2016
JOIN T IMPLEMENTATION STRATEGY
Saint Thomas Midtown Hospital, Saint Thomas West Hospital,
and Saint Thomas Health

DAVIDSON COUNTY, TENNESSEE
COMMUNITY HEALTH NEEDS ASSESSMENT
# Joint Implementation Strategy:
Saint Thomas Midtown Hospital & Saint Thomas West Hospital

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Joint Implementation Strategy:
Saint Thomas Midtown Hospital & Saint Thomas West Hospital

Implementation Strategy Narrative

Overview
Saint Thomas Midtown Hospital, Saint Thomas Hospital for Specialty Surgery, Saint Thomas West Hospital and Saint Thomas Health conducted the assessment in partnership with the Vanderbilt University Medical Center. Saint Thomas Health and Vanderbilt University Medical Center participated in the CHNA on behalf of their not-for-profit hospitals. The community served for purposes of this CHNA and Implementation Strategy was defined as Davidson County, Tennessee.

The objectives of the CHNA and subsequent community health improvement plans/implementation strategies were:

1. Provide an unbiased comprehensive assessment of Davidson County’s health needs and assets;
2. Use the CHNA to collectively identify priority health needs for partnering organizations’ community benefit and community health improvement activities;
3. Provide an objective assessment of the community, upon which the partnering organizations may continue collaborating to support and improve health within the county; and
4. Fulfill Internal Revenue Service regulations related to 501(c)(3) non-profit hospital status for federal income taxes.

The CHNA process included a review of secondary health data, interviews of community representatives and leaders, community listening sessions, and a community meeting to review findings and discern unmet health needs. The collaborating team received input from public health experts, including the local public health department.

The 2016 CHNA provided Saint Thomas Midtown Hospital, Saint Thomas Hospital for Specialty Surgery, Saint Thomas West Hospital and Saint Thomas Health with a basis for addressing the health needs of the county and a reference for the development of this Implementation Strategy (IS), ensuring alignment with the community needs. This Implementation Strategy will guide the Community Benefit and Community Health Improvement efforts for Saint Thomas Midtown Hospital, Saint Thomas West Hospital and Saint Thomas Health for fiscal years 2017 – 2019.
**Prioritized Needs**

The results of the data review, community interviews and listening sessions were presented to the community representatives and leaders at the September 10, 2015 Community Health Summit sponsored by the CHNA team members with participation of the local health department. The meeting attendees then provided collective input into the needs and resources of the community.

The unmet health needs identified for Davidson County, Tennessee, by this CHNA are:

- **Access to Care / Care Coordination**
- **Social Determinants**
- **Mental and Emotional Health / Substance Abuse**
- **Wellness and Disease Prevention**

**Needs That Will Not Be Addressed**

All priority health needs will be addressed.
**Summary of Implementation Strategy**

**Prioritized Need #1: Access to Care / Care Coordination**

**GOAL:** Improve access to comprehensive, quality healthcare services through increasing availability and affordability of care while advocating for increased health insurance coverage.

**Strategy 1: Engage state legislators and other key stakeholders to advocate for expanded access to care in Tennessee**

- The target population is Tennessee residents who currently fall in the gap between qualifying for TennCare and qualifying for subsidized health insurance through the Health Insurance Marketplace.
- This strategy targets those who are still without access to health insurance and thus are typically medically underserved.
- This strategy addresses a policy change and has drawn from other states who have proposed a version of access expansion to the federal government that the state has specifically designed

**Anticipated Impact:**
- Increase legislative support by 50% for expanded healthcare access/coverage by January 2018
- Expand healthcare access/coverage in Tennessee by July 2018
- Alignment with State Priorities: Tennessee State Health Plan Principle 2, Access to Care – People in Tennessee should have access to healthcare and the conditions to achieve optimal health
- Alignment with National Priorities: Healthy People 2020 Objective AHS-1 – Increase the proportion of persons with health insurance

**Strategy 2: Address the outpatient care needs of recently hospitalized vulnerable individuals by going beyond usual discharge planning**

- This strategy’s target population is individuals who, upon preparing to be discharged from the hospital, meet the Saint Thomas Health financial assistance policy, have medically indicated care following discharge yet alternative insurance and community resources could not make the needed care following discharge financially possible for the patient.
- This strategy is specific to individuals who are at risk of being medically underserved without our assistance, as they are not in a financial position to secure the care that they need to recover fully from their hospitalization.
- This strategy ensures that patients receive medically necessary care that otherwise would be out of their reach and prevents them from being ‘non-compliant’ due to resource constraints. It is built upon the evidence base cited by Healthy People 2020’s Access to Health Services topic: Improving health care services includes increasing access to and use of evidence-based preventive services. This is a Systems Change to identify and provide for services that would not be received following discharge without this assistance.
Anticipated Impact:
- 70% of patients annually will follow up on STH-given referrals and receive the needed resources
- Alignment with State Priorities: Tennessee State Health Plan Goal 2d. People in Tennessee are able to obtain appropriate quality health care services to meet their needs
- Alignment with National Priorities: Healthy People 2020 Objective AHS-6 – Reduce the proportion of people who are unable to obtain or delay in obtaining necessary medical care, dental care, and prescription medication

Strategy 3: Operate a Dispensary of Hope Charitable Pharmacy to provide medication assistance for uninsured and underinsured individuals who experience financial hardship, as well as to assist patients with navigating other community resources as needed
- This strategy’s target population is uninsured and underinsured individuals who demonstrate financial hardship and thus are in need of assistance to obtain necessary medications.
- This strategy provides medication access to an underserved patient population, addressing access barriers due to cost of care.
- This strategy is built upon the evidence base that has been generated by the unique Dispensary of Hope Distribution Center model, which works with leading drug manufacturers to increase the supply of essential medicine to patients in need; the Dispensary of Hope Pharmacy links the medications made available from the Distribution Center to the individuals in need of a means to fill a prescription affordably.

Anticipated Impact:
- Annually fill 38,000 prescriptions for unaffordable medications to qualifying individuals who enroll in Dispensary of Hope through medications obtained through the DOH Distribution Center, Saint Thomas Health Safety Net list, or physician donated samples.
- Assist qualifying individuals with obtaining $100,000 worth of medication assistance annually through manufacturer sponsored Patient Assistance Programs
- Alignment with State Priorities: Tennessee State Health Plan Principle 2, Access to Care – People in Tennessee should have access to healthcare and the conditions to achieve optimal health
- Alignment with National Priorities: Healthy People 2020 Objective AHS-6 – Reduce the proportion of people who are unable to obtain or delay in obtaining necessary medical care, dental care, and prescription medication

Strategy 4: Distribute donated medication to charitable pharmacies and clinics
- The target population is uninsured patients at or below 200% of the federal poverty guideline
- This program addresses health disparities and challenges of the underserved by providing medication to those who cannot afford pharmaceutical therapies
- This strategy is driven by the CBO report, “Effects of the ACA on Health Insurance Coverage,” stating 30 million Americans will still be uninsured in 2024
Anticipated Impact:

- From July 2016 – June 2019, provide 10,500 uninsured Davidson County residents with needed prescription medications
- From July 2016 – June 2019, fill 130,000 prescriptions for uninsured Davidson County residents
- Alignment with State Priorities: Tennessee State Health Plan Principle 2, Access to Care – People in Tennessee should have access to healthcare and the conditions to achieve optimal health
- Alignment with National Priorities: Healthy People 2020 Objective AHS-6 – Reduce the proportion of people who are unable to obtain or delay in obtaining necessary medical care, dental care, and prescription medication

Strategy 5: Provide a medical home for an increased number of uninsured and underinsured individuals, thus expanding their access to a full range of needed medical care

- The target population is uninsured and underinsured community members who are in need of a medical home through which they can obtain both primary and specialist care
- This strategy seeks to provide a medical home to individuals without another feasible option, individuals who are medically underserved due to financial or other barriers to obtaining care
- This strategy is built upon the evidence base cited by Healthy People 2020’s Access to Health Services topic: People with a usual source of care have better health outcomes and fewer disparities and costs. This is a systems change, adjusting the practice’s scheduling infrastructure to respond to community needs

Anticipated Impact:

- By June of 2017, increase encounters within the Family Health Centers with uninsured and underinsured individuals by 5%
- By June of 2017, increase access for uninsured and underinsured Family Health Center patients to specialty care by 10%
- Alignment with Local Priorities: Safety Net Consortium of Middle Tennessee – Alignment on their objective to increase public awareness and use of safety net services and available insurance options
- Alignment with State Priorities: Tennessee State Health Plan Goal 2d. People in Tennessee are able to obtain appropriate quality health care services to meet their needs
- Alignment with National Priorities: Healthy People 2020 Objective AHS-5 – Increase the proportion of persons who have a specific source of ongoing care

Strategy 6: Increase access to healthcare by removing traditional financial and insurance hurdles, through financial assistance and emergency care policies

- The target population is members of the community who are experiencing poverty and are either uninsured or underinsured
- This strategy specifically seeks to make a full range of healthcare services available to those who are medically underserved
- This strategy is a Policy Change, in line with Ascension Health’s Financial Assistance Policy, in effect July 1, 2016, that represents Ascension Health’s mission to serve all persons, with special attention to those who are poor and vulnerable

**Anticipated Impact:**
- Provide community members with income levels at or below 400% of the Federal Poverty Level with financial assistance as outlined in Saint Thomas Health’s Financial Assistance Policy
- Alignment with State Priorities: Tennessee State Health Plan Goal 2d. People in Tennessee are able to obtain appropriate quality health care services to meet their needs
- Alignment with National Priorities: Healthy People 2020 Objective AHS-6 – Reduce the proportion of people who are unable to obtain or delay in obtaining necessary medical care, dental care, and prescription medication

**Strategy 7: Implement community-wide Medical Missions at Home that integrate medical, dental, vision and behavioral health, along with broader community resources**
- The target population is low income, uninsured, underinsured, and underserved in the selected communities.
- This strategy addresses social determinants of health, health disparities and the challenges of the underserved by providing access to free medical, dental, vision, behavioral health care and social services
- This strategy has been developed over the past eight years as STH has held over 25 medical missions to increase access to care per TN State Health Plan and Healthy People 2020 Objectives

**Anticipated Impact:**
- Increase awareness of and connection to social services and other resources through 600 encounters with community agencies annually
- Increase access to a medical home by increasing the proportion of medical mission attendees who are scheduled for a follow-up visit by 14%
- Alignment with State Priorities: Tennessee State Health Plan Principle 2, Access to Care – People in Tennessee should have access to healthcare and the conditions to achieve optimal health
- Alignment with National Priorities: Healthy People 2020 Objective AHS-6 – Reduce the proportion of people who are unable to obtain or delay in obtaining necessary medical care, dental care, and prescription medication

**Strategy 8: Convene a Middle Tennessee Oral Health Coalition to improve the oral and overall health of the dentally underserved in Middle Tennessee**
- The target population is Middle Tennessee residents who are dentally uninsured or underinsured and fall below 200% of the federal poverty level
- This strategy focuses on the challenges experienced by those who are dentally underserved and works to alleviate their unmet need for dental care
The Middle Tennessee Oral Health Coalition is a member of the American Network of Oral Health Coalitions, looking to national best practices to engage community partners all working to impact oral health and therefore the overall health of the dentally underserved in Middle Tennessee.

