals to community resources, with a greater than 60 percent follow-up rate.

BIOTEL SOCIAL WORK PROGRAM

Parkland Health created the BioTel Social Work Program in 2015 in response to the significant resources expended by emergency medical services (EMS) on patients with low acuity medical needs exacerbated by social stressors. This innovative program deploys a social worker and a paramedic to conduct a home visit; the social worker provides medical case management and connects patients to needed social services. Common barriers requiring intervention are lack of insurance, lack of access to transportation, mobility concerns, and limited health literacy.

The program is mutually funded by Parkland Health and 14 EMS agencies. Contracts are calculated based on the number of EMS runs and the city’s population, making the cost of a social worker sustainable, regardless of municipality size.

The program has served more than 340 patients and reduced by 58 percent inappropriate 911 use by frequent 911 users in DeSoto and Garland, Texas. Due to this success, partnering cities are eager to expand the program, and EMS agencies remain willing to shoulder the cost of this model.
Gage Awards for COVID-19 Innovations recognize inventive 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.
University Medical Center of El Paso (UMC El Paso) serves a community that is 82 percent Hispanic. COVID-19 cases and hospitalization rates are two to three times higher for Hispanic people, due to higher rates of chronic conditions and socioeconomic factors.

Since December 2020, the health system has administered 327,000 COVID-19 vaccines through a central hub site, four neighborhood health clinics, a mobile health clinic that visited rural and underserved areas, and two county jail facilities. UMC also staffed Texas' first binational COVID-19 vaccine effort between El Paso and its sister city of Ciudad Juárez, Mexico, which had a 30 percent vaccination rate before the health system intervened.

The health system targeted its efforts toward demographic groups with low vaccination rates through Super Senior Thursdays held in collaboration with community organizations, a mobile unit deployed to ZIP codes with low vaccination rates, and a clinic at the Marcelino Serna Port of Entry in Tornillo, Texas, that provided one-dose vaccines to maquiladora workers.

As of November 29, 2021, 91.7 percent of people 65 and older were fully vaccinated and 99.9 percent were partially vaccinated. As of early October, 75.8 percent of those 12 and older were fully vaccinated and 87.9 percent partially vaccinated, and 69.3 percent of those 5 and older were fully vaccinated and 84.7 percent partially vaccinated.

Harborview Medical Center partnered with Public Health—Seattle & King County (PHSKC) to improve access to COVID-19 testing and vaccination for low-income and minority populations, people with limited English proficiency (LEP), and people experiencing homelessness.

Harborview and PHSKC collected demographic data to identify communities in King County at risk for COVID-19 infection with higher risk of poor outcomes. To mitigate barriers to care, they created mobile walk-up, no-cost testing sites at locations that were easily accessible and trusted by at-risk communities, including churches, mosques, schools, housing units, homeless shelters, encampments, and food banks. Testing sites transitioned into vaccination sites once vaccines became available.

With support from the HealthierHere Resiliency Fund, communities hired community health workers and cultural mediators. In-kind donations from businesses and community organizations provided masks, food assistance, and health hygiene kits distributed at mobile sites.

From April 2020 to March 2021, Harborview and PHSKC performed 21,758 COVID-19 tests at more than 50 sites. From February to October 2021, mobile outreach teams administered 9,457 vaccine doses at more than 37 locations; of those vaccinated, 70 percent identified as Black, indigenous, and people of color; one-third were from a LEP population; and 14 percent were housing insecure. Future efforts include pediatric vaccine initiatives and a CEO listening tour to identify community health care needs.
COVID-19 INNOVATIONS

A NOVEL PLATFORM TO DELIVER STANDARD, EXPERT COVID-19 DECISION SUPPORT

To help physicians and patients interpret test results for SARS-CoV-2, the virus that causes COVID-19, University of Texas Medical Branch (UTMB) pathology faculty developed a compendium of expert interpretive commentary.

Initially deployed in October 2020, the compendium grew to include more than 170 comments that describe different patterns of polymerase chain reaction, immunoglobulin G, and immunoglobulin M test results. The supporting application observes all patient COVID-19 test results, considers the patterns of each patient’s testing history, matches results to an expert interpretation, and delivers the interpretation and diagnostic summary to the patient with their test results. UTMB revised the compendium four times to incorporate emerging literature; new testing types, including antibody test results; and vaccination status.

