2019

Implementation Strategy

Hickman County, Tennessee

Saint Thomas Hickman Hospital

Saint Thomas Health

Ascension

Saint Thomas Hickman Hospital Implementation Strategy

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Saint Thomas Hickman Hospital Implementation Strategy

Implementation Strategy Narrative

Overview

Saint Thomas Hickman Hospital and Saint Thomas Health conducted a Community Health Needs Assessment (CHNA) collaboratively with the Hickman County Health Department and Hickman County Health Council. The community served for purposes of this CHNA and Implementation Strategy was defined as Hickman County, Tennessee.

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

1. Provide an unbiased comprehensive assessment of Hickman 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
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, a community intercept survey, and a community meeting to review findings and discern unmet health needs. The partnering organizations collaborated with Vanderbilt University Medical Center on shared processes of secondary data review and the design and analysis of interviews of community leaders and representatives. The partnering organizations received input from public health experts, including the local public health department partner.

The 2019 CHNA provided Saint Thomas Hickman 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 Hickman Hospital and Saint Thomas Health for fiscal years 2020 – 2022.

Prioritized Needs

The results of the data review, community interviews, listening sessions and the online community survey were presented to the community representatives and leaders at the February 6th, 2019 Hickman County Health Summit meeting, which included Hickman County Health Department, and Saint Thomas Health. The meeting attendees represented covered a broad spectrum of the community, including those focusing on the underserved population. They were asked to provide collective input into the needs of the community.

Stakeholders present decided upon the needs of Mental Health/Substance Abuse, Physical Inactivity/Obesity, Transportation, and Education. During the CHNA and Implementation Strategy brainstorming phase across the Ascension Tennessee ministry (7 counties), community benefit and hospital leaders agreed to a collective impact model toward addressing needs that appeared in multiple counties. This model is an effort to allocate resources in ways that can more meaningfully impact priority areas. The 4 needs chosen appeared in 5 or more of the counties surveyed. The ministry is committed to addressing Summit-specific needs within the 4 broader categories over the course of this cycle.

Additionally, our Community Benefit work will utilize an equity and advocacy framework. This will ensure we are aware of how systems need to change to decrease inequities and increase equity. Effective and sustainable change is most successful when people and communities impacted by the change are included throughout the process.

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

Access to Care

Mental Health

Obesity (Healthy Weight)

Substance Abuse

Needs That Will Not Be Addressed

All priority health needs will be addressed.

Summary of Implementation Strategy

Prioritized Need #1: Access to Care

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

Strategy 1: Grow the 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.

Strategy 2: Provide health insurance enrollment and navigation assistance to community members who are either uninsured or need assistance navigating their current insurance.

Strategy 3: Maximize use of Mobile Health Units, including breast cancer screening compliance through Our Mission in Motion Mobile Mammography.

Strategy4: Improve access to care via telemedicine consultations, including when acute stroke symptoms are present.

Strategy 5: 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.

Strategy 6: Empower victims of sexual assault through the provision of Sexual Assault Nurse Examiner care and advocacy, ensuring that victims receive trauma-informed care and are connected to appropriate resources.

Strategy 7: Address transportation concerns by partnering with South Central Area Transit Service (SCATS)

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

Prioritized Need #2: Mental Health

GOAL: Support mental and emotional health, decrease stigma and increase access to behavioral health services.

Strategy 1: Offer emotional support through the hosting of a support group for those in the role of caring (or supporting those who are caring) for someone with Alzheimer's Disease or any chronic medical condition.

Strategy 2: Integrate behavioral health services with primary medical care to care for the behavioral as well as physical needs of underserved Hickman County residents.

Strategy 3: Improve community knowledge of wellness and disease prevention by offering a series of educational courses, approaching both the physical and mental aspects of priority health areas in Hickman County.

Strategy 4: Identify and provide care for those at risk for suicide through Zero Suicide Initiative.