**Anticipated Impact:**
- Advocate for the needs of the underserved through presenting a summary of needs to the Oral Health Caucus by December 2016
- Annually conduct a review of available community resources and update the website/printed listing accordingly
- By 2017, the State Oral Health Plan will be submitted
- Alignment with State Priorities: Priority for Consideration 5 within Goal 2d. of the Tennessee State Health Plan – Access to appropriate health and dental clinics impacts people’s ability to obtain appropriate services, especially for underserved populations
- Alignment with National Priorities: Healthy People 2020 Objective AHS-6.3 – Reduce the proportion of persons who are unable to obtain or delay in obtaining necessary dental care

**Strategy 9: Increase breast cancer screening compliance through Our Mission in Motion Mobile Mammography**
- The strategy’s target population is low-income, uninsured women in Rutherford County.
- Our Mission In Motion Mobile Mammography will reduce barriers by providing access to screening mammography and breast health education to uninsured and underserved women. OMIM has a particular focus on serving low-income uninsured African-American women, seeking to address racial health disparities.
- This strategy is informed by evidence found on Healthy People 2020 and Tennessee Cancer Coalition

**Anticipated Impact:**
- Conduct 28 community outreach visits annually in Davidson County to provide free mammography services
- Provide 160 free screening mammograms annually to low-income uninsured African-American women in Davidson County
- Increase the number of women screened with the recommended frequency by 10%
- Alignment with State Priorities: Reduce female breast cancer mortality through increased awareness, early detection, diagnosis and treatment. Mortality rates for 2005-2009 and reduction goal by June 2017: Breast rate of 24.0, reduce to 22.0 (TN Cancer Coalition)
- Alignment with National Priorities: By 2020, reduce the female breast cancer death rate from 23% to 20.7% (CDC/NCHS and Census)

**Strategy 10: Improve access to care via telemedicine consultations when acute stroke symptoms are present**
- The target population is residents of Davidson County with a suspected acute stroke event
- This strategy addresses health disparities and barriers to care by providing easy access to stroke-trained physicians in underserved communities
• This strategy has been developed by Saint Thomas Health in the successful development and management of the Saint Thomas Health Stroke Network across Tennessee, along with the successful operation of telemedicine clinical locations via HRSA grant 11-089

Anticipated Impact:
• Limit patient transfers to more acute facilities to those that are medically appropriate
• Annually meet or exceed the national average for IV tPA utilization (2.8% as of last published standard)
• Alignment with National Priorities: Healthy People 2020 Objective HDS-19.3 – Increase the proportion of eligible patients with strokes who receive acute reperfusion therapy within 3 hours from symptom onset

Strategy 11: Expand access to dental care through a new dental residency program and practice
• The target population is Middle Tennessee residents who are dentally uninsured or underinsured
• This strategy focuses on the challenges experienced by those who are dentally underserved and works to alleviate their unmet need for dental care
• This strategy is built upon the evidence base cited by Healthy People 2020’s Access to Health Services topic: People with a usual source of care have better health outcomes and fewer disparities and costs.

Anticipated Impact:
• Provide care for 8,000 dentally underserved patients annually at full residency compliment
• Alignment with State Priorities: Priority for Consideration 5 within Goal 2d. of the Tennessee State Health Plan – Access to appropriate health and dental clinics impacts people’s ability to obtain appropriate services, especially for underserved populations
• Alignment with National Priorities: Healthy People 2020 Objective AHS-6.3 – Reduce the proportion of persons who are unable to obtain or delay in obtaining necessary dental care

Strategy 12: Provide community-based organizations with financial support toward their work in one of the Prioritized Need areas
• The target population is residents of Davidson County served by identified partner organizations
• All organizations will be assessed on the basis of the attention they pay to issues of health disparities and the needs of the underserved
• The evidence base will be dependent upon the specific work of each community organization but is one of the selection criteria that is reviewed and considered in determining partners

Anticipated Impact:
• The work of community organizations working to meet the Priority Needs will be furthered through a partnership with Saint Thomas Health. Specific objectives will be dependent upon the specific actions and interventions of each selected partner organization. Each organization will submit its anticipated impact in its request seeking financial support from Saint Thomas Health
• Alignment in local, state and national priorities will be dependent upon the particular focus of each selected partner organization
Prioritized Need #2: Social Determinants

GOAL: Strengthen community resources and navigation assistance to foster social and physical environments that promote good health for all.

Strategy 1: Implement an anti-human trafficking initiative throughout Saint Thomas Health so that victims of human trafficking who seek medical care will be identified and connected with the assistance they need
- The target population is victims of human trafficking
- This strategy is focused on a group of highly marginalized and vulnerable people, seeking to first address immediate safety needs and to then provide them with a point of connection to a full range of socioeconomic resources, along with needed physical and mental health care
- This strategy is evidence-based, upon the program developed and successfully operated at Via Christi Health in Wichita, Kansas. This is a policy change, as Saint Thomas Health will adopt Ascension Health’s policy for caring for victims of human trafficking

Anticipated Impact:
- By June 2018, 100% of identified victims will be assisted in accordance with Ascension Health guidance
- Alignment with National Priorities: Healthy People 2020 Objective IVP-8.1 – Increase the proportion of the population residing within the continental United States with access to trauma care

Strategy 2: Provide resource navigation support to community members in need, recognizing how critical economic stability and social environments that promote good health are to improve an individual’s and a community’s health
- The target population is persons in need of socioeconomic resources
- This strategy is aiming to address social determinants, to provide the underserved with resources needed, which in turn will reduce health disparities across socioeconomic divides
- This will be a pilot program seeking to develop an evidence base but will utilize specifically trained associates who are able to navigate a full range of community resources. This strategy is a system change as Saint Thomas Health seeks to holistically serve members of the community, addressing first the priorities of the patient before looking specifically at their healthcare needs.

Anticipated Impact:
- 80% of callers receiving at least one referral to a community resource by December 2017
- 70% of callers receiving assistance from the referral by December 2017
- 2 areas with resource deficiencies supplemented by June 2019
- Alignment with State Priorities: Tennessee State Health Plan Goal 1a. People in Tennessee have the necessary support and opportunities for healthy living
- Alignment with State Priorities: Tennessee State Health Plan Goal 1c. Health disparities between and among populations, as well as the underlying causes of these disparities, are eliminated
• Alignment with National Priorities: Healthy People 2020 Objective SDOH-3.1 – Proportion of persons living in poverty
• Alignment with National Priorities: Healthy People 2020 Objective NWS-13: Reduce household food insecurity and in doing so reduce hunger

Strategy 3: Increase healthcare exposure for Maplewood High School and other MNPS students to healthcare as they consider and prepare to enter the healthcare workforce, while increasing access to primary care for members of the surrounding community

• The target population is Maplewood students – freshman through senior years – along with medically underserved residents of the community surrounding Maplewood.
• This strategy seeks to strengthen healthcare education and employment opportunities for students as they prepare to graduate from high school, with a particular focus on students who do not plan to immediately pursue further education. Maplewood’s student body is 77% black, and 88% of students are on free & reduced lunch. 9% of Maplewood students achieve the minimum testing scores to attend college in Tennessee. This strategy provides a direct alternative to college, assisting students develop skills they can leverage to be employable within Nashville’s healthcare workforce in the months following graduation.
• Kash, Kathleen M. School-to-Work Programs Effectiveness. Online Journal of Workforce Education and Development. Volume III, Issue 4 – Summer 2009: “An effective School-to-Work program is achievable with a great partnership with businesses and a curriculum that trains and teaches students for the workforce.”

Anticipated Impact:
• Annually, 50% of students who complete the Saint Thomas Scholars Program will pass an industry certification
• 100 community residents will select the clinic as their primary care provider each year, with at least two visits within 12 months
• Alignment with Local Priorities: Advance health equity by decreasing income inequality
• Alignment with State Priorities: Tennessee State Health Plan Principle 5 -- Workforce
• Alignment with National Priorities: Healthy People 2020 Objective – Economic Stability

Strategy 4: Provide firsthand exposure and experience for sophomores, juniors, and seniors in Metro Nashville Public Schools as they consider and prepare to enter the healthcare workforce

• The target population is MNPS students – sophomore through senior years.
• This strategy seeks to strengthen healthcare education and employment opportunities for students as they prepare to graduate from high school, with a particular focus on students who do not plan to immediately pursue further education. 30% of MNPS students achieve the minimum testing scores to attend college in Tennessee. This strategy provides a direct alternative to college, assisting students develop skills they can leverage to be employable within Nashville’s healthcare workforce in the months following graduation. 3 in 4 MNPS students are economically disadvantaged, and 44% are black; this strategy seeks to address economic and racial disparities.
achievable with a great partnership with businesses and a curriculum that trains and teaches students for the workforce."

**Anticipated Impact:**
- Annually, 50% of students who complete the Saint Thomas Scholars Program will pass an industry certification
- Annually, 75% of students who complete the Saint Thomas Scholars Program will reach an employment goal or continue their education
- Alignment with Local Priorities: Advance health equity by decreasing income inequality
- Alignment with State Priorities: Tennessee State Health Plan Principle 5 -- Workforce
- Alignment with National Priorities: Healthy People 2020 Objective – Economic Stability

**Strategy 5: Implement community-wide Medical Missions at Home that integrate medical, dental, vision and behavioral health, along with broader community resources**
- Details cited under Prioritized Need #1: Access to Care / Care Coordination

**Strategy 6: Improve resource navigation support to community members in need through piloting the addition of a Navigation Specialist to the South Nashville Family Resource Center staff**
- The target population is Davidson County residents living in the South Nashville community who are in need of socioeconomic resources
- This strategy is aiming to address social determinants, to provide the underserved with resources needed, which in turn will reduce health disparities across socioeconomic divides
- This will be a pilot program seeking to develop an evidence base but will utilize a specifically trained associate able to navigate a full range of community resources.

**Anticipated Impact:**
- Annually, 70% of South Nashville Family Resource Center clients access the needed resources
- 2 areas shown by data collected to have resource deficiencies supplemented by June 2019
- Alignment with State Priorities: Tennessee State Health Plan Goal 1a. People in Tennessee have the necessary support and opportunities for healthy living
- Alignment with State Priorities: Tennessee State Health Plan Goal 1c. Health disparities between and among populations, as well as the underlying causes of these disparities, are eliminated
- Alignment with National Priorities: Healthy People 2020 Objective SDOH-3.1 – Proportion of persons living in poverty
- Alignment with National Priorities: Healthy People 2020 Objective NWS-13: Reduce household food insecurity and in doing so reduce hunger
Strategy 7: Formalize community partnerships to pilot a model for better meeting the resource needs of residents of a specific geography

- The target population is residents of Davidson County zip code 37211 who are in need of socioeconomic resources
- This strategy is aiming to address social determinants, to provide the underserved with resources needed, which in turn will reduce health disparities across socioeconomic divides
- This will be a pilot program seeking to develop an evidence base as well as seeking to expand to other geographies. This strategy is a system change as Saint Thomas Health seeks to holistically serve members of the community, addressing first the priorities of the patient before looking specifically at their healthcare needs.

