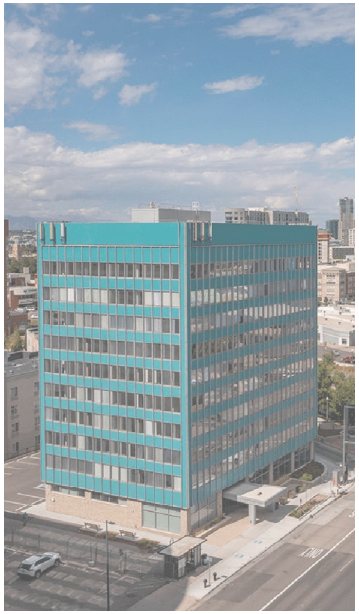
2026

American Hospital Association — Dick Davidson

# NVA Award™

## Collaboration for Healthier Communities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## Collaboration for Healthier Communities

Each year, the American Hospital Association honors five programs led by AHA-member hospitals as "bright stars of the health care field." Winners are recognized for their achievements in improving 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 (www.aha.org/nova) is directed and staffed by the AHA's field engagement division.


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**WINNER** **ANN & ROBERT H. LURIE CHILDREN'S HOSPITAL OF CHICAGO** | Chicago

# Care coordination over prosecution: An innovative approach to juvenile justice

A decade ago, Chicago's Cook County had a juvenile arrest rate about 60% above the Illinois statewide average. Ann & Robert H. Lurie Children's Hospital of Chicago was well-positioned to help address that problem through Strengthening Chicago's Youth (SCY), a violence prevention program at the Patrick M. Magoon Institute for Healthy Communities, the hospital's hub for community-focused initiatives. In 2017, it joined forces with community partners to establish the Juvenile Justice Collaborative (JJC), which helps justice-involved youth avoid further trouble.

Lurie Children's serves as the "partnership steward" for the JJC, which includes 13 youth service providers, an external care coordination hub, and the Illinois Collaboration on Youth. "What was unique about this approach was that we brought our expertise in child development, and the community also brought theirs and their understanding of how to engage and work with young people," said Leslie Helmcamp, executive director of SCY and director of Violence Prevention Initiatives at the Magoon Institute.

Collaboration was built in from the start. "We spent a year developing the JJC model through consensus voting on each aspect of the model." Helmcamp said. "If partners were not on board with a certain approach, we would take it back to the table to continue discussing and moving forward. It can be challenging when you're dealing with ten different organizations, but it's really that intentional process of building trust that makes it happen."

The hallmark of the JJC, which serves youth arrested for nonviolent felonies or serious misdemeanors, is its care coordination, which relies on social services rather than prosecution. "One of our missions is to improve children's health; we promote that here, even for those who don't come to us for care," said Karen Sheehan, M.D., medical director of the Magoon Institute. "As pediatric experts in child development, we knew that warehousing these young people in the Juvenile Temporary Detention Center was not the way to help them become strong youth and young adults."

Referrals come through the Cook County state's attorney or the Juvenile Probation Department. JJC care coordinators determine appropriate interventions using the Child and Adolescent Needs and Strengths assessment (CANS). CANS identifies the youth's future aspirations and pinpoints immediate needs, such as behavioral health treatment, substance abuse counseling or assistance with basic needs like groceries. Program leaders have built in victim-support services based on CANS results because many of the youths have been exposed to violence. Care coordinators also develop family care plans.

"The JJC is a great example of the impact hospitals and community partners can achieve together by focusing upstream on prevention," said Tom Shanley, M.D., Lurie Children's president and CEO. Lurie Children's based the JJC's wraparound services on how it manages the complex medical needs of its patients.

"The idea was for us to take everything we know about care coordination from a clinical sense and see if we could apply that to a different population, which was justice-involved youth," said Mary Kate Daly, Lurie Children's senior vice president and chief of community health.

Photo courtesy of Ann & Robert H. Lurie Children's Hospital of Chicago

**JUVENILE JUSTICE COLLABORATIVE:** The hallmark of the JJC, which serves youth arrested for nonviolent felonies or serious misdemeanors, is its care coordination, which relies on social services rather than prosecution.

