

2019

Implementation Strategy

Rutherford County, Tennessee

Saint Thomas Rutherford Hospital



Saint Thomas
Health



Ascension

Saint Thomas Rutherford Hospital Implementation Strategy

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Saint Thomas Rutherford Hospital Implementation Strategy

Implementation Strategy Narrative

Overview

Saint Thomas Rutherford Hospital and Saint Thomas Health conducted the assessment in partnership with the Rutherford County Health Department, Rutherford County Wellness Council, Primary Care & Hope Clinic, and 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 Community Health Needs Assessment (CHNA) and this Implementation Strategy was defined as Rutherford County, Tennessee.

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

1. Provide an unbiased comprehensive assessment of Rutherford 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 partner.

The 2019 CHNA provided Saint Thomas Rutherford 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 Rutherford Hospital and Saint Thomas Health for fiscal years 2020-2022. In addition, we will leverage and support one another on specific strategies.

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 December 12th, 2018 Rutherford 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, Access to Basic Needs with a concentration on housing, Enhance Resources and Services, and Nutrition and Obesity. 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.

Ascension Saint Thomas' community benefit department also commits significant resources to helping build capacity in other community plans, including the Rutherford County CHIP (Community Health Improvement Plan). We are committed to aligning our strategies when possible and finding other opportunities to collaborate for the betterment of the community.

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 Rutherford 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: 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.

Strategy 2: 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

Strategy 3: Implement community-wide Medical Missions at Home that integrate medical, dental, vision and behavioral health, along with broader community resources.

Strategy 4: Maximize Mobile Health Unit activity, including Mobile Mammography.

Strategy 5: Pharmacist-driven improvement in medication management through community education sessions and patient-specific pharmacotherapy clinic appointments.

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.

Strategy 7: Improve access to care via telemedicine, including stroke consultations.

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: 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: Grow the Faith & Health Task Force, partnering with faith communities, to provide state of the art wellness promotion and health care that embodies physical, psychological, social and spiritual care for individuals.

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

Strategy 3: Offer chaplain services at the Saint Louise Family Medicine Center to integrate spiritual care with physical and mental care, seeking to care holistically for patients.

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 nutrition, exercise, chronic disease management and chronic disease prevention.

Strategy 1: Operate a community-based breastfeeding clinic to support and educate breastfeeding families.

Strategy 2: Provide nutrition counseling that will improve food choices.

Strategy 3: 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: Provide community space and coordination for monthly Narcotics Anonymous meetings at Saint Thomas Rutherford Hospital.

Strategy 2: Provide community space, capacity-building coordination and other resources, in support of We C.A.R.E.

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

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

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: Operate Dispensary of Hope pharmacies provide medication assistance for uninsured & underinsured individuals who experience financial hardship, as well as assisting 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 need assistance to obtain necessary medications.
- This strategy provides medication access to an underserved patient population, addressing access barriers due to cost of care.
- Evidence base strategy 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; Renew applications
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 – Rutherford Hospital
7. Promote awareness of Dispensary of Hope in the community

ANTICIPATED IMPACT:

1. Annually fill 30,000 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.

STRATEGY 2: 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 system change, adjusting the practice's scheduling infrastructure to respond to community needs

RESOURCES:

- Saint Louise Family Medicine Center
- Saint Thomas Medical Partners – Family Health Center – Eagleville
- PCMH Guidelines
- Saint Thomas – Rutherford Leadership

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 Family Medicine Resident Physicians at Saint Louise Family Medicine Center to expand practice capacity
5. Develop and annually update a list of specialists willing to see uninsured and underinsured patients
6. Facilitate needed specialist referrals to secure needed specialty care for patients

ANTICIPATED IMPACT:

- I. By June of 2017, increase appointment availability for uninsured and underinsured individuals by 10%
- II. By June of 2017, increase access for uninsured and underinsured individuals to specialty care by 10%

STRATEGY 3: 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 ten years as STH has held 40 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 and develop details
3. Communicate event details to community
4. Register patients for care at event
5. Administer medical examinations, fill prescriptions, conduct lab tests, vision exams, dental care, mammograms, and other available services
6. Register patients currently without a medical home for follow-up appointments
7. Provide information on social services and other community resources

ANTICIPATED IMPACT:

- III. Increase awareness of and connection to social services and other resources annually
- IV. Increase access to a medical home by increasing the proportion of medical mission attendees who are scheduled for a follow-up visit by 10%

STRATEGY 4: Maximize Mobile Health Unit activity, including Mobile Mammography.

