2024 PREMIER CARES AWARD

WORKSHEET

Award overview. The annual Premier Cares Award honors community agencies and programs that support those excluded from, or underserved by, the mainstream health delivery system. To be considered, your program must be a stand-alone, not-for-profit entity that operates independently from a hospital or healthcare system. Program also must be affiliated with a Premier member organization in some way.

Underserved populations include - but are not limited to - those which:

- Suffer severely limited access to medical, dental or mental healthcare providers
- Bear high infant mortality
- Face low income, high poverty
- Experience high levels of drug abuse
- Are economically or medically vulnerable
- Possess a unique care need which is not being met through traditional means

Submission criteria - The program must be:

- a stand-alone entity which operates independently from a hospital or healthcare system.
- a not-for-profit entity, in either the public or private sector.
- able to show results covering a full one-year span prior to January 2024.
- replicable.
- affiliated with a Premier member hospital or healthcare system in some way.
- able to articulate a sustainable future vision for the program

Applications must be fully completed and will be scored on the following:

- Clear statement of unmet need
- Innovation/creativity
- Outcomes/results (one full year of data required)
- Future vision
- Ease of replicability
- Financial impact

Review and judging:

- The Cares Award operations team will inspect each application to assure that criteria is met and that all sections are complete.
- Using the stated criteria as a guide, a multi-disciplinary Premier staff panel will review and score all applications and will select the top five entries.
- An external panel of healthcare industry leaders will review and score the top five entries. Of those, the entry with the highest score will be deemed the winner.
- You will be notified of application status no later than February 19, 2024.

If your program is the winner, Premier will:

- Craft media announcements about your award – some for Premier to administer and others for you and your organization to edit and utilize at your own discretion.
- Create a brief video highlighting your program which will be shared with you and posted to various Premier websites and social media platforms.
- Present your leaders with a $100,000 check.

APPLICATION BEGINS HERE

PROGRAM FUNDAMENTALS

**Items with an asterisk are mandatory*

Official Program Title (Capitalize Each Word) *	
Program Address *	
Program City *	
Program State *	
Zip Code *	
Program Website (if available)	
Program Facebook (if available)	
Program LinkedIn (if available)	
Program Twitter (if available)	
Program Contact First Name *	
Program Contact Last Name *	
Program Contact Job Title *	
Program Contact Email Address *	
Program Contact Work Phone *	
Program Contact Mobile Phone *	
Submitter Name (if different from Program Contact)	
Please list all of the local hospitals or healthcare systems this program is affiliated with. (please separate each affiliation with a semi-colon) *	
Do any of the hospitals or health systems you are associated with provide space or funding? (if yes, provide details) *	No/Yes
Program Tax Status (must be not-for-profit in public or private sector)	*501c3 /501c(other) /Private Not-For-Profit / Other
Program Geographic Service Area *	
Program Population(s) Served *	
Number of People Served Annually by Program *	
Number of Full Time Program Employees *	
Number of Part Time Program Employees *	
Number of Program Volunteers *	
Length of Time Program in Existence *	
Program Annual Total Expense Budget *	
Major Source(s) of Program Funding *	
Which of the following types of payment does your program accept (check all that apply) *	Medicaid /Medicare / ACA / None of the above / Other
What percent of your total revenue is derived from these sources? *	