Since 2017, the JJC has enrolled nearly 1,500 youths and connected 1,300 of them to care coordination and community-based services. JJC has a roughly 73% completion rate. Of the graduates, 89% had their charges dropped, avoiding 125 prosecutions. Eighteen percent of participants received a new charge within 12 months, compared with 28% of the matched comparison group.

It has been encouraging to hear feedback from participants, said Britinia Johnson, manager of Violence Prevention Initiatives at the Magoon Institute. "Many of the young people viewed this as a second chance, a wake-up call and an opportunity to potentially change the direction of their decision-making," she said. ●

# Reaching every child: Alabama's powerful telebehavioral health program

During the past decade, Children's of Alabama has doubled its number of inpatient beds, expanded outpatient services and managed exponential increases in emergency department visits. But when President and CEO Tom Shufflebarger assesses everything the hospital is doing, the Pediatric Access to Telemental Health Services (PATHS) stands out. "It's as powerful as anything we do right now," he said.

Children's of Alabama launched PATHS in 2019 to address a critical need identified by provider surveys, workforce analyses and results from the federal Youth Risk Behavior Surveillance System: Alabama ranked among the lowest nationally for child psychiatrist-to-population ratios, with rising rates of anxiety, depression and behavioral challenges among youth.

The focus of PATHS is to help physicians and their clinical teams treat mild-to-moderate behavioral health conditions. The service is especially critical in rural areas where behavioral health specialists are scarce. PATHS' partners include the Alabama Department of Mental Health (ADMH) and the University of Alabama at Birmingham.

PATHS includes three main components:

- **Consultation Line:** Enrolled providers obtain real-time diagnostic and treatment advice from psychiatrists, psychologists and social workers.
- **Project ECHO:** Biweekly telementoring sessions with providers that include case discussions and expert-led education.
- **Direct Telemedicine:** Children receive behavioral health care via secure telehealth connections within their primary care provider's office.

Since 2019, the PATHS program has completed over 2,000 consultations with primary care providers throughout the state of Alabama. These consultations allow patients with mild to moderate behavioral health conditions to receive treatment in their primary care provider's office.

PATHS Director Margo Harwell said one of the main psychiatrists handling the tele-consults has told her those have become one of her favorite parts of the job. Harwell said the psychiatrist could never have had such a statewide impact without the consultation line. The number of enrolled practices has grown from the initial five to 130, bringing the total to approximately 500 providers enrolled in the program.

The program is on pace to have hosted well over 100 ECHO sessions by the end of this year. Another feature of PATHS is connecting practices, schools and community agencies with appropriate resources and educational opportunities. For instance, in 2024, PATHS received grant funding to train 30 rural community therapists in Parent-Child Interaction Therapy. Training like this can cost as much as $6,000 per therapist, said Brandy Reeve, vice president of behavioral health services. "These providers have been given [training] for free through our collaboration and partnership with ADMH," she said. "And now they're back in their home counties, providing evidence-based treatment for children that reside close to them, and otherwise there wouldn't be anything like that for them."

The pediatricians are the "shining stars" of the program, Harwell said. "I'm amazed daily at the work that's being done in our state and the willingness of our providers to do everything they can to support families," she said.

