Excellence and Innovation in Care

The 2026 Gage Awards

About America's Essential Hospitals

America's Essential Hospitals is the leading association and champion for hospitals dedicated to 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 and access to health care. We support our more than 400 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 other services. Supported by Essential Hospitals Institute, the association's research and education arm, 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 quality of care, population health, and operational excellence. 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 https://essentialhospitals.org/research/gage-awards. There, find videos and podcasts highlighting award-winning projects.

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

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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, environmental, and economic factors play a larger role in health outcomes, quality of life, and life expectancy.

These social drivers 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, environmental, and economic factors that influence health and quality of life. Take a virtual tour of community-integrated health care programs nationwide, and share a program of your own at EssentialCommunities.org.

QUALITY IMPROVEMENT

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. Quality improvement programs may include evidence-based interventions, standardized practices, bundles of care, and checklists.

Supporting Mothers with Substance Use Disorder

DENVER HEALTH
est. 1860
FOR LIFE'S JOURNEY

Denver Health

Denver

OB Perinatal Addiction Recovery (OB PEAR) Program

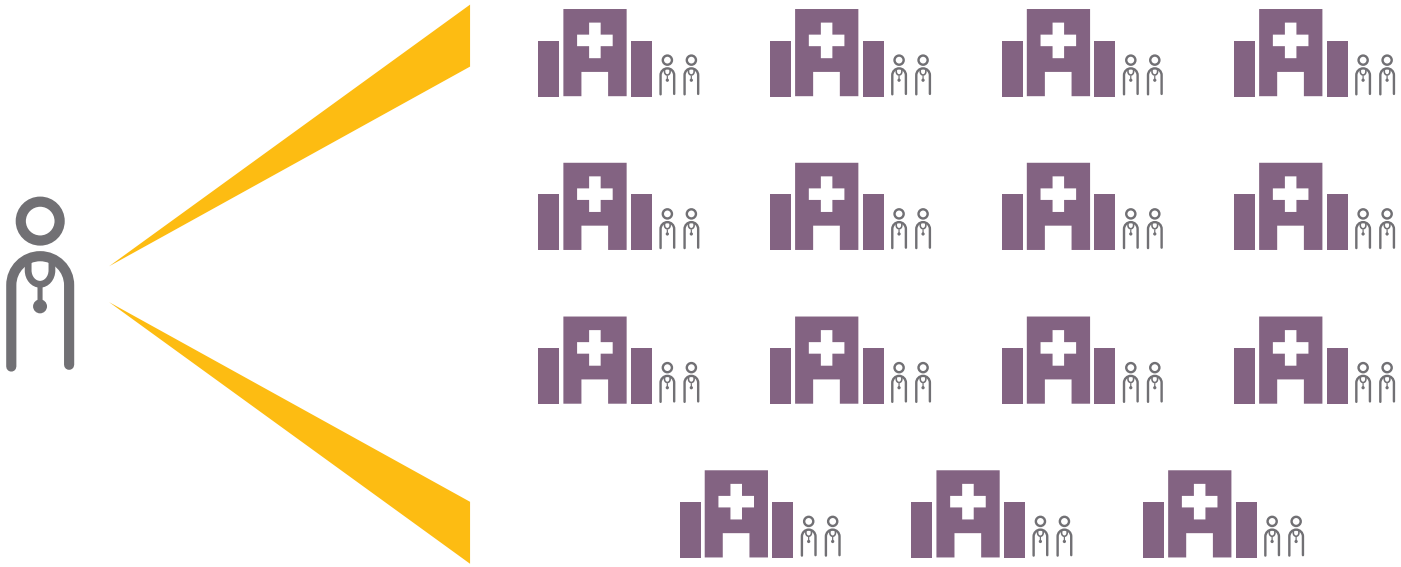
Team Members: K. Culp, S. Fabbri, R. Pierce, D. Lynne, L. Penny

>60%

OF PATIENTS DISCHARGED OPIOID-FREE

The OB Perinatal Addiction Recovery (OB PEAR) Program at Denver Health (DH) aims to reduce maternal morbidity driven by substance use disorder (SUD), improve access to evidence-based SUD treatment, decrease stigma, and coordinate care. The Colorado Maternal Mortality Review Committee found that suicide and unintentional drug overdose are leading causes of maternal morbidity and that nearly 90% of those deaths were preventable. At DH, 85% of pregnant patients are publicly insured, and 41% speak a language other than English. In 2024, more than 4,300 births—over half of all Denver County deliveries—occurred at DH. Nearly 12% of pregnant patients had SUD, and more than 40% had behavioral health comorbidities, underscoring the need for integrated care for all.

