2021

AHA Dick Davidson

NOVA Award

Collaboration for Healthier Communities

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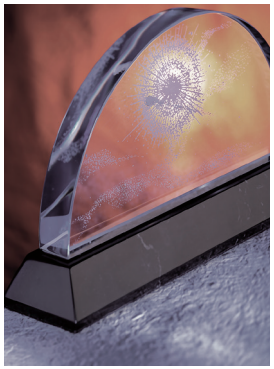
Each year, the American Hospital Association honors up to five programs led by AHA-member hospitals as "bright stars of the health care field." Winners are recognized for their work to improve community health status in collaboration with other community stakeholders.

In 2018, the AHA NOVA Award was renamed in memory of Dick Davidson, who led the Association as president and CEO from 1991 to 2007. Davidson championed the role of hospitals in improving the health of their communities and drove the creation of this award in 1994.

The AHA Dick Davidson NOVA Award is directed and staffed by the AHA's Office of the Secretary. Visit www.aha.org/nova for more information.



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WINNER **COMMONSPIRIT HEALTH** | San Francisco

Creating a healthier community for all

Through two innovative programs, CommonSpirit Health plays a crucial role in meeting needs surrounding wellness and homelessness.

The Connected Community Network (CCN) program closes the gap between medical and nonmedical providers to address social determinants of health.

"When the social determinants of health drive as much as 80% of health outcomes, creating a solution with our partners in the community was critical," said Ji Im, system senior director, community and population health.

When Dignity Health and Catholic Health Initiatives merged to become CommonSpirit Health in 2019, the CCN was identified as an organization "Bright Spot." The program now operates in more than 20 communities throughout multiple states and continues to grow.

"As a system of health care institutions — anchors in our communities — we have a natural role to convene everyone involved in helping people who are struggling to gain health and improve their lives," said CommonSpirit Health CEO Lloyd H. Dean. "Especially during the pandemic, we've been called upon to bring people together for a shared purpose. This has been our role for decades — generations, even. We're inspired by the Catholic sisters who founded many of our hospitals and believe that health care is a basic human right."

The CCN links hospitals, clinics and local community organizations that provide vital services, including shelter, chronic disease management, legal aid and family services, for supporting healthy populations. The network is designed to connect individuals in need to appropriate community resources while collectively tracing the outcomes in one accountable ecosystem.

The program promotes standardized screening for social needs across care settings like clinics and hospitals. Screenings provide insights regarding the barriers patients and their families face in accessing services and programs to address unmet social needs that influence health. "We are the catalyst, but every community must take ownership through a neutral convener."

One such CCN convener is United Way of San Joaquin County. CEO Kristen Spracher-Birtwhistle said United Way and its local community partners "now are better able to understand if the services are delivered, how the delivery is happening and if they are keeping people well."

One of the unique aspects of CCN is that costs are covered through a community bank model rather than having to rely on grants. Contributors to the community bank are considered funding partners. "CCN is sustainable because of different funding partners, all pitching into the community bank, so it's not up to one entity," said Tammy Shaff, director of community health at Dignity Health St. Joseph's Medical Center in Stockton.

The biggest obstacle to CCN was that all the potential partners were busy with their jobs, Im said. "It took a lot of people jumping the chasm and saying, 'We've got to do this together.'"

When COVID-19 erupted, CCN pivoted toward such community engagement efforts as exposure assessment, social needs screening and integrated self-referral websites. CommonSpirit's Virtual Care Anywhere telehealth service offered free virtual visits for anyone experiencing COVID-19 symptoms.

Photo courtesy of CommonSpirit Health

ONSITE CONNECTIONS: The Salvation Army Mobile Street Outreach team speak with two homeless men to help build relationships and provide case management services. The fully-equipped mobile office supports real-time referrals to resources through the Connected Community Network.

CCN's success has been demonstrated by several metrics. For example, a 2018 study in California showed that impacted patients received an average of 2.1 referrals for services like behavioral health, housing and chronic disease management. Referrals resulted in fewer return visits to the hospital.

CommonSprit also is being recognized for its Homeless Health Initiative (HHI), a comprehensive investment program to prevent homelessness and serve the health and social needs of people experiencing homelessness.

"The Homeless Health Initiative is a systemwide strategy to keep people housed so they can address other social needs and their health care," said Ashley Brand, system director of community and homeless health.

Natascha Garcia, management analyst with San Joaquin Whole Person Care, said HHI "is about taking down silos, working with partners, and identifying where the individual is and what they need, not what we think people need."

Art Flores, a project manager for HHI partner Stocktonians Taking Action to Neutralize Drugs (STAND), helped find permanent housing for a 70-year-old patient with lung disease who was sleeping in a truck. "I visited him yesterday and he was practically dancing," Flores said. "After tonight, he won't be homeless."