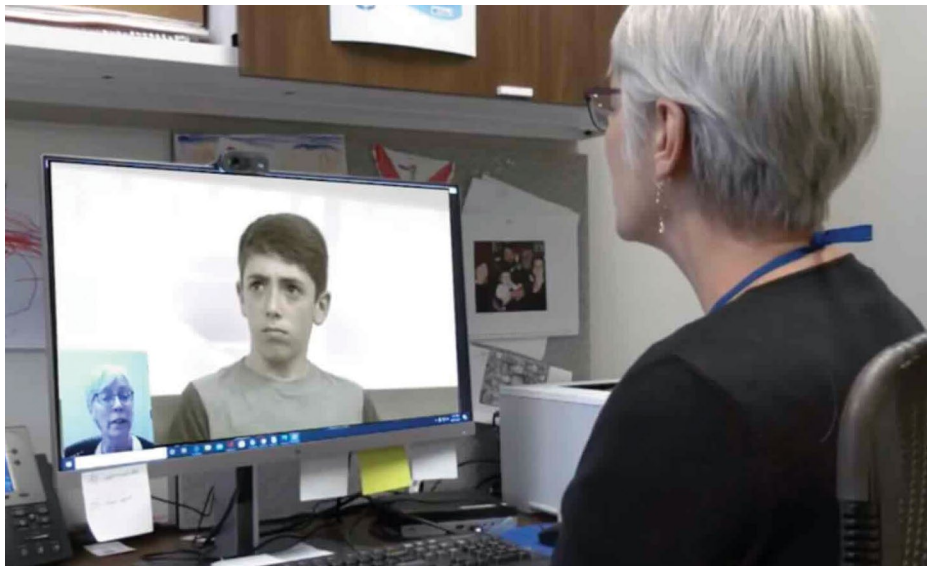

Photo courtesy of Children's of Alabama

**DIRECT TELEMEDICINE:** Children receive behavioral health care via secure telehealth connections within their primary care provider's office.

Since it began, PATHS has facilitated more than 2,100 telemedicine sessions. Between 2024 and 2025, telemedicine and teletherapy visits increased by 25%.

PATHS also provides behavioral health training to school systems across Alabama. During the past two years, PATHS has trained more than 1,200 school personnel. Feedback from attendees has stuck with Reeve. Educators say their previous training was attending a class or watching a webinar. But learning from a psychologist is different. "What we hear from them is, 'I've never had anything like this before. I've not had this level of instruction that helps me make it through the day in the classroom," Reeve said. "For me, that is really impactful."

Grant dollars from the federal Health Resources and Services Administration provide the lion's share of PATHS funding. Health care funding is always a bit uncertain, but Shufflebarger is committed to maintaining PATHS, one way or another. "We're not going to lose that momentum," he said.

# In Denver, homeless patients have HOPE

A hospital can treat a medical crisis, but for patients experiencing homelessness, recovery often depends on something the hospital cannot provide by itself: a safe place to go next. That reality is driving Denver Health's Housing Outreach, Partnerships and Engagement (HOPE) program, a hospital-based partnership model that is improving community health by addressing homelessness.

As a safety-net health system, Denver Health is on the front lines of metro Denver's homelessness crisis, with nearly 1 in 5 hospitalized adults unhoused. These patients face complex health challenges that make it harder to access the housing and services they need to achieve stability and well-being.

Co-led by Sarah Stella, M.D., and Mara Prandi-Abrams, HOPE extends partnership development work begun in 2018, ensuring hospitalization serves as a moment of connection for those in need.

Many of those served by the program have chronic physical and behavioral health conditions, substance use disorders or disabilities. Some are older adults facing homelessness for the first time. Others are veterans, people fleeing domestic violence or young adults.

Community partnerships are central to HOPE's work. Denver Health staff work alongside housing and homelessness-response partners every day.

"Health care is good at saying, 'Oh, we know how to solve this issue, and we want to tell you how to fix your problem,'" Stella said. "That's not the approach needed here. We're all challenged by folks who have unmet needs and sometimes lack the resources to meet them."

By integrating data from the Metro Denver Homeless Initiative and other partners, the team proactively identifies patients during hospital visits and helps create warm handoffs to partners with housing expertise, programs and community relationships to help patients take the next step. The program has now served 680 patients, with 75% receiving direct support to address patient-specific housing barriers or to support housing entry.

Denver Health also funds a portion of the recuperative care beds operated by the Colorado Coalition for the Homeless. Patients discharged to these beds continue to receive necessary care without tying up a hospital bed. Over the past three years, Denver Health has discharged roughly 725 patients to these beds, with an estimated 20% transitioning to more permanent housing after their recuperative stay.

In 2023, the health system partnered with the Denver Housing Authority to open the 655 Broadway Transitional Housing Program, which provides 14 apartments with supportive services for unhoused patients who are older or disabled.