Strategy 5: Provide community-based organizations with financial support toward their work in one of the Prioritized Need areas.

Prioritized Need #3: Obesity (Healthy Weight)

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: Improve community knowledge of wellness and disease prevention by offering a series of educational courses, approaching both the physical and mental aspects of priority health areas in Hickman County.

Strategy 2: Provide CPR/First Aid Classes for Hickman County Schools Faculty and Staff.

Strategy 3: Increase the amount of nutritious food available to and consumed by low-income families through the provision of materials and education for an individualized raised-bed garden.

Strategy 4: Provide food boxes, sensitive to chronic condition, to community members who are experiencing food insecurity

Strategy 5: Increase community physical activity by creating a public use walking trail in the community.

Strategy 6: Provide community-based organizations with financial support toward their work in one of the Prioritized Need areas.

Prioritized Need #4: Substance Abuse

GOAL: Decrease the incidence of substance misuse through identifying, treating and/or referring to treatment, and supporting those in need.

Strategy 1: Integrate and develop partnership with Buffalo Valley, Inc. by offering substance misuse services to community members who are suffering from addiction.

Strategy 2: Identify vulnerable populations at risk for opioid misuse at ER and RHC and provide resources for prevention, support and treatment.

Strategy 3: Provide community-based organizations with financial support toward their work in one of the Prioritized Need areas

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An action plan follows for each strategy, including the resources, proposed actions, planned collaboration, and anticipated impact.

Prioritized Need #1: Access to Care

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

Action Plan

STRATEGY 1: Grow the Dispensary of Hope Charitable Pharmacy to provide medication assistance for uninsured & underinsured individuals who experience financial hardship, as well as to assist patients with navigating other community resources as needed.

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. Coordinate applications for manufacturers' Patient Assistance Programs
3. Provide resources for transition of newly eligible Medicare patients to Medicare Part D
4. Coordinate electronic ordering of insulin samples & storage of them for physician health partners.
5. Provide free & discounted medications and testing supplies to uninsured and underinsured individuals
6. Provide discharge medications to patients who received care at Saint Thomas – Hickman Hospital
7. Promote awareness of Dispensary of Hope in the community

STRATEGY 1: Grow the Dispensary of Hope Charitable Pharmacy to provide medication assistance for uninsured & underinsured individuals who experience financial hardship, as well as to assist patients with navigating other community resources as needed.
ANTICIPATED IMPACT: I. Provide 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 through 2022. II. Assist qualifying individuals with obtaining medication assistance through manufacturer sponsored Patient Assistance Programs

STRATEGY 2: Provide health insurance enrollment and navigation assistance to community members who are either uninsured or need assistance navigating their current insurance.

BACKGROUND INFORMATION:

- The target population is community members who are either uninsured or need assistance navigating their current insurance.
- This strategy targets community members who are vulnerable because of their current insurance status; this seeks to alleviate disparity in health insurance literacy to ensure community members are equipped to make an insurance plan selection or access the care they need with their current insurance
- This strategy utilizes a Navigator specifically trained to navigate HealthCare.gov

RESOURCES:

- Saint Thomas – Hickman Health Insurance Navigator with private office
- Insurance eligibility confirmation software

COLLABORATION:

- N/A

ACTIONS:

1. Distribute flyers and resources regarding open enrollment assistance availability
2. Produce public advertisements of open enrollment assistance availability
3. Offer navigation of HealthCare.gov
4. Offer year-round navigation on other insurance questions
5. Provide resource navigation assistance for those who remain uninsured or otherwise express need
6. Follow up to ensure all needed guidance has been received

ANTICIPATED IMPACT:

III. Increase public awareness of enrollment assistance offered to drive a 10% increase in enrollment counseling visits each open enrollment season
IV. Confirm that 50% of eligible visitors become enrolled in health insurance during the open enrollment period

STRATEGY 3: Maximize Mobile Health Unit activity, including breast cancer screening compliance through Our Mission in Motion Mobile Mammography

BACKGROUND INFORMATION:

- The strategy's target population is low-income, uninsured women in Hickman 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.
- This strategy is informed by evidence found on Healthy People 2020 and Tennessee Cancer Coalition.

