2016
IMPLEMENTATION STRATEGY
Saint Thomas Rutherford Hospital, Saint Thomas Health

RUTHERFORD COUNTY, TENNESSEE
COMMUNITY HEALTH NEEDS ASSESSMENT
# Saint Thomas Rutherford Hospital Implementation Strategy

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Implementation Strategy Narrative

Overview

Saint Thomas Rutherford Hospital and Saint Thomas Health conducted the assessment in partnership with the Rutherford County Health Department, Rutherford County Wellness Council, Primary Care & Hope Clinic, and Vanderbilt University Medical Center. Saint Thomas Health and Vanderbilt University Medical Center participated in the CHNA on behalf of their not-for-profit hospitals. The community served for purposes of this Community Health Needs Assessment (CHNA) and this Implementation Strategy was defined as Rutherford County, Tennessee.

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

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

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

The 2016 CHNA provided Saint Thomas Rutherford Hospital and Saint Thomas Health with a basis for addressing the health needs of the county and a reference for the development of this Implementation Strategy (IS), ensuring alignment with the community needs. This Implementation Strategy will guide the Community Benefit and Community Health Improvement efforts for Saint Thomas Rutherford Hospital and Saint Thomas Health for fiscal years 2017 – 2019.
Prioritized Needs
The results of the data review, community interviews and listening sessions were presented to the community representatives and leaders at the September 3, 2015 Community Health Summit sponsored by the partnering organizations. The meeting attendees then provided collective input into the needs and resources of the community.

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

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

Needs That Will Not Be Addressed
All priority needs will be addressed.
Summary of Implementation Strategy

Prioritized Need #1: Access to Care / Care Coordination

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

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

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

**Anticipated Impact:**

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

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

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

**Anticipated Impact:**

- 70% of patients annually will follow up on STH-given referrals and receive the needed resources
• Alignment with State Priorities: Tennessee State Health Plan Goal 2d. People in Tennessee are able to obtain appropriate quality health care services to meet their needs
• Alignment with National Priorities: Healthy People 2020 Objective AHS-6 – Reduce the proportion of people who are unable to obtain or delay in obtaining necessary medical care, dental care, and prescription medication

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

Anticipated Impact:
• Annually fill 30,000 prescriptions for unaffordable medications to qualifying individuals who enroll in Dispensary of Hope through medications obtained through the DOH Distribution Center, Saint Thomas Health Safety Net list, or physician donated samples.
• Alignment with State Priorities: Tennessee State Health Plan Principle 2, Access to Care – People in Tennessee should have access to healthcare and the conditions to achieve optimal health
• Alignment with National Priorities: Healthy People 2020 Objective AHS-6 – Reduce the proportion of people who are unable to obtain or delay in obtaining necessary medical care, dental care, and prescription medication

Strategy 4: 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 5: Increase access to healthcare by removing traditional financial and insurance hurdles, through financial assistance and emergency care policies
• The target population is members of the community who are experiencing poverty and are either uninsured or underinsured
• This strategy specifically seeks to make a full range of healthcare services available to those who are medically underserved
• This strategy is a Policy Change, in line with Ascension Health’s Financial Assistance Policy, in effect July 1, 2016, that represents Ascension Health’s mission to serve all persons, with special attention to those who are poor and vulnerable

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

Strategy 6: Increase access to hospice care and grief support & counseling
• The target population is Rutherford County residents and loved ones in need of hospice care and/or grief counseling
• Both hospice care and grief support are provided independent of a patient’s ability to pay for the services, thus caring for the underserved and addressing health disparities in access to hospice care or grief support
• This strategy is evidence-based, upon Alive Hospice’s 40 years of providing hospice care in Middle Tennessee
Anticipated Impact:
- By December 2017, there will be a 50% decrease in travel time for community members seeking hospice care
- Annually, 90% of Grief Support clients will reach performance targets while under the care of a grief counselor
- Alignment with Local Priorities: Access to Care and Mental & Emotional Health are identified as priority areas by the Rutherford County Health Department
- Alignment with State Priorities: Tennessee State Health Plan Goal 2d. People in Tennessee are able to obtain appropriate quality health care services to meet their needs
- Alignment with National Priorities: Healthy People 2020 Objective AHS-6 – Reduce the proportion of people who are unable to obtain or delay in obtaining necessary medical care, dental care, and prescription medication