Through these partnership efforts, the average hospital length of stay for this population decreased from 11 days in 2022 to eight days in 2025. Last year, the hospital reduced its uncompensated care for the homeless population by more than $6 million.


Photo courtesy of Denver Health and Hospital Authority

**HOSPITALIZATION AS AN OPPORTUNITY FOR HOUSING CONNECTION:** HOPE social workers meet with a hospitalized patient to access housing needs.

Prandi-Abrams said HOPE is a triple win, beginning with better patient outcomes. It's also "good for our providers because they feel like they have a safe place to discharge patients to, and it also supports stronger financial stewardship through reduced avoidable costs."

By helping bridge two systems, health care and housing, that have historically operated too far apart, HOPE challenges the idea that homelessness is a problem to be solved outside the hospital's walls.

Denver Health CEO Donna Lynne said HOPE's success shows what is possible when housing is treated as part of health care.

Hospital funding, grants and philanthropy can only take the program so far, and major government support remains uncertain. However, Lynne sees promise in Denver Health's partnership with Colorado Medicaid to expand housing support.

"We put our toes in the water," Lynne said. "Now we have a proof point." ●

**WINNER** **JACKSON-MADISON COUNTY GENERAL HOSPITAL** | Jackson, Tenn.

# Low-tech, high-impact: Cutting homelessness across 23 rural counties

The U.S. health care system is awash in technology, but Jackson-Madison County General Hospital (JMCGH) has found a simple 4-by-6-inch handout to be one of the most effective ways to reduce homelessness in a roughly 10,000-square-mile swath of rural Tennessee.

The hospital prints the neon-colored Community Connection Cards, which include information for a host of services across 23 counties. "They are the hottest thing in West Tennessee; I can't keep them," said Vicki Lake, director of JMCGH Community Health Institute. "I have a whole library," Lake said, "and people from law enforcement to children's services, to health departments, to schools" request them. Hospital staff also give them to at-risk patients upon discharge.

The Community Connection Cards are just one component of the Collaborating to Address Homelessness program, which JMCGH leads as the flagship safety-net institution for West Tennessee Healthcare, under the leadership of President and CEO Tina Prescott.

The 25-year-old program includes 30 cross-sector agencies that are part of the region's Continuum of Care, established through the federal Department of Housing and Urban Development (HUD). HUD provides a significant portion of funding for the program, including $5.6 million per year distributed among more than two dozen partner agencies.

Prescott said Collaborating to Address Homelessness is part of the hospital's mission to be more than just a health care provider. "We want to take care of you beyond the four walls of this hospital to the extent we can," she said, "and hope that we are able to continue to do that through innovative programs like this."

In one instance earlier this year, the hospital treated and rehabilitated a homeless man during a three-month stay. He was close to losing his toes to gangrene when he was admitted. A hospital partner, Tennessee Homeless Solutions, located the man's brother, who lived in the Northeast U.S., and he came to take his brother home.

Evidence of the collaboration's effectiveness includes a nearly 70% reduction in the service area's homeless population between 2007 and 2024, following a five-year period in which the homeless population increased by nearly 200%.

Meanwhile, of the nearly 2,100 clients Collaborating to Address Homelessness served in 2024, only 3.5% returned to homelessness after the first year. The major reasons for success included the client paying rent, staying with friends/family, moving to transitional housing or entering substance abuse treatment.

Prescott attributed the program's success to the staff across all the partnering agencies that "live, eat, sleep, breathe how to get this work done. It's just a passion that they have that we appreciate."

The eight housing navigators located throughout the service area are one hallmark of the program. The navigators' duties include prevention, street outreach, case management and follow-up care.

Most noteworthy, perhaps, is the fact that JMCGH provides free grant-writing services to its partner agencies. Lake, who has more than 30 years of experience at the hospital and decades of collaboration with regional partners, handles grant-writing duties. She has secured $171 million in grant funding for partners since 1995. "She is definitely what I call a gift to our community," Prescott said.