WINNER **LUMINIS HEALTH** | Annapolis, Md.

COVID-19 program helps the most vulnerable population

In March 2020, as the COVID-19 pandemic was rearing its head, Luminis Health received a distressing call from a low-income housing complex for seniors. The housing manager was hearing conflicting information about COVID-19 prevention and didn't know how to keep residents safe.

Luminis responded with a solid, innovative approach by launching its COVID-19 Community Prevention Program. It was designed to provide education and resources to the most vulnerable residents of the health system's service area, through comprehensive community outreach. The effort focused on low-income, senior apartment complexes, many of which are located in African American and Hispanic communities.

"We realized early on during the pandemic that certain communities we serve didn't have access to testing, hygiene products and the level of education they needed to deal with COVID-19," said Tori Bayless, Luminis Health CEO. "Our mission is to enhance the health of the people in those communities. And we wanted to do some myth busting, to let people know what they needed to do to protect themselves and their families."

The goals of the program were to:

- Educate residents about COVID-19 prevention measures — wearing masks, social distancing and hand hygiene.
- Connect residents with available testing resources and provide direction on quarantining and isolation procedures in response to positive tests.
- Provide available resources related to food scarcity and financial insecurity to address social determinants of health.
- Prevent worsening health disparities by improving knowledge about COVID-19 infection, prevention and community resources for support.

"It was a scary time," said Charlotte Wallace, a Luminis community health nurse who built the program and headed the outreach team. "When we went door to door and talked to residents, some were terrified and others had no idea what was going on. There was a ton of confusion."

The biggest obstacle Wallace had to overcome was a lack of suitable educational materials. Materials were available from the Centers for Disease Control and Prevention website, but Wallace said she had to create content that was more accessible to the residents she was visiting.

Wallace said it was a challenge to persuade some apartment managers to let her go door to door as the pandemic ramped up, but she persisted until they agreed.

The approach was multipronged and offered unique support. Besides COVID-19 educational content, the team provided information about mental health and other resources. Team members screened residents for depression as needed and brought items like soap and laundry detergent. "On one visit, I called an ambulance for a well check and they took the resident to the hospital," Wallace said.

Wallace's team partnered with organizations that provided food. "At times I would notice that a senior wasn't doing well and I would do a food insecurity screening. Two or three times I realized somebody needed help, and I contacted county resources to have food delivered to them."

Photo courtesy of Luminis Health

DOOR TO DOOR: Besides providing COVID-19 educational content, team members screened nursing home residents for depression and provided items like soap and laundry detergent.

The COVID-19 Community Prevention Program is funded by Luminis Health and a variety of individual donors and grant funds. Donations from 565 donors ranged from $5 to $50,000 for a total of $1,087,497 in a few months.

The program has reached more than 50,000 residents and may have helped flatten the initial curve of COVID-19. Statistics show a decline in positivity and hospitalizations in the Luminis service area after interventions began.

The program now is focused on COVID-19 vaccinations, which are administered in public areas of the apartment complexes. Luminis is also working with community leaders to increase vaccine confidence in communities of color.

Bayless said the program is replicable if hospitals and health systems "buy into this model. It's a departure from hospital-centric thinking and getting these teams out into the community." ●

WINNER **MEMORIAL HEALTHCARE SYSTEM** | Hollywood, Fla.

Helping seniors lead safe, independent, connected lives

As adults age into their senior years, many contend with growing challenges to independent living. This issue takes center stage in areas like Florida, which has the highest concentration of older residents in the United States.

Most seniors want to maintain independence, but health and safety concerns can derail those plans. Even those who are able to live alone safely can face loneliness.

"A lot of times, the elderly are overlooked," said Aurelio Fernandez III, president and CEO of Memorial Healthcare System. "We saw a need and established a program that helps those most in need."

The Memorial ALLIES [Adults Living Life Independently, Educated & Safe] Program addresses social isolation and related issues that threaten the independence of older adults. The no-cost services include increased and improved coordinated care, monthly health screenings, nutritious daily meals, social connections, transportation assistance and education to prevent fraud and abuse.

ALLIES started as a 2017 pilot program supported by a $65,000 grant from the Community Foundation of Broward. Over the past three years, the program has grown to six full-time home visiting counselors and case managers, thanks to additional funding through the Community Foundation of Broward and funding from the Frederick A. DeLuca Foundation [Subway restaurant chain] and the Florida Blue Foundation [Blue Cross Blue Shield], for a total of $331,000 annually.

"The program stemmed from understanding what seniors need and can benefit from, and implementing a program that would fit their needs," said Tim Curtin, Memorial Healthcare's executive director of community services.