RESOURCES:

- Saint Thomas Medical Partners
- Saint Thomas Hickman Hospital
- Our Mission In Motion Mobile Mammography staff
- Saint Thomas Midtown and West Centers for Breast Health

COLLABORATION:

- TN Breast and Cervical Cancer Screening Program
- Susan G. Komen Central Tennessee
- Advanced Diagnostic Imaging

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
4. Explore other Mobile Health Unit opportunities

ANTICIPATED IMPACT:

V. Conduct at least 6 community outreach visits annually in Hickman County to provide free mammography services

VI. Increase the number of women screened with the recommended frequency by 10%

STRATEGY 4: Improve access to care via telemedicine consultations, including when acute stroke symptoms are present

BACKGROUND INFORMATION:

- The target population is residents of Hickman 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 Hickman Hospital Staff
- Telemedicine Services
- Consulting Stroke-trained Physician

COLLABORATION:

- N/A

ACTIONS:

1. Increase use of system 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 telemedicine visits
4. Conduct a patient survey to confirm timely access to health services

ANTICIPATED IMPACT:

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

STRATEGY 5: 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 Hickman 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:

IX. 80% of callers receiving at least one referral to a community resource by June 2022
X. 70% of callers receiving assistance from the referral by June 2022

STRATEGY 6: Empower victims of sexual assault through the provision of SANE care and advocacy, ensuring that victims receive trauma-informed care and are connected to appropriate resources.

BACKGROUND INFORMATION:

- The target population is victims of sexual assault in Hickman County age 13 and older
- This strategy works to eliminate barriers to sexual assault victims receiving the care they need
- Training from the International Association of Forensic Nurses is utilized in preparing SANE nurses. A standardized screening tool is utilized to assess all sexual assault patients, in line with the findings of the following study: Brown, B., DuMont, J., Macdonald, S., Bainbridge, D., (April/June 2013) A Comparative Analysis of Victims of Sexual Assault With and Without Mental Health Histories: Acute and Follow-up Care Characteristics. Journal of Forensic Nurses, 9(2), 76-83. This maintains hospital policy, by which a SANE nurse will be the proper associate to care for patients who are victims of sexual assault.

RESOURCES:

- Saint Thomas – Hickman Hospital Providers
- SANE Exam Space and Materials

COLLABORATION:

- SANE Training – International Association of Forensic Nurses

ACTIONS:

1. Train select Saint Thomas – Hickman Hospital providers to be SANE-certified
2. Conduct trainings with ED staff to increase awareness of SANE program
3. ED staff refer patients who are victims of sexual assault to the on-duty SANE nurse
4. Provide comprehensive medical-forensic exams to victims
5. Refer patients to other needed resources

ANTICIPATED IMPACT:

XI. By December 2021, two associates will be trained (or will maintain training) in SANE and thus will be able to provide trauma-informed care and needed resources to victims of sexual assault.

XII. By June 2022, all patients who present as acute sexual assault victims will be referred to the on-duty SANE associate for follow-up support and care.

STRATEGY 7: Address transportation concerns by partnering with South Central Area Transit Service (SCATS)

BACKGROUND INFORMATION:

- The target population is community members in need of a ride to an appointment or errand
- This strategy is focused on a group of marginalized and vulnerable people, seeking to address the social determinant of transportation for community members who may not be able to drive anymore or don't have access to a car.
- Addressing social determinants of health is a primary prevention activity, a main focus of both the Tennessee Dept. of Health and Health and Human Services.