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

Anticipated Impact:
- Increase awareness of and connection to social services and other resources through 300 encounters with community agencies annually
- Increase access to a medical home by increasing the proportion of medical mission attendees who are scheduled for a follow-up visit by 14%
- Alignment with State Priorities: Tennessee State Health Plan Principle 2, Access to Care – People in Tennessee should have access to healthcare and the conditions to achieve optimal health
- Alignment with National Priorities: Healthy People 2020 Objective AHS-6 – Reduce the proportion of people who are unable to obtain or delay in obtaining necessary medical care, dental care, and prescription medication

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

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

Strategy 9: Increase access to acute dental care for residents of Rutherford County by providing triage services on the Mobile Health Unit

• The target population is dentally uninsured and underserved residents of Rutherford County.
• Dental Care Triage via the Mobile Health Unit will assist in removing barriers to access by providing dental x-rays at sites around Rutherford County, assessing which patients are in need of acute dental follow-up and scheduling them for follow-up accordingly. This will both increase accessibility of dental attention to underserved areas of Rutherford County and increase the capacity of the Health Department to care for acute dental needs by screening in advance
• This strategy is supported by free and reduced lunch data in both Murfreesboro City and Rutherford County Schools, Public Transportation access, and centralized locations (walkability) to determine sites of service. Additionally, ancillary support services within the public school system partner with MHU staff to determine pockets of vulnerability and need within the community

Anticipated Impact:
• By June 2017, 90% of patients identified to have a dental follow-up need will have received that follow-up care
• Alignment with Local Priorities: Access to Care is identified as a priority area by the Rutherford County Health Department
• Alignment with State Priorities: Priority for Consideration 5 within Goal 2d. of the Tennessee State Health Plan – Access to appropriate health and dental clinics impacts people’s ability to obtain appropriate services, especially for underserved populations
• Alignment with National Priorities: Healthy People 2020 Objective AHS-6.3 – Reduce the proportion of persons who are unable to obtain or delay in obtaining necessary dental care

Strategy 10: Increase access to both primary and mental health care to residents of Rutherford County by providing services on the Mobile Health Unit

• The target population is uninsured and underserved residents of Rutherford County
• Primary & Mental Health Care via the Mobile Health Unit will assist in removing barriers to access by providing services at targeted locations throughout Rutherford County. Additionally, services can be accessed at a reduced fee or free of charge as needed
• This strategy is supported by free and reduced lunch data in both Murfreesboro City and Rutherford County Schools, Public Transportation access, and centralized locations (walkability) to determine sites of service. Additionally, ancillary support services within the public school system partner with MHU staff to determine pockets of vulnerability and need within the community

Anticipated Impact:
• Increase awareness of primary health care resources in Rutherford County, with the MHU shared as a resource to 100% of Rutherford County Schools and Murfreesboro City Schools beginning in the 2016-2017 school year
• Increase the ability of Rutherford County residents to access primary and mental care by serving 750 residents annually who otherwise would have no access
• Alignment with Local Priorities: Access to Care and Mental & Emotional Health are identified as priority areas by the Rutherford County Health Department
• 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
• 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-12 – Increase the proportion of homeless adults with mental health problems who receive mental health services

Strategy 11: Increase breast cancer screening compliance through Our Mission in Motion Mobile Mammography
• The strategy’s target population is low-income, uninsured women in Rutherford County.
• Our Mission In Motion Mobile Mammography will reduce barriers by providing access to screening mammography and breast health education to uninsured and underserved women.
• This strategy is informed by evidence found on Healthy People 2020 and Tennessee Cancer Coalition