For what purpose(s) would the Cares Award dollars be used? *	
Has your program achieved Cares Award Finalist status within the past 5 years? *	No / I don't know / Yes; if yes, what year?
How did you hear about the Premier Cares Award? *	• I received an email notice directly from Premier • An email notice was forwarded to me by a local hospital or healthcare system representative • The information was shared by a member of the program's board • Social Media - Twitter, Facebook, other • Premier Inc Blog • Other
Program Mission – What is the strategic vision for this program? *(50 words)* ***Examples:*** *"Provide compassionate, holistic care with a spirit of healing and hope to indigent drug addicts."* *"Deliver comprehensive, top quality healthcare to vulnerable, low-income patients and their families."* *"To inspire well-being by providing the best care to every needy pregnant teen through integrated clinical practice, education and continuing support."*	
Program Purpose/Statement of Need – What problem(s) does the program solve and how? (300 words) ***Examples:*** *"This is a comfort care home which provides comprehensive clinical and emotional support to patients who are at the end of life and have no families or no homes. Its patients live at the facility and its caregivers provide respite, medication, safety and the opportunity to die with dignity. We do not duplicate any services that other agencies provide."* *"Our local population is 25% Latinx, 27.9% of whom live below the poverty level. In addition, approximately 32% of Latinx people are without health insurance. Per a local community health survey, preventive care and early detection of chronic diseases among this population were identified as key needs. This program uses a specially equipped mobile unit to provide free basic services and screenings to this population - medical exams, immunizations, eye care, dental care, diabetes testing, mammograms, etc. The mobile approach allows us to offer services*	

where they are most convenient such as food banks, migrant housing units, schools, fire stations, etc."	
Innovative Aspects – How is this program "one of a kind" or different from programs which have similar goals? (150 words) ***Examples:*** *"We are the only safety-net healthcare provider that offers employment placement as an integral part of the clinic's continuum of care and as a direct benefit of our clients' health improvement."* *"Our program has a uniquely strong and involved board that has helped us to create innovative partnerships with local pharmacies, hospitals, home health organizations, dentists, hearing specialists and others. We also recycle gently used medical devices such as wheelchairs, walkers, crutches, lift chairs, etc. Strong leadership and strong partnerships allow us to effectively assist people who are struggling with a variety of healthcare needs in a customized manner."* *"A partnership between food banks and community healthcare providers is innovative in that it approaches hunger as a social determinant of health issue. This partnership can address both food insecurity and limited access to healthy food – factors that place low-income individuals and families at higher risk of diabetes and numerous other diet-related chronic health conditions. By incorporating food insecurity into the medical record, we can identify food insecure patients and refer them to the food bank for appropriate nutritional support."*	
Replicability – What are the critical success factors that support replicability of the program, assuring that this approach can be effectively adopted by others? (150 words) ***Examples:*** *"Critical success factors: 1) Highly experienced leader re: meeting the unique healthcare needs of uninsured, indigent, homeless women and children living in poverty. 2) Focus on continuous improvement re: services*	

and clinic operations such that we may effectively anticipate and respond to changing client needs and technology advances. 3) Steadfast adherence to delivery model principles which include: convenience (located where clients live); ease of use (prompt walk-in care on all visits); affordability (all free services); continuity (unlimited clinic visits); comprehensive approach (medical, mental health, specialty services); employment support (access, support, follow-up, etc.)." *"Factors that have led to our success include an unwavering commitment to our mission and the women and children we serve, a staff and board that fully embrace our mission and a wide network of other agencies and organizations we collaborate with to provide each resident the unique support she needs to succeed. We have an excellent reputation within our community and across the state. Key outreach occurs with former residents, obstetricians, churches and crisis pregnancy centers. We also partner with residential drug treatment facilities, doctors, mental health specialists, early childhood intervention agencies, nursing schools, churches, and many other organizations to nurture and guide these women as they make critical and long-standing improvements in their lives."*	
Future Vision – In this section, share strategies and plans for the future. Focus on items like: maintain; maintain and enhance; expand geographic reach; expand target population; expand services; upgrade equipment; hire staff, etc. (150 words) ***Examples:*** "Our vision is to bring the healing power of art to every pediatric cancer patient in the state as follows: 1) Seek opportunities to expand services in our current chapters. 2) Establish new partnerships area hospitals. 3) Pilot a mission-aligned revenue model to financially support sustainability." "Our future vision includes the expansion of our educational approach to supporting autistic or Asperger's	