Launched with Maternal Overdose Matters Plus and the Colorado Perinatal Care Quality Collaborative, OB PEAR integrates SUD screening, treatment, and care coordination into routine prenatal and postpartum care. OB PEAR's team spans more than 15 clinical departments, including obstetrics clinics, labor and delivery, postpartum care, social work, pharmacy, and behavioral health. Standardized workflows, shared decision-making practices, and regular interdisciplinary meetings strengthened coordination between inpatient and outpatient teams and supported sustainable implementation. Peer recovery coaches from Operation Care by HardBeauty extend care beyond the hospital.



PROVIDER CAPACITY EXPANDED FROM **ONE** TO **30** TRAINED CLINICIANS ACROSS **15** CLINICS

Coaches hear patients' perspectives, particularly on birthing experiences and child protective services processes, to inform program design.

From May 2024 to August 2025, use of the validated 5Ps Prenatal Substance Abuse Screening Tool, a tool designed by the Institute for Health and Recovery to detect substance use in pregnant individuals, has exceeded 96%, with no disparities by race, ethnicity, or payer. Staff stigma and bias training increased awareness of overdose and suicide as leading maternal mortality contributors from under 10% to 60%, while rates of staff expressing empathy toward patients with SUD rose from 40% to 85%. Harm reduction efforts identified 136 at-risk patients and distributed 174 naloxone kits. Patient-specific opioid-prescribing protocols reduced average cesarean-delivery discharge opioid prescriptions from 52.7 to 18.4 morphine milligram equivalents, with over 60% of patients discharged opioid-free. Standardized workflows reduced urine toxicology testing to less than 1% of pregnant patients and connected 97% of patients screening positive for SUD to care. Provider capacity expanded from one to 30 trained clinicians across 15 clinics, reducing treatment wait times to less than a week.

> "A big part of the OB PEAR program was education, particularly related to destigmatizing substance use disorder and treatment in pregnancy...to our clinical staff such that we can provide equitable, high-quality care to everyone with respect to dignity, regardless of their walks of life."
>
> STEFKA FABBRI, MD
> Chair, OBGYN Department
> Denver Health

OB PEAR integrates SUD screening, treatment, and care coordination into routine prenatal and postpartum care to reduce maternal morbidity.

Ensuring Physician Trainees' Well-Being

Hennepin Healthcare

Hennepin Healthcare

Minneapolis

RISE – Improving Health by Caring for Physician Trainees

Team Members: To come

Hennepin Healthcare, an urban academic safety net health system, launched the Resident Integrated Support Environment (RISE) to lower high rates of suicide and untreated illness and reduce barriers to care among physician trainees. Demanding and inflexible schedules, stigma around seeking help, and concerns about licensure consequences often prevent trainees from accessing timely medical and mental health services. RISE was designed to remove these barriers through confidential, flexible, and comprehensive care tailored to trainees' unique needs.

The program aims to normalize and facilitate access to care for trainees through integrated primary care, psychiatric and psychological services, and financial counseling. Trainees can schedule appointments easily via direct messaging. Appointment times accommodate clinical responsibilities and are available often the same

RISE provides a safe atmosphere for physician trainees to seek physical and mental health care.

day or next day and always within two weeks. Care is delivered in person or via video visit and is billed through standard insurance, enabling a financially self-sustaining program and keeping care costs in-house. RISE adopts a whole-person approach by screening for social drivers of health and adverse childhood events and connecting trainees to appropriate resources.

RISE was developed and continues to be led by front-line physicians who identified access gaps through their direct experiences caring for trainees in distress. Initial seed funding included a $130,000 donation from retired faculty, and the clinical program now operates entirely through insurance reimbursement. Ongoing program leadership and care delivery remain aligned with graduate medical education and front-line clinical teams.

> "While being a physician is surely an honor and a privilege, it's also a high-risk profession. The age-old culture of 'physician, heal thyself' runs deep and for decades or more has been one barrier to physicians seeking high-quality medical and psychiatric care for themselves."
>
> ELIZABETH GOELZ, MD
> Chief Wellness Officer
> Hennepin Healthcare

>80%

OF PHYSICIAN TRAINEES ACCESS RISE SERVICES DURING TRAINING

Since its formal launch in 2019, annual visits increased from approximately 200 in the first year to more than 1,000 visits annually across primary care, psychiatry, and psychology. More than 80% of physician trainees access RISE services during training, and all are seen within two weeks of first contact. Appointment fail rates remain low at 1% for primary care and 3% for psychiatry and psychology. Fewer than 10% of trainees are up to date on preventive care before they enter the program, while more than 95% of those receiving RISE primary care meet all evidence-based preventive care criteria. A certified financial planner met with 68% of trainees during training. Collectively, these outcomes reflect RISE's effectiveness in reducing stigma, improving access, and supporting physician well-being.

