

FOSTER G. MCGAW PRIZE FOR EXCELLENCE IN COMMUNITY SERVICE PROFILES OF 2015 WINNER AND FINALISTS



Suggested Citation: Health Research & Educational Trust. (2016, June). Foster G. McGaw Prize for Excellence in Community Service: Profiles of 2015 winner and finalists. Chicago, IL: Health Research & Educational Trust. Accessed at www.hpoe.org.

Accessible at: www.hpoe.org/mcgawprize2015profiles

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INTRODUCTION

The Foster G. McGaw Prize 2015 winners and finalists are a diverse group of hospitals and health systems with innovative programs that significantly improve the health and well-being of their communities. This guide profiles the 2015 prize winners and finalists:

2015 WINNER

- » Massachusetts General Hospital, Boston

2015 FINALISTS

- » Lancaster General Health/Penn Medicine, Lancaster, Pennsylvania
- » St. Joseph, Queen of the Valley Medical Center, Napa, California
- » ThedaCare, Appleton, Wisconsin

The efforts of these health care organizations fully embody the prize's criteria: leadership, commitment, partnerships, breadth and depth of initiatives, and community involvement.

- » **Leadership.** The health delivery organization takes a proactive role in establishing the web of relationships needed to address the community's health and social issues, and to improve the community's well-being.
- » **Commitment.** Individuals and departments throughout the health delivery organization, including governance, administration and patient care, are involved on an ongoing basis in the organization's community service plan and/or initiatives.
- » **Partnerships.** The health delivery organization has alliances with the community, including physicians, other health-related organizations, business and government, to identify and meet community health needs.
- » **Breadth and depth of initiatives.** The health delivery organization's community service initiatives: (a) exceed the provision of only acute medical and health care services; (b) address major health-related issues in the community; (c) constitute a significant and sustainable, ongoing effort by the health delivery organization; and (d) demonstrate an impact on the community's health status and/or quality of life.
- » **Community involvement.** There is a high level of community response to, acceptance of and participation in the health delivery organization's community service initiatives.

Since 1986, the Foster G. McGaw Prize has been awarded annually to recognize hospitals and health systems for excellence in community service. The Baxter International Foundation, the American Hospital Association and the Health Research & Educational Trust sponsor the award. For more information about the Foster G. McGaw Prize and a list of past winners and finalists, visit www.aha.org/about/awards/foster.

FOSTER G. MCGAW PRIZE 2015 WINNER
MASSACHUSETTS GENERAL HOSPITAL
BOSTON

ADDRESSING SOCIAL AND ECONOMIC DETERMINANTS OF HEALTH

BACKGROUND

Massachusetts General Hospital (MGH), a 1,000-bed tertiary care hospital serving Eastern Massachusetts, also serves as a community hospital for three highly diverse low-income communities north of Boston — Revere, Chelsea and Charlestown. In 1995, the MGH Center for Community Health Improvement (CCHI) was established to partner with these communities to address social, economic and environmental obstacles to health and health care.

Immense challenges face the communities served by MGH. In 2014, an estimated 22 percent of Boston residents lived below the federal poverty level and from 2012 to 2013, the city's homeless population grew by 4 percent to 7,255. An escalating opioid crisis also threatens public health and safety. Deaths from opioid overdoses rose 46 percent statewide from 2013 to 2014. Though the health care and biotechnology sectors are major employers in the area, low educational attainment prevents many people from accessing employment in these higher-paying industries. Due to the city's high cost of living, some Boston residents struggle to afford housing and other necessities.

In 2007, MGH affirmed its community commitment by adding a strong statement to its mission, creating a board committee on community health and holding every clinical chief accountable for community engagement. The MGH mission now refers not only to improving the health of MGH patients in diverse communities, but also to improving the health of the entire community, and to addressing the conditions in the community that impact health. As a result of this fundamental change, the MGH Board of Trustees formed a Community Health Committee. In 2014, the hospital integrated community health even more fully into governance by creating the Executive Committee on Community Health. Governance of community health is now parallel and equivalent to that of other mission components, sending a strong message that it is highly valued within the institution. The Executive Committee on Community Health is chaired by the chief of medicine and is made up of hospital and community leaders. The newly created position of vice president for community health serves as executive sponsor of the committee.

Through MGH's community health needs assessments, communities identified substance use — particularly the opiate epidemic — as their number one health concern. The assessments influenced MGH to develop a new comprehensive clinical initiative designed to transform care for patients with substance use disorders. This initiative, spanning from the community to the bedside, became the leading clinical priority of the entire hospital's strategic plan, and is the first time in MGH's history that the community determined the hospital's clinical agenda. The goal is to reduce costs and prevent chronic disease as MGH focuses on better managing the health of populations and controlling health care spending.

INTERVENTIONS

Five major initiatives and programs supported by MGH are described here.

Collaborating to Prevent Substance Use

Revere CARES is a community coalition founded in 1997 as a result of CCHI's first community assessment. With staff, financial and other support from MGH, it has engaged multiple sectors including city government, schools, police, faith organizations, public health, housing, business, health and human service providers, the community development corporation, parents and youth to successfully advocate for policy, systems and environmental change to reduce and prevent alcohol, tobacco and other drug use and opioid addiction and overdose among teens and young adults. MGH supports a similar coalition in Charlestown, and both coalitions have provided the foundation of the hospital's new substance use disorders initiative.

Assessment data in the late 1990s revealed spiking rates of tobacco, alcohol and marijuana use among teens. A pervasive lack of hope, powerlessness and a negative self-image had settled over the community. The community mobilized through Revere CARES and responded with multiple strategies to build on the community's assets and reduce risk factors, including an after-school program to provide positive alternative activities for youth; a social marketing campaign that encouraged thousands of parents to know where their kids are, with whom, and when they'll be home; changes in school, police and liquor licensing policies; medication take-back events and more.

Starting in 2004, Revere CARES responded to the rapidly increasing opiate epidemic by obtaining funding for an adolescent treatment program, launching an annual memorial vigil for those lost to drugs and alcohol to reduce stigma, successfully advocating for Revere firefighters to be the first in the state to carry Narcan (which reverses overdoses), revising the opioid prescription policy at MGH Revere Health Center (which also informed a new policy for all of MGH primary care practices), and obtaining funding for a drop-in center for those struggling with addiction. In 2009, Revere CARES was recognized with the CADCA (Coalition of AntiDrug Coalitions of America) Got Outcomes award for its contributions to significant reductions in key indicators of teen substance use as measured by the Youth Risk Behavior Survey.