Anticipated Impact:

- Secure four community partners by December 2016 with whom to coordinate resource navigation
- By June 2018, see a 25% increase in accessibility of resources within the top two identified priority areas
- Alignment with State Priorities: Tennessee State Health Plan Goal 1a. People in Tennessee have the necessary support and opportunities for healthy living
- Alignment with State Priorities: Tennessee State Health Plan Goal 1c. Health disparities between and among populations, as well as the underlying causes of these disparities, are eliminated
- Alignment with National Priorities: Healthy People 2020 Objective SDOH-3.1 – Proportion of persons living in poverty
- Alignment with National Priorities: Healthy People 2020 Objective NWS-13: Reduce household food insecurity and in doing so reduce hunger

Strategy 8: Provide community-based organizations with financial support toward their work in one of the Prioritized Need areas

- Details cited under Prioritized Need #1: Access to Care / Care Coordination
Prioritized Need #3: Mental and Emotional Health / Substance Abuse

**GOAL:** Improve mental and emotional health while decreasing the incidence of substance abuse through identifying, treating or referring to treatment, and supporting those in need.

**Strategy 1:** Train and support a network of Faith Community Nurses, to equip them to improve the health of their congregations

- The target population is nurses who are interested in health ministry in their faith communities, to then impact the members of their faith communities
- This strategy equips nurses to provide unique access to case management support for those in faith communities who experience vulnerabilities for a variety of reasons, including the following: elderly, recently hospitalized, have multiple comorbidities, poor emotional health, narrow support systems, and struggle with health literacy. This strategy utilizes community members’ ties to a faith community to provide them with a trusted connection to the healthcare system and to better meet their complex health needs
- This strategy provides training in a specialty practice of nursing recognized by the American Nurses Association as Faith Community Nursing

**Anticipated Impact:**

- By June 2017, increase % of trained FCN’s who have provided community health resource materials to their congregation by 50%
- By June 2017, increase % of trained FCN’s who have taken action to target a priority health area in the congregation by 50%
- By June 2019, increase % of trained FCN’s who report improved health literacy/disease management among their target population by 50%
- Alignment with Local Priorities: Nashville’s Faith & Health Collaborative, with the objective to equip faith communities to address health needs in their congregations
- Alignment with State Priorities: Tennessee Department of Health’s Faith-Based Health Initiative
- Alignment with National Priorities: Healthy People 2020 Objective ECBP-10 – Increase the number of community-based organizations (including local health departments, Tribal health services, nongovernmental organizations, and State agencies) providing population-based primary prevention services

**Strategy 2:** Provide mental health screening, counseling, and psychiatric medication management to community members who seek care at Saint Thomas Medical Partners’ Davidson Family Health Center PCMH sites.

- The target population is uninsured and underinsured community members who utilize Saint Thomas Medical Partners – Family Health Center – West, Holy Family Health Center or the Internal Medicine Center as their PCMH.
- Physical wellness cannot be achieved without mental wellness. Providing treatment and support is essential for all patients, in particular for those living within poverty or in areas where healthcare is not easily accessed. Screening and treatment of mental disease illnesses our clinics will lead to healthier patients and healthier communities.
This strategy is built upon the evidence base cited by Healthy People 2020’s Access to Health Services topic: People with a usual source of care have better health outcomes and fewer disparities and costs.

**Anticipated Impact:**
- By July 2017, 90% of PCMH patients in the respective practice will be screened for behavioral health needs
- By December 2017, 90% of patients with a positive screen will be receiving needed behavioral healthcare.
- Alignment with State Priorities: Tennessee State Health Plan Goal 1c: Health disparities between and among populations, as well as the underlying causes of these disparities, are eliminated – Behavioral Health cited as a Priority
- Alignment with National Priorities: Healthy People 2020 Objective MHMD-5 – Increase the proportion of primary care facilities that provide mental health treatment onsite or by paid referral
- Alignment with National Priorities: Healthy People 2020 Objective MHMD-9 – Increase the proportion of persons with mental health disorders who receive treatment
- Alignment with National Priorities: Healthy People 2020 Objective MHMD-11 – Increase depression screening by primary care providers

**Strategy 3: Integrate psychological and pastoral counseling into a primary care site, to care seamlessly for a patient’s physical and behavioral health needs within one site of care**
- The target population is community members in need of behavioral health care in addition to the care they are currently receiving for their physical health
- This strategy seeks to address the behavioral health needs of the underserved, who otherwise would not obtain needed mental health support.
- This strategy is based upon a model and structure utilized in North Carolina to integrate behavioral health services with medical care. This will be a pilot for Saint Thomas Health, to assess the efficacy and impact of this model within our practices

**Anticipated Impact:**
- By December 2017, demonstrate an improvement in mental health of 90% of patients who complete the recommended course of therapy
- Alignment with State Priorities: Tennessee Department of Health’s Faith-Based Health Initiative
- Alignment with National Priorities: Healthy People 2020 Objective HRQOL/WB-1.2 – Increase the proportion of adults who self-report good or better mental health

**Strategy 4: Provide community-based organizations with financial support toward their work in one of the Prioritized Need areas**
- Details cited under Prioritized Need #1: Access to Care / Care Coordination
Prioritized Need #4: Wellness and Disease Prevention

GOAL: Promote and support a healthy lifestyle through strengthening community resources that will positively impact nutrition, exercise, chronic disease management and chronic disease prevention.

Strategy 1: Operate and expand a community-based breastfeeding clinic to support and educate breastfeeding families
- The strategy’s target population is breastfeeding families in Davidson County
- The clinic addresses health disparities and barriers to care by providing lactation services at no cost, services that otherwise would be out of reach for underserved families.
- Evidence-based lactation consulting practices are utilized in caring for the clinic’s patients. Lactation consultants, certified by the board of lactation, staff the clinic.

Anticipated Impact:
- By June 2017, 87% of mothers who visited the clinic will still be breastfeeding at 6 months
- Alignment with State Priorities: TN State Health Plan Goal 1c. Health disparities between and among populations, as well as the underlying causes of these disparities, are eliminated
- Alignment with National Priorities: By 2020, increase the number of infants who have breastfed: ever from 74 to 81.9%, at 6 months from 43.5 to 60.6%, at 1 year from 22.7 to 34.1%, exclusively through 3 months from 33.6 to 46.2%, exclusively through 6 months from 14.1 to 25.5% (CDC/Healthy People 2020 Guidelines)
- Alignment with National Priorities: Healthy People 2020 Objective MICH-3.1 – Reduce the rate of deaths among children aged 1 to 4 years

Strategy 2: Train and support a network of Faith Community Nurses, to equip them to improve the health of their congregations
- Details cited under Prioritized Need #3: Mental and Emotional Health / Substance Abuse

Strategy 3: Implement a community-wide campaign that integrates education and barrier reduction to increase breast cancer screening
- The strategy’s target population is low-income, underserved, uninsured women in Davidson County between the ages of 40 and 70
- The campaign will address health disparities and barriers to care by providing community education and free screenings to low-income women.
- The strategy is informed by evidence found on The Community Guide and What Works for Health

Anticipated Impact:
- By June 2017, increase local women’s knowledge of breast cancer resources to 80% as measured by community survey
- By June 2017, increase local women’s self-reported breast cancer screenings from 68% to 73% as measured by W survey
- By June 2018, increase the proportion of women over 40 who receive a clinical breast exam from 79.1% to 85% as measured by BRFSS
• Alignment with State Priorities: By 2018, increase the proportion of early-stage diagnoses of breast cancer among all women by 25% (State Cancer Registry)
• Alignment with National Priorities: By 2020, reduce the female breast cancer rate from 23% to 20.7% (CDC/NCHS and Census)
• Alignment with National Priorities: Healthy People 2020 Objective C-3 – Reduce the female breast cancer death rate

Strategy 4: Improve maternal and infant health through offering prenatal education via Centering Pregnancy classes and lactation consulting
• The target population is community members who are either pregnant or new mothers
• This strategy addresses health disparities and cares for the underserved by increasing access to prenatal care and lactation consulting available to un/underinsured patients, including the Hispanic and African American populations
• This strategy is in line with national recommendations for prenatal care and utilizes evidence-based lactation consulting practices

Anticipated Impact:
• By December 2017, 90% of patients will be completing the full prenatal course of care
• By December 2017, 40% of patients will be exclusively breastfeeding at 3 months
• Alignment with National Priorities: By 2020, increase the number of infants who have breastfed: ever from 74 to 81.9%, at 6 months from 43.5 to 60.6%, at 1 year from 22.7 to 34.1%, exclusively through 3 months from 33.6 to 46.2%, exclusively through 6 months from 14.1 to 25.5% (CDC/Healthy People 2020 Guidelines)

Strategy 5: Implement a community-wide campaign to provide nutrition counseling that will improve food choices
• The strategy’s target population is low-income Davidson County residents who are either uninsured or underinsured.
• The campaign will address health disparities and barriers to care by providing community education and free nutrition counseling to low-income community members.
• This strategy is built upon the evidence base cited by Healthy People 2020’s Nutrition and Weight Status topic.

Anticipated Impact:
• By February 2017, increase number of obese patients receiving dietary counseling by 10% 
• By September 2017, decrease average BMI by 5% for patients receiving dietary counseling
• Alignment with State Priorities: Obesity is cited as one of the Tennessee Department of Health’s four priorities
• Alignment with National Priorities: Healthy People 2020 Objective NWS-8 – Increase the proportion of adults who are at a healthy weight
Strategy 6: Increase physical activity by offering weekly exercise classes to community members

- The strategy’s target population is adults and children residing in Davidson County’s South Nashville community
- Exercise classes provide physical activity opportunities to the vulnerable population that does not have alternative options for exercise
- This strategy's evidence-based source is Cardiovascular Exercise Videos

Anticipated Impact:

- By June 2019, 2,500 community members will have attended one or more of the offered exercise classes
- Alignment with State Priorities: Physical activity is cited as one of the Tennessee Department of Health’s four priorities
- Alignment with National Priorities: Healthy People 2020 Objective PA-1 – Reduce the proportion of adults who engage in no leisure-time physical activity

Strategy 7: Provide community-based organizations with financial support toward their work in one of the Prioritized Need areas

- Details cited under Prioritized Need #1: Access to Care / Care Coordination

An action plan follows for each prioritized need, including the resources, proposed actions, planned collaboration, and anticipated impact of each strategy.
# Prioritized Need #1: Access to Care / Care Coordination

**GOAL:** Improve access to comprehensive, quality healthcare services through increasing availability and affordability of care while advocating for increased health insurance coverage.

## Action Plan

<table>
<thead>
<tr>
<th>STRATEGY 1: Engage state legislators and other key stakeholders to advocate for expanded access to care in Tennessee</th>
</tr>
</thead>
</table>

**BACKGROUND INFORMATION:**
- The target population is Tennessee residents who currently fall in the gap between qualifying for TennCare and qualifying for subsidized health insurance through the Health Insurance Marketplace.
- This strategy targets those who are still without access to health insurance and thus are typically medically underserved.
- This strategy addresses a policy change and has drawn from other states who have proposed a version of Medicaid Expansion to the federal government that the state has specifically designed

**RESOURCES:**
- Saint Thomas Health Executive Representatives
- Saint Thomas Health Vice President of Advocacy

**COLLABORATION:**
- N/A

**ACTIONS:**
1. Saint Thomas Health leadership from each district meets with each state legislator who represent their district regarding increasing access and coverage for all Tennesseans
2. STH VP of Advocacy conducts follow up visits with each state legislator
3. Engage state legislators on other health policy that affects our health system and the health of Tennesseans

**ANTICIPATED IMPACT:**
1. Increase legislative support by 50% for expanded healthcare access/coverage by January 2018
2. Expand healthcare access/coverage in Tennessee by July 2018
**STRATEGY 2:** Address the outpatient care needs of recently hospitalized vulnerable individuals by going beyond usual discharge planning

**BACKGROUND INFORMATION:**
- This strategy’s target population is individuals who, upon preparing to be discharged from the hospital, meet the Saint Thomas Health financial assistance policy, have medically indicated care following discharge yet alternative insurance and community resources could not make the needed care following discharge financially possible for the patient.
- This strategy is specific to individuals who are at risk of being medically underserved without our assistance, as they are not in a financial position to secure the care that they need to recover fully from their hospitalization.
- This strategy ensures that patients receive medically necessary care that otherwise would be out of their reach and prevents them from being ‘non-compliant’ due to resource constraints. It is built upon the evidence base cited by Healthy People 2020’s Access to Health Services topic: Improving health care services includes increasing access to and use of evidence-based preventive services. This is a Systems Change to identify and provide for services that would not be received following discharge without this assistance.