Parkland
Cancer Center

Parkland Health

Dallas

Data-Informed Multidisciplinary Team Optimizing Cancer Urgent Care

Team Members: A. Hong, U. Dickerson, N. Sadeghi

Parkland Health established its Oncology Acute Care (OAC) clinic in 2017 to provide cancer patients timely, oncology-specific urgent care as an alternative to the emergency department (ED). Health system leaders designed the clinic to mitigate acute symptoms related to chemotherapy and cancer treatment while avoiding unnecessary ED visits and hospitalizations. A mixed-methods evaluation revealed that OAC was underused due to low patient awareness, inconsistent messaging, and care navigation barriers despite strong patient interest. In response, Parkland Health launched a data-driven, human-centered design initiative in 2023 to increase OAC use and improve acute symptom management.

Clinic staff provide cancer patients with timely, oncology-specific urgent care as an alternative to the emergency department.

A multidisciplinary OAC workgroup used patient interviews, stakeholder input, and workflow mapping to redesign how patients with cancer access acute care. With input from the Patient and Family Advisory Council, the workgroup standardized terminology and messaging for a "cancer nurse phone line," shifted patient education to higher-impact touchpoints such as post-chemotherapy infusion, and developed culturally and linguistically appropriate education materials in English and Spanish. The workgroup implemented a structured electronic health record triage template to support real-time monitoring of process and outcome measures. The OAC workgroup translated a Medicare avoidable hospital visit quality measure into a series of tangible tasks and process measures that turns data into actionable clinical information.

The OAC workgroup includes 20 members representing infusion and clinic nursing, nurse navigation, advanced practice providers, patient access, social work, patient advocacy, physicians, researchers, and quality improvement specialists. Partnerships with Parkland's Center of Innovation and Value and UT Southwestern support the initiative through a care delivery research collaborative, funded through an American Cancer Society grant and a Texas Health Resources Clinical Scholars Award. The workgroup meets monthly, and improvements are sustained through workflow integration and cross-disciplinary trust.

Early results demonstrate improved access to OAC and reduced reliance on the ED. Avoidable hospitalizations within 30 days of chemotherapy decreased from 15% to 10%. Call volumes tripled and remain high three years after implementation. More than half of calls were converted to same-day OAC visits, while one-third were resolved over the phone. Patient satisfaction reached 90%, with qualitative feedback highlighting gratitude for timely, specialized care.

Onvida Health

Yuma, Ariz.

Rural Hospital Readmission Reduction Program

Team Members: L. Wiley, A. Gonzalez, B. Smith, M. Smith

96%

OF PARTICIPANTS HAVE REMAINED SAFELY AT HOME POST-DISCHARGE SINCE OCTOBER 2023

Onvida Health launched the Hospital Readmission Reduction Program in 2012 to reduce 30-day hospital readmissions and improve outcomes for Medicare beneficiaries and patients with chronic illness. Data revealed that Medicare patients, particularly those with congestive heart failure (CHF) and chronic obstructive pulmonary disease, experienced the highest readmission rates. Risk factors included limited access to follow-up care, difficulty refilling medications, difficulty understanding discharge instructions, transportation barriers, and insufficient caregiver support. In response, Onvida Health united clinical, educational, and social support into a single post-discharge model designed to strengthen transitions from inpatient care to recovery at home.

Onvida Health serves Yuma County, Ariz., an under-resourced and predominately rural community region. To meet rural patients' unique needs, Onvida Health tailored the Hospital Readmission Reduction Program using evidence-based transitional care models. The health system implemented nurse-led follow-ups, medication reconciliation, and partnerships with community resources.

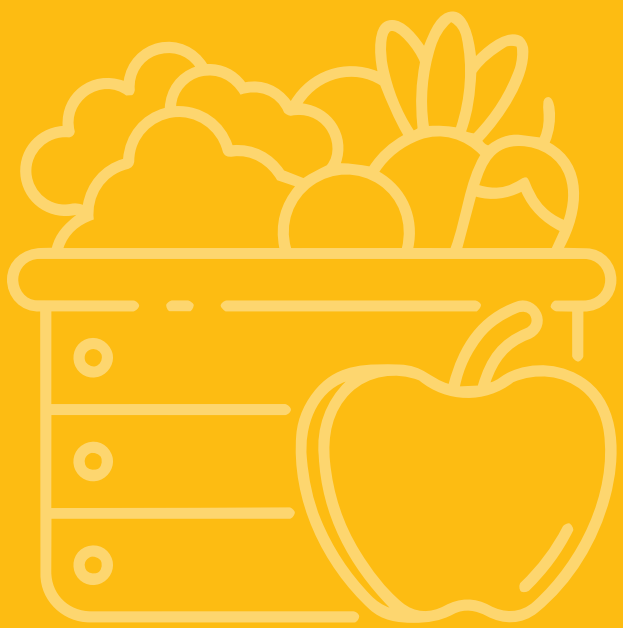
An interdisciplinary team, including nurse practitioners, registered nurses, medical assistants, a dietitian, and a phlebotomist, works closely with pharmacists, primary care providers, and social workers to support high-risk patients. Together, the team standardized follow-up protocols, refined care pathways for high-risk conditions, and implemented medication education practices to improve understanding and adherence. Additionally, patient and family feedback shaped the program design by identifying gaps in education and support during the post-discharge period. Initially, the program was fully funded by the hospital's operational quality-improvement budget, but it is now built into Onvida Health's annual quality and population health budgets, which ensures long-term stability.

