2019

Implementation Strategy

White County, Tennessee

Saint Thomas Highlands Hospital

Saint Thomas Health

Ascension

Saint Thomas Highlands Implementation Strategy

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Saint Thomas Highlands Hospital Implementation Strategy

Implementation Strategy Narrative

Overview

Saint Thomas Highlands Hospital and Saint Thomas Health conducted a Community Health Needs Assessment (CHNA) collaboratively with Stratasan, a healthcare consulting firm. The community served for purposes of this CHNA and Implementation Strategy was defined as White County, Tennessee.

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

1. Provide an unbiased comprehensive assessment of White 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 received input from public health experts, including the local public health department partner.

The 2019 CHNA provided Saint Thomas Highlands 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 Highlands 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 28 community representatives and leaders representing 21 unique organizations at the White County Health Summit meeting, which included local health department staff, 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 prioritized the needs of Mental Health/Substance Abuse, Obesity, Access to Care, and Kids/Poverty. 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 White 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: Improve access to primary and specialty care services.

Strategy 2: Maximize use of mobile health units, including breast cancer screening compliance through Our Mission In Motion Mobile Mammography.

Strategy 3: Improve access to care and explore telemedicine consultations, including when acute stroke symptoms are present.

Strategy 4: 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.

Prioritized Need #2: Mental Health

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

Strategy 1: Integrate behavioral health services with primary medical care to care for the behavioral as well as physical needs of underserved White County residents.

Strategy 2: Provide community support for those suffering from Alzheimer's Disease by hosting Alzheimer's Support Group.

Strategy 4: 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 healthy eating, active living, chronic disease management and chronic disease prevention.

Strategy 1: Explore opportunities to increase active living and healthy eating.

Strategy 2: 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: Explore and enhance existing resources and mobilizations in the community related to substance misuse.

Strategy 2: 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: Improve access to primary care and specialty care services.
BACKGROUND INFORMATION: • The strategy's target population is for the broader White County community. • This strategy is informed by evidence found on Healthy People 2020.
RESOURCES: • Saint Thomas Medical Partners • Saint Thomas Highlands Hospital
COLLABORATION: • N/A
ACTIONS: 1. Recruit more primary care and specialty care doctors to support the demand/need from the community. 2. Explore telemedicine options for some patient needs.
ANTICIPATED IMPACT: I. Reduce the proportion of persons who are unable to obtain or delay in obtaining necessary medical care, dental care, or prescription medicines

STRATEGY 2: Maximize use of mobile health units, including breast cancer screening compliance through Our Mission In Motion Mobile Mammography.

BACKGROUND INFORMATION:

- The strategy's target population is low-income, uninsured residents in White 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 Highlands 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. Explore Mobile Health Unit capabilities related to other community-specific needs.
2. Schedule community outreach visits
3. Provide free screening mammograms to low-income, uninsured and underinsured women
4. Distribute breast health educational materials at community events, including information about 2D and 3D mammography capabilities Saint Thomas DeKalb Hospital
5. Explore expanding scope of service of Mobile Health Units to respond to community needs, e.g. working Coordinated School Health to provide screenings at schools

ANTICIPATED IMPACT:

II. Conduct 12 community outreach visits annually in White County to provide free mammography services

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

STRATEGY 3: Improve access to care via telemedicine consultations when acute stroke symptoms are present

BACKGROUND INFORMATION:

- The target population is residents of White County with identified access to care/transportation limitations; some target residents are also at risk for 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 Highlands 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
5. Explore other telemedicine options, including telepsych services.