Results

Between 1999 and 2013, the percentage of youth using alcohol in the past 30 days declined from 59 percent to 37 percent, according to a Youth Risk Behavior Survey. Binge drinking declined from 41 percent to 20 percent, and cigarette use from 37 percent to 12 percent. These reductions and others are statistically significant even when controlling for race, gender, age and number of years in the United States. The number of deaths involving one or more opioids has declined (preliminary data: 15 deaths in 2009, 10 in 2010 and 8 in 2011). Between January 2013 and October 2014, Narcan reversed 105 overdoses.

Lessons Learned

MGH has learned that working together with the community, rather than doing for the community, builds local capacity and increases sustainability of successful initiatives.

Healthy Eating/Active Living

Healthy Chelsea and Revere on the Move (ROTM), founded in 2010 and 2008, respectively, are citywide, multisector coalitions that are changing the food and physical environments so that healthy choices about eating and active living are easier to make. With support from the Center for Community Health Improvement, these coalitions of local government, schools, businesses, residents, youth and others are making policy, systems and environmental changes.

Revere on the Move worked with the city of Revere to create a bicycle network and partnered with WalkBoston to create a 1.8-mile walking trail and conduct a “walkability audit” that resulted in traffic-calming measures and designation as a Safe Routes to School initiative. City planning departments in both communities have engaged residents in landscaping parks. Pediatrics practices at MGH Revere and Chelsea worked with the Appalachian Mountain Club’s Outdoors Rx program to write “prescriptions” for physical activity, and the club provides family activities in local parks.

Playworks’ Recess 360 model has been adopted in four Chelsea schools to use daily recess for fun and vigorous physical activity. Chelsea also launched Fit Minutes, adding daily fitness breaks for 3,000 students. Both Healthy Chelsea and Revere on the Move participate in Mass in Motion, a state Department of Public Health network that provides training, analysis of city-specific health outcomes, and information sharing.

The Chelsea Youth Food Movement advocates for better nutrition in school meals. Healthy Chelsea’s Corner Store Connection promotes fresh produce in local stores, and Healthy Chelsea, Stop and Compare Supermarket, and MGH are labeling 870 beverages to reduce purchases of sugar-sweetened beverages and studying results. The Fresh Fruit and Vegetable Program in three Chelsea elementary schools provides nutritious snacks to 1,670 students three times a week. Healthy Chelsea and Chelsea’s Board of Health led the successful passage of a ban on artificial trans fats in food service establishments. In Revere, Revere on the Move has created eight healthy markets, and also worked with the Revere Chamber of Commerce and the MGH Nutrition Department to launch a healthy dining campaign that is helping 14 restaurants promote healthy menus. Revere on the Move provided 12 mini-grants for a communitywide garden, encouraging use of WIC vouchers, and for two public school gardens that are linked to core curricula, nutrition education and after-school activities.

Results

In addition to progress in changing the food and physical environments, according to the Youth Risk Behavior Survey, there has been a 5 percent increase in physical activity among high school students in Revere and Chelsea between 2012 and 2014. School body mass index (BMI) data will be tracked over time.

Lessons Learned

By working together, communities can begin to create a culture of health. Future plans for Revere include adding more walking trails, revitalizing the farmers market and forming a bicycle commission. Playworks will expand to three additional schools in Chelsea, and community garden plot owners in Chelsea and Revere will receive nutrition and cooking education.

STEM and Developing Youth Assets

Educational attainment is correlated with economic status and a significant predictor of health. Boston Public Schools students reflect the demographics of many urban school districts; they come from low-income families and are disproportionately students of color. About 70 percent enroll in college, but only 49 percent of 2006 graduates who began college had graduated six years later. For 25 years, MGH has offered opportunities for Boston youth interested in health and science careers, and more recently the hospital is extending these opportunities to Chelsea and Revere high school and college students. About 650 youth in grades 3 through college participated in 2014. English is a second language for more than half of students, and more than 60 percent are the first in their families to attend college. More than 400 MGH staff and faculty volunteer nearly 15,000 hours annually in these programs.

In grades 3 through 8, weekly STEM (science, technology, engineering and math) clubs build excitement in STEM subjects and careers. MGH staff members are science fair mentors for about 50 seventh- and eighth-graders, and eighth-graders participate in a paid summer internship at MGH. Mentors and students may extend their relationship through a partnership with Big Brothers Big Sisters of Massachusetts Bay.

Each year, about 120 high school students at East Boston, Revere, and Chelsea high schools, the Edward M. Kennedy Academy for Health Careers, and other Boston public schools have exceptional opportunities for hands-on exposure to STEM careers in paid internships and job shadowing at MGH. These experiences spark college aspirations, introduce them to health and science professionals, and help them learn about education to career pathways. High school students also receive tutoring, stress management, intensive college preparation including financial literacy, SAT prep, and college essay writing. Students and their families visit nearby colleges and attend a summer STEM camp. Every year since 1991, about 200 students have been employed in summer jobs at MGH. Since 2012 and continuing into the future, MGH is supporting these students in college with \$5,000 annual scholarships, tutoring, financial counseling, mentoring, networking, and yearly summer employment for 40 college students, with the goal of increasing college retention and graduation for urban youth.

Results

As of 2015, three classes of high school students are in college. An initial review of 50 students found that 82 percent remain in college. Among high school students, the annual retention rate in the program is 93 percent and the average GPA is 3.38. Every student in the class of 2014 enrolled in college. Nineteen science fair mentees won a spot at the competitive citywide science fair in 2015.

Lessons Learned

By elevating the academic bar for at-risk students and providing consistent access, nurturing relationships with caring adults, and exposure to careers in health and science, underserved and underrepresented students are able to thrive in post-secondary school. MGH plans to continue to expand the number of students reached.

Addressing Social Determinants and Improving Access for Vulnerable Populations

Even when financial obstacles to health care are removed, social, cultural, linguistic, racial and socioeconomic barriers — the social determinants of health — can prevent people from seeking care or following through on recommended treatment and contribute to health inequities. At MGH Chelsea, a comprehensive set of initiatives meets the needs of the most vulnerable populations with the help of community health workers, navigators, home visitors and more. The staff are from 24 countries, speak 20 languages and had nearly 28,000 contacts with nearly 10,000 patients in 2014. Below are some examples of their work.