Program outcomes demonstrate significant improvement in care quality and utilization. In 2024, only 3.99% of program patients were readmitted within 30 days, compared with a readmission rate of 14.3% of all Medicare patients at Onvida Health. CHF readmissions declined to 3.6% between July 2024 and July 2025. Since October 2023, 96% of participants have remained safely at home post-discharge. Onvida Health's systemwide Medicare payment readmission penalty decreased from 1.69% per patient in 2017 to only 0.05% per patient in 2023. Patients also reported high satisfaction levels, reflecting improved access, education, and support during recovery.

Onvida Health tailored the Hospital Readmission Reduction Program to meet the unique needs of rural patients.

POPULATION HEALTH

Gage Awards for population health recognizes innovative programs that improve health outcomes by addressing the factors that shape well-being—such as housing, food access, transportation, and social support. Successful initiatives extend beyond hospital walls, engage community resources, and form strong partnerships to support healthier populations.



Wellness Initiatives Improve Community Health Trends

SBH Health System

Bronx, N.Y.

SBH Health and Wellness Center

Team Members: A. Lin; D. Perlstein, M. Kulshreshtha, A. Gellman, A. Jovel

SBH Health System serves a community that has ranked among New York's unhealthiest counties since 2009. This community faces systemic challenges including income inequality, housing instability, food insecurity, limited safe spaces for physical activity, and neighborhood safety concerns. In response, the health system converted a parking lot into the SBH Health and Wellness Center, a comprehensive wellness hub within a $156 million mixed-use development. This program shifts care upstream by prioritizing ambulatory services and targeting key social determinants of health, while aligning financial sustainability with community well-being.

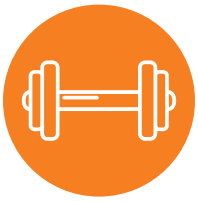
Guided by a community health needs assessment, SBH identified three priorities: chronic condition prevention, access to affordable housing and nutritious food, and community safety. Core program components include:

- 314 affordable housing units, including 94 units for individuals who have experienced homelessness and high Medicaid users
- A medically based fitness center that integrates physical activity into clinical care
- A rooftop farm and food distribution partnerships
- A teaching kitchen offering culturally relevant nutrition education
- Wellness and movement programs tailored to diverse ages and abilities

314 AFFORDABLE HOUSING UNITS OCCUPIED

300 PARTICIPANTS

41% INCREASE IN UNDERSTANDING HEALTHY FOOD CHOICES



1,023 MEMBERS JOINED A GYM

Targeted initiatives include stroke recovery and post-surgical rehabilitation; Alzheimer's-friendly Tai Chi; youth fitness; and a gun violence prevention boxing program focused on conflict resolution, self-esteem, and physical health.

SBH donated hospital-owned land and invested $27.6

> "The wellness center gives our primary care teams the tools to really address what drives health outside of the exam room."
>
> DAVID PERLSTEIN, MD
> President and CEO
> SBH Health System

million to develop 50,000 square feet of wellness space, with additional support from state and local funding sources. Key partners include L+M Development for housing, BronxWorks for on-site wraparound services, Healthplex Associates for medically integrated fitness programming, and a Culinary Center led by a chef and registered dietitian. Additional collaborations with schools, public agencies, professional sports organizations, and community groups expand reach and impact.

Since implementation, all 314 affordable housing units are occupied. The Healthy Living Program enrolled 300 participants, achieving measurable improvements in body mass index, strength, muscle mass, and fat reduction. Teaching kitchen participants reported a 41% increase in understanding of healthy food choices, while youth in the gun violence prevention program improved de-escalation skills from a baseline score of 1.6 to 4.2 (on a five-point scale). Gym membership grew from zero to 1,023 members, monthly food pantry distribution doubled, and patient satisfaction increased.

Alzheimer's-friendly Tai Chi helps community members of all abilities stay active.

Using Telehealth to Monitor Cardiac Care

TMC Health

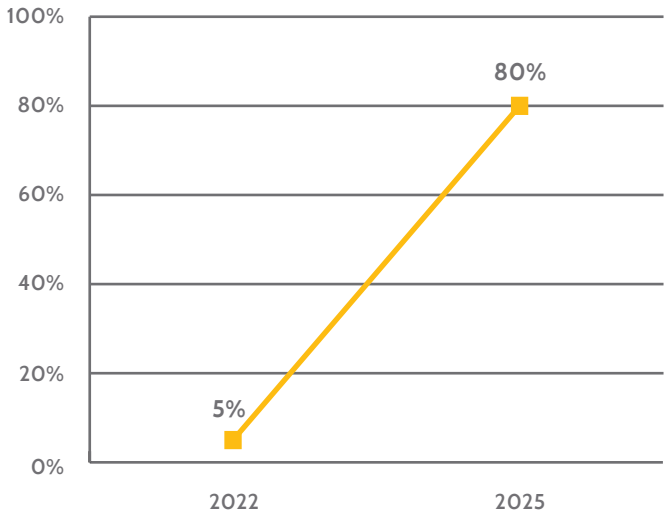
Tucson, Ariz.

