AMERICA'S ESSENTIAL HOSPITALS

The 2023

GAGE AWARDS

EXCELLENCE INNOVATION

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. Learn more at EssentialHospitals.org.

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 vital2023.org/gage-awards.

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

Shannon Sale, MHA, chair
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Airica Steed, EdD, MBA, RN
Wendy Wilcox, MD, MBA, MPH

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.

COVID-19 Resources

Since the earliest days of the pandemic, essential hospitals have anchored the front lines of the battle against COVID-19. Here, you will find a rich collection of guidance for hospitals and other providers from federal agencies and other expert sources.

Other 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 infectious disease threats, including Zika virus and Ebola.

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. It also includes a sample emergency contact list provided by one of our members.

Support For Patients and Communities Act – Grant and Demonstration Opportunity Tracker

America's Essential Hospitals created this tracker to serve as a resource to members. It focuses on opportunities that will be available to essential hospitals and state projects that could include essential hospitals, and it is organized by how the program appears in the text of the law.

Opioid Resources for Essential Hospitals

Essential hospitals play a key role in treating and preventing opioid misuse and responding to the nation's opioid epidemic. America's Essential Hospitals has compiled relevant federal resources on this evolving health crisis.

Immigration and Health Care: Resources for Essential Hospitals

This library of resources on patient and provider rights includes a comprehensive provider toolkit from the National Immigration Law Center, with fact sheets and templates on patient rights and records privacy and sample messages to display for patients.

IT Security Resources for Essential Hospitals

As hospitals increasingly rely on health information technology (IT), the risk of cybersecurity breaches also increases. America's Essential Hospitals has established this resource page to support hospitals as they work to prevent and respond to IT attacks.

Physician Payment Program Resources for Essential Hospitals

The Medicare Access and CHIP Reauthorization Act of 2015 established a new approach to physician payment: the Quality Payment Program. This page contains infographics and resources to help essential hospitals navigate these changes.

Resources on Sociodemographic Factors and Health Outcomes

A large and growing body of evidence shows sociodemographic factors, such as age, race, ethnicity, and language, and socioeconomic status, such as income and education, can influence health outcomes. This library presents research on the need to risk adjust for these factors.

Cost of Care Conversations Library

This library features guides, videos, infographics, and other tools to help essential hospitals and clinicians talk with vulnerable patients about the cost of care and to incorporate these conversations into the clinical workflow.

QUALITY

Winner

Building a Systemwide Culture of Quality

Standardizing workflows and screening tools helped reduce documentation burden and monitor improvement at UK HealthCare.

UK HealthCare

Enabling Transformation: UK HealthCare Whole System Quality

UK HealthCare
Lexington, Kentucky

Team Members: Mark Birdwhistell, MPA; Jay Grider, DO, PhD, MBA; Trudi Matthews, MA; Jessica Sass, MSN, APRN

UK HealthCare, in Lexington, Kentucky, the academic health system of the University of Kentucky, and the University of Louisville, as the two state teaching hospitals, worked with Kentucky Medicaid to design a value-based Medicaid directed payment program. The program focused on improving care for Kentucky's toughest health challenges, including cancer, heart disease, obesity, behavioral health, and substance use disorders. UK HealthCare then leveraged this directed payment program to accelerate its whole system quality transformation.

Program partners identified 14 associated quality measures, including:

- Cancer screening.
- Readmissions
- Well child visits.
- Use of opioids at high dosage.
- Tobacco and body mass index screening and follow-up.
- Blood pressure and hemoglobin A1c (HbA1C) control.
- Depression screening.

The health system was responsible for annual improvement targets for these metrics, increasing the number of targets required to earn at-risk funds, and increasing the portion of Medicaid directed payments at risk from 5 percent in year one to 20 percent in years four and five.