**RESOURCES:**
- Saint Thomas Health Care Management staff

**COLLABORATION:**
- Community resources

**ACTIONS:**
1. Identify qualifying patients
2. Maintain updated resource listings
3. Refer patients to specific resources that will be financially covered by Saint Thomas Health
4. Follow up with patients to determine whether they accessed the resources

**ANTICIPATED IMPACT:**
III. 70% of patients annually will follow up on STH-given referrals and receive the needed resources
<table>
<thead>
<tr>
<th>STRATEGY 3: Dispensary of Hope pharmacies provide medication assistance for uninsured &amp; underinsured individuals who experience financial hardship, as well as assisting patients with navigating other community resources as needed.</th>
</tr>
</thead>
</table>

**BACKGROUND INFORMATION:**
- This strategy’s target population is uninsured and underinsured individuals who demonstrate financial hardship and thus are in need of assistance to obtain necessary medications.
- This strategy provides medication access to an underserved patient population, addressing access barriers due to cost of care.
- This strategy is built upon the evidence base that has been generated by the unique Dispensary of Hope Distribution Center model, which works with leading drug manufacturers to increase the supply of essential medicine to patients in need; the Dispensary of Hope Pharmacy links the medications made available from the Distribution Center to the individuals in need of a means to fill a prescription affordably.

**RESOURCES:**
- Dispensary of Hope Distribution Center
- Saint Thomas Health Marketing
- Dispensary of Hope Pharmacy Staff
- Saint Thomas Health Care Management

**COLLABORATION:**
- Patient Assistance Programs
- Manufacturer Coupons

**ACTIONS:**
1. Conduct initial application interviews
2. Renew applications
3. Coordinate applications for manufacturers’ Patient Assistance Programs
4. Provide resources for transition of newly eligible Medicare patients to Medicare Part D
5. Coordinate electronic ordering of insulin samples & storage of them for physician health partners.
6. Provide free & discounted medications and testing supplies to uninsured and underinsured individuals
7. Provide discharge medications to patients who received care at Saint Thomas – Rutherford Hospital
8. Promote awareness of Dispensary of Hope in the community

**ANTICIPATED IMPACT:**
IV. Annually fill 38,000 prescriptions for unaffordable medications to qualifying individuals who enroll in Dispensary of Hope through medications obtained through the DOH Distribution Center, Saint Thomas Health Safety Net list, or physician donated samples.
V. Assist qualifying individuals with obtaining $100,000 worth of medication assistance annually through manufacturer sponsored Patient Assistance Programs
<table>
<thead>
<tr>
<th>STRATEGY 4: Distribute donated medication to charitable pharmacies and clinics</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>BACKGROUND INFORMATION:</strong></td>
</tr>
<tr>
<td>• The target population is uninsured patients at or below 200% of the federal poverty guideline</td>
</tr>
<tr>
<td>• This program addresses health disparities and challenges of the underserved by providing medication to those who cannot afford pharmaceutical therapies</td>
</tr>
<tr>
<td>• This strategy is driven by the CBO report, “Effects of the ACA on Health Insurance Coverage,” stating 30 million Americans will still be uninsured in 2024</td>
</tr>
<tr>
<td><strong>RESOURCES:</strong></td>
</tr>
<tr>
<td>• Dispensing sites</td>
</tr>
<tr>
<td>• Dispensary of Hope staff</td>
</tr>
<tr>
<td>• Funding</td>
</tr>
<tr>
<td>• IT infrastructure</td>
</tr>
<tr>
<td><strong>COLLABORATION:</strong></td>
</tr>
<tr>
<td>• Medication donors</td>
</tr>
<tr>
<td>• Volunteers</td>
</tr>
<tr>
<td>• Research institutions/firms</td>
</tr>
<tr>
<td><strong>ACTIONS:</strong></td>
</tr>
<tr>
<td>1. Procure medication donations for 70% of the medication target list, that covers the most common chronic conditions</td>
</tr>
<tr>
<td>2. Distribute medication to dispensing sites</td>
</tr>
<tr>
<td>3. Retain 90% of existing dispensing site partnerships nationwide</td>
</tr>
<tr>
<td>4. Increase dispensing sites by 40% nationwide</td>
</tr>
<tr>
<td>5. Launch a pilot program to help 25% of dispensing sites increase medication throughput by 10%</td>
</tr>
<tr>
<td><strong>ANTICIPATED IMPACT:</strong></td>
</tr>
<tr>
<td>VI. From July 2016-June 2019, provide 10,500 uninsured Davidson County residents with needed prescription medication.</td>
</tr>
<tr>
<td>VII. From July 2016-June 2019, fill 130,000 prescriptions for uninsured Davidson County residents</td>
</tr>
</tbody>
</table>
STRATEGY 5: Provide a medical home for an increased number of uninsured and underinsured individuals, thus expanding their access to a full range of needed medical care

**BACKGROUND INFORMATION:**
- The target population is uninsured and underinsured community members who are in need of a medical home through which they can obtain both primary and specialist care.
- This strategy seeks to provide a medical home to individuals without another feasible option, individuals who are medically underserved due to financial or other barriers to obtaining care.
- This strategy is built upon the evidence base cited by Healthy People 2020’s Access to Health Services topic: People with a usual source of care have better health outcomes and fewer disparities and costs. This is a systems change, adjusting the practice’s scheduling infrastructure to respond to community needs.

**RESOURCES:**
- Saint Thomas Medical Partners – Family Health Center – West
- Holy Family Health Center
- Internal Medicine Center
- University of Tennessee Obstetrics and Gynecology Center
- PCMH Guidelines

**COLLABORATION:**
- Specialist referral network
- University of Tennessee Health Science Center

**ACTIONS:**
1. Conduct survey to identify patient appointment needs
2. Develop and implement expanded schedules in response to communicated needs
3. Communicate expanded hours into the community
4. Host Internal Medicine Resident Physicians at the Internal Medicine Center to expand practice capacity
5. Host Obstetrics & Gynecology Resident Physicians at the University of Tennessee Obstetrics and Gynecology Center to expand the care available in a medical home specific to women’s health needs
6. Develop and annually update a list of specialists willing to see uninsured and underinsured patients
7. Facilitate needed specialist referrals to secure needed specialty care for patients

**ANTICIPATED IMPACT:**
- VIII. By June of 2017, increase encounters within the Family Health Centers with uninsured and underinsured individuals by 5%
- IX. By June of 2017, increase access for uninsured and underinsured Family Health Center patients to specialty care by 10%
<table>
<thead>
<tr>
<th>STRATEGY 6: Increase access to healthcare by removing traditional financial and insurance hurdles, through financial assistance and emergency care policies.</th>
</tr>
</thead>
<tbody>
<tr>
<td>BACKGROUND INFORMATION:</td>
</tr>
<tr>
<td>- The target population is members of the community who are experiencing poverty and are either uninsured or underinsured</td>
</tr>
<tr>
<td>- This strategy specifically seeks to make a full range of healthcare services available to those who are medically underserved</td>
</tr>
<tr>
<td>- This strategy is a Policy Change, in line with Ascension Health’s Financial Assistance Policy, in effect July 1, 2016, that represents Ascension Health’s mission to serve all persons, with special attention to those who are poor and vulnerable</td>
</tr>
<tr>
<td>RESOURCES:</td>
</tr>
<tr>
<td>- Ascension Health Financial Assistance Policy</td>
</tr>
<tr>
<td>- Ascension Health Emergency Care Policy</td>
</tr>
<tr>
<td>- Patient registration associates</td>
</tr>
<tr>
<td>COLLABORATION:</td>
</tr>
<tr>
<td>- N/A</td>
</tr>
<tr>
<td>ACTIONS:</td>
</tr>
<tr>
<td>1. Make new Ascension Health Financial Assistance Policy publicly available</td>
</tr>
<tr>
<td>2. Assist patients who may qualify for financial assistance in completing the application</td>
</tr>
<tr>
<td>3. Provide 24/7 access to emergency care</td>
</tr>
<tr>
<td>ANTICIPATED IMPACT:</td>
</tr>
<tr>
<td>- Provide community members with income levels at or below 400% of the Federal Poverty Level with financial assistance as outlined in Saint Thomas Health’s Financial Assistance Policy</td>
</tr>
</tbody>
</table>
**STRATEGY 7:** Implement community-wide Medical Missions at Home that integrate medical, dental, vision and behavioral health, along with broader community resources

**BACKGROUND INFORMATION:**
- The target population is low income, uninsured, underinsured, and underserved in the selected communities.
- This strategy addresses social determinants of health, health disparities and the challenges of the underserved by providing access to free medical, dental, vision, behavioral health care and social services.
- This strategy has been developed over the past eight years as STH has held over 25 medical missions to increase access to care per TN State Health Plan and Healthy People 2020 Objectives.

**RESOURCES:**
- Volunteers
- Senior Leadership
- Medical Supplies
- Other Supplies
- Marketing

**COLLABORATION:**
- Students
- Community Agencies

**ACTIONS:**
1. Identify communities in need and locations for Medical Missions at Home
2. Recruit volunteers
3. Communicate event details to volunteers
4. Communicate event details to community
5. Set up for event
6. Register patients for care at event
7. Administer medical examinations
8. Fill prescriptions
9. Conduct lab tests
10. Conduct vision exams
11. Provide dental care
12. Conduct mammograms
13. Register patients currently without a medical home for follow-up appointments
14. Provide information on social services and other community resources
**STRATEGY 7:** Implement community-wide Medical Missions at Home that integrate medical, dental, vision and behavioral health, along with broader community resources

**ANTICIPATED IMPACT:**

XI. Increase awareness of and connection to social services and other resources through 600 encounters with community agencies annually

XII. Increase access to a medical home by increasing the proportion of medical mission attendees who are scheduled for a follow-up visit by 14%

---

**STRATEGY 8:** Convene a Middle Tennessee Oral Health Coalition to improve the oral and overall health of the dentally underserved in Middle Tennessee

**BACKGROUND INFORMATION:**

- The target population is Middle Tennessee residents who are dentally uninsured or underinsured and fall below 200% of the federal poverty level
- This strategy focuses on the challenges experienced by those who are dentally underserved and works to alleviate their unmet need for dental care
- The Middle Tennessee Oral Health Coalition is a member of the American Network of Oral Health Coalitions, looking to national best practices to engage community partners all working to impact oral health and therefore the overall health of the dentally underserved in Middle Tennessee

**RESOURCES:**

- Saint Thomas Health Representation on Oral Health Coalition
- Financial Support

**COLLABORATION:**

- Brentwood Baptist Mobile Unit
- Interfaith Dental Clinic
- Hope Smiles
- Matthew Walker Comprehensive Health Center
- Metro Public Health Department
- Meharry Medical College
- Middle Tennessee Consortium of Safety Net Providers
- Neighborhood Health
- Salvus Center
- Tennessee Department of Health
- Tennessee Primary Care Association
- Tennessee State University School of Hygiene
- Triax Dental
**STRATEGY 8:** Convene a Middle Tennessee Oral Health Coalition to improve the oral and overall health of the dentally underserved in Middle Tennessee

**ACTIONS:**
1. Conduct monthly meetings with Coalition members to further coordination opportunities
2. Maintain resource listings for Middle Tennessee oral health resources
3. Advocate for legislation that will support access to dental care for the underserved
4. Participate in the development of the state oral health plan to improve oral health of all

**ANTICIPATED IMPACT:**
XIII. Advocate for the needs of the underserved through presenting a summary of needs to the Oral Health Caucus by December 2016
XIV. Annually conduct a review of available community resources and update the website/printed listing accordingly
XV. By 2017, the State Oral Health Plan will be submitted

---

**STRATEGY 9:** Increase breast cancer screening compliance through Our Mission In Motion Mobile Mammography

**BACKGROUND INFORMATION:**
- The strategy’s target population is low-income, uninsured women in Davidson County.
- Our Mission In Motion Mobile Mammography will reduce barriers by providing access to screening mammography and breast health education to uninsured and underserved women. OMIM has a particular focus on serving low-income uninsured African-American women, seeking to address racial health disparities.
- This strategy is informed by evidence found on Healthy People 2020 and Tennessee Cancer Coalition.

