2016
IMPLEMENTATION STRATEGY
Saint Thomas Hickman Hospital, Saint Thomas Health

HICKMAN COUNTY, TENNESSEE
COMMUNITY HEALTH NEEDS ASSESSMENT

Saint Thomas Health
preparing for Saint Thomas Hickman Hospital
Saint Thomas Health
Saint Thomas Hickman Hospital Implementation Strategy

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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. An outside consultant, Primary Focus, was used to conduct, analyze and summarize findings of a community intercept survey.

The 2016 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 2017 – 2019.
**Prioritized Needs**

The results of the secondary data review, community interviews and community intercept survey were presented to community representatives and leaders at the October 7, 2015 Hickman County Health Council meeting, which included the Hickman County Health Department and Saint Thomas Health. The meeting attendees then provided collective input into the needs of the community.

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

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

**Needs That Will Not Be Addressed**

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

Prioritized Need #1: Wellness and Disease Prevention

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

**Strategy 1: Provide CPR/First Aid Classes for Hickman County Schools Faculty and Staff**
- The target population is Hickman County Schools (HCS) 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

**Anticipated Impact:**
- Certify 100% of course attendees in First Aid and CPR Administration annually
- Alignment with National Priorities: 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

**Strategy 2: Develop and support a local network of Faith Community Nurses, to equip them to improve the health of their congregations**
- The target population is nurses who are interested in health ministry in their faith communities, to then impact the members of their faith communities
- This strategy equips nurses to provide unique access to case management support for those in faith communities who experience vulnerabilities for a variety of reasons, including the following: elderly, recently hospitalized, have multiple comorbidities, poor emotional health, narrow support systems, and struggle with health literacy. This strategy utilizes community members’ ties to a faith community to provide them with a trusted connection to the healthcare system and to better meet their complex health needs
- This strategy provides training in a specialty practice of nursing recognized by the American Nurses Association as Faith Community Nursing

**Anticipated Impact:**
- By June 2019, train five Faith Community Nurses who implement programming for a priority health need in their congregation
- By June 2019, 80% of FCNs will report improvement in the priority health area among the target members of their congregation
- Alignment with State Priorities: Tennessee Department of Health’s Faith-Based Health Initiative
- Alignment with National Priorities: Healthy People 2020 Objective ECBP-10 – Increase the number of community-based organizations (including local health departments, Tribal health
services, nongovernmental organizations, and State agencies) providing population-based primary prevention services

Strategy 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

- 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

Anticipated Impact:

- By June 2019, six courses in priority health areas will have been taught, with participants demonstrating at least a 50% knowledge increase in the topics addressed
- Alignment with Local Priorities: Hickman County’s Health Council has a Healthy Food Coalition, also focused on offering health education resources
- Alignment with State Priorities: Tennessee State Health Plan Goal 1b. People in Tennessee – including adults, children, youth, families, and communities – understand and practice behaviors that promote and maintain good health
- Alignment with National Priorities: Healthy People 2020 Objective NWS-8 – Increase the proportion of adults who are at a healthy weight
- Alignment with National Priorities: Healthy People 2020 Objective ECBP-10 – Increase the number of community-based organizations (including local health departments, Tribal health services, nongovernmental organizations, and State agencies) providing population-based primary prevention services

Strategy 4: 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

- 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

Anticipated Impact:

- 80% of families growing gardens will, in their second year of gardening, increase consumption of vegetables in their diets 1-2 servings each day during the growing season
• 85% of gardeners will return to garden each year
• Alignment with Local Priorities: Hickman County’s Health Council has a Healthy Food Coalition, also prioritizing access to and consumption of healthy foods
• Alignment with State Priorities: Tennessee State Health Plan, Goal 1a. People in Tennessee have the necessary support and opportunities for healthy living – Priority 3: Availability of and Preferences for Healthy Food
• Alignment with National Priorities: 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

Strategy 5: Provide food boxes, sensitive to chronic condition, to community members who are experiencing food insecurity

• 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, or 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

Anticipated Impact:
• Alleviate food insecurity for 50 families a month, through June of 2019, through the provision of a food box
• Increase wellness promotion through nutrition education being made available in each food box by June 2017
• Alignment with Local Priorities: Hickman County Health Council’s Healthy Food Coalition
• Alignment with National Priorities: Healthy People 2020 Objective NWS-13 – Reduce household food insecurity and in doing so reduce hunger
• Alignment with National Priorities: Healthy People 2020 Objective D-3 – Reduce the diabetes death rate
• Alignment with National Priorities: Healthy People 2020 Objective HDS-2 – Reduce coronary heart disease deaths
• Alignment with National Priorities: Healthy People 2020 Objective CKD-7 – Reduce the number of deaths among persons with chronic kidney disease
Strategy 6: Increase community physical activity by creating a public use walking trail on the hospital campus

- 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](http://activelivingresearch.org/files/ALR_Brief_PowerofTrails_0.pdf). This is an environmental change, making the hospital campus more conducive to physical activity

**Anticipated Impact:**

- By June 2017, observe a 50% increase in the utilization of the hospital campus as an opportunity to obtain exercise
- Alignment with State Priorities: Physical inactivity is identified by the Tennessee Department of Health as one of four top priorities
- Alignment with National Priorities: Healthy People 2020 Objective PA-2 – Increase the proportion of adults who meet current federal physical activity guidelines for aerobic physical activity and for muscle-strengthening activity