Hearts Close to Home

Team Members: J. Strange, A. Evans, J. Zibart, V. Cooper, G. Kartchner

> "It's not just about convenience, it's about community and … people being proud of the health care system that they have."
>
> JULIA STRANGE
> Vice President, External Affairs and Brand
> TMC Health

TMC Health launched Hearts Close to Home to improve access to cardiac rehabilitation among rural patients. A Community Health Needs Assessment revealed that only 5% of eligible patients living in rural communities participated in cardiac rehabilitation following a cardiac event, compared with a national average of 34%. The health system identified distance, transportation challenges, and associated financial and physical burdens as primary barriers. Hearts Close to Home removes these obstacles by delivering monitored, evidence-based cardiac rehabilitation through a telehealth-enabled model that allows patients to receive care close to home.



INCREASE IN REHAB ENGAGEMENT

TMC Health consulted with Cochise County residents who had experienced cardiac events, including both participants and nonparticipants in traditional rehabilitation. Feedback consistently identified transportation as the most significant barrier, with patients seeking high-quality, supervised care from trusted local providers. TMC Health selected its facility Benson Hospital as the pilot site. The health system invested in telehealth infrastructure that enables real-time clinical oversight by TMC cardiac rehabilitation specialists alongside in-person nursing support at the local site. The program also integrates behavioral health screening and support to treat anxiety and depression and connects patients to community resources that reinforce long-term recovery.

More than $250,000 in philanthropic support from the TMC Health Foundation and Arizona Complete Health supported telehealth and monitoring technology, including the VitalChat telehealth platform and ScottCare physiological monitoring systems, as well as staff training. The Sulphur Springs Valley Electric Cooperative provided additional infrastructure support. Shared staffing, system integration, and continued philanthropic investment support sustainability. Partnerships with local food pantries and organizations such as Produce on Wheels Without Waste and Market on the Move connect patients with heart-healthy foods that reinforce their rehabilitation goals.

Program success is measured by participation, clinical outcomes, and quality-of-life indicators. Between

September 2022 and September 2025, Hearts Close to Home achieved an 80% referral-to-enrollment rate, more than double the national average. Among participants, 81% improved functional capacity by at least 40%, 87% maintained blood pressure below 130/80, and 80% demonstrated improvements in depression and anxiety. Collectively, participants avoided more than 158,000 miles of travel, illustrating the program's impact on access, outcomes, and patient experience.

158,000 MILES OF TRAVEL WERE AVOIDED

Hearts Close to Home removes transportation and financial obstacles to care by delivering monitored, evidence-based cardiac rehabilitation through a telehealth-enabled model.

NYC HEALTH+ HOSPITALS | Elmhurst

NYC Health + Hospitals/Elmhurst

Queens, N.Y.

A Transition Care Program to Reduce Emergency Room Visits and Admissions by >50% among High-Risk Patients with Social Determinants of Health

Team Members: M. Paul, J. L. Romano, S. Warner, N. Lopez, K. Riviera, A. Rodriguez

As a level I trauma center serving a diverse and largely immigrant community, NYC Health + Hospitals/Elmhurst recorded 85,675 emergency department (ED) visits in 2023. Many of these visits were driven by unmet social needs among vulnerable patients. In response to ED overcrowding and high rates of non acute ED utilization and hospitalizations, the safety net hospital launched a 90 day ED Follow Up care coordination program in March 2023.

A collaboration between the departments of Social Work and Emergency Medicine, this program is staffed by three community liaison workers (CLWs) and supervised by a program director and a licensed clinical social worker. Each CLW manages 30–35 patients weekly and completes an average of 14.7 encounters (telephone and in-person visits) per patient in 90 days.

Patients are identified through real-time daily electronic health record reviews of the ED board, followed by a screening for their social determinants of health. Elmhurst screens roughly 80% of ED patients—around 9,000 individuals per quarter—underscoring its institutional commitment to health equity. Services include linkage to primary care, insurance enrollment, medical transportation, food and housing resources, legal aid, and health care navigation. A central focus is supporting immigrant patients by enhancing their health literacy and fostering self-advocacy, particularly for those who are uninsured, underinsured, asylum seekers, or undocumented.

The program partners with many community-based organizations, including Make the Road New York and Voces Latinas, to ensure warm handoffs for patients requiring legal, immigration, or specialized social service support.