Community partners play a big role in the program's ability to meet seniors' needs, said Nina Beauchesne, Memorial Healthcare executive vice president. "We partnered with the city of Hollywood. We needed a place to help our senior population with exercise, education and socialization. They allowed us to use a city facility that was not being utilized. It helps us operate something that's cost-effective and gives seniors high-quality, community-based services."

Other community involvement has included high school student volunteers who teach seniors new technology skills.

Many of the services are provided in the seniors' homes. For example, team members visiting seniors do an environmental safety scan. "We check to see if it's a safe dwelling," Curtin said. "Are there loose throw rugs? How is the lighting? Are there smoke alarms and fire extinguishers? We ask them if they have trouble getting in and out of the bathtub and shower. We'll offer to have a grab bar installed if they don't have one."

When COVID-19 hit, ALLIES staffers quickly pivoted to ensure they could continue to monitor, assist and interact with seniors in unique ways. They met such challenges as distribution of food and other supplies, safety checks, making reservations for vaccinations and engaging with individuals who have limited access to information technology. The South Florida Digital Alliance helped seniors stay connected by donating repurposed laptops.

Photo courtesy of Memorial Healthcare System

GATHERING WITH FRIENDS: During the COVID-19 pandemic, seniors expressed the desire to visit with friends so team members organized 10-at-a-time senior gatherings at local parks.

But technology could not stave off all the loneliness. Curtin said, "Around the holidays in December, I got a call from a client who said, 'Tim, we've got to get back together in person. I'd rather die of COVID-19 than die of loneliness. All this remote work and people dropping off food is great, but I want to be back with my friends.'"

In response to that plea, Curtin and his team members started holding 10-at-a-time senior gatherings at a park gazebo. "The first time we got them back together, they were so happy to see each other again that some of them cried," he said.

The program is replicable, Fernandez said, "but it has to be part of your mission and your vision of what your role is in the community." ●

WINNER **PROVIDENCE HEALTH & SERVICES** | Portland, Ore.

Building a bridge to behavioral health and substance-use care

Several years ago, Providence Health & Services saw a pattern of extremely high emergency department (ED) visits from behavioral health and substance-use patients. The majority were homeless. Medical services from a variety of disconnected sources did little to resolve their underlying issues.

"Some of them were showing up in the ER three to four times a week," said Robin Henderson, Psy.D., Providence chief executive for behavioral health.

Providence was committed to caring for those patients, but the ED formed a loose link in a fragmented, underresourced health care system. In pursuit of a better way to serve those patients, Providence established the Better Outcomes thru Bridges program, known as BOB. The program utilizes peer support, outreach and community partnerships to help the most vulnerable people in the community.

"We meet that person in the initial encounter in the emergency room," said Becky Wilkinson, BOB program manager.

"We want to reduce emergency department recidivism and help folks get connected to the services they need. We're the ones who are going to walk alongside them throughout their journey, and let them guide their care with our support."

BOB helps patients (referred to within BOB as "clients") with behavioral health issues, and substance-use and chronic pain disorders connect with and maintain follow-up care frequently after hospitalization or an ED visit. BOB staff members include licensed clinical social work, bachelor's degree-level outreach workers and peer support specialists.

The program operates out of multiple locations to help as many patients as possible. Besides EDs, the contact points include primary care and specialty clinics, a regional behavioral health call center, community behavioral health agencies, other treatment providers, schools and housing agencies.

"At one point at our Portland campus, there was a homeless person who had encamped under the stairwell of one of our medical office buildings," Henderson said. "He had mental health issues. BOB case workers got to know him, earned his trust, and eventually helped him find a new home."

When the COVID-19 pandemic hit, Providence caregivers became aware of rampant outbreaks of the virus in homeless shelters. "A number of COVID-19-positive individuals were showing up in the ER, but we couldn't discharge them back to a homeless shelter until we had vaccines," Henderson said. "We rented a block of rooms at a local motel and staffed that with BOB caregivers. Because BOB was able to quickly pivot, we were able to get people who were homeless and COVID-19-positive into a safe place where they would not infect others."

In another response to COVID-19, the BOB program helped provide supplies and services to students and families through its school outreach program, Wilkinson said.

BOB also played a crucial role amid the wildfires that plagued Oregon in the late summer and fall of 2020. "We suddenly had homeless people who were even more homeless," Henderson said. "BOB worked with a local church to provide them with shelter, food and stabilization. We were able to pivot in a day because of the relationships BOB has built in the community. That is one of the unique traits of BOB."

In addition to helping patients receive the care they needed, ED utilization rates decreased 45% after engagement with the BOB program.

Henderson said the BOB program can serve as a template for other programs that target the social determinants of health. "It requires the establishment of a trusting relationship to get someone to believe we're here to help them and we're going to stick with them." ●

Photo courtesy of Providence Health & Services

HELPING THE HELPLESS: The Better Outcomes thru Bridges program, known as BOB, uses peer support, outreach and community partnerships to help the homeless and other vulnerable people in the Portland community.