Listed online as the point of contact for the collaboration, Lake often fields emails directly from people seeking assistance. She is usually in the office by 4 a.m. and often answers calls from people in partner agencies an hour later.

"I'm very close to several of these people," Lake said. "I have worked with them for many, many years, and you have to have that kind of working relationship in the hospital and outside the hospital to make this work." ●

Photo courtesy of Jackson Madison County General Hospital

**BACKPACKS FOR THE HOMELESS:** Jackson/West Tennessee Continuum of Care volunteers put together homeless hygiene bags, which are distributed free of charge to at-risk residents.

# Helping patients bounce back: The HUB's role in connecting care and community

In South Florida, the thought of discharging a patient to a home without air conditioning is a nonstarter. Enter The Community Helping to Uplift and Bounce Back (HUB). The Memorial Regional Hospital program connects patients in need with services, so they don't have to remain in the hospital longer than medically necessary. Memorial Regional is in Hollywood, Fla., between Miami and Fort Lauderdale.

It's not that hospital case managers weren't telling patients about utility-assistance programs, food pantries and other resources before The HUB launched in August 2023. But the hospital had nothing in place to ensure the patient accessed the services, said Tim Curtin, vice president of community services.

So, he converted four of the most experienced case managers into mobile connectors and started The HUB with approximately $335,000. The budget came from funds that Curtin convinced the IT department would be better spent on his approach rather than on the planned purchase of software to facilitate electronic referrals to assistance organizations.

The results? Approximately $10 million in savings in The HUB's first two years, calculated from reduced emergency department visits and readmissions among the population served. In those two years, The HUB reduced emergency department visits by nearly 30% and readmissions by 27.9%. It also fulfilled 94.9% of identified needs, achieved 98.8% patient satisfaction and increased patient knowledge of available resources by 92.7%.

The HUB focuses on patients with multiple needs and provides intensive case management. If someone is applying for Medicaid or housing, for instance, the case manager checks in regularly to see how the process is going.

The HUB operates under the philosophy of "Do For, Do With, Do Themselves" to walk beside the patient before making the warm handoff, so the patient can handle matters on their own. For example, a case manager might discuss how to manage a diabetic condition during a visit to a local food pantry. "Everyone's a little different," Curtin said. "But The HUB really brings that human element rather than just giving them a flier or guide to resources and saying, 'Good luck, hope you make it there.'"

HUB success stories include a 79-year-old patient recovering from necrotizing fasciitis who received a refrigerator for medication storage, utility support and coordinated follow-up care — enabling a safe recovery at home.

The HUB also coordinated groceries, utility assistance and school resources for the family of a 13-year-old recovering from orthopedic surgery, enabling full recovery without readmission.

The HUB's core partners include CareerSource Broward, which assists patients and caregivers with job readiness and employment opportunities; Women in Distress, a domestic violence agency; and TOP (Transportation Options Program), which provides transportation for medical appointments and essential errands. Supporters also include the Nonprofit Executive Alliance, a coalition of area nonprofit CEOs who run safety-net organizations.

Implementing The HUB was not without stumbling blocks. Curtin said nurses and admissions staff were initially uncomfortable asking the relatively intrusive questions needed to determine a patient's nonmedical needs. Patients, too, wondered why the hospital they had come to many times before now wanted to know whether they had gone to bed hungry or felt unsafe at home.

It was an underestimation on Curtin's part. "I'm a social worker by trade. I have a master's in social work," he said. "We ask. We pry. We ask a lot of personal questions during an intake." So the hospital "took a step back and had to educate both sides," Curtin said.

Memorial Healthcare System President and CEO Shane Strum said the American Hospital Association's recognition of The HUB is "a testament to Memorial's and the Community HUB team's vision, intent and effort to continue to improve the lives of our patients and families well beyond discharge from the four walls of the hospital."


Photo courtesy of Memorial Regional Hospital

**HEALTHY BABY, HEALTHY MOM:** The HUB coordinates groceries and newborn essentials, such as diapers, formula and purified water for at-risk mothers.

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