The program has enrolled 1,164 patients, and both ED visits and hospitalizations decreased by more than 50%. This reflects the impact of tailored social needs support, strengthened health literacy, and improved continuity of care for high risk patients facing significant barriers to health care. Between 2023 and January 2026, only 31% of discharged patients returned to the ED within six months—a 68% reduction—while inpatient hospitalizations decreased by 58%, with only 1% requiring hospitalization post intervention.

These outcomes underscore the program's role in reducing avoidable utilization, improving continuity of care, and generating cost savings for a safety net system. The hospital saw an upwards of $25 million in cost savings from prevented ED visits and hospitalizations between 2023–2026, thanks to the ED Follow-Up Program's intervention.

NYC Health + Hospitals/Elmhurst launched a 90-day ED Follow-Up care coordination program to reduce avoidable utilization, improve continuity of care, and generate cost savings.

UNIVERSITY MEDICAL CENTER OF EL PASO

University Medical Center of El Paso

El Paso

Age-Friendly Health System Initiative

Team Members: Executive, Administrative & Operational Leadership Team; Provider, Clinic Operations & Frontline Staff; Data, Informatics & Analytics Team; Quality and Performance Outcomes Staff

University Medical Center (UMC) El Paso's Age-Friendly Health System initiative is a multidisciplinary, collaborative strategy to transform access to care for older adults. Guided by the Institute for Healthcare Improvement's (IHI's) nationally recognized framework—What Matters, Medication, Mentation and Mobility—the initiative targets the unique realities of aging across the United States-Mexico border.

UMC El Paso serves one of the most under-resourced urban-rural regions in the United States. According to UMC's Health-Related Social Needs survey, 27% of older adults reported food insecurity, 30% reported transportation barriers, and 27% reported housing instability. Additionally, the ratio of primary care physicians to patients is 1 to 2,003, representing almost double the national benchmark. These realities reinforced UMC's commitment to expanding access to care for older adults.

UMC El Paso's Age-Friendly Health System initiative expands access to preventative care and integrates social needs screenings for patients 65 and older.

Four objectives guide the initiative's implementation and evaluate sustainability:

1. Expand access to preventative care for adults 65 and older.
2. Integrate social needs screening into every encounter.
3. Strengthen care coordination through multidisciplinary referrals.
4. Improve chronic condition outcomes through consistent follow-up and medication management.

UMC's Patient Experience Team launched a Patient Family Advisory Council, which includes four community members over 65 who provide ongoing input on clinic experience, accessibility, and communication materials. UMC El Paso also leveraged strong community and academic partnerships to strengthen program implementation, including collaborations with the University of Texas at El Paso, the Area Agency on Aging, and the UMC Emergency Department's Geriatric Emergency Department Accreditation program. These partnerships support workforce training, community education, and connection to local resources for older adults and caregivers. Support through UMC's operational budget ensures long-standing sustainability, and clinical, administrative, and community sectors drive multidisciplinary support.

Within its first year, the initiative increased annual wellness visits by 68%; expanded social needs screening to over 80% of encounters; and increased annual referrals for social work, behavioral health, and clinical pharmacy services from 1,679 to 3,614. These gains strengthened care coordination, improved chronic condition management, and generated an estimated $232,507.88 in added value, reinforcing the initiative's sustainability and return on investment.

OPERATIONAL EXCELLENCE

The Gage Award for operational excellence honors programs that transform health care operations to improve efficiency, workforce engagement, and service delivery. These initiatives streamline workflows, optimize resources, and implement best practices to enhance patient care and overall performance.

Providing Unique Emergency Psychiatric Care

UK HealthCare

UK HealthCare

Lexington, Ky.

From Crisis to Care: EmPATH in Action

Team Members: L. Jasinski, M. Woods, E. Morris, A. Cooley, J. Chandler

63.5%
DECLINE IN INPATIENT PSYCHIATRIC ADMISSIONS

13%
DECREASE IN 30-DAY READMISSIONS TO STATE PSYCHIATRIC HOSPITAL

92.1%
DECREASE IN EMERGENCY ROOM BOARDING TIME

UK HealthCare's (UKHC's) Emergency Psychiatric Assessment, Treatment, and Health (EmPATH) program is a 24/7 psychiatric emergency observation unit designed to replace emergency department (ED) boarding with a treatment-first model for individuals experiencing a behavioral health crisis. EmPATH's goal is to restore hope through compassionate, accessible, and therapeutic care. Program objectives include:

- Accelerating safe crisis stabilization
- Improving continuity of care and downstream outcomes
- Decompressing the ED to optimize throughput
- Enhancing financial sustainability through avoided admissions and reduced sitter use
- Improving patient and staff safety

> "I think the biggest part of the EmPATH model is giving hope—giving those moments of connection and moments of hope that somebody might not have had, and it might be on their worst day."
>
> LINDSEY JASINSKI, PHD
> Chief Administrative Officer
> Eastern State Hospital
> UK HealthCare

Core program activities emphasize rapid, specialized psychiatric care, with evaluation and treatment occurring within minutes of arrival. Services include embedded social work, on-site community mental health services and transportation, a co-located long-acting injectable clinic, universal infectious disease screening, evidence-based suicide interventions, and peer support focused on healing and recovery. Daily interdisciplinary huddles with inpatient services and community partners strengthen care pathways, while therapeutic transport and post-discharge engagement support care continuity.