BACKGROUND INFORMATION:

- The target population is uninsured and underserved residents of Rutherford County.
- The 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.
- This strategy is informed by evidence found on Healthy People 2020 and Tennessee Cancer Coalition
- Primary & Mental Health Care via the Mobile Health Unit will assist in removing barriers to access by providing services at targeted locations throughout Rutherford County. Additionally, services can be accessed at a reduced fee or free of charge as needed.

RESOURCES:

- Mobile Health Unit Team
- Saint Louise Clinic Providers
- Saint Thomas Rutherford Hospital
- Our Mission In Motion Mobile Mammography staff
- Premier Radiology Center for Breast Health
- Saint Thomas Medical Partners

COLLABORATION:

- Community Partners/Sites of Service TN Breast and Cervical Cancer Screening Program
- Susan G. Komen Central Tennessee
- Murfreesboro Radiology Inc.

ACTIONS:

1. Deliver physical health services, including screening mammograms at designated sites of services, utilizing Our Mission in Mammography staff, Saint Louise Clinic providers and resident physicians
2. Deliver mental health services at sites of service through on-site resources from the Guidance Center
3. Screen for substance abuse during mental health care provision, providing referrals as needed
4. Strengthen relationships with staff at MHU sites of service to ensure community partners understand the scope of our services and how to connect families with the MHU
5. Evaluate effectiveness of sites of service every quarter
6. Assess potential new sites of service as needed

ANTICIPATED IMPACT:

- V. Increase the ability of Rutherford County residents to access primary & mental care by serving residents annually who otherwise would have no access
- VI. Increase the number of women screened with the recommended frequency by 10%

STRATEGY 5: Pharmacist-driven improvement in medication management through Community Education Sessions and Patient Specific Pharmacotherapy Clinic Appointments

BACKGROUND INFORMATION:

- The target population is community members who are taking high risk medications, at risk for or already managing complications from cardiovascular disease, diabetes, or COPD, or in need of smoking cessation
- This strategy addresses needs of the underserved by allowing more frequent contact with a healthcare professional. This strategy also addresses health disparities through its emphasis on health education & literacy, with time preserved within each appointment for that education to occur.
- This strategy is evidence-based and the integration of clinically trained pharmacists in the ambulatory setting is specifically cited by TheCommunityGuide.org. In addition, Healthy People 2020 and the CDC Disease and Stroke Prevention Program discuss evidence-based strategies to improve population health that can be accomplished through a Pharmacotherapy clinic.

RESOURCES:

- Pharmacist with needed supplies and dedicated space
- Saint Louise Clinic Providers & Staff

COLLABORATION:

- N/A

ACTIONS:

1. Increase access to Pharmacotherapy Clinic services for St. Louise Clinic patients
2. Deliver education to clinic providers about Pharmacist's abilities and the Pharmacotherapy Clinic's services
3. Educate patients regarding their disease, long-term complications, and self-monitoring techniques
4. Educate patients on importance of adherence, self-care, and close follow-up
5. Provide periodic community education/support groups for various chronic disease states (for example, heart failure and diabetes)
6. Deliver Pharmacotherapy services by improving access to care, use of evidence-based medicine, and adherence

ANTICIPATED IMPACT:

- VII. By June 2021, increase the number of patients that are able to receive Pharmacotherapy Clinic services as reported through AthenaNet
- VIII. By June 2021, achieve a 25% improvement in the number of patients that attain goal disease state-specific parameters as reported through AthenaNet
- IX. Annually provide 12 community education events on chronic disease management and self-monitoring as reported through program records that result in a 50% increase in attendee knowledge.