Promoting healthy choices to improve community well-being

In 2013, Fort Worth stood at an unimpressive 185 out of 190 reported metro areas on the Gallup National Health and Well-Being Index. During the following year, plans to improve that ranking were undertaken by Texas Health Resources, the city of Fort Worth, the Fort Worth Chamber of Commerce and other community leaders.

The partners agreed to pursue their goals through Blue Zones Project, a community-led well-being improvement initiative based on the research of Dan Buettner, a National Geographic Explorer and Fellow and award-winning journalist who discovered five places in the world – dubbed Blue Zones – where people live the longest, healthiest lives. Blue Zones Project aims to make healthy choices easier through permanent changes to a community's environment, policy and social networks.

"Our engagement with Blue Zones Project stems from an evaluation of whether we were fulfilling our mission," said Barclay Berdan, Texas Health Resources CEO. "Our mission is to improve the health of the people in the communities we serve. How can we do a better job of pursuing and living the mission? We had a lot of conversations with other leaders in the community about how to have a lasting impact on well-being."

David Tesmer, Texas Health Resources chief community and policy officer, played a leading role in bringing Blue Zones Project to Fort Worth. "Being a faith-based nonprofit, Blue Zones Project is a natural fit in our effort to be proactive in the health and well-being of our community," he said.

Matthew Dufrene, a Texas Health Resources vice president who leads Blue Zones Project work in the Fort Worth area, emphasized that the program is a communitywide initiative. "We have worked with more than 500 partners to date, and that number continues to grow."

Blue Zones Project targeted health objectives from many different standpoints, such as:

- Healthier food options in restaurants, grocery stores and schools.
- Increased opportunities to stay physically active through walking groups and parks.
- Policy objectives to influence the built environment, tobacco use and the availability and consumption of healthful foods.

The broad coalition of participants ultimately included more than 340 worksites, schools, restaurants, grocery stores and faith-based communities. Financial support came from more than 20 entities, including some of Fort Worth's largest employers, health care systems and philanthropic foundations.

"Our community partners provided invaluable input on how to address food deserts and food insecurity within the city," Tesmer said. "Blue Zones Project has donated more than 200,000 pounds of produce to underserved areas, and we've worked together to change city ordinances to help expand the availability of fresh food carts."

Blue Zones Project established a Double Up Food Bucks program in multiple locations across Fort Worth. The program allows low-income families eligible for Supplemental Nutrition Assistance Program benefits to obtain fresh fruits and vegetables for half the price they would pay at a farmers' market or grocery store.

Photo courtesy of Texas Health Resources

DOUBLE THE BENEFITS: The Double Up Food Bucks program in a high-need Fort Worth communities allows low-income families eligible for Supplemental Nutrition Assistance Program benefits to obtain fresh fruits and vegetables for half the price they would pay at a farmers market or grocery store.

In 2019, Fort Worth's equivalent rank on the Gallup National Health and Well-Being Index shot up to 31st (tied) out of 156 metro areas.

"Our efforts helped raise well-being in Fort Worth," Berdan said. "The city became a certified Blue Zones Community in late 2018, the largest in the country."

When COVID-19 hit in early 2020, Blue Zones Project realigned its efforts to respond. The program provided vaccinations and COVID-19 educational materials, Dufrene said.

Blue Zones Project served as a conduit for multiple community partners and sought innovative ways to increase food access during the pandemic. Blue Zones Project worked with schools, community centers and homeless services to provide funding for essential hygiene supplies for 450 families. Books and supplies were provided to schools, community centers and homeless shelters.

Dufrene said Blue Zones Project initiatives are replicable, but it takes long-term commitment by elected officials, community leaders, chambers of commerce and hospital systems. "A high level of collaboration is required." ●

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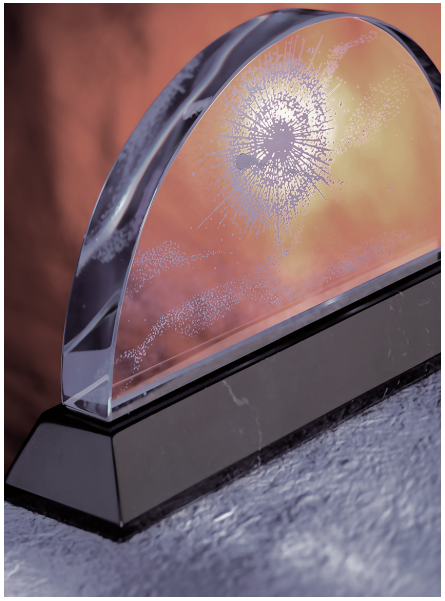

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