RESOURCES:

- Support staff to coordinate with SCATS

COLLABORATION:

- South Central Area Transit Service (SCATS)

ACTIONS:

1. Identify staff who can coordinate with SCATS to get patients where they need to be in the community.
2. Develop baseline of rides SCATS is providing community members.
3. Develop data sharing agreement with TNCARE, SCATS, etc.
4. Track rides and destinations of community members.

ANTICIPATED IMPACT:

XIII. By December 2021, increase # of rides and unique # of riders for community members to regional destinations from baseline by 10%.

STRATEGY 5: 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 Hickman 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
- Community Health and Benefit Committee

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

OBJECTIVE:	LOCAL / COMMUNITY PLAN:	STATE PLAN:	"HEALTHY PEOPLE 2020" (or OTHER NATIONAL PLAN):
I –XIII	N/A	TN State Health Plan is increasing its focus on social, economic, and environmental factors that directly influence the health status of the people of Tennessee.	HP 2020's framework reflects 5 key areas of SDOH: • Economic stability • Education • Social and Community Context • Health and Health Care • Neighborhood and Build Environment
I-XIII	N/A	TN State Health Plan Principle 2, Access to Care – People in TN should have access to healthcare and the conditions to achieve optimal health	
III, IV	N/A	Access to health insurance is a TN State Health Plan Priority	Healthy People 2020 Objective AHS-1 – Increase the proportion of persons with health insurance
I-XIII	N/A		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
V, IX	N/A	TN State Health Plan Goal 2d. People in TN are able to obtain appropriate quality healthcare services to meet their needs	
V, VI	N/A	Reduce female breast cancer mortality through increased awareness, early detection, diagnosis and treatment	HP 2020 C3: Reduce the female breast cancer death rate
VII, VIII	N/A	TN State Health Plan Priority Area – Health Care Delivery Model in Rural Areas	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
XV, XVI	Healthy People 2020 Objective IVP-8.1 – Increase the proportion of the population residing within the continental United States with access to trauma care

Prioritized Need #2: Mental Health

GOAL: Support mental and emotional health, decrease stigma and increase access to behavioral health services.

Action Plan

STRATEGY 1: Offer emotional support through the hosting of a support group for those in the role of caring (or supporting those who are caring) for someone with Alzheimer's Disease or any chronic medical condition.
BACKGROUND INFORMATION: • The target population is community members who are in the role of caring (or supporting those who are caring) for someone with Alzheimer's Disease or any chronic medical condition. • This strategy seeks to care for the underserved by providing additional emotional support to those serving as caregivers, expanding their support network • This support group is based upon the Alzheimer's Association of Middle Tennessee support group facilitator training
RESOURCES: • Support Group Facilitator • Facilitation Space
COLLABORATION: • N/A
ACTIONS: 1. Schedule and advertise monthly support group meetings 2. Facilitate support group 3. Send monthly reminders and support material to group attendees
ANTICIPATED IMPACT: I. 80% of attendees will report an increased quality of life, an improved support network, and decreased isolation annually via survey by June 2022.

STRATEGY 2: Integrate behavioral health services with primary medical care to care for the behavioral as well as physical needs of underserved Hickman County residents

BACKGROUND INFORMATION:

- The target population is medically underserved residents, both children and adults, of Hickman County in need of behavioral healthcare services
- This strategy seeks to expand access to behavioral healthcare services to address behavioral health needs in Hickman County that are currently going unmet, providing care to underserved patients.
- All behavioral healthcare will be evidence-based and provided by appropriately licensed professionals

RESOURCES:

- Hickman Medical Clinic Medical Providers
- Saint Thomas – Hickman Hospital ED Providers
- Hickman Behavioral Health Providers

COLLABORATION:

- Centerstone
- Hickman County Drug Court

ACTIONS:

1. Educate Hickman Medical Clinic medical providers on the behavioral health offerings and when a referral may be indicated
2. Medical providers will refer patients in need for behavioral health services
3. Clinic Navigator and Program Manager will serve as liaisons between the Medical and Behavioral Health services, guiding patients to receive needed care
4. Conduct broader community awareness to increase awareness of new behavioral health resources
5. Psychiatric Nurse Practitioner and Licensed Clinical Social Worker will engage patients in an appropriate therapy plan
6. Licensed Clinical Social Worker will provide additional support services as needed by patients
7. Centerstone will provide assessment via telemedicine in the ED for mental health crises
8. Provide behavioral health support to those being cared for through the Hickman County Drug Court, as needed

ANTICIPATED IMPACT:

II. By June 2022, demonstrate an improvement in mental health of 90% of patients who complete the recommended course of therapy

STRATEGY 3: Improve community knowledge of wellness and disease prevention by offering a series of educational courses, approaching both the physical and mental aspects of priority health areas in Hickman County.

BACKGROUND INFORMATION:

- The target population is community members who are in need of wellness support across a range of health priorities.
- This program addresses health disparities by seeking to increase health literacy on priority health topics, with a particular focus on those who are medically underserved and otherwise would not have access to this information.
- A variety of evidence-based curricula will be utilized; one example is Stanford's Diabetes Self-Management Program, a part of their Steps to Healthier Living resources.

RESOURCES:

- Saint Thomas – Hickman Hospital Director of Food & Nutrition

COLLABORATION:

- Hickman County Health Department

ACTIONS:

1. Identify priority health areas to be addressed by courses
2. Identify evidence-based curricula to correspond to desired topics
3. Determine a location for the course
4. Advertise the course to community members
5. Teach the course
6. Make available one-on-one dietary coaching

ANTICIPATED IMPACT:

III. By June 2022, six courses in priority health areas will have been taught, with participants demonstrating at least a 50% knowledge increase in the topics addressed.

STRATEGY 4: Educate hospital and ER staff on suicide prevention and warning signs through *Zero Suicide Initiative.*

BACKGROUND INFORMATION:

- The target population is community members who show signs of severe depression and suicidal ideation.
- This strategy works to eliminate stigma around pursuing mental health assistance and how to gain the help of trained professionals if you are contemplating harming yourself or another person.
- Training and resources from the Suicide Prevention Resource Center are cultivated from evidence-based practices from the Henry Ford Health System, Centerstone, and SAMHSA (Substance abuse and Mental Health Services Administration).

RESOURCES:

- Saint Thomas – Hickman Hospital Providers

COLLABORATION:

- Suicide Prevention Resource Center

ACTIONS:

1. Conduct organizational self-study to assess what elements of suicide safer care it currently has in place.
2. Use framework from assessment to train providers on safer suicide care.
3. Provide better comprehensive screenings and assessments for patients at risk of suicide.
4. Engage and refer patients to other needed supports and resources as indicated.

ANTICIPATED IMPACT:

IV. By December 2022, reduce rate of suicide in county (32.2 per 100,000 in 2017) by 25%.

STRATEGY 5: 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 Hickman 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
- Community Health and Benefit Committee

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

OBJECTIVE:	LOCAL / COMMUNITY PLAN:	STATE PLAN:	"HEALTHY PEOPLE 2020" (or OTHER NATIONAL PLAN):
I, II, III, IIV	N/A	TN State Health Plan – Behavioral health a priority to address health disparities in TN	
I	N/A		Healthy People 2020 Objective HRQOL/WB-1.2 – Increase the proportion of adults who self-report good or better mental health
II	N/A		Healthy People 2020 Objectives MHMD-6 and MHMD-9 – Increase the proportion of children and persons with mental health disorders who receive treatment
III	N/A	TN State Health Plan Goal 1b. People in TN understand and practice behaviors that promote and maintain good health	Healthy People 2020 Objective HRQOL/WB-1.2 – Increase the proportion of adults who self-report good or better mental health
IV	N/A		HP 2020 MHMD-1: Reduce the suicide rate

Prioritized Need #3: Obesity (Healthy Weight)

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

STRATEGY 1: Improve community knowledge of wellness and disease prevention by offering a series of educational courses, approaching both the physical and mental aspects of priority health areas in Hickman County.