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 Rutherford County age 13 and older
- This strategy works to eliminate barriers of 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 is a policy change at the hospital, by which a SANE nurse will be the proper associate to care for patients who are victims of sexual assault

RESOURCES:

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

COLLABORATION:

- SANE Training – International Association of Forensic Nurses

ACTIONS:

1. Expand the staff certified in SANE by identifying additional associates to attend the training
2. Conduct ongoing training with ED staff to increase awareness of SANE program
3. ED staff refers 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
6. Attend community events to raise awareness of sexual assault and the SANE resources

ANTICIPATED IMPACT:

- X. Increase the % of presenting victims who are referred to SANE by 10%
- XI. Increase referrals provided to victims by 100%
- XII. Increase patient call-backs by 100%, to assess further needed resources

STRATEGY 7: Improve access to care via telemedicine consultations, including 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 telemedicine visits
4. Conduct a patient survey to confirm timely access to health services
5. Explore other telehealth options

ANTICIPATED IMPACT:

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

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 Rutherford County served by identified partner organizations
- All organizations will be assessed based on 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

OBJECTIVE:	LOCAL / COMMUNITY PLAN:	STATE PLAN:	“HEALTHY PEOPLE 2020” (or OTHER NATIONAL PLAN):
I – XXVII	Rutherford County Health Department recognizes Access to Care / Care Coordination as a Priority Health Need		
I, II			Healthy People 2020 Objective AHS-1 – Increase the proportion of persons with health insurance
I, II, IV, X, XI		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, V, VI, VII, VIII, IX, XVI, XVII		TN State Health Plan Goal 2d. People in TN are able to obtain appropriate quality healthcare services to meet their needs	
III, IV, VII, VIII, IX, X, XI			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, XVI, XVII			Healthy People 2020 Objective AHS-5 – Increase the proportion of persons who have a specific source of ongoing care

XII, XIII, XIV, XV	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	Healthy People 2020 Objective AHS-6.3 - Reduce the proportion of persons who are unable to obtain or delay in obtaining necessary dental care
XVIII, XIX	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%
XX, XXI, XXII		Healthy People 2020 Objective RD-11 – Reduce hospitalizations for chronic obstructive pulmonary disease
XXIII, XXIV, XXV		Healthy People 2020 Objective IVP-8.1 – Increase the proportion of the population residing within the continental United States with access to trauma care
XXVI, XXVII		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

Prioritized Need #2: Mental Health

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

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

BACKGROUND INFORMATION:

- The target population is uninsured and underinsured community members who utilize Saint Louis Family Medicine Center or Family Health Center – Eagleville 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 Louis Family Medicine Center
- Saint Thomas Medical Partners – Family Health Center – Eagleville
- PCMH Guidelines
- Saint Thomas – Rutherford Leadership

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.
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:

- I. 90% of PCMH patients in the respective practice will be screened for behavioral health needs
- II. 90% of patients with a positive screen will be receiving needed behavioral healthcare

STRATEGY 3: Offer chaplain services at the Saint Louise Family Medicine Center to integrate spiritual care with physical and mental care, seeking to care holistically for patients.

BACKGROUND INFORMATION:

- The target population is community members who are in need of emotional support and open to receiving this support through a chaplain.
- This chaplaincy service addresses health disparities by providing emotional support for the underserved who are experiencing needs beyond their acute physical necessities.
- There is a growing evidence base representing the positive impact of chaplaincy care on their patients. Chaplain care both addresses traditional religious needs of patients and families while seeks to care for spiritual needs, and the emotional, physical, and social dimensions of care more broadly (Carey, Polita, Marsden, & Krikheli, [2014](#); Galek, Vanderwerker et al., [2009](#); Montonye & Calderone, [2009](#); Winter-Pfändler & Flannelly, [2013](#); Zullig et al., [2014](#)). This is a systems change, engaging steps at the practice to integrate physical, behavioral, and spiritual care

RESOURCES:

- Saint Louise Chaplain
- Saint Louise Staff
- Saint Louise Behavioral Health Providers

COLLABORATION:

- N/A

ACTIONS:

1. Chaplain speaks with patients while in the waiting room, and while waiting for a provider in an individual room, to provide spiritual counsel
2. Chaplain refers patients to the behavioral health staff when a patient is in need of follow-up or more extensive care

ANTICIPATED IMPACT:

III. 70% of patients referred to Behavioral Health by Chaplaincy will seek follow-up care, ensuring an increased proportion of patients with mental and emotional health needs receive needed care

STRATEGY 7: 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 Rutherford County age 13 and older
- This strategy works to eliminate barriers of 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 is a policy change at the hospital, by which a SANE nurse will be the proper associate to care for patients who are victims of sexual assault

RESOURCES:

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

COLLABORATION:

- SANE Training – International Association of Forensic Nurses

ACTIONS:

1. Expand the staff certified in SANE by identifying additional associates to attend the training
2. Conduct ongoing training with ED staff to increase awareness of SANE program
3. ED staff refers 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
6. Attend community events to raise awareness of sexual assault and the SANE resources

ANTICIPATED IMPACT:

- IV. By December 2021, two or more 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.
- V. By June 2022, all patients who present as acute sexual assault victims will be referred to the on-duty SANE associate for follow-up care and support.

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 Rutherford 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

OBJECTIVE:	LOCAL / COMMUNITY PLAN:	STATE PLAN:	“HEALTHY PEOPLE 2020” (or OTHER NATIONAL PLAN):
I, II		TN Department of Health’s Faith-Based Health Initiative	Healthy People 2020 Objective ECBP-10 – Increase the number of community-based organizations providing population-based primary prevention services
I – V	Rutherford County Health Department recognizes Mental and Emotional Health / Substance Abuse as a Priority Health Need		
I		TN State Health Plan Goal 1c. Behavioral Health cited as a Priority	Healthy People 2020 Objective MHMD-5 – Increase the proportion of primary care facilities that provide mental health treatment onsite or by paid referral Healthy People 2020 Objective MHMD-9 – Increase the proportion of persons with mental health disorders who receive treatment
I			Healthy People 2020 Objective MHMD-11 – Increase depression screening by primary care providers
III		Spiritual health cited as a component of the TN State Health Plan’s targets toward moving TN residents toward optimal health	Healthy People 2020 Objective HRQOL/WB-1.2 – Increase the proportion of adults who self-report good or better mental health
IV, V			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 #3: Obesity (Healthy Weight)

GOAL: Promote and support a healthy lifestyle through strengthening community resources that will positively impact healthy eating and active living.

Action Plan

<p>STRATEGY 1: Operate a community-based breastfeeding clinic to support and educate breastfeeding families</p>
<p>BACKGROUND INFORMATION:</p> <ul style="list-style-type: none"> • The strategy's target population is breastfeeding families in Rutherford 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.
<p>RESOURCES:</p> <ul style="list-style-type: none"> • Breastfeeding Outreach Clinic Staff • Dedicated clinic space, with needed materials • Saint Thomas Health Providers & Staff
<p>COLLABORATION:</p> <ul style="list-style-type: none"> • Non-Saint Thomas Health Providers • TN Dept. of Health • Rutherford County Health Dept. • Doulas • Post-Partum Support Groups • Community-Based Organizations serving mothers and babies
<p>ACTIONS:</p> <ol style="list-style-type: none"> 1. Employ certified lactation consultants to provide evidence based practice methods for breastfeeding to support families 2. Open the clinic for 10 hours per week and available for drop-in 3. Saint Thomas maternal/newborn staff refer breastfeeding families 4. Other community physicians/providers refer breastfeeding families to the clinic 5. Advertise the clinic through social media
<p>ANTICIPATED IMPACT:</p> <ol style="list-style-type: none"> I. 70% of mothers who visited the clinic will still be breastfeeding at 3 months II. 70% of mothers who visited the clinic will still be breastfeeding at 6 months III. Increase number of families visiting the breastfeeding clinic yearly by 10%.

STRATEGY 2: Provide nutrition counseling that will improve food choices.

BACKGROUND INFORMATION:

- The strategy's target population is low-income Rutherford 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 Louise Family Medicine Center

COLLABORATION:

- N/A

ACTIONS:

1. Survey Saint Louise Family Medicine Center 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:

- IV. Increase number of obese patients receiving dietary counseling by 10%.
- V. Decrease average BMI by 5% for patients receiving dietary counseling.