**RESOURCES:**
- Saint Thomas Medical Partners
- Saint Thomas Midtown Hospital
- Saint Thomas West Hospital
- Our Mission In Motion Mobile Mammography staff

**COLLABORATION:**
- TN Breast and Cervical Cancer Screening Program
- Susan G. Komen Central Tennessee
- Advanced Diagnostic Imaging
### STRATEGY 9: Increase breast cancer screening compliance through Our Mission In Motion Mobile Mammography

**ACTIONS:**
1. Schedule community outreach visits
2. Provide free screening mammograms to low-income, uninsured and underinsured women
3. Distribute breast health educational materials at community events

**ANTICIPATED IMPACT:**
XVI. Conduct 28 community outreach visits annually in Davidson County to provide free mammography services
XVII. Provide 160 free screening mammograms annually to low-income uninsured African-American women in Davidson County
XVIII. Increase the number of women screened with the recommended frequency by 10%

### STRATEGY 10: Improve access to care via telemedicine consultations when acute stroke symptoms are present

**BACKGROUND INFORMATION:**
- The target population is residents of Rutherford County with a suspected acute stroke event
- This strategy addresses health disparities and barriers to care by providing easy access to stroke-trained physicians in underserved communities
- This strategy has been developed by Saint Thomas Health in the successful development and management of the Saint Thomas Health Stroke Network across Tennessee, along with the successful operation of telemedicine clinical locations via HRSA grant 11-089

**RESOURCES:**
- Saint Thomas Rutherford Hospital Staff
- Telemedicine Services
- Consulting Stroke-trained Physician

**COLLABORATION:**
- N/A

**ACTIONS:**
1. Increase system use to conduct telemedicine consultations in response to possible stroke symptoms
2. Increase physician and staff telemedicine education participation for competency in NIHSS use, Stroke Telemedicine use, and Stroke ID/Triage
3. Collect peer evaluations and responses from physicians and staff on the benefits of conducting
### STRATEGY 10: Improve access to care via telemedicine consultations when acute stroke symptoms are present

- telemedicine visits

4. Conduct a patient survey to confirm timely access to health services

### ANTICIPATED IMPACT:

- **XIX.** Limit patient transfers to more acute facilities to those that are medically appropriate
- **XX.** Annually meet or exceed the national average for IV tPA utilization (2.8% as of last published standard)

### STRATEGY 11: Expand access to dental care through a new dental residency program and practice

#### BACKGROUND INFORMATION:
- The target population is Middle Tennessee residents who are dentally uninsured or underinsured
- This strategy focuses on the challenges experienced by those who are dentally underserved and works to alleviate their unmet need for dental care
- This strategy is built upon the evidence base cited by Healthy People 2020’s Access to Health Services topic: People with a usual source of care have better health outcomes and fewer disparities and costs.

#### RESOURCES:
- Saint Thomas Health Graduate Medical Education

#### COLLABORATION:
- University of Tennessee Medical Center – College of Dentistry

#### ACTIONS:
1. Build practice site and infrastructure
2. Begin residency program, with ten residents providing general dental care and six residents providing orthodontic care
3. Promote the availability of dental care through this practice
4. Conduct mobile outreach, serving members of the community who are unable to travel to the practice to receive dental care

#### ANTICIPATED IMPACT:

- **XXI.** Provide care for 8,000 dentally underserved patients annually at full residency complement
<table>
<thead>
<tr>
<th>STRATEGY 12: Provide community-based organizations with financial support toward their work in one of the Prioritized Need areas</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>BACKGROUND INFORMATION:</strong></td>
</tr>
<tr>
<td>• The target population is residents of Davidson County served by identified partner organizations</td>
</tr>
<tr>
<td>• All organizations will be assessed on the basis of the attention they pay to issues of health disparities and the needs of the underserved</td>
</tr>
<tr>
<td>• The evidence base will be dependent upon the specific work of each community organization but is one of the selection criteria that is reviewed and considered in determining partners</td>
</tr>
<tr>
<td><strong>RESOURCES:</strong></td>
</tr>
<tr>
<td>• Financial Support</td>
</tr>
<tr>
<td><strong>COLLABORATION:</strong></td>
</tr>
<tr>
<td>• Community Organizations</td>
</tr>
<tr>
<td><strong>ACTIONS:</strong></td>
</tr>
<tr>
<td>1. Make publicly available a Program Proposal form, through which community organizations can request a financial partnership from Saint Thomas Health</td>
</tr>
<tr>
<td>2. Receive Program Proposals from community organizations who seek support for a program working to meet one of the Priority Needs</td>
</tr>
<tr>
<td>3. Partnership decisions made by committee review</td>
</tr>
<tr>
<td>4. Financial support is provided to selected organizations, and outcomes are reviewed annually</td>
</tr>
<tr>
<td><strong>ANTICIPATED IMPACT:</strong></td>
</tr>
<tr>
<td>The work of community organizations working to meet the Priority Needs will be furthered through a partnership with Saint Thomas Health. Specific objectives will be dependent upon the specific actions and interventions of each selected partner organization. Each organization will submit its anticipated impact in its request seeking financial support from Saint Thomas Health.</td>
</tr>
</tbody>
</table>
## Alignment with Local, State & National Priorities

<table>
<thead>
<tr>
<th>OBJECTIVE:</th>
<th>LOCAL / COMMUNITY PLAN:</th>
<th>STATE PLAN:</th>
<th>“HEALTHY PEOPLE 2020” (or OTHER NATIONAL PLAN):</th>
</tr>
</thead>
<tbody>
<tr>
<td>I, II</td>
<td></td>
<td></td>
<td>Healthy People 2020 Objective AHS-1 – Increase the proportion of persons with health insurance</td>
</tr>
<tr>
<td>I, II, IV, V, VI, VII, XI, XII</td>
<td>TN State Health Plan Principle 2, Access to Care – People in TN should have access to healthcare and the conditions to achieve optimal health</td>
<td></td>
<td></td>
</tr>
<tr>
<td>III, VIII, IX, X</td>
<td>TN State Health Plan Goal 2d. People in TN are able to obtain appropriate quality healthcare services to meet their needs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>III, IV, V, VI, VII, X, XII</td>
<td></td>
<td></td>
<td>Healthy People 2020 Objective AHS-6 – Reduce the proportion of people who are unable to obtain or delay in obtaining necessary medical care, dental care, and prescription medication</td>
</tr>
<tr>
<td>VIII, IX</td>
<td>Safety Net Consortium of Middle TN – Alignment on their objective to increase public awareness and use of safety net services and available insurance options</td>
<td></td>
<td>Healthy People 2020 Objective AHS-5 – Increase the proportion of persons who have a specific source of ongoing care</td>
</tr>
<tr>
<td>XIII, XIV, XV, XXI</td>
<td>Priority for Consideration 5 within Goal 2d. of the TN State health Plan – Access to appropriate health and dental clinics impacts people’s ability to obtain appropriate services, especially for underserved populations</td>
<td></td>
<td>Healthy People 2020 Objective AHS-6.3 - Reduce the proportion of persons who are unable to obtain or delay in obtaining necessary dental care</td>
</tr>
<tr>
<td>XVI, XVII, XVIII</td>
<td>Reduce female breast cancer mortality through increased awareness, early detection, diagnosis and treatment</td>
<td>By 2020, reduce the female breast cancer death rate from 23% to 20.7%</td>
<td></td>
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<tr>
<td>XIX, XX</td>
<td>Healthy People 2020 Objective HDS-19.3 – Increase the proportion of eligible patients with strokes who receive acute reperfusion therapy within 3 hours from symptom onset</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
**Prioritized Need #2: Social Determinants**

**GOAL:** Strengthen community resources and navigation assistance to foster social and physical environments that promote good health for all.

**Action Plan**

<table>
<thead>
<tr>
<th>STRATEGY 1:</th>
<th>Implement an anti-human trafficking initiative throughout Saint Thomas Health so that victims of human trafficking who seek medical care will be identified and connected with the assistance they need</th>
</tr>
</thead>
</table>

**BACKGROUND INFORMATION:**
- The target population is victims of human trafficking
- This strategy is focused on a group of highly marginalized and vulnerable people, seeking to first address immediate safety needs and to then provide them with a point of connection to a full range of socioeconomic resources, along with needed physical and mental health care
- This strategy is evidence-based, upon the program developed and successfully operated at Via Christi Health in Wichita, Kansas. This is a policy change, as Saint Thomas Health will adopt Ascension Health’s policy for caring for victims of human trafficking

**RESOURCES:**
- Ascension Health Training Materials

**COLLABORATION:**
- End Slavery Tennessee

**ACTIONS:**
1. Identify priority areas for staff to receive trafficking awareness training
2. Conduct initial training
3. Adopt policy regarding care for victims of human trafficking
4. Follow the process specified by the policy to direct actions upon suspecting a trafficking situation

**ANTICIPATED IMPACT:**
1. By June 2018, 100% of identified victims will be assisted in accordance with Ascension Health guidance
**STRATEGY 2:** Provide resource navigation support to community members in need, recognizing how critical economic stability and social environments that promote good health are to improve an individual’s and a community’s health.

**BACKGROUND INFORMATION:**
- The target population is persons in need of socioeconomic resources.
- This strategy is aiming to address social determinants, to provide the underserved with resources needed, which in turn will reduce health disparities across socioeconomic divides.
- This will be a pilot program seeking to develop an evidence base but will utilize specifically trained associates who are able to navigate a full range of community resources. This strategy is a system change as Saint Thomas Health seeks to holistically serve members of the community, addressing first the priorities of the patient before looking specifically at their healthcare needs.