ANTICIPATED IMPACT:

IV. Limit patient transfers to more acute facilities to those that are medically appropriate

V. Annually meet or exceed the national average for IV tPA utilization (2.8% as of last published standard)

STRATEGY 4: Provide community-based organizations with financial support toward their work in one of the Prioritized Need areas, with a particular focus on organizations addressing the priority health needs of Access to Care, Mental Health, Substance Abuse, and Obesity

BACKGROUND INFORMATION:

- The target population is community members 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 Benefit, Health and Wellness Committee (internal experts on Community Benefit)
- Other 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:

VI. 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	N/A	Access to Care is 1 of 12 "vital signs" the TN Dept. of Health measures to gauge a person's overall health.	Access to Health Services-6.1 Reduce the proportion of persons who are unable to obtain or delay in obtaining necessary medical care, dental care, or prescription medicines
II-III	N/A	Reduce female breast cancer mortality through increased awareness, early detection, diagnosis and treatment	By 2020, reduce the female breast cancer death rate from 23% to 20.7%
IV-V	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
I-VII	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	Accessing Health Services (AHS): AHS-6.2 Reduce the proportion of persons who are unable to obtain or delay in obtaining necessary medical care
I	N/A	TN State Health Plan Goal 2d. People in TN are able to obtain appropriate quality healthcare services to meet their needs	Monitoring the increasing use of telehealth as an emerging method of delivering health care is a Healthy People 2020 priority.

Prioritized Need #2: Mental Health

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

Action Plan

STRATEGY 1: Integrate behavioral health services with primary medical care to care for the behavioral as well as physical needs of underserved White County residents

BACKGROUND INFORMATION:

- The target population is medically underserved residents, both children and adults, of White County in need of behavioral healthcare services
- This strategy seeks to expand access to behavioral healthcare services to address behavioral health needs in White 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:

- Saint Thomas River Park Medical Providers
- White County Behavioral Health Providers

COLLABORATION:

- Centerstone

ACTIONS:

1. Educate Saint Thomas Highlands 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/or 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. Providers will provide additional support services as needed by patients
6. Identify and partner with other social services agencies

ANTICIPATED IMPACT:

I. Increase the proportion of children and persons with mental health disorders who receive treatment

STRATEGY 2: Provide community space and coordination for monthly Alzheimer's Support Group meetings.

BACKGROUND INFORMATION:

- The target population is residents of White County suffering from dementia/Alzheimer's Disease and their families.
- Meetings consist of providing patients and family members with education and resources that can help manage the effects of Alzheimer's Disease

RESOURCES:

- In-Kind Support (Space, coordination)

COLLABORATION:

- Community Organizations
- Healthcare Organizations
- Government Organizations

ACTIONS:

1. Make publicly available a schedule for community members to access on St. Thomas Highland's website/calendar.
2. Promote meetings in public settings and with other community groups working on the prioritized health need of mental health and access to care.
3. Continue to coordinate with Alzheimer's Disease organizations and community groups regarding logistics/location, etc.
4. Host at least 4 meetings at St. Thomas Highlands Hospital annually.

ANTICIPATED IMPACT:

II. 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: 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 White 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 Highlands Hospital Providers
- SANE Exam Space and Materials

COLLABORATION:

- SANE Training – International Association of Forensic Nurses

ACTIONS:

1. Train select Saint Thomas River Park 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:

III. 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.

IV. 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 4: Provide community-based organizations with financial support toward their work in one of the Prioritized Need areas, with a particular focus on organizations addressing the priority health needs of Access to Care, Mental Health, Substance Abuse, and Obesity

BACKGROUND INFORMATION:

- The target population is community members 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 Benefit, Health and Wellness Committee (internal experts on Community Benefit)
- Other Community Organizations

ACTIONS:

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

ANTICIPATED IMPACT:

V. 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	N/A	TN State Health Plan – Behavioral health a priority to address health disparities in TN TN State Health Plan Priority Area – Health Care Delivery Model in Rural Areas	Healthy People 2020 Objectives MHMD-6 and MHMD-9 – Increase the proportion of children and persons with mental health disorders who receive treatment
II	N/A	Preventable hospital stays are on of the TN Dept of Health's 12 "Vital Signs" for overall population health	Healthy People 2020 DIA-1: Increase the proportion of adults aged 65 years and older with diagnosed Alzheimer's disease and other dementias, or their caregiver, who are aware of the diagnosis
II	N/A		Healthy People 2020 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 chronic disease programs
I, II, III, IV, V	N/A	TN State Health Plan Goal 1b. People in TN understand and practice behaviors that promote and maintain good health	
III, IV	N/A		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 #1: Obesity (Healthy Weight)

GOAL: Promote and support a healthy lifestyle through strengthening community resources that will positively impact nutrition, exercise, and other social determinants of health related to healthy weight.