Among a portfolio of whole system quality interventions, UK HealthCare appointed dyads across the enterprise to lead quality initiatives and participate in Quality Collaboratives to share work, ask questions, and receive feedback. This methodical approach to implementing change built trust among hospital staff.

Leaders established standard rooming protocols for nursing staff to close gaps, provider standard workflows and standing orders to reduce documentation burden, and performance dashboards to monitor improvement at the enterprise, unit, and provider levels.

The introduction of screening tools helped save one patient's life.

"She had a patient appointment, and because of the new culture, the provider encouraged her to get the mammogram that she was delinquent on while she was there that day," recalls Mark Birdwhistell, MPA, senior vice president and chief administrative officer at UK HealthCare. "That day, she learned she had early-stage breast cancer. But, by catching it early in the process, we were able to ensure a good patient outcome."

From July 2019 to June 2022, UK HealthCare:

- Increased depression screening by 64 percentage points.
- Increased well child visits for children ages 3 to 6 by 45 percentage points.
- Increased blood pressure control by 27 percentage points.
- Decreased uncontrolled HbA1c rates for patients with diabetes by 9 percentage points.
- Reduced readmissions rates by more than one percentage point.
- Increased breast and colorectal cancer screening rates by 4 percentage points.
- Significantly reduced high-dose opioid use.

> Before we started this program, we'd come up with an idea to change something with operations, and clinic staff would be very worried or nervous that this would be a big change. Now, having that structure, they see the plan laid out, and they'll see that we'll evaluate it, and we can go back to the way things were before. So, it feels safer to try these new experiences.
>
> **Callie Rzasa, MD**
> *Medical director of pediatric cardiology, UK HealthCare*

Honorable Mention

Incentivizing Quality Care

Improving the patient experience at NYC Health + Hospitals started with making patients feel seen and heard.

NYC HEALTH + HOSPITALS

Care Improvement Contest

NYC Health + Hospitals
New York

Team Members: Jeremy Segall, MA, RDT, LCAT; Komal Lodaria, MA

To improve health equity, NYC Health + Hospitals, in New York, launched the Care Improvement Contest initiative to educate health care workers on patient experience and build their capacity to lead successful quality improvement projects.

Eleven teams documented the current state of the inpatient experience; discussed gaps, challenges, and barriers to success; and devised and tested solutions. Projects focused on nurse leader rounding, interdisciplinary provider rounding, empathy skill building and teach-back training, complex discharge planning and post-discharge follow-up, and daily management system boards and whiteboards.

"Some of the things we did were very simple," says Tulip Williams, RN, BSN, director of nursing at NYC Health + Hospitals/Jacobi and North Central Bronx. "We went back to basics: Knocking on the patient's door before we entered, sitting at the patient's bedside rather than standing. Patients' perception is important."

Contest leadership evaluated these initiatives using hospital ratings on patient satisfaction surveys, as well as the number of documented performance improvement projects based on Care Improvement Contest efforts, the number of equity lenses applied to examine disparities in perceptions of care received, and the rate of change in the selected outcome measure per project. Project team members presented their work at daily huddles, and effective projects were chosen for presentation to the health system board of directors.

Winning projects included:

- Third quarter 2021: Jacobi Unit 5D (Medicine/Telemetry) implemented a nurse leader rounding practice on admitted patients, used the teach-back method to ensure patients understood their care plans, improved their nursing handoff report, conducted post-discharge phone calls to ensure continuity of care, and participated in empathy training. To ensure these solutions were equitably applied, the team also increased the use of interpreter services. Scores for communication with nurses increased from 46.81 to 77.34 percent.
- Fourth quarter 2021: Metropolitan Unit 4C (Mother/Baby) increased collaboration between obstetric and pediatric services through physician-led multidisciplinary rounds to discuss care plans for the mother and baby together. These practices were complemented by Service Excellence trainings on staff communication and regularly sharing patient experience data during huddles and at the nurses' station. Scores for communication with physicians increased from 74.67 to 95.83 percent.
- First quarter 2022: North Central Bronx Unit 9B (Medicine/Surgery) implemented a structured bedside rounding practice for admitted patients, which became interdisciplinary over the course of the project. Leaders also introduced "Welcome Rounds" for newly admitted patients to meet with a nursing leader on the unit and a Patient/Guest Relations team member. Scores for communication with nurses increased from 50.53 to 79.79 percent.
- Second quarter 2022: Woodhull Unit 8200 (Medicine) practiced uninterrupted listening time during patient interactions, captured patient needs on whiteboards, streamlined bedside medication administration, and performed quality checks on these practices. Scores for communication with nurses increased from 59.08 to 74.75 percent.