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

- 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

**Anticipated Impact:**

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

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

Strategy 1: 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

- 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

Anticipated Impact:
- 80% of attendees will report an increased quality of life and an improved support network annually
- Alignment with Local Priorities: Hickman County Health Council’s Behavioral Health & Suicide Prevention Sub-Committee
- Alignment with State Priorities: Tennessee State Health Plan – Behavioral health is cited as a priority to address health disparities in Tennessee
- Alignment with National Priorities: Healthy People 2020 Objective HRQOL/WB-1.2 – Increase the proportion of adults who self-report good or better mental health

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

- 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

Anticipated Impact:
- By June 2019, demonstrate an improvement in mental health of 90% of patients who complete the recommended course of therapy
- Alignment with Local Priorities: Hickman County Health Council’s Behavioral Health & Suicide Prevention Sub-Committee
- Alignment with State Priorities: Tennessee State Health Plan – Behavioral health is cited as a priority to address health disparities in Tennessee
Alignment with National Priorities: Healthy People 2020 Objective MHMD-9 – Increase the proportion of persons with mental health disorders who receive treatment
Alignment with National Priorities: Healthy People 2020 Objective MHMD-6 – Increase the proportion of children with mental health problems who receive treatment

Strategy 3: Develop and support a local network of Faith Community Nurses, to equip them to improve the health of their congregations
- Details cited under Prioritized Need #1: Wellness and Disease Prevention

Strategy 4: 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
- Details cited under Prioritized Need #1: Wellness and Disease Prevention

Strategy 5: Offer chaplain services at the Hickman Medical Clinic to integrate spiritual care with physical and mental care, seeking to care holistically for patients
- 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 clinic to integrate physical, behavioral, and spiritual care

Anticipated Impact:
- By June 2017 and after, 70% of patients referred to Behavioral Health by Chaplaincy will seek follow-up care, ensuring that an increased proportion of patients with mental and emotional health needs receive needed care
- Alignment with Local Priorities: Hickman County Health Council’s Behavioral Health & Suicide Prevention Sub-Committee
- Alignment with State Priorities: Spiritual health cited as a component of the Tennessee State Health Plan’s targets toward moving Tennessee residents toward optimal health
- Alignment with National Priorities: Healthy People 2020 Objective HRQOL/WB-1.2 – Increase the proportion of adults who self-report good or better mental health
Strategy 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

- 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 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

Anticipated Impact:

- By December 2017, have two associates trained in SANE who are able to provide trauma-informed care and needed resources to victims of sexual assault
- By June 2018, all patients who present as acute sexual assault victims will be referred to the on-duty SANE associate
- Alignment with National Priorities: Healthy People 2020 Objective IVP-8.1 – Increase the proportion of the population residing within the continental United States with access to trauma care

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

- Details cited under Prioritized Need #1: Wellness and Disease Prevention
Prioritized Need #3: Access to Care / Care Coordination

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

**Strategy 1: Engage state legislators and other key stakeholders to advocate for expanded access to care in Tennessee**
- The target population is Tennessee residents who currently fall in the gap between qualifying for TennCare and qualifying for subsidized health insurance through the Health Insurance Marketplace.
- This strategy targets those who are still without access to health insurance and thus are typically medically underserved.
- This strategy addresses a policy change and has drawn from other states who have proposed a version of access expansion to the federal government that the state has specifically designed

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

**Strategy 2: Open a Dispensary of Hope Charitable Pharmacy to provide medication assistance for uninsured and underinsured individuals who experience financial hardship, as well as to assist patients with navigating other community resources as needed**
- This strategy’s target population is uninsured and underinsured individuals who demonstrate financial hardship and thus are in need of assistance to obtain necessary medications.
- This strategy provides medication access to an underserved patient population, addressing access barriers due to cost of care.
- This strategy is built upon the evidence base that has been generated by the unique Dispensary of Hope Distribution Center model, which works with leading drug manufacturers to increase the supply of essential medicine to patients in need; the Dispensary of Hope Pharmacy links the medications made available from the Distribution Center to the individuals in need of a means to fill a prescription affordably.

**Anticipated Impact:**
- 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.
- Assist qualifying individuals with obtaining medication assistance through manufacturer sponsored Patient Assistance Programs
• Alignment with State Priorities: Tennessee State Health Plan Principle 2, Access to Care – People in Tennessee should have access to healthcare and the conditions to achieve optimal health
• Alignment with National Priorities: Healthy People 2020 Objective AHS-6 – Reduce the proportion of people who are unable to obtain or delay in obtaining necessary medical care, dental care, and prescription medication

Strategy 3: Increase access to healthcare by removing traditional financial and insurance hurdles, through financial assistance and emergency care policies

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

Anticipated Impact:
• Provide community members with income levels at or below 400% of the Federal Poverty Level with financial assistance as outlined in Saint Thomas Health’s Financial Assistance Policy
• Alignment with Local Priorities: Access to Care is recognized by the Hickman County Health Department as a Priority Health Need
• Alignment with State Priorities: Tennessee State Health Plan Goal 2d. People in Tennessee are able to obtain appropriate quality healthcare services to meet their needs
• Alignment with National Priorities: Healthy People 2020 Objective AHS-6.2 – Reduce the proportion of persons who are unable to obtain or delay in obtaining necessary medical care

Strategy 4: Provide health insurance enrollment and navigation assistance to community members who are either uninsured or need assistance navigating their current insurance