- » *Immigrant and refugee health program.* For 15 years, this program has aided refugees from countries such as Bosnia, Somalia, Iraq and Bhutan, many of whom have experienced trauma, violence and war. Under a contract with the Massachusetts Department of Public Health, MGH Chelsea completed 107 refugee health assessments in 2014. Ninety-five percent of all new refugees are connected to primary care within 30 days. The program also deals with the urgent needs of newly arrived immigrants, most recently with 300 high-risk children from Central America who experienced extreme trauma and separation. Physicians, nurses, mental health providers and community health workers comprise this team. In 2014, the program saw 990 refugees and immigrants.
- » *Cancer navigation.* Navigators help patients identify and overcome barriers to cancer screening and follow-up. In 2014, 794 patients were screened for colon, breast or cervical cancer or received follow-up diagnostic services. A randomized control trial showed that patients with navigation were 50 percent more likely to receive screening.
- » *Home visiting for high-risk new mothers.* Home visitors, child development specialists and a fatherhood coordinator support healthy child development from pregnancy through age 3 for the highest-risk families. Child development specialists saw more than 300 families. Home visitors use an evidence-based model to forge bonds with first-time parents to promote attachment and reduce abuse and neglect. In 2014, 70 high-risk refugee and immigrant mothers received intensive home visiting. According to validated measures, 98 percent of the parents had high rates of bonding with their children, and 97 percent of children demonstrated mastery for social behavior, emotion regulation and well-being.
- » *Food security.* Patients and families in the pediatric, adult and obstetrics departments are screened for food insecurity and are identified and provided assistance with connecting to food resources, including SNAP, WIC and emergency food assistance. Of the 4,500 patients screened, 20 percent were food insecure and offered assistance. In 2014, MGH Chelsea opened a food pantry for undocumented patients who do not qualify for food assistance. The food pantry distributed more than 17,000 pounds of food.

Lessons Learned

Future plans include reorganizing the community health workers team to align with the MGH population health management goals of managing care of high-risk patients, enhancing patient self-efficacy, reducing costs and decreasing hospital readmissions.

Medical-Legal Partnership

The Legal Initiative for Children (LINC) at MGH Chelsea, a collaboration between MGH and the Lawyers' Committee for Civil Rights and Economic Justice, was launched in 2003 to improve the health and well-being of low-income families whose children are patients of the MGH Chelsea pediatric practice and whose health may be affected by the family's legal problems. LINC focuses primarily on housing stability and family income, the social determinants of health viewed as most critical to child and family health. In 2012, the Boston Bar Association reported that homelessness exacerbates physical, emotional and psychological problems and increases health care costs fourfold.

MGH Chelsea pediatricians or mental health providers make referrals to a manager of the Chelsea community health team when they think a family would benefit from an attorney's assistance. That manager screens the referrals and often consults with a community health worker who may be familiar with the family to gather additional information that might be helpful to the attorney. The LINC attorney, who is on site one day per week, partners with the community health and clinical teams and provides representation to prevent eviction, obtain child support orders, file for unemployment benefits, apply for subsidized housing, complete naturalization forms, appeal denial of disability awards and facilitate access to public benefits.

Results

In fiscal year 2014, LINC served 136 new families through 234 contacts with 475 associated activities. There were 57 total successful outcomes: 10 individuals obtained Social Security benefits and three obtained disability benefits, five families avoided eviction, 10 families attained public housing, hazardous living conditions were controlled for six families, and nine issues with landlords were resolved. Additional outcomes included transferring families to new housing units, obtaining unemployment benefits and resolving security deposit issues. The vast majority of the remainder of cases were still in process at year's end. Outcomes in 2014 are representative of outcomes for families over the past 12 years.

Lessons Learned

Medical care alone is not sufficient to address some of the barriers to good health. By partnering with legal professionals, health care can take a more comprehensive approach to patients' needs.

The hospital would like to expand this program to additional clinical departments at Chelsea and extend it to the other MGH health centers; it also is exploring a partnership with the local community development corporation to screen pediatric families for housing stability.

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FOSTER G. MCGAW PRIZE 2015 FINALIST
LANCASTER GENERAL HEALTH/PENN MEDICINE
LANCASTER, PENNSYLVANIA

MEETING THE HEALTH NEEDS AND BEYOND OF VULNERABLE POPULATIONS

BACKGROUND

Lancaster General Hospital (LGH), a 630-bed hospital, is part of Lancaster General Health (LG Health), a not-for-profit health care system located in south central Pennsylvania. It serves a 943-square-mile county made up of large rural areas, suburban areas, small towns and the county seat, Lancaster City. Lancaster County is known for its Pennsylvania German traditions and its population of Old Order Amish religious sects. In August 2015, LG Health became a member of Penn Medicine.

In the Lancaster County population, about 24 percent of residents are children under 18 and 16 percent are seniors. About 91 percent of county residents are white; 9.5 percent are Latino; 4.7 percent are African-American; and 2.1 percent are Asian. More than 10 percent of the county's population live below poverty level, and more than 67,000 are uninsured. About 16 percent of county residents did not finish high school.

Lancaster City is a minority-majority community, with 39 percent Latino, 16 percent African-American, 3 percent Asian and 55 percent white residents. In the city, nearly 26 percent of residents are under age 18, and nearly 9 percent are seniors. About 29 percent of residents live in poverty, and about 24 percent did not complete high school.

Lancaster County does not have a county public health agency. Lancaster City employs the county's solitary public health officer, who is also a member of the faculty in LGH's Family Medicine Residency Program. To help fill this gap, LG Health and more than 30 community partners created LiveWell Lancaster County, a health collaborative working to make Lancaster County a healthier place to "live, work and play." LG Health has been doing community health needs assessments since the mid-1990s. In 2012, LG Health and Ephrata Community Hospital joined forces with community partners to consolidate their health needs assessments into one in-depth, countywide assessment.

Lancaster County consistently ranks among the healthiest Pennsylvania counties, yet critical modifiable health risks, particularly adult obesity and adult smoking, are increasing after hitting five-year lows. Additional areas of concern include depression, particularly among youth, and an increasing number of mothers who do not receive early prenatal care. The county also has an important health challenge in identifying and reaching vulnerable populations facing health care inequities, especially city residents.

Community benefit priorities are guided by the chief executive officer and the community-led board of trustees. The board's Mission and Community Benefit Committee provides oversight for all community benefit activities, establishes local health priorities and monitors the health status of communities served. The community health needs assessment serves as the basis for analyses of needs in the community, with an understanding of existing assets that may fill the needs. Once priorities are established, logic models are developed with the hospital's community partners. Hospital staff apply a Plan-Do-Study-Act (PDSA) evaluation to all initiatives.

INTERVENTIONS

Partnering with Amish Neighbors

Lancaster County is home to America's oldest Amish settlement, where more than 27,000 people live a centuries-old "Plain" lifestyle. LG Health works closely with the Amish community in order to understand its religious beliefs, practices and current health care needs, and to develop programs that meet these needs. LG Health's CEO and CFO meet quarterly with Amish bishops to discuss how LG Health can assist the Amish community with health care costs. The Amish tend to view health care as something that is sought only for illness or injury. LG Health works with community partners, grant foundations and Amish community leaders to provide preventive services and health care that improves the Amish community's health and well-being.

Results

Examples of how LG Health programs are improving Amish people's health include:

ChildProtect has been providing free immunizations to at-risk Amish children since 1990. LGH has partnered with Amish bishops and local fire companies to provide 162,500 free immunizations to 72,500 children in rural Lancaster County.