These small-scale projects also affected overall hospital patient experience ratings. From the third quarter of 2021 to the second quarter of 2022:

- Hospital rating scores increased from 61.61 to 64.33.
- Scores evaluating communication with nurses increased from 69.21 to 71.72 percent.
- Scores for communication with physicians increased by 3.17 percent.

"What we learned was that, through the power and approach of performance improvement, and with intentional support of care providers, we can actually change [not only] the perception but also the actual experience of a patient receiving care at our facilities," says Jeremy Segall, MA, RDT, LCAT, assistant vice president and system chief wellness officer at NYC Health + Hospitals.

Highlighted Program

Reducing Readmissions in Substance Use Disorder Patients

HennepinHealthcare

Hennepin Healthcare
Minneapolis

Team Members: Heather Rhodes, PharmD

Hennepin Healthcare partnered with Hennepin Health (HH), a county-based accountable care organization (ACO) serving the state's Medicaid program, to confront the leading cause of 30-day readmissions within the HH population: acute and chronic complications of substance use disorder (SUD). The health system deployed a certified peer support specialist (CPSS) to the inpatient, emergency department (ED), and community settings to build rapport, promote continuity of care, and connect patients with SUD to social services and treatment resources.

The CPSS reflects the population the program aims to serve—a person of color with lived experience and an extensive professional network. In June 2021, Hennepin began identifying patients with SUD via case file review by the ACO's case management, referral by its addiction medicine team, and CPSS review of the ED patient list. The CPSS then visited the patient to confirm eligibility and connect them to outpatient social service support and treatment resources. In response to patient feedback, the CPSS began carrying business cards, which encouraged patients who initially declined support to follow up.

From June 2021 through October 2022, Hennepin screened 660 patients for eligibility, and 334 agreed to intervention. Patients were primarily Black and American Indian men in their early 40s, 16 percent of whom were experiencing homelessness and 40 percent of whom experienced mental illness. The readmissions rate fell from more than 30 percent in the first month of the program to 14.5 percent after 12 months and 11.4 percent after 16 months. In the readmitted cohort, 40 percent of encounters were medical, one-third were related to medical and SUD needs, and slightly more than a quarter were solely SUD-related. Ten percent of patients were discharged to a treatment or detoxification facility.

Highlighted Program

Safer @ Home

Health Services
LOS ANGELES COUNTY

Los Angeles General Medical Center
Los Angeles

Team Members: Josh Banerjee, MD, MPH, MS

Los Angeles General Medical Center expanded a home-based care program first introduced to provide oxygen for COVID-19 patients during the pandemic. Safer @ Home provides concierge-level, protocolized care to hemodynamically stable patients with acute medical conditions that normally result in hospitalization. Patients receive daily calls, remote vital sign monitoring, and focused return visits.

From September 1 to November 30, 2022, Safer @ Home cared for 162 patients with 19 different primary diagnoses. Compared with patients hospitalized for those same diagnoses during the previous year, Safer @ Home patients spent 549 fewer days in the hospital, an average of 3.4 fewer bed days per patient. No patients died, and 30-day return emergency department and hospital admission rates were both 12 percent—lower than baseline hospital readmission rates. The program resulted in a net savings of $1,160,610.98 in three months.