• 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

Anticipated Impact:
• Increase public awareness of enrollment assistance offered to drive a 10% increase in enrollment counseling visits each open enrollment season
• Confirm that 50% of eligible visitors become enrolled in health insurance during the open enrollment period
• Alignment with State Priorities: Access to health insurance is a Tennessee State Health Plan Priority
• Alignment with National Priorities: Healthy People 2020 Objective AHS-1 – Increase the proportion of persons with health insurance

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

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

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

Strategy 6: Implement community-wide Medical Missions at Home that integrate medical, dental, vision and behavioral health, along with broader community resources

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

Anticipated Impact:
• Increase awareness of and connection to social services and other resources through 150 encounters with community agencies annually
• Increase access to a medical home by increasing the proportion of medical mission attendees who are scheduled for a follow-up visit by 14%
• Alignment with State Priorities: Tennessee State Health Plan Principle 2, Access to Care – People in Tennessee should have access to healthcare and the conditions to achieve optimal health
• Alignment with National Priorities: Healthy People 2020 Objective AHS-6 – Reduce the proportion of people who are unable to obtain or delay in obtaining necessary medical care, dental care, and prescription medication

Strategy 7: Increase breast cancer screening compliance through Our Mission in Motion Mobile Mammography
• 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

Anticipated Impact:
• Conduct 12 community outreach visits annually in Hickman County to provide free mammography services
• Increase the number of women screened with the recommended frequency by 10%
• Alignment with State Priorities: Reduce female breast cancer mortality through increased awareness, early detection, diagnosis and treatment. Mortality rates for 2005-2009 and reduction goal by June 2017: Breast rate of 24.0, reduce to 22.0 (TN Cancer Coalition)
• Alignment with National Priorities: By 2020, reduce the female breast cancer death rate from 23% to 20.7% (CDC/NCHS and Census)

Strategy 8: 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
• Details cited under Prioritized Need #2: Mental and Emotional Health / Substance Abuse

Strategy 9: Improve access to care via telemedicine consultations when acute stroke symptoms are present
• 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

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

**Strategy 10: Provide community-based organizations with financial support toward their work in one of the Prioritized Need areas**
• Details cited under Prioritized Need #1: Wellness and Disease Prevention
Prioritized Need #4: Social Determinants

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

Strategy 1: Anti-Human Trafficking Initiative
- The target population is victims of human trafficking
- This strategy is focused on a group of highly marginalized and vulnerable people, seeking to first address immediate safety needs and to then provide them with a point of connection to a full range of socioeconomic resources, along with needed physical and mental health care
- This strategy is evidence-based, upon the program developed and successfully operated at Via Christi Health in Wichita, Kansas. This is a policy change, as Saint Thomas Health will adopt Ascension Health’s policy for caring for victims of human trafficking

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

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

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

Strategy 3: Support high school students from Hickman County in their medical education pursuits
• The target population is high school seniors in Hickman County who will be pursuing post-secondary education in a medical field
• This strategy seeks to alleviate the financial burden of medical education and long-term seeks to address health disparities by increasing the proportion of natives of rural counties who attain clinical degrees
• This strategy seeks to annually encourage students to pursue their medical education goals, with the goal that they will attain their educational goals and that they will consider returning to Hickman County to expand the provision of healthcare in their home county

Anticipated Impact:
• 100% of students offered financial support will enroll in an institution that will grant the healthcare degree of their choosing
• Alignment with Local Priorities: Hickman County Education Foundation is a partnership between the Hickman County Chamber of Commerce and Hickman County Schools
• Alignment with State Priorities: Tennessee State Health Plan Principle 5: Health Workforce
• Alignment with National Priorities: Healthy People 2020 Objective SDOH-2 – Proportion of high school completers who were enrolled in college the October immediately after completing high school

Strategy 4: Implement community-wide Medical Missions at Home that integrate medical, dental, vision and behavioral health, along with broader community resources
• Details cited under Prioritized Need #3: Access to Care / Care Coordination

Strategy 5: Provide food boxes, sensitive to chronic condition, to community members who are experiencing food insecurity
• Details cited under Prioritized Need #1: Wellness and Disease Prevention

Strategy 6: Provide community-based organizations with financial support toward their work in one of the Prioritized Need areas
• Details cited under Prioritized Need #1: Wellness and Disease Prevention

An action plan follows for each prioritized need, including the resources, proposed actions, planned collaboration, and anticipated impact of each strategy.
Prioritized Need #1: Wellness and Disease Prevention

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

**Action Plan**

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<th>STRATEGY 1: Provide CPR/First Aid Classes for Hickman County Schools Faculty and Staff</th>
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**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:**
1. Certify 100% of course attendees in First Aid and CPR Administration annually
STRATEGY 2: Develop and support a local network of Faith Community Nurses, to equip them to improve the health of their congregations

BACKGROUND INFORMATION:

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

RESOURCES:

- Foundations of Faith Community Nursing curriculum and course offered through Saint Thomas – West Hospital
- Financial support to Faith Community Nurses in completing training and initiating congregation-specific programming

COLLABORATION:

- Hickman County faith congregations

ACTIONS:

1. Identify partner congregations around Hickman County
2. Meet with faith leaders from partner congregations
3. Advertise bi-annual Foundations of Faith Community Nursing course
4. Train nurses through Foundations of Faith Community Nursing course
5. Provide resources to support congregation-specific health initiatives

ANTICIPATED IMPACT:

II. By June 2019, train five Faith Community Nurses who implement programming for a priority health need in their congregation
III. By June 2019, 80% of FCNs will report improvement in the priority health area among the target members of their congregation
**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:**
IV. By June 2019, 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:** 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:**
- V. 80% of families growing gardens will, in their second year of gardening, increase consumption of vegetables in their diets 1-2 servings each day during the growing season
- VI. 85% of gardeners will return to garden each year
STRATEGY 5: Provide food boxes, sensitive to chronic condition, to community members who are experiencing food insecurity

BACKGROUND INFORMATION:
- 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:
VII. Alleviate food insecurity for 50 families a month, through June of 2019, through the provision of a food box.
VIII. Increase wellness promotion through nutrition education being made available in each food box by June 2017.
<table>
<thead>
<tr>
<th>STRATEGY 6: Increase community physical activity by creating a public use walking trail on the hospital campus</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>BACKGROUND INFORMATION:</strong></td>
</tr>
<tr>
<td>• The target population is any community member in need of a safe designated walking space</td>
</tr>
<tr>
<td>• 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</td>
</tr>
<tr>
<td>• 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’: <a href="http://activelivingresearch.org/files/ALR_Brief_PowerofTrails_0.pdf">http://activelivingresearch.org/files/ALR_Brief_PowerofTrails_0.pdf</a>. This is an environmental change, making the hospital campus more conducive to physical activity</td>
</tr>
<tr>
<td><strong>RESOURCES:</strong></td>
</tr>
<tr>
<td>• Investment in signs to mark the trail &amp; the distance covered</td>
</tr>
<tr>
<td>• Investment in exercise equipment</td>
</tr>
<tr>
<td><strong>COLLABORATION:</strong></td>
</tr>
<tr>
<td>• N/A</td>
</tr>
<tr>
<td><strong>ACTIONS:</strong></td>
</tr>
<tr>
<td>1. Determine best placement for walking trail and measure out trail distance</td>
</tr>
<tr>
<td>2. Design and purchase signs to mark walking trail</td>
</tr>
<tr>
<td>3. Install signs to designate walking trail</td>
</tr>
<tr>
<td>4. Install exercise equipment for public use</td>
</tr>
<tr>
<td>5. Promote availability of trail and equipment in the community</td>
</tr>
<tr>
<td><strong>ANTICIPATED IMPACT:</strong></td>
</tr>
<tr>
<td>IX. By June 2017, observe a 50% increase in the utilization of the hospital campus as an opportunity to obtain exercise</td>
</tr>
</tbody>
</table>
**STRATEGY 7:** Provide community-based organizations with financial support toward their work in one of the Prioritized Need areas

**BACKGROUND INFORMATION:**
- The target population is residents of 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

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

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

<table>
<thead>
<tr>
<th>OBJECTIVE:</th>
<th>LOCAL / COMMUNITY PLAN:</th>
<th>STATE PLAN:</th>
<th>“HEALTHY PEOPLE 2020” (or OTHER NATIONAL PLAN):</th>
</tr>
</thead>
<tbody>
<tr>
<td>I</td>
<td></td>
<td></td>
<td>Healthy People 2020 Objective HDS-16.2 &amp; 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</td>
</tr>
<tr>
<td>I – IX</td>
<td>Hickman County Health Department recognizes Wellness and Disease Prevention as a Priority Health Need</td>
<td></td>
<td></td>
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<tr>
<td>II, III</td>
<td></td>
<td>TN Department of Health’s Faith-Based Health Initiative</td>
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<tr>
<td>II, III, IV</td>
<td></td>
<td></td>
<td>Healthy People 2020 Objective ECBP-10 – Increase the number of community-based organizations providing population-based primary prevention services</td>
</tr>
<tr>
<td>IV, V, VII, VIII</td>
<td>Hickman County Health Council’s Healthy Food Coalition</td>
<td></td>
<td></td>
</tr>
<tr>
<td>IV</td>
<td></td>
<td>TN State Health Plan Goal 1b. People in TN understand and practice behaviors that promote and maintain good health</td>
<td>Healthy People 2020 Objective NWS-8 – Increase the proportion of adults who are at a healthy weight</td>
</tr>
<tr>
<td>V, VI</td>
<td></td>
<td>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</td>
<td>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</td>
</tr>
<tr>
<td>Section</td>
<td>Objective Description</td>
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<tr>
<td>VII</td>
<td>Healthy People 2020 Objective NWS-13 – Reduce household food insecurity and in doing so reduce hunger</td>
<td></td>
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</tr>
<tr>
<td>VII, VIII</td>
<td>Healthy People 2020 Objective D-3 – Reduce the diabetes death rate</td>
<td></td>
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<tr>
<td>VII, VIII</td>
<td>Healthy People 2020 Objective HDS-2 – Reduce coronary heart disease deaths</td>
<td></td>
<td></td>
</tr>
<tr>
<td>VII, VIII</td>
<td>Healthy People 2020 Objective CKD-7 – Reduce the number of deaths among persons with chronic kidney disease</td>
<td></td>
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</tr>
<tr>
<td>IX</td>
<td>Physical inactivity is identified by the TN Department of Health as one of four top priorities</td>
<td></td>
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<tr>
<td></td>
<td>Healthy People 2020 Objective PA-2 – Increase the proportion of adults who meet current federal physical activity guidelines for aerobic physical activity and for muscle-strengthening activity</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
**Prioritized Need #2: Mental and Emotional Health / Substance Abuse**