Since 2009, LG Health has held health education programs in the homes of Amish women to educate them on a wide range of health and healthy lifestyle issues. About 30 to 50 Amish women consistently attend the lectures and are linked with medical services if needed. LG Health also has distributed health information tailored to the Plain community in nine businesses that Amish people own or frequent.

Since 2005, the Lancaster County Safe Kids Coalition has reached more than 1,000 people in the Plain community through farm and family safety days. This program is a partnership between Amish farmers and their safety committee, health professionals, agricultural experts and first responders to teach farm safety.

The Clinic for Special Children is a nationally recognized primary pediatric care for uninsured Amish and Mennonite children with complex genetic disorders. The hospital provides office space and financial assistance.

LG Health also worked with the Lancaster Coalition Against Family Violence to develop a guide for the Amish called "Domestic Violence: A Resource Guide for Clergy."

Lessons Learned

Developing trusting relationships is key. All communication to the Amish goes through a limited number of staff so the message can remain consistent. All health educational gatherings flow through one person who has developed very strong working relationships with the community over the past five years. Providing programs in the homes of the Plain community and at common gathering sites such as fire halls provides easy access from a geographic perspective, provides familiarity and removes barriers related to navigating an unfamiliar location. The importance of immunizations will continue to be a theme for the program. The educational home health lectures will continue to highlight the critical role that these type of preventive health practices play in enhancing health and reducing costs. LG Health also will be reviewing the curriculum for the schools to enhance youth knowledge base.

Care Connections

LG Health's Care Connections provides medical, behavioral health and socioeconomic services to chronically ill and complex patients who consume disproportionate amounts of care and costs. LG Health operates the program in conjunction with Lancaster County Human Services and with support from the Pennsylvania Department of Public Welfare. The program supports an interdisciplinary team of professionals who closely coordinate care and engage the patients. Patients typically remain in the program for about six months. At that point, medical issues have been stabilized and patients have learned how to navigate the health system and be more accountable for their care.

Results

Since 2011, Care Connections has enrolled more than 200 patients. Sixty-one percent of patients graduate and return to their original primary care provider's office. Among Care Connections graduates, inpatient hospitalizations have decreased 66 percent, and emergency room visits have decreased 33 percent. The number of patient days in the hospital has decreased 80 percent. Patients also are more engaged in their care. More than half of Care Connections patients have enrolled in the electronic health record patient portal and actively use the website for communication, refills and education. In a small 90-day trial of the use of patient engagement tools, more than 70 percent of patients signed up for text-message health reminders. Post-intervention medication adherence rates significantly increased. One managed Medicaid payer's analysis showed that in a small subgroup of patients, total spending per month per member decreased from \$2,550 pre-Care Connections to \$1,760 post-Care Connections.

Lessons Learned

Although LG Health deploys community-based programs, there is a distinct subset of high medical-, behavioral- and social-risk patients who consume disproportionate amounts of care and costs. Care Connections has learned that integration with the community is crucial to the program's success. This work has been driven by relationship building and outreach. The team collaborates with organizations within the medical community as well as those outside, such as transportation agencies and food banks, to leverage support for patients. In the future, LG Health hopes to use Care Connections as a model for high-risk management for other populations, such as frail elderly patients and high-risk obstetrical and pediatric patients.

Lighten Up Lancaster County

In Lancaster County, 64 percent of adults and 30 percent of children and youth are overweight or obese. Recognizing the link between obesity and serious chronic disease, LG Health is committed to empowering the community to eat healthier and move more. In 2007, LG Health established Lighten Up Lancaster County (LULC), a community-led coalition that has more than 1,000 members, comprised of individuals and organizations, including elected officials, school districts, the medical community, corporations, faith-based groups, farmers and county planners. The program promotes:

- » *Awareness and education* achieved through billboards, websites, social media, print and broadcast media, and numerous efforts to educate workplaces, schools and community partners about “making the healthy choice the easy choice.”
- » *Behavioral change*, including offering shopping tours; establishing protocols for physicians to screen, counsel and refer individuals to a weight counselor; and offering healthy vendor toolkits to support healthier food choices in the workplace.
- » *Systems policy and environmental change*, including working with businesses, schools and food pantries to ensure all people have access to healthy food and physical activity opportunities; educating elected officials on how to build a more walkable community; assisting businesses in becoming more bicycle friendly; and increasing the strength of school wellness councils across Lancaster County.

Results

In fiscal year 2014, Lighten Up Lancaster County had more than 2.4 million media impressions, spreading the word about the obesity epidemic and ways to improve health where people live, learn, work and play. Also, 453 referrals were made to weight management services within LG Health. Thirty-two businesses employing a total of more than 13,000 employees completed and met high levels on the CDC Worksite Health scorecard, which assesses current wellness policies and programs. The County Planning Commission adopted a Complete Streets policy, and several local committees implemented a resolution affecting 81,000 residents. Complete Streets policies will ensure that streets are designed for all. The hospital was designated first in the state as baby friendly, providing an environment that encourages breastfeeding above other feeding options.

Lessons Learned

Community collaboration and building trusting relationships with key stakeholders are vital to success. Effecting transformational change requires working with partners in government and the business community to evaluate and change policies, implement system changes that enhance sustainability, and institute cultural change to influence behavior.

Providing a Healthy Home for Local Refugees

Church World Services (CWS) and Lutheran Refugee Services (LRS) have resettled more than 3,000 refugees in Lancaster County since 2008, including people from Russia, Burma, Vietnam, Haiti, Nepal, Bhutan and Iraq, most with few resources or language skills. The Pennsylvania Department of Health found that medical assessments were a challenge to schedule within the required 30 days. LG Health partnered with the state health department to develop a program to ensure that refugees have access to care. The LGH Family Medicine Residency Program took the lead, partnering with a free clinic to utilize a site easily accessible by public transportation. LG Health convened the Lancaster County Refugee Health Network to develop process flows and a consensus of expectations for medical providers. Original partners included Church World Services, Lutheran Refugee Services, the two local federally qualified health centers, two free clinics, LGH and the residency program. The clinical component is an important piece of a broader community effort to provide refugees with all of the necessary services and to integrate them into the Lancaster County community.

Results

The Refugee Health Network led to the Lancaster County Refugee Coalition, which addresses all aspects of refugee integration with representatives from refugee communities, local colleges, health and human services organizations, churches, and educational and community organizations. The clinical component now falls under the coalition's umbrella and continues to ensure that 100 percent of new refugees receive initial health assessments and have access to a medical home. Health education classes and services are offered to groups of refugees who share culture and language, thus increasing participation by providing information and care in the most comfortable setting for them.