Highlighted Program

Patient Navigation and Transitions of Care

University Health

University Health
San Antonio

Team Members: Brian Lewis, MBA

After a rise in 30-day readmission rates, University Health launched a navigation program targeted toward patients within Centers for Medicare & Medicaid Services episodic readmission categories. A team of two registered nurses and one pharmacist uses daily electronic health records, as well as the LACE+ risk of readmission tool, to identify episodic patients to target interventions, education, and timely follow-up. Clinical navigators ensure warm hand-offs for patients and their families and provide updates at biweekly transitions of care team meetings attended by hospital leadership.

During the COVID-19 pandemic, the team prioritized navigation for COVID-19 patients and patients with congestive heart failure, identified as the highest priority with chronic health conditions. Regular operations resumed in mid- to late-2022.

From October 2020 to September 2021, navigated patients had a 30-day readmissions rate of 5.5 percent, compared with an 11.7 percent readmissions rate for the non-navigated patient population. From October 2021 to September 2022, the navigated population had a 4.8 percent readmission rate, compared with 10.1 percent for the non-navigated population. From October 2021 to September 2022, 88.1 percent of patients were educated, 61.1 percent attended a follow-up appointment, and 98.2 percent received follow-up calls.

POPULATION HEALTH

Winner

Parkland Health Reaches into the Community

Parkland Health works to mitigate disparities in obstetric outcomes through its Extending Maternal Care After Pregnancy (eMCAP) Program, which provides in-home care, telehealth care, and community health worker outreach to obstetric patients.

Parkland
Care. Compassion. Community.

Advancing Health Equity in Dallas County

Parkland Health
Dallas

Team Members: Donna Persaud, MD, MBA; Jessica Hernandez, MHA; Teresita Oaks, MPH; Michael Malaise, ScD; Philip Huang, MD, MPH

A Community Health Needs Assessment and data analysis revealed that one-third of Dallas ZIP codes ranked in the five highest-need Social Needs Index scores. Individuals in those ZIP codes, who are predominantly Black and Hispanic, live at or below the poverty level and face low education and employment levels, lower life expectancies, and barriers to health care coverage. These challenges result in higher morbidity and mortality rates for diabetes, hypertension, and pediatric asthma, along with more patients presenting in late-stage breast cancer.

"It's incumbent upon us to try to reach into society, especially to serve our patients who might not have the means to access health care," says Cesar Termulo, MD, associate medical director, community-oriented primary care, at Parkland Health. "There might be issues with transportation; lots of them might not have adequate cellphone or internet usage. So, there are a lot of factors that prevent a patient from being able to access our clinics."

To address these disparities, Parkland established nine population health initiatives focused on access to care, behavioral health, breast health, diabetes, hypertension, maternal and child health, pediatric asthma, sexually transmitted infections, and cultural competency.

Parkland hired community health workers from target ZIP codes to perform health screenings, connect individuals with social resources, and provide cultural competency materials approved by Parkland Health's Patient Advisory Council.

The health system implemented a community health record to document screenings and associated care navigation. Parkland trained more than 105 community agency staff to help people apply for health care coverage, resulting in 987 applications, of which 86 percent were successful. Working with local organizations, the system supported a farmers market offering fresh produce to 1,500 people and 15 community gardens in targeted ZIP codes.

Between 2019 and 2022, Parkland reported:

- A 264 percent increase in primary care encounters.
- A 123 percent increase in annual hypertension screenings.
- A 40 percent increase in the percentage of newly diagnosed HIV patients treated within 30 days.
- A 16 percent increase in blood pressure control.
- A 12 percent increase in chlamydia testing within at-risk ZIP codes.
- A 7 percent increase in annual mammograms.

The health system also implemented diabetes screening and follow-up, screening 415 in 2021 and more than 1,153 in 2022, and evaluated diabetes control as measured by a hemoglobin A1c level less than 9. The disparity in diabetes control between diabetes patients living in at-risk ZIP codes and all Parkland patients dropped from 2.7 percent in 2019 to 0.7 percent in 2022.