Anticipated Impact:
• Conduct 12 community outreach visits annually in Rutherford 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 12: Pharmacist-driven improvement in medication management through community education sessions and patient-specific pharmacotherapy clinic appointments

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

Anticipated Impact:
- By June 2017, increase the number of patients that are able to receive Pharmacotherapy Clinic services from 6 per week to 50 per week as reported through AthenaNet
- By June 2017, achieve a 25% improvement in the number of patients that attain goal disease state-specific parameters as reported through AthenaNet
- Annually provide 12 community education events on chronic disease management and self-monitoring as reported through program records that result in a 50% increase in attendee knowledge
- Alignment with National Priorities: Healthy People 2020 Objective HDS-21 – Increase the proportion of adults with a history of cardiovascular disease who are using aspirin or antiplatelet therapy to prevent recurrent cardiovascular events
- Alignment with National Priorities: Healthy People 2020 Objective D-13 – Increase the proportion of adults with diabetes who perform self-blood glucose monitoring at least once daily
- Alignment with National Priorities: Healthy People 2020 Objective RD-11 – Reduce hospitalizations for chronic obstructive pulmonary disease
- Alignment with National Priorities: Healthy People 2020 Objective TU-1 – Reduce tobacco use by adults

Strategy 13: 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

- The target population is victims of sexual assault in Rutherford County age 13 and older
- This strategy works to eliminate barriers of sexual assault victims receiving the care they need
- Training from the International Association of Forensic Nurses is utilized in preparing SANE nurses. A standardized screening tool is utilized to assess all sexual assault patients, in line with the findings of the following study: Brown, B., DuMont, J., Macdonald, S., Bainbridge, D., (April/June 2013) A Comparative Analysis of Victims of Sexual Assault With and Without Mental Health Histories: Acute and Follow-up Care Characteristics. Journal of Forensic Nurses, 9(2), 76-83. This is a policy change at the hospital, by which a SANE nurse will be the proper associate to care for patients who are victims of sexual assault
Anticipated Impact:
- By June 2017, increase the % of presenting victims who are referred to SANE by 10%
- By June 2017, increase referrals provided to victims by 100%
- By June 2017, increase patient call-backs by 100%, to assess further needed resources
- 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
- Alignment with National Priorities: Healthy People 2020 Objective IVP-40 – Reduce sexual violence

Strategy 14: Improve access to care via telemedicine consultations when acute stroke symptoms are present
- The target population is residents of Rutherford County with a suspected acute stroke event
- This strategy addresses health disparities and barriers to care by providing easy access to stroke-trained physicians in underserved communities
- This strategy has been developed by Saint Thomas Health in the successful development and management of the Saint Thomas Health Stroke Network across Tennessee, along with the successful operation of telemedicine clinical locations via HRSA grant 11-089

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

Strategy 15: Provide community-based organizations with financial support toward their work in one of the Prioritized Need areas
- The target population is residents of Rutherford County served by identified partner organizations
- All organizations will be assessed on the basis of the attention they pay to issues of health disparities and the needs of the underserved
- The evidence base will be dependent upon the specific work of each community organization but is one of the selection criteria that is reviewed and considered in determining partners

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: Implement a Faith Community Wellness Program, partnering with faith communities, to provide state of the art wellness promotion and health care that embodies physical, psychological, social and spiritual care for individuals

• The target population is faith leaders and their congregants across Rutherford County
• The collective energy and commitment of all collaborating in this strategy (physicians, Nurse Navigators, FCNs, clergy and faith community care teams) brings together an integration of services that imparts great benefits to many populations, with focus on the underserved and uninsured. This strategy aims to extend access to supplementary services to many individuals who otherwise would have limited or no access
• This strategy is evidence-based, upon the model for congregational health developed by the Methodist Health System in Memphis, Tennessee