Lessons Learned

The coalition partnered with the school district of Lancaster and special education services provider, Lancaster-Lebanon Intermediate Unit 13, to develop a refugee community school based at a local middle school that provides a forum for refugees to share their own customs, beliefs and ideas with the community while also offering programs and classes to ease integration. The classes include cultural orientation, adult English as a second language (ESL) instruction, General Education Development (GED), financial literacy, civic engagement and job training.

Tobacco Free Coalition

LG Health is a key driver of the Tobacco Free Coalition of Lancaster County, a multisector partnership that includes hospitals, the American Cancer Society, schools, health and human services groups, municipalities and more. Coalition partners are committed to reducing tobacco use by adults and preventing its use in future generations, particularly as the e-cigarette and hookah become more popular among young people. The coalition has helped reduce tobacco use by promoting:

- » *Awareness and education.* The coalition created a public service announcement featuring youth that has had more than 500,000 views through Facebook, YouTube, a movie theater and in 13 primary care practices.
- » *Behavior change.* The coalition promotes — and LG Health provides — access to tobacco cessation treatment for inpatients, work sites, primary care provider offices and various community locations. LG Health also facilitates LifeSkills®, an evidence-based tobacco and addiction prevention curriculum that has reached more than 6,000 school students across the county.
- » *Policy and environmental change.* LG Health and its coalition partners have promoted a “Young Lungs at Play” initiative that has led to 18 municipalities adopting tobacco-free green spaces (parks and playgrounds). LG Health has embedded an electronic referral for tobacco cessation into its electronic health record, which allows providers to efficiently refer patients for tobacco dependence treatment.

Results

The percentage of current adult smokers in the county decreased from 24 percent in 2001-2003 to 14 percent in 2010-2012. The percentage of adults in tobacco dependence treatment services who had not smoked 30 days postintervention increased from 37 percent in fiscal year 2013 to 60 percent in fiscal year 2014. Referrals from providers to LG Health tobacco dependence treatment services increased from 1,030 in fiscal year 2013 to 1,138 in fiscal year 2014. And more than 80 percent of students participating in LifeSkills reported an increase in their knowledge.

Lessons Learned

Collaboration and partnership are vital to success. Using evidenced-based practices, understanding tobacco addiction and providing personalized treatment have contributed to residents’ reduction in tobacco use. Tobacco use is a complex issue, and together, the coalition partners have raised awareness, enhanced treatment and influenced policy that has shifted the needle toward healthier behavior.

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FOSTER G. MCGAW PRIZE 2015 FINALIST
ST. JOSEPH HEALTH, QUEEN OF THE VALLEY MEDICAL CENTER
NAPA, CALIFORNIA
PROMOTING AND SAFEGUARDING THE HEALTH OF THE COMMUNITY

BACKGROUND

St. Joseph Queen of the Valley is a 191-bed, acute-care medical center located within the city and county of Napa, California. Queen of the Valley is a major diagnostic and therapeutic medical center for Napa County and the surrounding region. While Napa is not a poor county, the cost of living is high. About 10 percent of residents live below the federal poverty level, and many more live below 200 percent of poverty. Approximately 34 percent of Napa County families with children under 18 were living below 200 percent of the federal poverty level between 2006 and 2010. Many children are not at a healthy weight, and there are high rates of chronic diseases. Napa County also has a high proportion of older adults. Other social factors affecting Napa residents are lack of affordable housing, high cost of food, limited access to transportation for those without automobiles and a growing academic achievement gap.

The Community Outreach Department of Queen of the Valley supports extensive community benefit programs and operates in concert with community partners. Community benefit programs derive from a strategic plan established through engagement of community members and stakeholders and based on needs identified through a community health needs assessment. A Community Benefit Committee appointed by the board of trustees serves as an extension of trustees to provide direct oversight for all charitable program activities. The hospital contributes 10 percent of its net margin to community benefit programs targeting the poor and 1.5 percent of its operating expenses to other community benefit programs and activities.

Community outreach staff at the hospital and community partners collaborate to expand access, leverage resources and address broad community concerns. Queen of the Valley is a convening member of the Napa County Collaborative of Health Organizations and Philanthropies. A report published every three years forms the basis for communitywide health planning among the collaborative members. In 2010, the collaborative extended the community input and analysis of community needs to develop a strategic, long-term community health improvement plan: Live Healthy Napa County. This plan spurred implementation of collective action strategies involving more than 100 organizations on issues such as obesity, mental health and poverty. Queen of the Valley also works with dozens of community and public agencies and schools in delivering services, providing cash and in-kind support to more than 45 local nonprofit organizations offering critical safety-net resources to Napa's most vulnerable populations. Resources include a domestic violence shelter, Boys & Girls Club nutrition program, Napa County family resource centers as well as programs addressing mental health, food security, housing, teen pregnancy, and gang tattoo removal. Required annual reporting has documented that thousands of individuals and families received critical services through these partnerships.

INTERVENTIONS

Five major initiatives and programs supported by Queen of the Valley Medical Center are described here.

Children's Mobile Dental

Launched in 2006, the Children's Mobile Dental Clinic provides free comprehensive dental services for children living at or below 200 percent of the federal poverty level. The program includes oral health screening in preschools and kindergartens serving low-income children; mobile dental clinic six-month examinations and cleaning; patient and parent/caregiver education at examinations; and mobile dental clinical procedures as determined by patient guidelines and needs.

Services are delivered in nine low-income schools and neighborhoods throughout the county. The clinic also screens and refers, as appropriate, preschool and kindergarten students at early care and education sites. Sedation or oral surgery is provided to low-income children requiring full mouth restoration and treatment.

In 2014, more than 2,040 children (including 339 new patients) were served through the mobile clinic, with a total of 4,682 visits. The clinic provided 2,688 procedures—fillings, extractions, pulpotomy, root canals, crowns, scaling and root planing, space maintainers—as well as 3,070 exams with fluoride varnish and cleanings. The mobile dental clinic also applied dental sealants to 1,135 teeth.

Results

Of 473 random chart audits performed, 72 percent of children who received treatment had reduced dental caries at follow-up. All patients and their families receive oral health education at each visit, and 98 percent of parents who responded to surveys reported improved oral health behaviors. The clinic also screened and referred, as appropriate, 818 preschool and kindergarten students at the school sites, and 126 were referred for a dental home. In 2015, nine low-income children—most under 5 years of age— received access to sedation or oral surgery at Queen of the Valley.

Lessons Learned

Providing parent and patient education and affordable, accessible care can make a huge difference in the oral health of children and sets healthy long-term patterns. In 2014, 84 percent of patients returned for regular checkups. In 2011, 91 percent of children in Napa had seen a dentist in the past six months, compared to 67 percent in 2008. Building relationships with providers of specialty care in the community has filled the gap for some children, but the need remains.