For patient Lawrence Opara, community health workers were key to helping him get his health back on track and keep his blood pressure stable.

"The health community workers are there to help you," he says. "My experience with them is awesome."

> As a woman of color who has lived and currently works in the communities that are hardest hit by high cancer and morbidity and mortality rates, this gives me an opportunity to give back to the community where I grew up.
>
> **Aeisha Taylor, MHA**
> *Mammography patient health educator, Parkland Health*

Honorable Mention

Community Health Workers Drive Health Forward

By spending time with patients in the emergency department, community health workers at Sinai Chicago identify their health needs and help coordinate their care after discharge.

Sinai Chicago

Community Health Worker Support Program

Sinai Chicago
Chicago

Team Members: Helen Margellos-Anast, MPH; Kelly McCabe, MSPH; Stacy Ignoffo, MSW; Gloria Seals; Jeanette Avila; Melinda Banks; René Bucio, Aaron Chestnut, MPH; Madeline Woodberry; Alyce Roberson; Jannette Guzman

Sinai Chicago serves the west and southwest sides of Chicago, home to predominately Black and Hispanic communities that have experienced decades of disinvestment and now face burdensome socioeconomic conditions and glaring health inequities.

In 2018, Sinai Urban Health Institute (SUHI), the health system's community-driven research center, piloted a program to identify social determinant of health (SDOH) needs among patients presenting to the emergency department (ED) with nonfatal gun violence injuries.

The pilot introduced community health workers (CHWs) into hospital operations and quickly expanded beyond patients with nonfatal gun violence to include patients with complex needs. Social workers and other department leaders refer all Sinai patients who are discharged from the ED and inpatient units and have a high or medium risk of readmission, as well as any COVID-19 patients, to the CHW Support Program (CSP).

CHWs contact patients post-discharge, screen patients for SDOH needs, reinforce discharge instructions, and help patients navigate follow-up care and community resources, based on need.

Melinda Banks, community health worker program coordinator at Sinai Chicago, recalls how spending time with one patient helped her identify his health needs.

"Spending a significant amount of time with him, I learned some of his home stressors," she says. "He shared that his wife sometimes makes frozen meals for him, so with that information, together with social work, we were able to connect him to a nutritionist to give him healthier eating options."

While developing the program, SUHI consulted its Community Advisory Committee, which comprises 10–15 community residents, leaders, and organizational representatives spanning age groups, neighborhoods, race/ethnicities, and occupations.

Since July 2020, more than 2,131 high-risk patients have been referred to the CSP, which has greatly improved health outcomes in the community. Fifty-two percent of patients referred were successfully screened for SDOH, and CHWs connected 83 percent of patients to services related to a variety of needs, including food insecurity, transportation, housing insecurity, behavioral health, asthma, and domestic violence.

CHWs also increased patient knowledge, self-sufficiency, and sense of self-efficacy and provided outreach, navigation, culturally appropriate education, informal counseling, social support, and advocacy once a patient leaves the hospital. Patients screened by CHWs had a 30-day readmissions rate of 22 percent, compared with a 31 percent readmissions rate for patients who were referred to the program and not screened.

> "It's very important that we do have community health workers that are reaching out to our patients because some of those patients live alone and they need that extra support. They need that extra emotional support to get on the path of living a healthier life."
>
> **Melinda Banks**
> *Community health worker program coordinator, Sinai Chicago*

Highlighted Program

Real-World Application of a County-Wide Substance Use Model

Health Care District of Palm Beach County
West Palm Beach, Florida

Team Members: Belma Andric, MD, MPH

At the peak of Palm Beach County, Florida's opioid crisis, the Health Care District of Palm Beach County (HCDPBC) determined that substance use disorder (SUD) should be treated under the house of medicine like any other serious condition.