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

### Action Plan

| 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 and an improved support network annually |
### 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 2019, demonstrate an improvement in mental health of 90% of patients who complete the recommended course of therapy.
**STRATEGY 3:** Develop and support a local network of Faith Community Nurses, to equip them to improve the health of their congregations

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

**RESOURCES:**
- Foundations of Faith Community Nursing curriculum and course offered through Saint Thomas – West Hospital
- Financial support to Faith Community Nurses in completing training and initiating congregation-specific programming

**COLLABORATION:**
- Hickman County faith congregations

**ACTIONS:**
1. Identify partner congregations around Hickman County
2. Meet with faith leaders from partner congregations
3. Advertise bi-annual Foundations of Faith Community Nursing course
4. Train nurses through Foundations of Faith Community Nursing course
5. Provide resources to support congregation-specific health initiatives

**ANTICIPATED IMPACT:**
III. By June 2019, train five Faith Community Nurses who implement programming for a priority health need in their congregation
IV. By June 2019, 80% of FCNs will report improvement in the priority health area among the target members of their congregation
**STRATEGY 4:** 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:**
- By June 2019, six courses in priority health areas will have been taught, with participants demonstrating at least a 50% knowledge increase in the topics addressed.
### STRATEGY 5: Offer chaplain services at the Hickman Medical Clinic 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 clinic to integrate physical, behavioral, and spiritual care.

### RESOURCES:
- Hickman Medical Clinic Chaplain
- Hickman Medical Clinic Staff
- Hickman 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:
VI. By June 2017 and after, 70% of patients referred to Behavioral Health by Chaplaincy will seek follow-up care, ensuring that an increased proportion of patients with mental and emotional health needs receive needed care.
**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 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 – 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:**

VII. By December 2017, have two associates trained in SANE who are able to provide trauma-informed care and needed resources to victims of sexual assault

VIII. By June 2018, all patients who present as acute sexual assault victims will be referred to the on-duty SANE associate
STRATEGY 7: Provide community-based organizations with financial support toward their work in one of the Prioritized Need areas

BACKGROUND INFORMATION:
- The target population is residents of 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

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.
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</tr>
</thead>
<tbody>
<tr>
<td>I, II, VI, VII, VIII</td>
<td>Hickman County Health Council’s Behavioral Health &amp; Suicide Prevention Sub-Committee</td>
<td>TN State Health Plan – Behavioral health a priority to address health disparities in TN</td>
<td></td>
</tr>
<tr>
<td>I, II</td>
<td></td>
<td>Healthy People 2020 Objective HRQOL/WB-1.2 – Increase the proportion of adults who self-report good or better mental health</td>
<td></td>
</tr>
<tr>
<td>I, VI</td>
<td></td>
<td>Healthy People 2020 Objectives MHMD-6 and MHMD-9 – Increase the proportion of children and persons with mental health disorders who receive treatment</td>
<td></td>
</tr>
<tr>
<td>II</td>
<td></td>
<td>TN State Health Plan Goal 1b. People in TN understand and practice behaviors that promote and maintain good health</td>
<td></td>
</tr>
<tr>
<td>III, IV</td>
<td>TN Department of Health’s Faith-Based Health Initiative</td>
<td></td>
<td></td>
</tr>
<tr>
<td>V</td>
<td>TN State Health Plan Goal 1b. People in TN understand and practice behaviors that promote and maintain good health</td>
<td></td>
<td></td>
</tr>
<tr>
<td>VI</td>
<td>Spiritual health cited as a component of the Tennessee State Health Plan's targets toward moving Tennessee residents toward optimal health</td>
<td></td>
<td></td>
</tr>
<tr>
<td>VII, VIII</td>
<td></td>
<td>Healthy People 2020 Objective IVP-8.1 – Increase the proportion of the population residing within the continental United States with access to trauma care</td>
<td></td>
</tr>
</tbody>
</table>
Prioritized Need #3: Access to Care / Care Coordination

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

**Action Plan**

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

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

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

**COLLABORATION:**
- N/A

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

**ANTICIPATED IMPACT:**
I. Increase legislative support by 50% for expanded healthcare access/coverage by January 2018
II. Expand healthcare access/coverage in Tennessee by July 2018
STRATEGY 2: Open a 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

ANTICIPATED IMPACT:
III. 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.
IV. Assist qualifying individuals with obtaining medication assistance through manufacturer sponsored
### STRATEGY 2: Open a Dispensary of Hope Charitable Pharmacy

Open a 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.

**Patient Assistance Programs**

### STRATEGY 3: Increase access to healthcare

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

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

**RESOURCES:**
- Ascension Health Financial Assistance Policy
- Ascension Health Emergency Care Policy
- Patient registration associates

**COLLABORATION:**
- N/A

**ACTIONS:**
1. Make new Ascension Health Financial Assistance Policy publicly available
2. Assist patients who may qualify for financial assistance in completing the application
3. Provide 24/7 access to emergency care