Action Plan

STRATEGY 1: Explore opportunities to increase active living and healthy eating.
BACKGROUND INFORMATION: • The target population is residents of White County with • This strategy addresses health disparities and barriers to care by • 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 Highlands Hospital • In-kind and other resources
COLLABORATION: • Sparta/White County Senior Center • Nonprofits • Government Agencies • Schools
ACTIONS: 1.) From January to June 2020, meet with and explore demographic data and community partnership potential with White County Senior Center. 2.) Identify current programming and gaps in programming 3.) Build knowledge and understanding of the opportunity 4.) Consider expanding quarterly events like “Dining Out with Diabetes” to a more embedded program with routine access to advice. 5.) Make recommendation
ANTICIPATED IMPACT: I. Increase the proportion of older adults with reduced physical or cognitive function who engage in light, moderate, or vigorous leisure-time physical activities (exploratory) II. Increase the proportion of persons with diagnosed diabetes who receive formal diabetes education

STRATEGY 2: Provide community-based organizations with financial support toward their work in one of the Prioritized Need areas, with a particular focus on organizations addressing the priority health needs of Access to Care, Mental Health, Substance Abuse, and Obesity

BACKGROUND INFORMATION:

- The target population is community members 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 Benefit, Health and Wellness Committee (internal experts on Community Benefit)
- Other 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:

III. 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	N/A	Obesity is one of the TN Dept. of Health's "Big 4" priority areas of population health Preventable Hospital stays are one of TN Dept of Health's 12 "Vital Signs"	HP 2020 Older Adults (OA -6) Increase the proportion of older adults with reduced physical or cognitive function who engage in light, moderate, or vigorous leisure-time physical activities (exploratory)
II	N/A	Obesity is one of the TN Dept. of Health's "Big 4" priority areas of population health Preventable Hospital stays are one of TN Dept of Health's 12 "Vital Signs"	HP 2020 Diabetes 14 (D-14): Increase the proportion of persons with diagnosed diabetes who receive formal diabetes education
I-III	N/A	Obesity is one of the TN Dept. of Health's "Big 4" priority areas of population health	

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: Identify and enhance existing resources in the community related to opioid abuse
BACKGROUND INFORMATION: • The target population is community members who are suffering from opioid abuse and their families. • This strategy is recommended by
RESOURCES: • Potential In-Kind Support
COLLABORATION: • Community Partners • Providers • Government
ACTIONS: 1.) Build understanding of opioid abuses 2.) If needed, form or join coalition to end opioid misuse (example: WE C.A.R.E., Prevention Coalition) that includes hospital providers, support staff, and community members. 3.) Post scheduled events/meetings on hospital website under “Community” 4.) Consider using in-kind space at hospital to support community work. 5.) Consider supporting, recommending promising practices in partnership with others.
ANTICIPATED IMPACT: I. Reduce the past-year nonmedical use of prescription drugs.

STRATEGY 4: Provide community-based organizations with financial support toward their work in one of the Prioritized Need areas, with a particular focus on organizations addressing the priority health needs of Access to Care, Mental Health, Substance Abuse, and Obesity

BACKGROUND INFORMATION:

- The target population is community members 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 Benefit, Health and Wellness Committee (internal experts on Community Benefit)
- Other Community Organizations

ACTIONS:

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

ANTICIPATED IMPACT:

II. 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	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	Healthy People 2020 Objective for Substance Abuse: SA-19: Reduce the past-year nonmedical use of prescription drugs