Anticipated Impact:
• Annually serve 1,000 individuals with Saint Thomas Rutherford Hospital congregational nurse navigation
• Annually reach 30,000 individuals through FCNs, congregational care team support, and education
• Alignment with State Priorities: Tennessee Department of Health’s Faith-Based Health Initiative
• Alignment with National Priorities: Healthy People 2020 Objective ECBP-10 – Increase the number of community-based organizations (including local health departments, Tribal health services, nongovernmental organizations, and State agencies) providing population-based primary prevention services

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

• The target population is uninsured and underinsured community members who utilize Saint Louise Family Medicine Center or Family Health Center – Eagleville as their PCMH.
• Physical wellness cannot be achieved without mental wellness. Providing treatment and support is essential for all patients, in particular for those living within poverty or in areas where healthcare is not easily accessed. Screening and treatment of mental disease illnesses our clinics will lead to healthier patients and healthier communities.
• This strategy is built upon the evidence base cited by Healthy People 2020’s Access to Health Services topic: People with a usual source of care have better health outcomes and fewer disparities and costs.
Anticipated Impact:
• By July 2017, 90% of PCMH patients in the respective practice will be screened for behavioral health needs
• By December 2017, 90% of patients with a positive screen will be receiving needed behavioral healthcare
• Alignment with Local Priorities: Rutherford County Health Department identifies Mental and Emotional Health / Substance Abuse as a Priority Health Need
• Alignment with State Priorities: Tennessee State Health Plan Goal 1c. Health disparities between and among populations, as well as the underlying causes of these disparities, are eliminated – Behavioral Health cited as a Priority
• Alignment with National Priorities: Healthy People 2020 Objective MHMD-5 – Increase the proportion of primary care facilities that provide mental health treatment onsite or by paid referral
• Alignment with National Priorities: Healthy People 2020 Objective MHMD-9 – Increase the proportion of persons with mental health disorders who receive treatment
• Alignment with National Priorities: Healthy People 2020 Objective MHMD-11 – Increase depression screening by primary care providers

Strategy 3: Offer chaplain services at the Saint Louise Family Medicine Center to integrate spiritual care with physical and mental care, seeking to care holistically for patients
• 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 an increased proportion of patients with mental and emotional health needs receive needed care
• 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 4: Increase access to hospice care and grief support & counseling
• Details cited under Prioritized Need #1: Access to Care / Care Coordination
Strategy 5: Increase access to both primary and mental health care to residents of Rutherford County by providing services on the Mobile Health Unit
- Details cited under Prioritized Need #1: Access to Care / Care Coordination

Strategy 6: Pharmacist-driven improvement in medication management through community education sessions and patient-specific pharmacotherapy clinic appointments
- Details cited under Prioritized Need #1: Access to Care / Care Coordination

Strategy 7: Empower victims of sexual assault through the provision of SANE care and advocacy, ensuring that victims receive trauma-informed care and are connected to appropriate resources
- Details cited under Prioritized Need #1: Access to Care / Care Coordination

Strategy 8: Provide community-based organizations with financial support toward their work in one of the Prioritized Need areas
- Details cited under Prioritized Need #1: Access to Care / Care Coordination
Prioritized Need #3: Wellness and Disease Prevention

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

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

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

Anticipated Impact:
- By June 2017, 70% of mothers who visited the clinic will still be breastfeeding at 3 months
- By June 2018, 70% of mothers who visited the clinic will still be breastfeeding at 6 months
- Alignment with National Priorities: By 2020, increase the number of infants who have breastfed: ever from 74 to 81.9%, at 6 months from 43.5 to 60.6%, at 1 year from 22.7 to 34.1%, exclusively through 3 months from 33.6 to 46.2%, exclusively through 6 months from 14.1 to 25.5% (CDC/Healthy People 2020 Guidelines)
- Alignment with National Priorities: Healthy People 2020 Objective MICH-3.1 – Reduce the rate of deaths among children aged 1 to 4 years

Strategy 2: Implement a Faith Community Wellness Program, partnering with faith communities, to provide state of the art wellness promotion and health care that embodies physical, psychological, social and spiritual care for individuals

- Details cited under Prioritized Need #2: Mental and Emotional Health / Substance Abuse