CARE Network

Queen of the Valley's Case Management, Advocacy, Resources and Education (CARE) Network, launched in 2000, is a community-based intensive disease management and transitional care program for patients who have been recently hospitalized or are most at risk for hospitalization or rehospitalization. Clients are referred from hospital social work and case management, primary and specialty care physicians, and community-based organizations. Services focus primarily on people living at 200 percent of the federal poverty level who are uninsured or underinsured. Many are monolingual Spanish-speakers; are homeless or precariously housed; lack access to medications, adequate food and social support and caregiving; have no medical home; are not enrolled in benefits and insurance programs for which they are eligible; are suffering depression; or are substance-involved and have lost hope. Many regularly used the ED for care and have been hospitalized due to uncontrolled medical problems. Typical patients are presenting with end-stage renal disease, cerebrovascular accident, cancer, chronic obstructive pulmonary disease, liver disease or debilitating injury.

CARE Network promotes timely delivery of necessary medical and support services; improved health outcomes and quality of life; linkages to other resources and support; and improved overall cost effectiveness of expenditures made on behalf of the target population. The program uses bilingual and bicultural case management teams of registered nurses, social workers, a behavioral health specialist and care aides focused on reducing acute medical, psychosocial and economic self-sufficiency needs of referred patients. Based on assessed needs, patients receive intensive, individualized one-to-one services, typically for three to six months, that provide medical care coordination and resources — working directly with health care providers — as well as navigation to critical community support services and benefits to address basic needs. Once high-acuity needs are addressed, staff works to enhance independence and disease self-management through education, coaching and linkage to ongoing support services. In 2014, CARE Network implemented a brief care transitions model to assist patients postdischarge who may not require long-term case management but are at risk of hospitalization without support. In 2014, CARE Network served 344 intensive cases and 378 brief care transitions cases.

Results

Intensive clients demonstrated a 66 percent reduction in hospitalizations and a 64 percent reduction in ED use. About 68 percent of 206 clients over three years showed improvement on the evidence-based Quality of Life assessment. And 95 percent of clients responding to a self-assessed health status survey reported that their ability to take care of their own health was "excellent" to "good." Altogether, 1,261 referrals for benefits and basic and medical needs were provided and obtained. A three-year evaluation of return on investment completed in 2013 found that the CARE Network reduced per-patient per-month health care costs by 74 percent.

Lessons Learned

Addressing basic needs — food, housing, medications, medical care — is critical to improving health outcomes in vulnerable populations. Effective interdisciplinary case management can reduce costs and improve health outcomes of high-cost users. Engagement and partnerships with other organizations ensure effective linkages.

Healthy for Life

Healthy for Life is a school-based obesity prevention program designed to emphasize lifelong fitness and healthy eating behaviors among children and adolescents. More than 40 percent of Napa County's fifth-, seventh-, and ninth-graders are overweight or obese, and nearly 50 percent of economically disadvantaged students are overweight or obese. Obesity is also a growing concern among low-income preschoolers, ages 2 to 4; the USDA reports that 18.3 percent of Napa County preschoolers are considered to be obese, twice the Healthy People 2020 objective.

The Healthy for Life program focuses on children at risk for obesity and their families, particularly those in low-income neighborhoods and schools. The program incorporates school-based obesity prevention; intervention with at-risk children; community and parent education; and community and school-policy advocacy. It is offered in selected elementary, middle school and high school classrooms. Curriculum components, depending on age level, may include nutrition, aerobic exercise and resistance training.

High-risk children are also referred to their physicians, and the physician may refer the child to Queen of the Valley's Wellness Center for a full nutritional assessment. Children assessed as obese are offered three sessions with a nutritionist or dietician.

The program is now in 18 schools. In 2015, the program expanded to K-2 classes at participating schools and increased the number of classrooms served by 30 percent. Queen of the Valley provided 20 grades K-2 teachers and 12 grades 3-5 teachers a full day of Healthy for Life training to incorporate the Sports Play and Active Recreation for Kids curriculum into physical education classes. The hospital funds the training and the teacher's time to participate in the training. Participating schools also receive fitness equipment and physical education curriculum for student use in teacher-directed education classes. In addition, Queen of the Valley's medical fitness center contributes a variety of resources to the Healthy for Life program, including a registered dietician and exercise instructors.

Results

More than 1,000 students participated in some portion of the program's exercise and fitness classes. By year-end, 18 percent of students classified as obese students had improved their weight status.

Lessons Learned

Tackling childhood obesity takes a whole-community, whole-child approach. This program is only as successful as the engagement of the schools and teachers trained to provide the program. Due to the lack of resources and time of many teachers in low-income schools, the program must add to the resources, be adaptable to the school and classroom setting and be easy to implement. Queen of the Valley is seeking to expand the program into more K-2 classrooms and is working with community partners on a broader childhood obesity agenda as part of the long-term community health improvement plan.

Community Health Education and Empowerment

Queen of the Valley is a primary provider of community health education among low-income Spanish-speaking community members in Napa, providing health education that seeks to teach how to prevent health problems, navigate the system of care, enhance health and wellness, and empower changes that can contribute to health now and in the future. The medical center has implemented three programs under this initiative: Parent University; a perinatal education series with prenatal and postnatal classes for parents and siblings; and a bilingual community health education curriculum.

Immigrant households make up 26 percent of Napa County, and that number is growing. For Parent University, Queen of the Valley partners with the Napa Valley Unified School District and a local nonprofit organization, On the Move, which is designed to create a learning environment for parents to gain critical parenting and leadership skills. To address the social determinants of health, a series of class curricula was offered at five Title I elementary schools with topics such as effective parenting techniques, healthy lifestyles, family literacy intervention, introduction to parent-teacher conferences, how to prepare children for college, introduction to computer use, how to be an effective volunteer, and leadership training. Bilingual community health education classes are provided at eight underserved community locations. Perinatal education workshops offer topics that include childbirth education, postpartum care, infant care, and breastfeeding.

Results

Parent University classes had a total of 1,176 parents and 7,436 participant encounters. About 63 percent of parents reported improved knowledge, and 67 percent reported improved confidence in their ability to apply knowledge in daily life. Thirty-six parents completed a leadership development course. In addition, 103 people attended bilingual health education classes, with 69 percent reporting improved knowledge and 75 percent reporting improved confidence on topic application. The perinatal program served 3,829 pregnant or postpartum women and their families, who attended 397 perinatal programs; for this program, 87 percent reported improved knowledge, and 85 percent reported improved confidence on topic application.

Lessons Learned

Culturally and linguistically appropriate programs are essential to expanding health literacy and empowering underserved individuals to be responsible for their own health and the health of their children. Empowering parents to become involved in their children's education will have a lasting effect on improving academic achievement among children with language and economic challenges.