BACKGROUND INFORMATION:

- The target population is community members who are in need of wellness support across a range of health priorities.
- This program addresses health disparities by seeking to increase health literacy on priority health topics, with a focus on those who are medically underserved and not have access.
- A variety of evidence-based curricula will be utilized; one example is Stanford's Diabetes Self-Management Program, a part of their Steps to Healthier Living resources.

RESOURCES:

- Saint Thomas – Hickman Hospital Director of Food & Nutrition
- Saint Thomas – System Clinical Nutrition Manager
- Saint Thomas – Clinical Dietitian

COLLABORATION:

- Hickman County Health Department
- UT Extension

ACTIONS:

1. Identify priority health areas to be addressed by courses
2. Identify evidence-based curricula to correspond to desired topics
3. Determine a location for the course
4. Advertise the course to community members
5. Teach the course; Make available one-on-one dietary coaching
6. Survey participants to ensure knowledge gains and for quality improvement.

ANTICIPATED IMPACT:

I. By June 2020, six courses in priority health areas will have been taught, with participants demonstrating at least a 50% knowledge increase in the topics addressed.

II. By March 2020, a monthly nutrition education class focusing on healthy eating and diabetes will have been taught, with participants demonstrating at least a 50% knowledge increase in the topics addressed.

STRATEGY 2: Provide CPR/First Aid Classes for Hickman County Schools Faculty and Staff

BACKGROUND INFORMATION:

- The target population is Hickman County Schools faculty and staff who have been identified by HCS to be trained
- This strategy addresses health disparities by ensuring that select Hickman County Schools faculty and staff can appropriately respond to scenarios requiring first aid or CPR, enabling students across the county to more quickly access needed care
- An evidence-based curriculum is utilized in administering the CPR/First Aid training

RESOURCES:

- Training Administrator
- Curriculum
- Other program materials

COLLABORATION:

- Hickman County Schools Faculty and Staff
- Training Space (HCS)

ACTIONS:

1. Schedule trainings with Hickman County Schools
2. Conduct CPR and First Aid classes for Hickman County Elementary, Middle, and High School faculty and staff

ANTICIPATED IMPACT:

III. Certify 100% of course attendees in First Aid and CPR Administration annually.

STRATEGY 3: Increase the amount of nutritious food available to and consumed by low-income families through the provision of materials and education for an individualized raised-bed garden

BACKGROUND INFORMATION:

- The target population is low-income residents of Hickman County.
- This strategy seeks to increase access to fresh, nutritious food among low-income community members (thus addressing health disparities), while empowering them to grow their own food. This strategy specifically addresses social determinants by targeting issues of healthy food access.
- This strategy has been developed by Lutheran Services in Tennessee, with an 80-90% success rate in their Healthy Garden program since 2011. This is an environmental change, changing the residents' environment so that they are able to grow their own produce

RESOURCES:

- Financial support
- Publicity: representation at STH Medical Mission events

COLLABORATION:

- Lutheran Services in Tennessee
- Hickman Health Department
- UT Extension
- Hickman County Chamber of Commerce

ACTIONS:

1. Identify community members interested in gardening
2. Work with gardeners to select desired plants for gardens
3. Plant gardens
4. Provide education throughout the growing season about caring for the plants, along with tips for cooking and healthy recipes
5. Select Champions to oversee gardeners' network in the neighborhood

ANTICIPATED IMPACT:

IV. 80% of families growing gardens will increase consumption of vegetables in their diets 1-2 servings each day during the growing season
V. 85% of gardeners will return to garden each year

STRATEGY 4: Provide food boxes, sensitive to chronic condition, to community members who are experiencing food insecurity

BACKGROUND INFORMATION:

1. The target population is patients of ST Hickman Hospital, Clinic, Senior Care, and the Centerville Dialysis Center who are identified as impacted by food insecurity and one of the following chronic diseases: diabetes, heart disease, and renal disease. This strategy is also an open resource for any community members who are food insecure, with the food tailored to their physical needs as much as possible.