HCDPBC partnered with HCA Florida JFK North Hospital and the Palm Beach County Commission in February 2020 to create an addiction-specialized emergency department (ED) staffed with experts trained in evidence-based addiction protocols and to provide outpatient care after discharge.

Through this unique coordinated care system, SUD patients, primarily the uninsured, receive immediate care and access to treatment to reduce the chance of relapse. ED patients first receive treatment for the most acute stage of their SUD. The continuum of care is ensured following their discharge from the ED through a warm handoff to the HCDPBC Federally Qualified Health Center outpatient clinic that is conveniently located within walking distance on the same campus. This approach affords patients access to the long-term quality care they would receive for any other chronic condition.

Since opening, the specialized ED has served more than 4,000 unique patients, and 55 percent of these patients accepted a warm handoff to the outpatient clinic. In 2021, the clinic also served more than 800 unique patients for medication-assisted treatment and had more than 12,100 visits for SUD.

Highlighted Program

Memorial's LivWell Program

Memorial Healthcare System
Hollywood, Florida

Team Members: Timothy Curtin, MBA, MSW

Memorial Healthcare System's LivWell Program aims to increase access to care, reduce health disparities, and improve health status through evidence-based strategies, home visits, and community-based activities in Broward County, Florida.

The county faces high rates of low health literacy; poor adherence to medications and treatment regimens; and poorer health outcomes, poverty, homelessness, immigration, and insurance status. In 2022, the United Way of Broward County Asset Limited, Income Constrained, Employed (ALICE) Report found that more than 50 percent of Broward families earn less than the cost of living for the county.

Since its inception, LivWell has served 544 individuals, increasing access to primary and preventive care for 98.8 percent of participants and eliminating transportation, linguistic, and other barriers related to social determinants of health. The program also reduced hospitalization and emergency visits, and 97.8 percent of participants experienced increased access to primary and preventive care through home visits by culturally competent program staff.

Highlighted Program

UTMB's Community Health Program: Empowered Care Coordination

The University of Texas Medical Branch
Galveston, Texas

Team Members: Craig Kovacevich, MA

The University of Texas Medical Branch (UTMB) Health's Department of Alternative Care Models provides community-based care and disease management services to adults with chronic conditions such as diabetes, hypertension, heart disease, and/or chronic obstructive pulmonary disease through its Community Health Program (CHP).

The program's goal is to encourage a more personal, referral-based level of care coordination that empowers the patient and caregiver to contribute toward more successful outcomes.

The CHP model includes a social worker who, along with the care manager and community health worker, ensures all patients enrolled in the program have a comprehensive intake assessment and are viewed through a "whole person" lens to best meet the patient's medical and social needs.

The program resulted in a more appropriate usage of health care resources, as reflected in an 85 percent decrease in inpatient encounters and a 42 percent decrease in emergency department visits. More than 40 percent of patients with diabetes saw a drop in their hemoglobin A1c values after participating in the program, and more than 50 percent of patients with hypertension saw a drop in either systolic or diastolic blood pressure values.

Explore Our Essential Communities

America's Essential Hospitals shares resources and promising practices to support essential hospitals and their partners in advancing population health. One such resource, the association's Essential Communities website, helps hospitals on the journey to community-integrated health care.

Studies show clinical care is only a small part of the many things that influence health. Social and economic factors play a larger role in health outcomes, quality of life, and life expectancy.

These social determinants of health encompass the conditions in which we live. Every aspect of living has some effect on our health, from healthy diet and exercise to safe streets and community parks. Intervening in these upstream factors can significantly affect downstream health outcomes.

Learn more about how our hospitals change the course of social and economic factors that influence health and quality of life, including climate change, structural racism, housing instability, food insecurity, lack of education, interpersonal violence, and more. Take a virtual tour of population health and antiracist programs nationwide, and share a program of your own at EssentialCommunities.org.