Integrated Behavioral Health Initiative

To address the critical challenge of access to mental health services by low-income people, Queen of the Valley began to integrate mental health screening and services into its programs and to work collaboratively with community partners to address gaps among critical populations not being adequately served through county programs.

In 2006, Queen of the Valley launched a postpartum depression program, which includes working with obstetricians and gynecologists to screen all pregnant and postpartum women in the county and offering free counseling and referral services to at-risk women. In 2008, the hospital integrated behavioral health into the CARE Network, providing free assessment and mental health services to low-income, chronically ill clients. Most recently, Queen of the Valley partnered in the launch of Healthy Minds, Healthy Aging, a community-based behavioral health initiative for underserved older adults at risk for behavioral or cognitive health issues.

Services are bilingual Spanish/English and include cognitive and behavioral health assessments, case management, and behavioral health therapy sessions, as well as community presentations, caregiver training and support, and health care provider outreach and training. Services provided through Healthy Minds and the CARE Network are implemented through a contract with Family Service of Napa Valley and offered onsite or in client homes.

Results

Referrals to behavioral health are identified through a variety of recognized tools, and 96 percent of those referred had scores indicating depressive symptoms appropriate for treatment. For these 244 clients, a total of 2,908 face-to-face therapy sessions or telephone contacts were provided. In addition to depression assessment, clients were assessed for other basic needs. For clients served, referrals and warm hand-offs to community resources and services, including benefits, medications, food and housing, were provided on more than 660 occasions. Of 53 clients discharged, 98 percent had an improved depression score.

Lessons Learned

An integrated approach to screening reduces stigma and increases acceptance of services. When the mental health provider is a trusted member of a case management or health care team, even seniors most reluctant to accept mental health care are more likely to agree. Spanish-speaking counseling staff are critical to reaching vulnerable populations in Napa County.

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COMMUNITY HEALTH IMPROVEMENT

BACKGROUND

ThedaCare is a community health system consisting of seven hospitals and several other health care organizations, including a group primary-care practice, behavioral health provider, laboratories, and a home care and senior services division. The health system serves nine Northeast Wisconsin counties anchored by the Fox Cities, a cluster of seven communities ranging in size from 20,000 to 80,000 residents. Located 25 miles south of Green Bay, the area is a mix of small urban industrial, suburban and rural communities.

Approximately 11 percent of the population in ThedaCare's service area lives at or below the poverty line. About 24 percent of the area's population is under 18, and 15 percent is age 65 and over. While nonwhite adult persons are still a minority, Hispanic, Asian and African-American populations are rapidly growing. Major community needs identified in ThedaCare's 2013 community health needs assessment include mental health, obesity, access to health care for underserved populations, alcohol/drug use, poverty and violence.

According to the University of Wisconsin Population Health Institute, medical care contributes to, at best, 20 percent of a person's overall health status (excluding genetics). Eighty percent is attributed to community-based factors such as education levels, jobs, the economy, lifestyle and behavior choices, and the environment. To gain the skills to engage the community in creating solutions, in 2002 ThedaCare committed more than \$60,000 to send two ThedaCare staff members and two community leaders through the yearlong Creating Healthier Communities Fellowship offered by Health Forum and the American Hospital Association. This education culminated in a commitment from the ThedaCare Board of Trustees to set aside an endowment fund with an annual additional contribution of margin to support creative, collaborative community solutions to systemic problems that affect health.

INTERVENTIONS

Five major initiatives and programs supported by ThedaCare are described here.

Community Health Action Team

Bringing the community together to collectively understand and address societal issues that affect health has been the role of the Community Health Action Team (CHAT) model since 2001. CHAT has gathered ThedaCare's communities around 13 distinct health concerns identified as major concerns in community health needs assessments, including affordable housing, alcohol use, childhood obesity, health of rural farm families, smoking, health of seniors, barriers to treatment for mental health needs, drug abuse, social supports for mental illness, understanding the area's Mexican population, understanding LGBT (lesbian, gay, bisexual and transgender) individuals, making end-of life-decisions and embracing diversity.

Each focus began with a “plunge” — an eight-hour field trip for 30 to 80 leaders from all sectors of the community, including business, health care, education, government, faith organizations, nonprofits, community foundations and other stakeholders passionate about the issue. The field trip gave participants first-hand experience on specific challenges. In debriefing meetings, stakeholders engage around gaps and opportunities, mobilizing community assets, creative problem solving, additional needed community engagement, and allocation of CHAT funding.

Each of the four CHAT Teams (one in each of the four major markets) is led by a group of 12 to 25 community members, including ThedaCare’s CEO and hospital presidents, who meet from four to 12 times a year to select plunge topics based on community needs, guide initiative development, allocate funding and leverage community assets.

Results

CHAT’s work has led to a wide array of major initiatives, and most have been in operation since 2001.

Lessons Learned

Success has come from “leading from behind.” While ThedaCare provides staffing support and funds to CHAT, ThedaCare’s name has always been one of many credited for any project, and major decisions are always made by the community group. This approach has made true collaboration possible.

Shawano Rural Health Initiative

In 2003, ThedaCare took a close look at the health care crisis of farm families by organizing a CHAT plunge to a local dairy farm where farmers, insurers, agriculture business leaders and state farming experts helped 40 community leaders understand the health care plight of the farming community.

Although farming provides 21 percent of jobs in Shawano County and accounts for 20 percent of economic activity, in 2003, 18 percent of Shawano’s farm families were completely uninsured. More had at least one uninsured family member, and most had no preventive care coverage at all. A grassroots team, led by ThedaCare and including leaders from the Farm Bureau, University of Wisconsin Agriculture Extension Office, the area farmers’ bank, school system, public health, dairy co-operatives, and others, met over eight months to find a solution for these families. In 2004, the Rural Health Initiative was created to improve access to health care, preventive services, and community resources; to improve occupational safety for farm families; to increase incidence of healthy behaviors and reduce risk; and to increase health status awareness through improved access to information, education and professional health care services.

A rural health coordinator makes farm visits to provide a free health risk assessment (HRA) of family history, lifestyle behaviors, safety risks, and screenings for blood pressure, glucose, cholesterol, body mass index (BMI), audiology, pulmonary function, skin cancer and mental health. The coordinator also provides health information and education; referrals to area services including health care, financial, social services or agriculture; and lends an ear as farmers deal with a solitary, 24/7 profession.

Results

From 2004 to 2015, the Rural Health Initiative reached 28 percent of farm families in Shawano County. Annually, 225 health risk assessments were conducted on the farm and 76 percent of those individuals were provided with follow-up care. Since 2010, despite the aging population, the Rural Health Initiative saw a 3.4 percent increase in biometrics and a 7 percent improvement in lifestyle habits. BMI, blood sugar and high-density lipoprotein (HDL) cholesterol levels have shown a marked decrease during follow-up visits. In 2010, the Rural Health Initiative expanded its services to two neighboring counties and also made inroads with large dairies employing Hispanic workers, resulting in implementation of a Spanish health risk assessment, an interpreter and cultural training. In 2014, the Rural Health Initiative served 83 Spanish-speaking participants, many battling diabetes and mental health issues.