**RESOURCES:**
- Saint Thomas Health Care Coordination Center
- Resource Navigator

**COLLABORATION:**
- N/A

**ACTIONS:**
1. Hire Resource Navigator for Davidson County
2. Promote the availability of Resource Navigators internally and externally
3. Resource Navigators receive referrals from providers & staff
4. Resource Navigators receive calls from other patients and community members
5. Collect data on resource gaps

**ANTICIPATED IMPACT:**
II. 80% of callers receiving at least one referral to a community resource by December 2017
III. 70% of callers receiving assistance from the referral by December 2017
IV. 2 areas with resource deficiencies supplemented by June 2019
**STRATEGY 3:** Increase healthcare exposure for Maplewood High School and other MNPS students to healthcare as they consider and prepare to enter the healthcare workforce, while increasing access to primary care for members of the surrounding community

**BACKGROUND INFORMATION:**
- The target population is Maplewood students – freshman through senior years – along with medically underserved residents of the community surrounding Maplewood.
- This strategy seeks to strengthen healthcare education and employment opportunities for students as they prepare to graduate from high school, with a particular focus on students who do not plan to immediately pursue further education. Maplewood’s student body is 77% black, and 88% of students are on free & reduced lunch. 9% of Maplewood students achieve the minimum testing scores to attend college in Tennessee. This strategy provides a direct alternative to college, assisting students develop skills they can leverage to be employable within Nashville’s healthcare workforce in the months following graduation.

**RESOURCES:**
- STH Providers & Staff
- Maplewood Academy Clinic

**COLLABORATION:**
- Metro Nashville Public Schools
- PENCIL Foundation

**ACTIONS:**
1. Construct the Maplewood Academy Clinic
2. Conduct primary care visits
3. Provide shadowing opportunities for Maplewood High School students to expose them to a full range of healthcare career opportunities
4. Provide training opportunities for the Metro Nashville Public School students selected to participate in the Saint Thomas Scholars Program

**ANTICIPATED IMPACT:**
- V. Annually, 50% of students who complete the Saint Thomas Scholars Program will pass an industry certification
- VI. 100 community residents will select the clinic as their primary care provider each year, with at least two visits within twelve months
**STRATEGY 4:** Provide firsthand exposure and experience for sophomores, juniors and seniors in Metro Nashville Public Schools as they consider and prepare to enter the healthcare workforce

**BACKGROUND INFORMATION:**
- The target population is MNPS students – sophomore through senior years.
- This strategy seeks to strengthen healthcare education and employment opportunities for students as they prepare to graduate from high school, with a particular focus on students who do not plan to immediately pursue further education. 30% of MNPS students achieve the minimum testing scores to attend college in Tennessee. This strategy provides a direct alternative to college, assisting students develop skills they can leverage to be employable within Nashville’s healthcare workforce in the months following graduation. 3 in 4 MNPS students are economically disadvantaged, and 44% are black; this strategy seeks to address economic and racial disparities.

**RESOURCES:**
- STH Providers & Staff
- STH Acute Care Facilities
- Saint Thomas Medical Partners clinic sites
- Saint Thomas Scholars Curriculum
- Course Instructors
- Maplewood Academy Clinic
- Transportation for field trips and Capstone

**COLLABORATION:**
- Metro Nashville Public Schools
- PENCIL Foundation

**ACTIONS:**
1. Conduct field trips within an STH facility for 450 MNPS sophomores annually
2. Receive applications for Saint Thomas Scholars Program
3. Interview and select 100 MNPS seniors who will undergo the Saint Thomas Scholars training program
4. Administer the Saint Thomas Scholars Program throughout the school year, preparing students for an industry certification and either employment or further education

**ANTICIPATED IMPACT:**
- Annually, 50% of students who complete the Saint Thomas Scholars Program will pass an industry certification
**STRATEGY 4:** Provide firsthand exposure and experience for sophomores, juniors and seniors in Metro Nashville Public Schools as they consider and prepare to enter the healthcare workforce

VIII. Annually, 75% of students who complete the Saint Thomas Scholars Program will reach an employment goal or continue their education

---

**STRATEGY 5:** Implement community-wide Medical Missions at Home that integrate medical, dental, vision and behavioral health, along with broader community resources

**BACKGROUND INFORMATION:**
- The target population is low income, uninsured, underinsured, and underserved in the selected communities.
- This strategy addresses social determinants of health, health disparities and the challenges of the underserved by providing access to free medical, dental, vision, behavioral health care and social services.
- This strategy has been developed over the past eight years as STH has held over 25 medical missions to increase access to care per TN State Health Plan and Healthy People 2020 Objectives

**RESOURCES:**
- Volunteers
- Senior Leadership
- Medical Supplies
- Other Supplies
- Marketing

**COLLABORATION:**
- Students
- Community Agencies

**ACTIONS:**
1. Identify communities in need and locations for Medical Missions at Home
2. Recruit volunteers
3. Communicate event details to volunteers
4. Communicate event details to community
5. Set up for event
6. Register patients for care at event
7. Administer medical examinations
8. Fill prescriptions
9. Conduct lab tests
**STRATEGY 5:** Implement community-wide Medical Missions at Home that integrate medical, dental, vision and behavioral health, along with broader community resources

10. Conduct vision exams  
11. Provide dental care  
12. Conduct mammograms  
13. Register patients currently without a medical home for follow-up appointments  
14. Provide information on social services and other community resources

**ANTICIPATED IMPACT:**
IX. Increase awareness of and connection to social services and other resources through 600 encounters with community agencies annually  
X. Increase access to a medical home by increasing the proportion of medical mission attendees who are scheduled for a follow-up visit by 14%

---

**STRATEGY 6:** Improve resource navigation support to community members in need through piloting the addition of a Navigation Specialist to the South Nashville Family Resource Center staff

**BACKGROUND INFORMATION:**
- The target population is Davidson County residents living in the South Nashville community who are in need of socioeconomic resources  
- This strategy is aiming to address social determinants, to provide the underserved with resources needed, which in turn will reduce health disparities across socioeconomic divides  
- This will be a pilot program seeking to develop an evidence base but will utilize a specifically trained associate able to navigate a full range of community resources.

**RESOURCES:**
- Holy Family Health Center

**COLLABORATION:**
- Catholic Charities

**ACTIONS:**
1. Hire a bilingual Navigation Specialist, preferably a resident of the South Nashville community, for the South Nashville Family Resource Center  
2. Train the Navigation Specialist on the services available both through the South Nashville Family Resource Center and Holy Family Health Center, to be able to serve as a liaison between the two organizations  
3. Navigation Specialist conducts intake for all clients of the Family Resource Center, identifying the
**STRATEGY 6:** Improve resource navigation support to community members in need through piloting the addition of a Navigation Specialist to the South Nashville Family Resource Center staff

<table>
<thead>
<tr>
<th>Priority needs of each</th>
</tr>
</thead>
<tbody>
<tr>
<td>4. Navigation Specialist directs each client to where they can access resources to address their priority needs</td>
</tr>
<tr>
<td>5. Navigation Specialist maintains database of clients, their expressed needs, and the resources they were referred to</td>
</tr>
<tr>
<td>6. Navigation Specialist conducts follow-up with each client to ensure needed resources were accessed, also documenting when resources were and were not accessed</td>
</tr>
<tr>
<td>7. Catholic Charities and Holy Family representatives meet monthly to review the data collected by the Navigation Specialist and consider where additional investment in on-site resources may be needed</td>
</tr>
</tbody>
</table>

**ANTICIPATED IMPACT:**

| XI. | Annually, 70% of South Nashville Family Resource Center clients access the needed resources |
| XII. | 2 areas shown by data collected to have resource deficiencies supplemented by June 2019 |

---

**STRATEGY 7:** Formalize community partnerships to pilot a model for better meeting the resource needs of residents of a specific geography

**BACKGROUND INFORMATION:**

- The target population is residents of Davidson County zip code 37211 who are in need of socioeconomic resources
- This strategy is aiming to address social determinants, to provide the underserved with resources needed, which in turn will reduce health disparities across socioeconomic divides
- This will be a pilot program seeking to develop an evidence base as well as seeking to expand to other geographies. This strategy is a system change as Saint Thomas Health seeks to holistically serve members of the community, addressing first the priorities of the patient before looking specifically at their healthcare needs.

**RESOURCES:**

- Holy Family Health Center
- Saint Thomas Medical Partners – Lenox Village

**COLLABORATION:**

- Catholic Charities
- United Way
- Siloam Family Health Center
- Other organizations serving the South Nashville community
STRATEGY 7: Formalize community partnerships to pilot a model for better meeting the resource needs of residents of a specific geography

ACTIONS:
1. Conduct a survey to better understand specific community resource priorities
2. Identify community organizations with possible alignment around these resource priorities
3. Determine opportunities to collaborate and a workflow to support that opportunity
4. Implement collaborative workflow to strengthen resource navigation offered

ANTICIPATED IMPACT:
XIII. Secure four community partners by December 2016 with whom to coordinate resource navigation
XIV. By June 2018, see a 25% increase in accessibility of resources within the top two identified priority areas

--------

STRATEGY 8: Provide community-based organizations with financial support toward their work in one of the Prioritized Need areas

BACKGROUND INFORMATION:
- The target population is residents of Davidson County served by identified partner organizations
- All organizations will be assessed on the basis of the attention they pay to issues of health disparities and the needs of the underserved
- The evidence base will be dependent upon the specific work of each community organization but is one of the selection criteria that is reviewed and considered in determining partners

RESOURCES:
- Financial Support

COLLABORATION:
- Community Organizations

ACTIONS:
1. Make publicly available a Program Proposal form, through which community organizations can request a financial partnership from Saint Thomas Health
2. Receive Program Proposals from community organizations who seek support for a program working to meet one of the Priority Needs
3. Partnership decisions made by committee review
4. Financial support is provided to selected organizations, and outcomes are reviewed annually

ANTICIPATED IMPACT:
<table>
<thead>
<tr>
<th>STRATEGY 8: Provide community-based organizations with financial support toward their work in one of the Prioritized Need areas</th>
</tr>
</thead>
<tbody>
<tr>
<td>The work of community organizations working to meet the Priority Needs will be furthered through a partnership with Saint Thomas Health. Specific objectives will be dependent upon the specific actions and interventions of each selected partner organization. Each organization will submit its anticipated impact in its request seeking financial support from Saint Thomas Health.</td>
</tr>
</tbody>
</table>
### Alignment with Local, State & National Priorities

<table>
<thead>
<tr>
<th>OBJECTIVE:</th>
<th>LOCAL / COMMUNITY PLAN:</th>
<th>STATE PLAN:</th>
<th>&quot;HEALTHY PEOPLE 2020&quot; (or OTHER NATIONAL PLAN):</th>
</tr>
</thead>
<tbody>
<tr>
<td>I</td>
<td></td>
<td></td>
<td>Healthy People 2020 Objective IVP-1.8 – Increase the proportion of the population residing within the continental United States with access to trauma care</td>
</tr>
<tr>
<td>II, III, IV, XI, XII, XIII, XIV</td>
<td></td>
<td>TN State Health Plan Goal 1a. People in TN have the necessary support and opportunities for healthy living</td>
<td></td>
</tr>
<tr>
<td>II, III, IV, XI, XII, XIII, XIV</td>
<td></td>
<td>TN State Health Plan Goal 1c. Health disparities between and among populations, as well as the underlying causes of these disparities, are eliminated</td>
<td>Healthy People 2020 Objective SDOH-3.1 – Proportion of persons living in poverty</td>
</tr>
<tr>
<td>II, III, IV, XI, XII, XIII, XIV</td>
<td></td>
<td></td>
<td>Healthy People 2020 Objective NWS-13 – Reduce household food insecurity and in doing so reduce hunger</td>
</tr>
<tr>
<td>IX</td>
<td></td>
<td>TN State Health Plan Principle 2, Access to Care – people in TN should have access to healthcare and the conditions to achieve optimal health</td>
<td></td>
</tr>
</tbody>
</table>
**Prioritized Need #3: Mental and Emotional Health / Substance Abuse**

**GOAL:** Improve mental and emotional health while decreasing the incidence of substance abuse through identifying, treating or referring to treatment, and supporting those in need.