C-suite leaders spearheaded the EmPATH initiative in collaboration with Kentucky managed care organizations and community organizations, including local mental health centers, law enforcement and emergency services, government officials, homelessness services, the health department, and behavioral health providers. An executive leadership committee guided internal workgroups spanning finance, operations, information technology, human resources, provider leadership, and communications to ensure alignment with program goals.

Before EmPATH, behavioral health emergencies accounted for one in seven UKHC ED visits, averaging more than 30 hours of treatment and often resulting in inpatient admission. Patients with primary mental health

concerns typically required one-to-one observation, with one ED alone logging 12,062 annual observation hours across clinical and security staff. In its first year, EmPATH served more than 6,000 patients, with 76% stabilized and discharged with outpatient follow-up. Follow-up with community mental health centers increased from 29% pre-implementation to over 65%. Inpatient psychiatric admissions declined by 63.5%, 30-day readmissions to the state psychiatric hospital decreased by 13%, and ED boarding time dropped by 92.1%. Average length of stay was 16.2 hours, compared to 16 or more hours for evaluation alone in the traditional ED. Reduced sitter use generated over $250,000 in annual savings while improving ED capacity and safety.

The 24/7 psychiatric emergency observation unit is designed to replace emergency department boarding for individuals experiencing a behavioral health crisis.

Multidisciplinary Approach to Reduce Emergency Visits

NYC HEALTH+ HOSPITALS | Bellevue

NYC Health + Hospitals/Bellevue

New York, N.Y.

Using a Multidisciplinary Inpatient "Lean" Team to Reduce ED Boarding

Team Members: N. Sikka, E. Karim, A. Uppal, E. Wei, A. Montelibano

NYC Health + Hospitals/Bellevue faced unprecedented operational strain following the COVID-19 pandemic, resulting in severe emergency department (ED) overcrowding and prolonged inpatient boarding. By early 2024, ED boarding times exceeded 23 hours. This delayed care, increased patient morbidity, and contributed to extended hospital stays. In response, hospital leadership launched the Inpatient Lean Team, a hospital-wide operational improvement initiative designed to mitigate systemic bottlenecks in patient flow and optimize inpatient capacity.

Core objectives include reclaiming unusable inpatient beds, accelerating discharges and room turnover, prioritizing interfacility transfers, and fostering real-time problem solving across clinical and operational teams.

Key activities include:

- Daily multidisciplinary evaluations of inpatient bed availability
- Proactive solutions, such as creating patient cohorts for infection prevention
- De-escalating behaviorally disruptive patients and expediting facilities repairs to reclaim usable inpatient bed space
- Streamlined discharge processes supported by early clinician orders, nursing coordination with transport teams, and utilizing mobile rovers linked with the electronic health record

Additional strategies include hospital-wide safety huddles, weekly performance metric tracking, expanded telemetry capacity, and expedited ED-to-inpatient nursing handoffs. A "transfer-back" program improved systemwide flow by optimizing specialty resources at Bellevue's tertiary care center. Previously, patients were transferred to Bellevue to wait weeks for specialty care and complete treatment there. Now, patients schedule procedures and imaging in advance and return to their local hospital once specialty needs are met, keeping care closer to home.

A multidisciplinary team and strong leadership

THE NATIONAL ED OVERCROWDING SCORE IMPROVED FROM AN AVERAGE OF 200 TO 9

alignment drove the project's success. Clinical, nursing, administrative, and ancillary teams collaborated to identify barriers, implement solutions, and support real-time escalation, with the Quality Improvement team overseeing data collection and outcomes.

Following implementation, Bellevue achieved sustained, month-over-month reductions in ED boarding time, reaching less than five hours by August 2025. The National ED Overcrowding Score improved from an average of 200, considered dangerously overcrowded, to 9, considered not crowded. Transfer wait time from other system hospitals decreased from over 24 hours to under five hours, and average inpatient length of stay declined from 9.1 days in 2024 to 7.9 days in 2025, while maintaining stable admission volume. Collectively, these efforts drove measurable performance gains and fostered a culture of shared accountability and continuous improvement.

> "Our goal was to reduce boarding time in our emergency department by bringing together all the stakeholders involved in moving a patient, which we discovered was almost everyone."
>
> NEHA SIKKA, MD,
> Clinical Research Fellow
> NYC Health + Hospitals/Bellevue

The Inpatient Lean Team mitigates systemic bottlenecks in patient flow and optimizes inpatient capacity.