**ANTICIPATED IMPACT:**
- Provide community members with income levels at or below 400% of the Federal Poverty Level with financial assistance as outlined in Saint Thomas Health’s Financial Assistance Policy
**STRATEGY 4:** 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:**
VI. Increase public awareness of enrollment assistance offered to drive a 10% increase in enrollment counseling visits each open enrollment season
VII. Confirm that 50% of eligible visitors become enrolled in health insurance during the open enrollment period
<table>
<thead>
<tr>
<th>STRATEGY 5: Provide a medical home for an increased number of uninsured and underinsured individuals, thus expanding their access to a full range of needed medical care</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>BACKGROUND INFORMATION:</strong></td>
</tr>
<tr>
<td>- 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</td>
</tr>
<tr>
<td>- 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</td>
</tr>
<tr>
<td>- This strategy is built upon the evidence base cited by Healthy People 2020’s Access to Health Services topic: People with a usual source of care have better health outcomes and fewer disparities and costs. This is a systems change, adjusting the practice’s scheduling infrastructure to respond to community needs</td>
</tr>
<tr>
<td><strong>RESOURCES:</strong></td>
</tr>
<tr>
<td>- Hickman Medical Clinic Staff</td>
</tr>
<tr>
<td>- PCMH Guidelines</td>
</tr>
<tr>
<td>- Saint Thomas – Hickman Leadership</td>
</tr>
<tr>
<td><strong>COLLABORATION:</strong></td>
</tr>
<tr>
<td>- Specialist referral network</td>
</tr>
<tr>
<td>- University of Tennessee Health Science Center</td>
</tr>
<tr>
<td><strong>ACTIONS:</strong></td>
</tr>
<tr>
<td>1. Conduct survey to identify patient appointment needs</td>
</tr>
<tr>
<td>2. Develop and implement expanded schedules in response to communicated needs</td>
</tr>
<tr>
<td>3. Communicate expanded hours into the community</td>
</tr>
<tr>
<td>4. Host Physician Assistant Residents to expand practice capacity and provide rural health training opportunities</td>
</tr>
<tr>
<td>5. Develop and annually update a list of specialists willing to see uninsured and underinsured patients</td>
</tr>
<tr>
<td>6. Facilitate needed specialist referrals to secure needed specialty care for patients</td>
</tr>
<tr>
<td><strong>ANTICIPATED IMPACT:</strong></td>
</tr>
<tr>
<td>VIII. By June of 2017, increase appointment availability for uninsured and underinsured individuals by 10%</td>
</tr>
<tr>
<td>IX. By June of 2017, increase access for uninsured and underinsured individuals to specialty care by 10%</td>
</tr>
</tbody>
</table>
### STRATEGY 6: Implement community-wide Medical Missions at Home that integrate medical, dental, vision and behavioral health, along with broader community resources

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

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

#### COLLABORATION:
- Students
- Community Agencies

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

**ANTICIPATED IMPACT:**

X. Increase awareness of and connection to social services and other resources through 150 encounters with community agencies annually

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

### STRATEGY 7: Increase breast cancer screening compliance through Our Mission In Motion Mobile Mammography

**BACKGROUND INFORMATION:**

- The strategy's target population is low-income, uninsured women in 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

**ANTICIPATED IMPACT:**

XII. Conduct 12 community outreach visits annually in Hickman County to provide free mammography services

XIII. Increase the number of women screened with the recommended frequency by 10%
### STRATEGY 8: 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 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 – 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:
XIV. By December 2017, have two associates trained in SANE who are able to provide trauma-informed care and needed resources to victims of sexual assault
XV. By June 2018, all patients who present as acute sexual assault victims will be referred to the on-duty SANE associate
<table>
<thead>
<tr>
<th>STRATEGY 9: Improve access to care via telemedicine consultations when acute stroke symptoms are present</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>BACKGROUND INFORMATION:</strong></td>
</tr>
<tr>
<td>• The target population is residents of Hickman County with a suspected acute stroke event</td>
</tr>
<tr>
<td>• This strategy addresses health disparities and barriers to care by providing easy access to stroke-trained physicians in underserved communities</td>
</tr>
<tr>
<td>• 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</td>
</tr>
<tr>
<td><strong>RESOURCES:</strong></td>
</tr>
<tr>
<td>• Saint Thomas Hickman Hospital Staff</td>
</tr>
<tr>
<td>• Telemedicine Services</td>
</tr>
<tr>
<td>• Consulting Stroke-trained Physician</td>
</tr>
<tr>
<td><strong>COLLABORATION:</strong></td>
</tr>
<tr>
<td>• N/A</td>
</tr>
<tr>
<td><strong>ACTIONS:</strong></td>
</tr>
<tr>
<td>1. Increase use of system to conduct telemedicine consultations in response to possible stroke symptoms</td>
</tr>
<tr>
<td>2. Increase physician and staff telemedicine education participation for competency in NIHSS use, Stroke Telemedicine use, and Stroke ID/Triage</td>
</tr>
<tr>
<td>3. Collect peer evaluations and responses from physicians and staff on the benefits of conducting telemedicine visits</td>
</tr>
<tr>
<td>4. Conduct a patient survey to confirm timely access to health services</td>
</tr>
<tr>
<td><strong>ANTICIPATED IMPACT:</strong></td>
</tr>
<tr>
<td>XVI. Limit patient transfers to more acute facilities to those that are medically appropriate</td>
</tr>
<tr>
<td>XVII. Annually meet or exceed the national average for IV tPA utilization (2.8% as of last published standard)</td>
</tr>
<tr>
<td>STRATEGY 10: Provide community-based organizations with financial support toward their work in one of the Prioritized Need areas</td>
</tr>
<tr>
<td>---</td>
</tr>
<tr>
<td><strong>BACKGROUND INFORMATION:</strong></td>
</tr>
<tr>
<td>• The target population is residents of Hickman County served by identified partner organizations</td>
</tr>
<tr>
<td>• All organizations will be assessed on the basis of the attention they pay to issues of health disparities and the needs of the underserved</td>
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<tr>
<td>• The evidence base will be dependent upon the specific work of each community organization but is one of the selection criteria that is reviewed and considered in determining partners</td>
</tr>
<tr>
<td><strong>RESOURCES:</strong></td>
</tr>
<tr>
<td>• Financial Support</td>
</tr>
<tr>
<td><strong>COLLABORATION:</strong></td>
</tr>
<tr>
<td>• Community Organizations</td>
</tr>
<tr>
<td><strong>ACTIONS:</strong></td>
</tr>
<tr>
<td>1. Make publicly available a Program Proposal form, through which community organizations can request a financial partnership from Saint Thomas Health</td>
</tr>
<tr>
<td>2. Receive Program Proposals from community organizations who seek support for a program working to meet one of the Priority Needs</td>
</tr>
<tr>
<td>3. Partnership decisions made by committee review</td>
</tr>
<tr>
<td>4. Financial support is provided to selected organizations, and outcomes are reviewed annually</td>
</tr>
<tr>
<td><strong>ANTICIPATED IMPACT:</strong></td>
</tr>
<tr>
<td>The work of community organizations working to meet the Priority Needs will be furthered through a partnership with Saint Thomas Health. Specific objectives will be dependent upon the specific actions and interventions of each selected partner organization. Each organization will submit its anticipated impact in its request seeking financial support from Saint Thomas Health.</td>
</tr>
</tbody>
</table>
Alignment with Local, State & National Priorities