In 13 months, UTMB completed more than 325,000 test interpretations and monitored COVID-19 outcomes to assess whether better distribution of COVID-19 test results reduced diagnostic ambiguity and improved outcomes. UTMB had:
- a mean length of stay of 6.5 days, compared with an 8.3-day regional average and 9.1-day national average;
- a 4.4 percent rate of escalation to the intensive care unit, compared with a 22.6 percent regional rate and 23.3 percent national rate; and
- a mortality rate of 7 percent, compared with a 10.1 percent regional rate and 12.7 percent national rate.

COVID-19 Resources for Essential Hospitals

In December 2019, a novel coronavirus (COVID-19) was first identified in Wuhan, Hubei Province, China. The World Health Organization declared COVID-19 a pandemic and the first U.S. infection was reported on January 21, 2020. The first confirmed case of person-to-person spread of the virus in the United States was reported shortly after, on January 30, 2020. All 50 states have reported cases of COVID-19.

Essential hospitals offer services vital to emergency response efforts nationwide. Federal agencies and other expert sources have made a rich collection of guidance available to help hospitals prepare for and respond to this outbreak of respiratory illness. America’s Essential Hospitals launched a COVID-19 resource library with a rich and growing collection of general and topical resources for essential hospitals and others with an interest in this pandemic.

Visit essentialhospitals.org/covid19 to explore topics related to the pandemic, including the Provider Relief Fund, vaccines, infection control, and more. The site also includes a look back at how essential hospitals responded during the first year of the pandemic, the challenges they faced, and their innovative solutions.

NEW YORK CITY TEST & TRACE CORPS

The NYC Test & Trace Corps (T2) is New York City’s comprehensive program to respond to COVID-19 and break chains of transmission. Launched in June 2020, the program identifies cases, provides intake for cases and exposures, and connects affected individuals to social services.

T2 created a testing program allowing residents and visitors to get tested regardless of immigration status, location, or insurance. Contact tracers ensure cases and close contacts are monitored and connected to needed resources. The program also ensures New Yorkers have access to food and other critical needs during isolation and quarantine.

In March 2020, the city could perform about 100 PCR tests per day; by December 2020, that number rose to 120,000 tests per day. By building a lab in the city, T2 also successfully reduced test result times from two weeks to a median of 24 hours. Since the program’s launch, T2 contact tracers have reached 88 percent of city residents diagnosed with COVID-19; these New Yorkers, in turn, identified 1.2 million others they exposed.

SPOTLIGHTED PROGRAM

UNIVERSITY OF TEXAS MEDICAL BRANCH
Galveston, Texas

Team Members: Peter McCaffrey, MD; Michael Laposata, MD, PhD; Christopher Zahner, MD; Alexandra Rapp, MD; Juan David Garcia, MBA; Ragini Desai; Michael O’Rourke; Merretta Kincaid; Steve Wallace; Artur Adib; Jabez Boyd; Alex Vo, PhD; Timothy Harlin, DSc, MBA; Gulshan Sharma, MD, MPH

HIGHLIGHTED PROGRAM

NYC HEALTH + HOSPITALS
New York

Team Members: Adam Shrier, MA

NYC Test & Trace Corps (T2) is New York City’s comprehensive program to respond to COVID-19 and break chains of transmission. Launched in June 2020, the program identifies cases, provides intake for cases and exposures, and connects affected individuals to social services.

In March 2020, the city could perform about 100 PCR tests per day; by December 2020, that number rose to 120,000 tests per day. By building a lab in the city, T2 also successfully reduced test result times from two weeks to a median of 24 hours. Since the program’s launch, T2 contact tracers have reached 88 percent of city residents diagnosed with COVID-19; these New Yorkers, in turn, identified 1.2 million others they exposed.

NYC Test & Trace Corps (T2) is New York City’s comprehensive program to respond to COVID-19 and break chains of transmission. Launched in June 2020, the program identifies cases, provides intake for cases and exposures, and connects affected individuals to social services.

In March 2020, the city could perform about 100 PCR tests per day; by December 2020, that number rose to 120,000 tests per day. By building a lab in the city, T2 also successfully reduced test result times from two weeks to a median of 24 hours. Since the program’s launch, T2 contact tracers have reached 88 percent of city residents diagnosed with COVID-19; these New Yorkers, in turn, identified 1.2 million others they exposed.