UNIVERSITY MEDICAL CENTER OF EL PASO

University Medical Center of El Paso

El Paso, Texas

Length of Stay Improvement Initiative

Team Members: Nursing Operational Leaders, Case Management, Ancillary and Support & Performance Improvement teams

University Medical Center of El Paso launched the Length of Stay (LOS) improvement initiative in March 2023 to target prolonged inpatient stays that crowded the emergency department (ED), delayed discharges, and constrained access for new patients. A baseline review from October 2022 to February 2023 identified an average LOS of 5.99 days and 1,357 admissions per month, highlighting the need for a more proactive, data-driven approach to patient flow and resource management.

The program aimed to safely reduce LOS, decrease ED boarding delays, improve the discharge process, and strengthen overall operational performance. Hospital leaders developed real-time dashboards that provided daily visibility into LOS, discharge barriers, and ancillary service turnaround times. In 2024, the hospital added provider dashboards that compared individual LOS with the Geometric Mean Length of Stay, peer benchmarks, and patient volumes, reinforcing transparency and accountability.

Rather than broadly increasing staffing, UMC focused on adjusting its ancillary services, expanding weekend coverage, and launching a discharge lounge to improve throughput with minimal additional investment. The initiative emphasized continuous improvement through structured 12-week pilot cycles. Interventions were tested, evaluated, scaled when effective, and discontinued when not, with lessons learned captured through formal reflection. This iterative approach embedded adaptability into daily operations and aligned operational decision-making with real-time performance data.

The chief operating officer, chief nursing officer, and chief medical officer provided executive oversight, supported by senior leaders from nursing operations, case management, procedural areas, outpatient clinics, ancillary services, and the ED. A physician oversight committee established in 2025 further aligned clinical practice with organizational strategy. Front-line teams, including hospitalists, bedside nurses, case managers, and ancillary staff, huddled daily and prioritized timely diagnostics and discharges.

After implementation in March 2023, LOS improved to 5.44 days while admissions increased to 1,459 per month. From October 2024 to August 2025, LOS further declined to 5.29 days as admissions rose to 1,471 per month, demonstrating that efficiency gains supported higher patient volumes. Performance was also validated externally through risk-adjusted benchmarking in the Vizient Clinical Database. UMC's LOS Index improved from 1.23 in July 2024 to 1.07 in June 2025, confirming that results reflected real clinical efficiency rather than shifts in patient acuity.

The Length of Stay improvement initiative embedded adaptability into daily operations and aligned operational decision-making with real-time performance data.

HARRISHEALTH

Harris Health

Houston

Centralization of Home-Based Care Models in a Home Division

Team Members: R. Dwivedi, A. M. Smith, S. S. Sheikh, M. Gilliam

Harris Health launched its Home Division to centralize and expand care delivered outside traditional hospital and clinic settings. Three programs—Hospital at Home, Home-Based Primary Care, and Outpatient Parenteral Antibiotic Therapy (OPAT)—alleviate system congestion and improve access to timely, patient-centered care.

Launched in 2024, Hospital at Home transfers eligible, clinically stable inpatients to receive acute care at home, reducing inpatient bed utilization. Home-Based Primary Care delivers house calls to proactively manage chronic conditions and prevent avoidable emergency department visits, while OPAT builds on Hospital at Home practices to provide at-home IV antibiotic treatments. Across all programs, in-home visits reinforce discharge education, medication adherence, and next steps in care.

The Home Division operates through a centralized operational structure with a unified departmental budget that allows programs to share resources and coordinate operations. Clinical staff, mobile care teams, home-based phlebotomy services, and IT infrastructure support flexible deployment of decentralized service delivery. This model reduces reliance on inpatient beds and brick-and-mortar clinics, improves patient flow, and relieves hospital congestion without expanding physical infrastructure. Program performance is monitored through clinical and operational measures, including readmission rates, emergency center utilization, hospitalizations, length of stay, line-associated infections, and fall rates.

An integrated team of nurses, pharmacists, dietitians, and case managers supports patients. Front-line clinicians and nurse leaders played a central role in designing workflows and transfer protocols, while physicians established eligibility criteria and care

Hospital at Home transfers eligible, clinically stable inpatients to receive acute care at home, reducing inpatient bed utilization.

escalation pathways. Pharmacy teams developed OPAT protocols and home infusion safety standards, and care management and social work teams coordinated discharge planning, patient education, and home readiness assessments. IT and informatics teams deployed remote monitoring tools and MyChart Bedside, a patient-facing Epic portal, while medical assistants delivered in-home diagnostics, immunizations, and follow-up care. Operations and finance leaders structured the Home Division as a stand-alone department, reinforcing stability. Continuous improvement is supported through a Nursing Community of Practice, monthly Operations Council and Patient Safety meetings, and daily interdisciplinary huddles.

In 18 months, the program saved the health system more than 1,000 inpatient bed days and reduced readmissions to 8%, compared with an average of 12–15% among Harris Health hospitals. Patient experience surveys showed satisfaction exceeding 90%, outperforming conventional inpatient and outpatient settings.

Dive Deeper

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