- This program serves those who are food insecure, which is a driver of health disparities as healthy and disease-appropriate food is more difficult to obtain and consume.
- This program utilizes Boston Medical Center's model for a chronic condition-specific food pantry, a program that received the 2012 James W. Varnum National Quality Health Care Award: https://development.bmc.org/foodpantry

RESOURCES:

- Saint Thomas – Hickman Providers & Staff

COLLABORATION:

- Second Harvest Food Bank
- Centerville Church of Christ
- Farmers' Market at River Park

ACTIONS:

1. Second Harvest delivers food to Centerville Church of Christ
2. Centerville Church of Christ prepares food boxes and provides to ST Hickman
3. Providers identify patients who are food insecure and have either diabetes, heart disease, or renal disease, and refer the patients to the Program Lead
4. Program lead provides a medically sensitive food box to the patients
5. Program lead provides a food box to broader community members who express a need for food in their home and seek help for this need at the hospital
6. Coordinate with the Farmers' Market at River Park to add a fresh food component to the current food provision option

ANTICIPATED IMPACT:

VI. Alleviate food insecurity for 30 families a month, through June of 2022, through the provision of a food box.

VII. Increase wellness promotion through nutrition education being made available in each food box by June 2022.

STRATEGY 5: Increase community physical activity by creating a public use walking trail

BACKGROUND INFORMATION:

- The target population is any community member in need of a safe designated walking space
- This strategy addresses health disparities and seeks to care for the underserved by providing a publicly available, free option for community members to be physically active
- This strategy is evidence-based; a brief from Active Living Research cites studies that indicate that 'trails make economic sense as an approach for physical activity promotion': http://activelivingresearch.org/files/ALR_Brief_PowerofTrails_0.pdf. This is an environmental change, making the hospital campus more conducive to physical activity

RESOURCES:

- Investment in signs to mark the trail & the distance covered
- Investment in exercise equipment

COLLABORATION:

- Hickman County Health Department
- Community Partners

ACTIONS:

1. Determine best placement for walking trail and measure out trail distance
2. Design and purchase signs to mark walking trail
3. Install signs to designate walking trail
4. Install exercise equipment for public use
5. Promote availability of trail and equipment in the community

ANTICIPATED IMPACT:

VIII. Reduce the proportion of adults who engage in no leisure-time physical activity

STRATEGY 6: 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 Hickman 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
- Community Health and Benefit Committee

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

OBJECTIVE:	LOCAL / COMMUNITY PLAN:	STATE PLAN:	"HEALTHY PEOPLE 2020" (or OTHER NATIONAL PLAN):
I,II	N/A	TN State Health Plan Goal 1a. People in TN have the necessary support and opportunities for healthy living –	HP 2020 NWS-8 – Increase the proportion of adults who are at a healthy weight HP 2020 D 14 – Increase the proportion of persons with diagnosed diabetes who receive formal diabetes education
III	N/A	TN State Health Plan Goal 1a. People in TN have the necessary support and opportunities for healthy living –	Healthy People 2020 Objective HDS-16.2 & 17.2 – Increase the proportion of adults aged 20 years and older who are aware of the early warning symptoms and signs of a heart attack and stroke
IV, V	N/A	Physical inactivity is identified by the TN Department of Health as one of four top priorities	HP 2020 PA 1 – Reduce the proportion of adults who engage in no leisure-time physical activity
IV, V	N/A	TN State Health Plan Goal 1a. People in TN have the necessary support and opportunities for healthy living – Priority 3: Availability and Preferences for Healthy Food	Healthy People 2020 Objectives NWS-14 and NWS-15 – Increase the contribution of fruits to the diets of the population aged 2 years and older; increase the variety and contribution of vegetables to the diets of the population aged 2 years and older
VI, VII	N/A	TN State Health Plan Goal 1a. People in TN have the necessary support and opportunities for healthy living – Priority 3: Availability and Preferences for Healthy Food	Healthy People 2020 Objective NWS-13 – Reduce household food insecurity and in doing so reduce hunger
VII	N/A	Physical inactivity is identified by the TN Department of Health as one of four top priorities	HP 2020 PA 1 – Reduce the proportion of adults who engage in no leisure-time physical activity