<table>
<thead>
<tr>
<th>OBJECTIVE: LOCAL / COMMUNITY PLAN:</th>
<th>STATE PLAN:</th>
<th>“HEALTHY PEOPLE 2020” (or OTHER NATIONAL PLAN):</th>
</tr>
</thead>
<tbody>
<tr>
<td>I - XVII Hickman County Health Department recognizes Access to Care as a Priority Health Need</td>
<td>TN State Health Plan Principle 2, Access to Care – People in TN should have access to healthcare and the conditions to achieve optimal health</td>
<td></td>
</tr>
<tr>
<td>I, II, III, IV, X, XI</td>
<td>Access to health insurance is a TN State Health Plan Priority</td>
<td>Healthy People 2020 Objective AHS-1 – Increase the proportion of persons with health insurance</td>
</tr>
<tr>
<td>I, II, VI, VII</td>
<td></td>
<td></td>
</tr>
<tr>
<td>III, IV, V, X, XI</td>
<td></td>
<td>Healthy People 2020 Objective AHS-6 – Reduce the proportion of people who are unable to obtain or delay in obtaining necessary medical care, dental care, and prescription medication</td>
</tr>
<tr>
<td>V, VIII, IX</td>
<td>TN State Health Plan Goal 2d. People in TN are able to obtain appropriate quality healthcare services to meet their needs</td>
<td></td>
</tr>
<tr>
<td>VIII, IX Safety Net Consortium of Middle Tennessee</td>
<td></td>
<td>Healthy People 2020 Objective AHS-5 – Increase the proportion of persons who have a specific source of ongoing care</td>
</tr>
<tr>
<td>XII, XIII</td>
<td>Reduce female breast cancer mortality through increased awareness, early detection, diagnosis and treatment</td>
<td>By 2020, reduce the female breast cancer death rate from 23% to 20.7%</td>
</tr>
<tr>
<td>XIV, XV</td>
<td></td>
<td>Healthy People 2020 Objective IVP-8.1 – Increase the proportion of the population residing within the continental United States with</td>
</tr>
<tr>
<td>XVI, XVII</td>
<td>TN State Health Plan Priority Area – Health Care Delivery Model in Rural Areas</td>
<td>Healthy People 2020 Objective HDS-19.3 – Increase the proportion of eligible patients with strokes who receive acute reperfusion therapy within 3 hours from symptom onset</td>
</tr>
</tbody>
</table>
Prioritized Need #4: Social Determinants