diagnosed children in integrated settings; the development of more formalized training manuals for daycare providers and teachers to facilitate replication of our approach; the expansion of workshops and training seminars focusing on strength-based education in public and private schools as well as technical colleges and universities."	
Outcomes/Success Measures – Describe how the program's success is measured. Outcomes data is preferred but outcomes may also be measured by: number of patients/families directly impacted, waiting lists to access program, improvement in health status indicators, examples of how program has been replicated, positive behavior changes, improved access to services, cost savings, ER visits avoided, testimonials, awards or other recognitions received, etc. This is not just activity or volume, but actual evidence which showcases how the program enhances the social responsibility of the community, improves health or fills an unmet community need. Data, charts and graphs are encouraged. (300 words) *Examples provided on last page of this document.*	
Testimonials – Provide at least one but no more than three brief testimonials from participants or their family members who have benefited from this program, including names, if possible. ***Example:*** *"This program helped me to manage my asthma so I could keep my job and support my family - Jane Smith."*	
Final Notes – Use this space to provide additional information that will underscore the value of this program and its impact on community health.	

OUTCOMES EXAMPLES

EXAMPLE 1. Data on the Well Patient Program's effectiveness can be seen in its readmission rate. In 2014, RMC's readmission rate was 6.76%. By the end of 2015, the Well Patient Program had helped reduce the readmission rate to 6.53%. By the end of 2016, the second year of the Well Patient Program, the readmission rate was 5.87%. The other measure regarding the Well Patient Program is RMC's Potentially Avoidable Utilization (PAU) rate. The PAU is based on the Preventable Quality Indicators, which are a set of Ambulatory Sensitive Conditions including chronic diseases such as Congestive Health Failure, Chronic Obstructive Pulmonary Disease, Hypertension, Asthma, and Diabetes as well as chronic conditions such as Pneumonia and Urinary Tract Infections. RMC's PAU rate for 2015 was 9.27%, and by the end of 2016 it was 8.15%. As the program has been implemented, its impact on the lives of those involved has been profound.

We've seen patients with chronic conditions achieve markedly improved health outcomes. In 2016, only 4% of patients in the program were readmitted to the hospital. That's a 96% success rate. By helping these patients make and keep appointments with their primary care physicians, their health outcomes tend to be much better than they were before the patients entered the program. Assistance provided varies with each patient, and can include home based physical or occupational therapies, as well as help with anxiety through teaching meditation. A CHW helped one patient rearrange the furniture in their home to make it less likely that the patient would fall. Many patients found help with transportation, and others received behavioral health counseling. The program is tailored to each patient, providing whatever assistance is needed.

EXAMPLE 2. Program has expanded from a walk-in clinic for immigrant farmworkers operating at a high school to three clinic sites for uninsured pulmonary patients (and their comorbidities). The program's success and effectiveness is measured through increase in new patients, reduction in ED visits and readmissions, patient enrollment in pharmaceutical programs and cost savings. From August 2013 to January 2017, ACLC impacted 1,388 patients through 3,172 patient visits. (Patients/year: 59-2013; 229-2014; 419-2015; 595-2016; 86-January 2017).

615 patients were tracked 12-month pre and post initial clinic visit from August 2013 through January 2016. Health status indicators and outcomes:

- ED visits decreased by 43.84% from 1,909 to 1,072
- Hospital readmissions decreased by 55.87% from 741 to 327
- Average readmissions per patient decreased from 1.20 to .53
- Average cost avoidance per $6,000/admit = $2,484,000

EXAMPLE 3. Our work has been significant in improving health outcomes in the last two years. Our depression screening rate is now 87%, which is more than four times higher our rate of 21% in 2015. We've also seen major success in colorectal cancer screenings with our screening rate jumping from 46% to 69% in the span of two years, which is higher than the city average of 61%. Finally, we are proud of our progress in hypertension control as our rate of 75% is which beats the control rate for all federally qualified health centers of 64%. These achievements are just a snapshot of the overall success our care coordination program has generated. As the attached charts illustrate, we met or exceeded 9 of our 15 quality benchmarks and came within 10% of meeting an additional 4 in 2016. Our overall improvements in quality are responsible for our ranking as a National Quality Leader Award winner – a designation given to only 5% of health centers nationwide. These achievements are a testament to the role of care coordination in providing patients with care that leads to healthier, more fulfilling lives.