Lessons Learned

Farmers are accustomed to professionals such as dairy nutritionists and milk haulers bringing services to the farm. A key learning was to adopt this successful model instead of expecting farmers to come to health care providers. Farmers are frugal and efficient people. When given education, they are eager to make lifestyle changes and stick to a plan.

P.A.R.T.Y. at the P.A.C.

After a local coalition identified reducing alcohol use and smoking by youth as community health priorities, ThedaCare's Trauma Center at Theda Clark Medical Center became the first organization to bring the Canadian program Prevent Alcohol and Risk-related Trauma in Youth (P.A.R.T.Y.) to the United States. The P.A.R.T.Y. program builds awareness among teenagers about the dangers of drinking; texting and driving; drinking and driving; not using seat belts; and other risky behaviors.

National reports have ranked Wisconsin as high as second in the nation for binge drinking among youth. Wisconsin is the only state where the first driving under the influence (DUI) offense is a civil rather than a criminal offense. Stricter legislation has proved difficult to pass, so educating youth in the state is critical to creating a safer future. Crash victims, family members, friends, and health professionals powerfully and emotionally tell their personal tragic stories, supplemented by reenactments, videos and meaningful discussion. The program uses facts, logic and emotion to effect positive change. It has evolved from a weekly six-hour, emergency department-based program for 1,000 teens from two local schools into a two-hour annual program held at the Fox Cities Performing Arts Center and attended by more than 5,000 students from 34 schools in seven counties. Each year, the program is scrutinized and updated using pre- and post-event survey data to ensure accuracy and identify developing trends to create maximum impact on today's teens.

Results

More than 35,000 students have participated since 1998, with the number increasing each year. Comparisons of pre- and post-surveys for 2014 indicate that students are 23 percent more likely to ask a driver to stop texting or talking on the phone, and 33 percent less likely to ride in a vehicle with a driver under the influence of alcohol or drugs. A trend analysis of the school-based Youth Risk Behavior Survey from three area schools whose students consistently attend the P.A.R.T.Y. program shows a nearly 25 percent increase in teens who wore a seat belt and a 32.4 percent decrease in teens driving after drinking alcohol.

Lessons Learned

Parents and teen advocacy groups are the most effective allies in this work. In 2013, parents were invited to attend the P.A.R.T.Y. program with pre- and post-educational components that help parents facilitate ongoing discussion. Teen advocacy groups reach out using a peer-to-peer approach. The desire to nurture teen group advocacy efforts led to the formation of the Winnebago County Teen Safe Driver Coalition, which works with school-based groups to create, educate and support peer-led awareness and safety campaigns.

Voices of Men

Voices of Men is an organization of males who are taking responsibility for ending violence against women and children. It was founded in 2007 when four domestic violence and sexual assault agencies held a Men's Summit. Inspired by the message, a group of men wanted to do more but lacked focus. The effort received a boost through a 2008 CHAT plunge on domestic violence led by ThedaCare. Following the plunge, a steering committee was formed to plan an intensive four-month initiative. The signature event was a community breakfast that drew more than 400 men who wanted to be part of the solution. This breakfast has become an annual event, attracting 783 men and teen boys in 2014 to learn about simple everyday behaviors that can degrade women and foster a culture that enables violence.

Domestic violence and sexual assault are often considered "women's issues." Voices of Men, which partners with women from four domestic violence and sexual assault agencies, is trying to change that. The premise is violence against women is rooted in sexism and how American culture teaches masculinity. The organization's educational efforts ask men to challenge sexism and redefine masculinity.

Results

To date, more than 2,000 men and teenage boys have attended the annual community breakfast. In addition, more than 2,500 men and teenage boys have taken the White Ribbon Pledge "never to commit, condone or remain silent about men's violence against women and children." An annual survey of breakfast participants revealed that 80 percent made a conscious effort to improve the way they treat women and girls; 58 percent spoke up when they heard an inappropriate comment made about women and girls; and 99 percent attended an event or took some kind of action in support of women or girls.

Lessons Learned

A significant lesson is that men can be good allies in this work. Men have significant privileges in American society and can use them to create a more just world.

Fox Valley Children's Mental Health Center/Catalpa Health

In 2005, 10 percent to 20 percent of youth in Fox Valley met the criteria for a mental disorder, and 80 percent of children with mental illness were not receiving treatment. A shortage of professional psychiatrists and psychologists meant the average wait time from need identification to treatment was 55 days.

A ThedaCare-led CHAT plunge on access to mental health services in 2007 brought much-needed attention to this issue. As a result, three competing health care providers, ThedaCare, Affinity Health System, and Children's Hospital of Wisconsin-Fox Valley, came together to open the Fox Valley Children's Mental Health Center in 2008. The intent was to provide an intake coordinator who would, in collaboration with a nurse practitioner, connect the person with the appropriate care option: access to a psychiatrist (in person or via telepsychiatry), evaluation by a nurse practitioner, referral to local behavioral health services, or emergency services.

While this work was a dramatic improvement over previous care options, a 2011 regional study confirmed the need for a broader continuum of care for mental health services, especially for youth. For example, 25 percent of 10th-graders indicated having experienced depression the previous year, and 14 percent said they had seriously considered suicide. The three collaborating care providers took another major step. They ceased their own pediatric mental health operations and formed a partnership to create Catalpa Health, a stand-alone 501(c)(3) not-for-profit dedicated to providing seamless, accessible and collaborative health services for children. Catalpa Health opened its doors in November 2012. In March 2014, Catalpa opened a new Access Center with three goals: reduce patient wait times, provide case management services to remove barriers, and create a personalized care plan for clients and families

Results

This pediatric mental health collaboration now provides area youth crisis appointments within 24 hours. Wait times for initial assessments and mental health therapy have been reduced from 54 days to less than five business days. Since 2012, this collaborative model has served more than 8,500 young patients in more than 47,000 visits. Currently, 49 percent of patients receive financial support through generous philanthropic donations.

Lessons Learned

First, an initial attempt by the three health systems to maintain their own practices and simply work together was not enough; they had to discontinue their own practices and create a whole new entity. Second, publicity around the new organization, as well as the caseload brought by each health organization, overwhelmed the system and, initially, wait times for new appointments were dramatically increasing. This resulted in the creation of an Access Center model that triaged the most serious issues, significantly reduced wait times overall, and added case management to assist in removing barriers to care. Finally, in addition to offering treatment in an office setting, it is important to take the care to where the children are.

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