**Action Plan**

<table>
<thead>
<tr>
<th>STRATEGY 1: Train and support a network of Faith Community Nurses, to equip them to improve the health of their congregations</th>
</tr>
</thead>
</table>

**BACKGROUND INFORMATION:**
- The target population is nurses who are interested in health ministry in their faith communities, to then impact the members of their faith communities
- This strategy equips nurses to provide unique access to case management support for those in faith communities who experience vulnerabilities for a variety of reasons, including the following: elderly, recently hospitalized, have multiple comorbidities, poor emotional health, narrow support systems, and struggle with health literacy. This strategy utilizes community members’ ties to a faith community to provide them with a trusted connection to the healthcare system and to better meet their complex health needs
- This strategy provides training in a specialty practice of nursing recognized by the American Nurses Association as Faith Community Nursing

<table>
<thead>
<tr>
<th>RESOURCES:</th>
</tr>
</thead>
</table>
- Faith Community Nurse Liaison
- Foundations of Faith Community Nursing curriculum and course offered through Saint Thomas – West Hospital

<table>
<thead>
<tr>
<th>COLLABORATION:</th>
</tr>
</thead>
</table>
- Faith congregations

| ACTIONS: |
| 1. Speak with members of both the faith and health communities to raise awareness of the specialty practice of FCN and of the training course |
| 2. Provide information to be shared externally to STH’s marketing department to recruit for FCN classes |
| 3. Secure needed resources for FCN class |
| 4. Recruit necessary faculty to administer FCN class |
| 5. Oversee and facilitate FCN class |
| 6. Recruit speakers for quarterly FCN Network Educational Meetings |
| 7. Communicate about and host quarterly meetings for FCN Network |
| 8. Provide ad hoc resources to FCN Network |
### STRATEGY 1: Train and support a network of Faith Community Nurses, to equip them to improve the health of their congregations

**ANTICIPATED IMPACT:**

I. By June 2017, increase % of trained FCN’s who have provided community health resource materials to their congregation by 50%

II. By June 2017, increase % of trained FCN’s who have taken action to target a priority health area in the congregation by 50%

III. By June 2019, increase % of trained FCN’s who report improved health literacy/disease management among their target population by 50%

### STRATEGY 2: Provide mental health screening, counseling, and psychiatric medication management to community members who seek care at Saint Thomas Medical Partners’ Davidson Family Health Center PCMH sites.

**BACKGROUND INFORMATION:**

- The target population is uninsured and underinsured community members who utilize Saint Thomas Medical Partners – Family Health Center – West, Holy Family Health Center or the Internal Medicine Center as their PCMH.

- Physical wellness cannot be achieved without mental wellness. Providing treatment and support is essential for all patients, in particular for those living within poverty or in areas where healthcare is not easily accessed. Screening and treatment of mental disease illnesses our clinics will lead to healthier patients and healthier communities.

- This strategy is built upon the evidence base cited by Healthy People 2020’s Access to Health Services topic: People with a usual source of care have better health outcomes and fewer disparities and costs.

**RESOURCES:**

- Saint Thomas Medical Partners – Family Health Center – West
- Holy Family Health Center
- Internal Medicine Center

**COLLABORATION:**

- N/A

**ACTIONS:**

1. Appropriately screen each patient as dictated by PCMH guidelines or Behavioral Health guidelines.
2. Review the screening tool and refer to Behavioral Health as needed.
3. Initial appointment with Behavioral Health team for counseling and/or medication.
**STRATEGY 2**: Provide mental health screening, counseling, and psychiatric medication management to community members who seek care at Saint Thomas Medical Partners’ Davidson Family Health Center PCMH sites.

4. As appropriate, patient will remain under the care of Behavioral Health until patient/ Behavioral Health team decide patient no longer needs Behavioral Health Care Management.

**ANTICIPATED IMPACT:**

IV. By July 2017, 90% of PCMH patients in the respective practice will be screened for behavioral health needs

V. By December 2017, 90% of patients with a positive screen will be receiving needed behavioral healthcare.

---

**STRATEGY 3**: Integrate psychological and pastoral counseling into a primary care site, to care seamlessly for a patient’s physical and behavioral health needs within one site of care

**BACKGROUND INFORMATION:**

- The target population is community members in need of behavioral health care in addition to the care they are currently receiving for their physical health
- This strategy seeks to address the behavioral health needs of the underserved, who otherwise would not obtain needed mental health support.
- This strategy is based upon a model and structure utilized in North Carolina to integrate behavioral health services with medical care. This will be a pilot for Saint Thomas Health, to assess the efficacy and impact of this model within our practices

**RESOURCES:**

- Saint Thomas Medical Partners

**COLLABORATION:**

- N/A

**ACTIONS:**

1. Hire an Intake Specialist and a master’s level professional counselor trained in Clinical Pastoral Therapy
2. Primary care providers conduct routine depression screenings, and introduce patients to the Intake Specialist when needed and patient is receptive to speaking with them
3. Intake Specialist conducts an initial assessment and schedules the patient for follow-up
4. Patient follows up for a visit with the counselor
5. Counselor recommends an overall plan and begins caring for the patient’s behavioral health needs
**STRATEGY 3:** Integrate psychological and pastoral counseling into a primary care site, to care seamlessly for a patient’s physical and behavioral health needs within one site of care

**ANTICIPATED IMPACT:**
VI. By December 2017, demonstrate an improvement in mental health of 90% of patients who complete the recommended course of therapy

---

**STRATEGY 4:** Provide community-based organizations with financial support toward their work in one of the Prioritized Need areas

**BACKGROUND INFORMATION:**
- The target population is residents of Davidson County served by identified partner organizations
- All organizations will be assessed on the basis of the attention they pay to issues of health disparities and the needs of the underserved
- The evidence base will be dependent upon the specific work of each community organization but is one of the selection criteria that is reviewed and considered in determining partners

**RESOURCES:**
- Financial Support

**COLLABORATION:**
- Community Organizations

**ACTIONS:**
1. Make publicly available a Program Proposal form, through which community organizations can request a financial partnership from Saint Thomas Health
2. Receive Program Proposals from community organizations who seek support for a program working to meet one of the Priority Needs
3. Partnership decisions made by committee review
4. Financial support is provided to selected organizations, and outcomes are reviewed annually

**ANTICIPATED IMPACT:**
The work of community organizations working to meet the Priority Needs will be furthered through a partnership with Saint Thomas Health. Specific objectives will be dependent upon the specific actions and interventions of each selected partner organization. Each organization will submit its anticipated impact in its request seeking financial support from Saint Thomas Health.
## Alignment with Local, State & National Priorities

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<thead>
<tr>
<th>OBJECTIVE:</th>
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<th>STATE PLAN:</th>
<th>“HEALTHY PEOPLE 2020” (or OTHER NATIONAL PLAN):</th>
</tr>
</thead>
<tbody>
<tr>
<td>I, II, III</td>
<td>Nashville’s Faith &amp; Health Collaborative – objective to equip faith communities to address health needs in their congregations</td>
<td>Healthy People 2020 Objective ECBP-10 – Increase the number of community-based organizations providing population-based primary prevention services</td>
<td></td>
</tr>
<tr>
<td>IV, V</td>
<td>TN State Health Plan Goal 1c: Health disparities between and among populations, as well as the underlying causes of these disparities, are eliminated – Behavioral Health cited as a priority</td>
<td>Healthy People 2020 Objective MHMD-5 – Increase the proportion of primary care facilities that provide mental health treatment onsite or by paid referral</td>
<td></td>
</tr>
<tr>
<td>IV, V</td>
<td>TN State Health Plan Goal 1c: Health disparities between and among populations, as well as the underlying causes of these disparities, are eliminated – Behavioral Health cited as a priority</td>
<td>Healthy People 2020 Objective MHMD-9 – Increase the proportion of persons with mental health disorders who receive treatment</td>
<td></td>
</tr>
<tr>
<td>IV, V</td>
<td>TN State Health Plan Goal 1c: Health disparities between and among populations, as well as the underlying causes of these disparities, are eliminated – Behavioral Health cited as a priority</td>
<td>Healthy People 2020 Objective MHMD-11 – Increase depression screening by primary care providers</td>
<td></td>
</tr>
<tr>
<td>I, II, III, VI</td>
<td>TN Department of Health’s Faith-Based Health Initiative</td>
<td>Healthy People 2020 Objective HRQOL/WB-1.2 – Increase the proportion of adults who self-report good or better mental health</td>
<td></td>
</tr>
</tbody>
</table>
Prioritized Need #4: Wellness and Disease Prevention

**GOAL:** Promote and support a healthy lifestyle through strengthening community resources that will positively impact nutrition, exercise, chronic disease management and chronic disease prevention.

**Action Plan**

<table>
<thead>
<tr>
<th>STRATEGY 1: Operate and expand a community based breastfeeding clinic to support and educate breastfeeding families</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>BACKGROUND INFORMATION:</strong></td>
</tr>
<tr>
<td>• The strategy’s target population is breastfeeding families in Davidson County</td>
</tr>
<tr>
<td>• The clinic addresses health disparities and barriers to care by providing lactation services at no cost, services that otherwise would be out of reach for underserved families.</td>
</tr>
<tr>
<td>• Evidence-based lactation consulting practices are utilized in caring for the clinic’s patients. Lactation consultants, certified by the board of lactation, staff the clinic.</td>
</tr>
<tr>
<td><strong>RESOURCES:</strong></td>
</tr>
<tr>
<td>• Breastfeeding Outreach Clinic Staff</td>
</tr>
<tr>
<td>• Dedicated clinic space, with needed materials</td>
</tr>
<tr>
<td>• Saint Thomas Health Providers &amp; Staff</td>
</tr>
<tr>
<td><strong>COLLABORATION:</strong></td>
</tr>
<tr>
<td>• Non-Saint Thomas Health Providers</td>
</tr>
<tr>
<td><strong>ACTIONS:</strong></td>
</tr>
<tr>
<td>1. Employ certified lactation consultants to provide evidence based practice methods for breastfeeding to support families</td>
</tr>
<tr>
<td>2. Designate a space for the clinic, stocked with appropriate materials</td>
</tr>
<tr>
<td>3. Open the clinic for 25-30 hours per week and available for drop-in</td>
</tr>
<tr>
<td>4. Saint Thomas maternal/newborn staff refer breastfeeding families</td>
</tr>
<tr>
<td>5. Other community physicians refer breastfeeding families to the clinic</td>
</tr>
<tr>
<td>6. Provide free breastfeeding classes to targeted populations</td>
</tr>
<tr>
<td>7. Advertise the clinic through social media</td>
</tr>
<tr>
<td>8. Serve outlying communities by providing traveling clinic services</td>
</tr>
<tr>
<td><strong>ANTICIPATED IMPACT:</strong></td>
</tr>
<tr>
<td>1. By June 2017, 87% of mothers who visited the clinic will still be breastfeeding at 6 months</td>
</tr>
</tbody>
</table>
**STRATEGY 2:** Train and support a network of Faith Community Nurses, to equip them to improve the health of their congregations

**BACKGROUND INFORMATION:**
- The target population is nurses who are interested in health ministry in their faith communities, to then impact the members of their faith communities.
- This strategy equips nurses to provide unique access to case management support for those in faith communities who experience vulnerabilities for a variety of reasons, including the following: elderly, recently hospitalized, have multiple comorbidities, poor emotional health, narrow support systems, and struggle with health literacy. This strategy utilizes community members’ ties to a faith community to provide them with a trusted connection to the healthcare system and to better meet their complex health needs.
- This strategy provides training in a specialty practice of nursing recognized by the American Nurses Association as Faith Community Nursing.