STRATEGY 3: 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 Rutherford 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

OBJECTIVE:	LOCAL / COMMUNITY PLAN:	STATE PLAN:	“HEALTHY PEOPLE 2020” (or OTHER NATIONAL PLAN):
I, II, III	Rutherford County Health Department recognizes Nutrition/Obesity as a Priority Health Need	Obesity is cited as one of the TN Department of Health’s four priorities	<p>HP 2020 MICH-21.4 – Increase the proportion of infants who are breastfed exclusively through 3 months</p> <p>HP 2020 MICH-21.5 – Increase the proportion of infants who are breastfed exclusively through 6 months</p>
IV, V	Rutherford County Health Department recognizes Nutrition/Obesity as a Priority Health Need	Obesity is cited as one of the TN Department of Health’s four priorities	HP 2020 Objective NWS-8 – Increase the proportion of adults who are at a healthy weight

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 by working upstream.

STRATEGY 1: Provide community space and coordination for monthly Narcotics Anonymous meetings at Saint Thomas Rutherford Hospital

BACKGROUND INFORMATION:

- The target population is residents of Rutherford County suffering from narcotics misuse or ideation of misuse.
- Narcotics Anonymous is rooted in the 12-Step/12 Principles Program, a methodology that is well-established worldwide, focused on peer support, sponsorship, and anonymity.
- Meetings consist of:
 - distribution of NA literature;
 - helpline information services;
 - presentations for treatment and healthcare staff, civic organizations, government agencies, and schools;
 - presentations to acquaint treatment or correctional facility clients with the NA program; and
 - maintaining NA meeting directories for individual information for any interested person

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 Rutherford's website/calendar.
2. Promote N.A. meetings in public settings and with other community groups working on the prioritized health need of substance abuse
3. Continue to coordinate with Narcotics Anonymous organization regarding logistics/location, etc.

ANTICIPATED IMPACT:

- I. Conduct 12 meetings at St. Thomas Rutherford Hospital annually.
- II. Reduce the past-year nonmedical use of prescription drugs

STRATEGY 2: Provide community space, coordination, and other resources, in support for We C.A.R.E.

BACKGROUND INFORMATION:

- The target population is health professionals and community members who want to learn how to support the opioid misuse prevention.
- This newly forming community group meets monthly to form grassroots solutions to preventing opioid misuse, opioid overdose, and Neonatal Abstinence Syndrome incidence.

RESOURCES:

- In-Kind Support (Space, coordination)
- Other resources as needed

COLLABORATION:

- Community Organizations
- Public Health Organizations
- Government Organizations
- Other Health Care Organizations

ACTIONS:

1. Make publicly available a schedule for community members to access on St. Thomas Rutherford's website/calendar.
2. Promote WE C.A.R.E. in public settings and with other community groups working on the prioritized health need of substance abuse.
3. Continue to coordinate with other community groups and community health plans to align solutions.

ANTICIPATED IMPACT:

- III. Conduct at least 6 meetings at St. Thomas Rutherford Hospital annually.
- IV. Reduce the past-year nonmedical use of prescription drugs.
- V. Increase abstinence from illicit drugs among pregnant women

Alignment with Local, State & National Priorities

OBJECTIVE:	LOCAL / COMMUNITY PLAN:	STATE PLAN:	“HEALTHY PEOPLE 2020” (or OTHER NATIONAL PLAN):
I, III	Rutherford County Health Department recognizes Mental Health and Substance Abuse as prioritized health need in 2020-2022 CHIP	TN Dept of Health considers Substance Abuse one of their “Big Four” priorities	
II, IV	Rutherford County Health Department recognizes Mental Health and Substance Abuse as prioritized health need in 2020-2022 CHIP	TN Dept of Health considers Substance Abuse one of their “Big Four” priorities	Healthy People 2020 Objective for Substance Abuse: SA-19: Reduce the past-year nonmedical use of prescription drugs
V	Rutherford County Health Department recognizes Mental Health and Substance Abuse as prioritized health need in 2020-2022 CHIP	TN Dept of Health considers Substance Abuse one of their “Big Four” priorities	MICH-11.4 Increase abstinence from illicit drugs among pregnant women