Prioritized Need #4: Substance Abuse

GOAL: Decrease the incidence of substance misuse through identifying, treating and/or referring to treatment, and supporting those in need.

STRATEGY 1: Integrate and develop partnership with Buffalo Valley, Inc. by offering substance misuse services to community members who are suffering from addiction.
BACKGROUND INFORMATION: • The target population is community members who are suffering from substance misuse and who are ready to seek treatment. • This strategy seeks to care for the underserved by providing alcohol or substance misuse treatment for those uninsured or underinsured. • This strategy is based upon the 12 Step Recovery Process: an evidence-based, multidimensional and non-stigmatizing approach.
RESOURCES: • Saint Thomas Hickman Hospital Providers • In Kind Support (space, other resources as needed)
COLLABORATION: • Buffalo Valley, Inc.
ACTIONS: 1. Identify patients who could benefit from drug treatment services through behavioral health screenings. 2. Refer to Buffalo Valley, Inc. for substance misuse treatment. 3. Judge Amy Puckett will also refer potential patients to Buffalo Valley for treatment.
ANTICIPATED IMPACT: I. Increase the proportion of persons who need alcohol and/or illicit drug treatment and received specialty treatment for abuse or dependence in the past year

STRATEGY 2: Identify vulnerable populations at risk for opioid misuse at ER and RHC and provide resources for prevention, support and treatment.

BACKGROUND INFORMATION:

- The target population is community members who are suffering from opioid addiction or a support person of an individual suffering from addiction, presenting at the ER and RHC
- This strategy seeks to drive at a system-wide issue of addressing a symptom of opioid abuse or withdrawal (pain, nausea) instead of the root cause (addiction).
- This strategy is recommended by FDA and AMA in order to intensify efforts to ensure safer prescribing of opioids.

RESOURCES:

- Saint Thomas Hickman Hospital Providers

COLLABORATION:

- Community Partners (potentially)

ACTIONS:

1. Prevent ER visits by communicating with community partners about what is available for drug treatment in the area on a routine basis.
2. Engage at-risk populations and their support systems on available treatment and support.

ANTICIPATED IMPACT:

II. Increase the proportion of persons who are referred for follow-up care for alcohol problems, drug problems after diagnosis, or treatment for one of these conditions in a hospital emergency department (ED)

Alignment with Local, State & National Priorities

OBJECTIVE:	LOCAL / COMMUNITY PLAN:	STATE PLAN:	"HEALTHY PEOPLE 2020" (or OTHER NATIONAL PLAN):
I	N/A	Substance Abuse is one of Tennessee Department of Health's "Big Four" priority areas; TN State Health Plan Goal 1b. People in TN understand and practice behaviors that promote and maintain good health	HP 2020 SA-8 Increase the proportion of persons who need alcohol and/or illicit drug treatment and received specialty treatment for abuse or dependence in the past year
II	N/A	Substance Abuse is one of Tennessee Department of Health's "Big Four" priority areas; TN State Health Plan Goal 1b. People in TN understand and practice behaviors that promote and maintain good health	HP 2020 SA -9 Increase the proportion of persons who are referred for follow-up care for alcohol problems, drug problems after diagnosis, or treatment for one of these conditions in a hospital emergency department (ED)