**RESOURCES:**
- Faith Community Nurse Liaison
- Foundations of Faith Community Nursing curriculum and course offered through Saint Thomas – West Hospital

**COLLABORATION:**
- Faith congregations

**ACTIONS:**
1. Speak with members of both the faith and health communities to raise awareness of the specialty practice of FCN and of the training course
2. Provide information to be shared externally to STH’s marketing department to recruit for FCN classes
3. Secure needed resources for FCN class
4. Recruit necessary faculty to administer FCN class
5. Overseer and facilitate FCN class
6. Recruit speakers for quarterly FCN Network Educational Meetings
7. Communicate about and host quarterly meetings for FCN Network
8. Provide ad hoc resources to FCN Network

**ANTICIPATED IMPACT:**
II. By June 2017, increase % of trained FCN’s who have provided community health resource materials to their congregation by 50%
III. By June 2017, increase % of trained FCN’s who have taken action to target a priority health area in the congregation by 50%
IV. By June 2019, increase % of trained FCN’s who report improved health literacy/disease management among their target population by 50%
### STRATEGY 3: Implement a community-wide campaign that integrates education and barrier reduction to increase breast cancer screenings

#### BACKGROUND INFORMATION:
- The strategy’s target population is low-income, underserved, uninsured, women in the county age 40 - 70.
- The campaign will address health disparities and barriers to care by providing community education and free screenings to low-income women.
- The strategy is informed by evidence found on The Community Guide and What Works for Health.

#### RESOURCES:
- Saint Thomas Medical Partners – Family Health Center – West
- Holy Family Health Center
- Internal Medicine Center
- Saint Thomas – Midtown Hospital
- Saint Thomas – West Hospital
- Mobile Mammography

#### COLLABORATION:
- Tennessee Breast and Cervical Program
- Women’s Breast Center
- Premier Radiology
- National Breast Cancer Foundation

#### ACTIONS:
1. Distribute educational brochures at the office and health fairs
2. Schedule mobile mammography for screenings at the clinic one day each month for the year.
3. Schedule patients at Premier radiology for diagnostic testing.
4. Schedule patients at the Women’s Breast Center for Surgeon consultations.

#### ANTICIPATED IMPACT:
- By June 2017, increase local women’s knowledge of breast cancer resources to 80% as measured by community survey.
- By June 2017, increase local women’s self-reported breast cancer screenings from 68% to 73% as measured by W survey.
- By June 2018, increase the proportion of women over 40 who receive a clinical breast exam from 79.1% to 85% as measured by BRFSS.
<table>
<thead>
<tr>
<th>STRATEGY 4: Improve maternal and infant health through offering prenatal education via Centering Pregnancy classes and lactation consulting</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>BACKGROUND INFORMATION:</strong></td>
</tr>
<tr>
<td>• The target population is community members who are either pregnant or new mothers</td>
</tr>
<tr>
<td>• This strategy addresses health disparities and cares for the underserved by increasing access to prenatal care and lactation consulting available to un/underinsured patients, including the Hispanic and African American populations</td>
</tr>
<tr>
<td>• This strategy is in line with national recommendations for prenatal care and utilizes evidence-based lactation consulting practices</td>
</tr>
<tr>
<td><strong>RESOURCES:</strong></td>
</tr>
<tr>
<td>• Holy Family Health Center</td>
</tr>
<tr>
<td><strong>COLLABORATION:</strong></td>
</tr>
<tr>
<td>• N/A</td>
</tr>
<tr>
<td><strong>ACTIONS:</strong></td>
</tr>
<tr>
<td>1. Conduct visits with female patients in which pregnancy is confirmed</td>
</tr>
<tr>
<td>2. Refer pregnant patients to the practice’s insurance application enrollment specialist for CoverKids</td>
</tr>
<tr>
<td>3. During a pre-natal visit, encourage patients to participate in the Centering Pregnancy pre-natal program</td>
</tr>
<tr>
<td>4. Schedule Centering Pregnancy classes as each cohort forms</td>
</tr>
<tr>
<td>5. Conduct Centering Pregnancy classes</td>
</tr>
<tr>
<td>6. At 36 weeks, refer the patient to their delivering obstetrician</td>
</tr>
<tr>
<td>7. Complete a post-partum visit 6-8 weeks after the patient delivers</td>
</tr>
<tr>
<td>8. At this post-partum visit, lactation consultant assesses breastfeeding success and counsels as needed</td>
</tr>
<tr>
<td><strong>ANTICIPATED IMPACT:</strong></td>
</tr>
<tr>
<td>VIII. By December 2017, 90% of patients will be completing the full prenatal course of care</td>
</tr>
<tr>
<td>IX. By December 2017, 40% of patients will be exclusively breastfeeding at 3 months</td>
</tr>
</tbody>
</table>
**STRATEGY 5:** Implement a community-wide campaign to provide nutrition counseling that will improve food choices.

**BACKGROUND INFORMATION:**
- The strategy’s target population is low-income Davidson County residents who are either uninsured or underinsured.
- The campaign will address health disparities and barriers to care by providing community education and free nutrition counselling to low-income community members.
- This strategy is built upon the evidence base cited by Healthy People 2020’s Nutrition and Weight Status topic.

**RESOURCES:**
- Saint Thomas Medical Partners – Family Health Center – West
- Holy Family Health Center

**COLLABORATION:**
- N/A

**ACTIONS:**
1. Survey patient knowledge of healthy food choices
2. Facilitate provider engagement
3. Providers will refer at least 5% of obese (as defined by BMI indicators) patients for dietary counseling each month
4. Survey class participants to acquire base knowledge of healthy choices
5. Conduct nutrition education sessions for overweight and obese adults

**ANTICIPATED IMPACT:**
X. By February 2017, increase number of obese patients receiving dietary counseling by 10%.
XI. By September 2017, decrease average BMI by 5% for patients receiving dietary counseling.
<table>
<thead>
<tr>
<th>STRATEGY 6: Increase physical activity by offering weekly exercise classes to community members</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>BACKGROUND INFORMATION:</strong></td>
</tr>
<tr>
<td>• The strategy’s target population is adults and children residing in Davidson County’s South Nashville community</td>
</tr>
<tr>
<td>• Exercise classes provide physical activity opportunities to the vulnerable population that does not have alternative options for exercise</td>
</tr>
<tr>
<td>• This strategy’s evidence-based source is Cardiovascular Exercise Videos</td>
</tr>
<tr>
<td><strong>RESOURCES:</strong></td>
</tr>
<tr>
<td>• Holy Family Health Center</td>
</tr>
<tr>
<td><strong>COLLABORATION:</strong></td>
</tr>
<tr>
<td>• Catholic Charities – South Nashville Family Resource Center</td>
</tr>
<tr>
<td>• Christ Church YMCA</td>
</tr>
<tr>
<td><strong>ACTIONS:</strong></td>
</tr>
<tr>
<td>1. Holy Family Health Center Dietician arranges 2 exercise classes per week</td>
</tr>
<tr>
<td>2. Patients are referred to the classes by Holy Family associates as indicated</td>
</tr>
<tr>
<td>3. Exercise classes are advertised through brochures, flyers, and the South Nashville Family Resource Center</td>
</tr>
<tr>
<td>4. Addition of YMCA group fitness instructors to lead on-site exercise classes</td>
</tr>
<tr>
<td><strong>ANTICIPATED IMPACT:</strong></td>
</tr>
<tr>
<td>XII. By June 2019, 2,500 community members will have attended one or more of the offered exercise classes</td>
</tr>
</tbody>
</table>
**STRATEGY 7:** Provide community-based organizations with financial support toward their work in one of the Prioritized Need areas

**BACKGROUND INFORMATION:**
- The target population is residents of Davidson County served by identified partner organizations
- All organizations will be assessed on the basis of the attention they pay to issues of health disparities and the needs of the underserved
- The evidence base will be dependent upon the specific work of each community organization but is one of the selection criteria that is reviewed and considered in determining partners

**RESOURCES:**
- Financial Support

**COLLABORATION:**
- Community Organizations

**ACTIONS:**
1. Make publicly available a Program Proposal form, through which community organizations can request a financial partnership from Saint Thomas Health
2. Receive Program Proposals from community organizations who seek support for a program working to meet one of the Priority Needs
3. Partnership decisions made by committee review
4. Financial support is provided to selected organizations, and outcomes are reviewed annually

**ANTICIPATED IMPACT:**
The work of community organizations working to meet the Priority Needs will be furthered through a partnership with Saint Thomas Health. Specific objectives will be dependent upon the specific actions and interventions of each selected partner organization. Each organization will submit its anticipated impact in its request seeking financial support from Saint Thomas Health.
## Alignment with Local, State & National Priorities

<table>
<thead>
<tr>
<th>OBJECTIVE:</th>
<th>LOCAL / COMMUNITY PLAN:</th>
<th>STATE PLAN:</th>
<th>“HEALTHY PEOPLE 2020” (or OTHER NATIONAL PLAN):</th>
</tr>
</thead>
<tbody>
<tr>
<td>I, VIII, IX</td>
<td>By 2020, increase the number of infants who have breastfed</td>
<td></td>
<td></td>
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<tr>
<td>I</td>
<td>TN State Health Plan Goal 1c. Health disparities between and among populations, as well as the underlying causes of these disparities, are eliminated</td>
<td>Healthy People 2020 Objective MICH-3.1 -- Reduce the rate of deaths among children aged 1 to 4 years</td>
<td></td>
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<tr>
<td>II, III, IV</td>
<td>Nashville’s Faith &amp; Health Collaborative – Objective to equip faith communities to address health needs in their congregations</td>
<td>TN Department of Health’s Faith-Based Health Initiative</td>
<td>Healthy People 2020 Objective ECBP-10 – Increase the number of community-based organizations providing population-based primary prevention services</td>
</tr>
<tr>
<td>V, VI, VII</td>
<td>By 2018, increase the proportion of early-stage diagnoses of breast cancer among all women by 25%</td>
<td>By 2020, reduce the female breast cancer death rate from 23% to 20.7%</td>
<td></td>
</tr>
<tr>
<td>V, VI, VII</td>
<td>Healthy People 2020 Objective C-3 – Reduce the female breast cancer death rate</td>
<td></td>
<td></td>
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<tr>
<td>X, XI</td>
<td>Obesity is cited as one of the TN Department of Health’s four priorities</td>
<td>Healthy People 2020 Objective NWS-8 – Increase the proportion of adults who are at a healthy weight</td>
<td></td>
</tr>
<tr>
<td>XII</td>
<td>Physical inactivity is cited as one of the TN Department of Health’s four priorities</td>
<td>Healthy People 2020 Objective PA-2 – Increase the proportion of adults who meet current federal physical activity guidelines for aerobic physical activity</td>
<td></td>
</tr>
</tbody>
</table>