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

**Action Plan**

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

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

**RESOURCES:**
- Ascension Health Training Materials

**COLLABORATION:**
- End Slavery Tennessee

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

**ANTICIPATED IMPACT:**
1. By June 2018, 100% of identified victims will be assisted in accordance with Ascension Health guidance
<table>
<thead>
<tr>
<th><strong>STRATEGY 2:</strong> 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.</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th><strong>BACKGROUND INFORMATION:</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>• The target population is persons in need of socioeconomic resources</td>
</tr>
<tr>
<td>• 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</td>
</tr>
<tr>
<td>• 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.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>RESOURCES:</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>• Saint Thomas Health Care Coordination Center</td>
</tr>
<tr>
<td>• Resource Navigator</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>COLLABORATION:</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>• N/A</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>ACTIONS:</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Hire Resource Navigator for Hickman County</td>
</tr>
<tr>
<td>2. Promote the availability of Resource Navigators internally and externally</td>
</tr>
<tr>
<td>3. Resource Navigators receive referrals from providers &amp; staff</td>
</tr>
<tr>
<td>4. Resource Navigators receive calls from other patients and community members</td>
</tr>
<tr>
<td>5. Collect data on resource gaps</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>ANTICIPATED IMPACT:</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>II. 80% of callers receiving at least one referral to a community resource by June 2019</td>
</tr>
<tr>
<td>III. 70% of callers receiving assistance from the referral by June 2019</td>
</tr>
<tr>
<td>STRATEGY 3: Support high school students from Hickman County in their medical education pursuits</td>
</tr>
<tr>
<td>------------------------------------------------</td>
</tr>
<tr>
<td><strong>BACKGROUND INFORMATION:</strong></td>
</tr>
<tr>
<td>• The target population is high school seniors in Hickman County who will be pursuing post-secondary education in a medical field</td>
</tr>
<tr>
<td>• This strategy seeks to alleviate the financial burden of medical education and long-term seeks to address health disparities by increasing the proportion of natives of rural counties who attain clinical degrees</td>
</tr>
<tr>
<td>• This strategy seeks to annually encourage students to pursue their medical education goals, with the goal that they will attain their educational goals and that they will consider returning to Hickman County to expand the provision of healthcare in their home county</td>
</tr>
<tr>
<td><strong>RESOURCES:</strong></td>
</tr>
<tr>
<td>• Financial Support</td>
</tr>
<tr>
<td><strong>COLLABORATION:</strong></td>
</tr>
<tr>
<td>• Hickman County Education Foundation</td>
</tr>
<tr>
<td><strong>ACTIONS:</strong></td>
</tr>
<tr>
<td>1. Hickman County High Schools’ teachers identify and nominate students who are interested in pursuing a career in healthcare</td>
</tr>
<tr>
<td>2. Scholarships are distributed to selected students for their post-secondary education pursuits to enter the medical field</td>
</tr>
<tr>
<td><strong>ANTICIPATED IMPACT:</strong></td>
</tr>
<tr>
<td>IV. 100% of students offered financial support will enroll in an institution that will grant the healthcare degree of their choosing</td>
</tr>
</tbody>
</table>
**STRATEGY 4:** Implement community-wide Medical Missions at Home that integrate medical, dental, vision and behavioral health, along with broader community resources

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

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

**COLLABORATION:**
- Students
- Community Agencies

**ACTIONS:**
1. Identify communities in need and locations for Medical Missions at Home
2. Recruit volunteers
3. Communicate event details to volunteers
4. Communicate event details to community
5. Set up for event
6. Register patients for care at event
7. Administer medical examinations
8. Fill prescriptions
9. Conduct lab tests
10. Conduct vision exams
11. Provide dental care
12. Conduct mammograms
13. Register patients currently without a medical home for follow-up appointments
14. Provide information on social services and other community resources
<table>
<thead>
<tr>
<th>STRATEGY 4: Implement community-wide Medical Missions at Home that integrate medical, dental, vision and behavioral health, along with broader community resources</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>ANTICIPATED IMPACT:</strong></td>
</tr>
<tr>
<td>V. Increase awareness of and connection to social services and other resources through 150 encounters with community agencies annually</td>
</tr>
<tr>
<td>VI. Increase access to a medical home by increasing the proportion of medical mission attendees who are scheduled for a follow-up visit by 14%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>STRATEGY 5: Provide food boxes, sensitive to chronic condition, to community members who are experiencing food insecurity</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>BACKGROUND INFORMATION:</strong></td>
</tr>
<tr>
<td>• 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.</td>
</tr>
<tr>
<td>• 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.</td>
</tr>
<tr>
<td>• 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: <a href="https://development.bmc.org/foodpantry">https://development.bmc.org/foodpantry</a></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>RESOURCES:</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>• Saint Thomas – Hickman Providers &amp; Staff</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>COLLABORATION:</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>• Second Harvest Food Bank</td>
</tr>
<tr>
<td>• Centerville Church of Christ</td>
</tr>
<tr>
<td>• Farmers’ Market at River Park</td>
</tr>
</tbody>
</table>
**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:**

VII. Alleviate food insecurity for 50 families a month, through June of 2019, through the provision of a food box.

VIII. Increase wellness promotion through nutrition education being made available in each food box by June 2017.
**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

**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 (Long-Term Outcomes for Prioritized Need #4)

<table>
<thead>
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<th>OBJECTIVE:</th>
<th>LOCAL / COMMUNITY PLAN:</th>
<th>STATE PLAN:</th>
<th>“HEALTHY PEOPLE 2020” (or OTHER NATIONAL PLAN):</th>
</tr>
</thead>
<tbody>
<tr>
<td>I</td>
<td></td>
<td></td>
<td>Healthy People 2020 Objective IVP-8.1 – Increase the proportion of the population residing within the continental United States with access to trauma care</td>
</tr>
<tr>
<td>I – VIII</td>
<td>Hickman County Health Department recognizes Social Determinants as a Priority Health Need</td>
<td></td>
<td></td>
</tr>
<tr>
<td>II, III</td>
<td>TN State Health Plan Goal 1a. People in TN have the necessary support and opportunities for healthy living</td>
<td></td>
<td>Healthy People 2020 Objective SDOH-3.1 – Proportion of persons living in poverty</td>
</tr>
<tr>
<td>II, III, V, VI</td>
<td>TN State Health Plan Goal 1c. Health disparities between and among populations, as well as the underlying causes of these disparities, are eliminated</td>
<td></td>
<td></td>
</tr>
<tr>
<td>II, III, VII, VIII</td>
<td></td>
<td></td>
<td>Healthy People 2020 Objective NWS-13 – Reduce household food insecurity and in doing so reduce hunger</td>
</tr>
<tr>
<td>IV</td>
<td>Hickman County Education Foundation is a partnership between the Hickman County Chamber of Commerce and Hickman County Schools</td>
<td>TN State Health Plan Principle 5 – Health Workforce</td>
<td>Healthy People 2020 Objective SDOH-2 – Proportion of high school completers who were enrolled in college the October immediately after completing high school</td>
</tr>
</tbody>
</table>