Strategy 3: Implement a community-wide campaign that integrates education and barrier reduction to increase breast cancer screenings

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

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

Strategy 4: Implement a community-wide campaign to provide nutrition counseling that will improve food choices
• The strategy’s target population is low-income Rutherford County residents who are either uninsured or underinsured
• The campaign will address health disparities and barriers to care by providing community education and free nutrition counseling to low-income community members
• The strategy is built upon the evidence base cited by Healthy People 2020’s Nutrition and Weight Status topic

Anticipated Impact:
• By February 2017, increase the number of obese patients receiving dietary counseling by 10%
• By September 2017, decrease average BMI by 5% for patients receiving dietary counseling
• Alignment with Local Priorities: Rutherford County Health Department recognizes Wellness and Disease Prevention as a Priority Health Need
• Alignment with State Priorities: Obesity is cited as one of the Tennessee Department of Health’s four priorities
• Alignment with National Priorities: Healthy People 2020 Objective NWS-8 – Increase the proportion of adults who are at a healthy weight

Strategy 5: Improve maternal and infant health through offering prenatal education and lactation consulting
• The target population is community members who are either pregnant or new mothers
• This strategy addresses health disparities and cares for the underserved by increasing access to prenatal care and lactation consulting available to un/underinsured patients, including the Hispanic and African American populations
• This strategy is in line with national recommendations for prenatal care and utilizes evidence-based lactation consulting practices

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

Strategy 6: Pharmacist-driven improvement in medication management through community education sessions and patient-specific pharmacotherapy clinic appointments
• Details cited under Prioritized Need #1: Access to Care / Care Coordination

Strategy 7: 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. 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

Strategy 8: Increase the physical activity of youth by constructing outdoor walking tracks at three Rutherford County Middle Schools
• The target population is students (and staff) of Smyrna Middle, LaVergne Middle, and Buchanan Middle Schools
• This strategy addresses health disparities by expanding opportunities for physical activity for students who are disproportionately obese and qualifying for free and reduced lunch.
• This strategy is evidence-based, as tracks have been implemented in Rutherford County elementary schools; data has shown increased physical activity and decreased rates of overweight and obese students at these schools. This is an environmental change, resulting in the permanent placement of a track to promote physical activity

Anticipated Impact:
• Observe an annual decrease in overweight and obesity among students by 0.5%
• Alignment with State Priorities: Physical inactivity and obesity are identified by the Tennessee Department of Health as two of four top priorities
• Alignment with National Priorities: Healthy People 2020 Objective NWS-10 – Reduce the proportion of children and adolescents who are considered obese

**Strategy 9: Provide community-based organizations with financial support toward their work in one of the Prioritized Need areas**

• Details cited under Prioritized Need #1: Access to Care / Care Coordination
Prioritized Need #4: Social Determinants

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

Strategy 1: Implement an anti-human trafficking initiative throughout Saint Thomas Health so that victims of human trafficking who seek medical care will be identified and connected with the assistance they need

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

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

Strategy 2: Provide resource navigation support to community members in need, recognizing how critical economic stability and social environments that promote good health are to improve an individual’s and a community’s health

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

Anticipated Impact:
- 80% of callers receiving at least one referral to a community resource by June 2019
- 70% of callers receiving assistance from the referral by June 2019
- Alignment with Local Priorities: Rutherford 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: Implement community-wide Medical Missions at Home that integrate medical, dental, vision and behavioral health, along with broader community resources
• Details cited under Prioritized Need #1: Access to Care / Care Coordination

Strategy 4: Formalize community partnerships to pilot a model for better meeting the resource needs of residents of a specific geography
• The target population is residents of Rutherford County zip code 37128 who are in need of socioeconomic resources
• This strategy is aiming to address social determinants, to provide the underserved with resources needed, which in turn will reduce health disparities across socioeconomic divides
• This will be a pilot program seeking to develop an evidence base as well as seeking to expand to other geographies. This strategy is a system change as Saint Thomas Health seeks to holistically serve members of the community, addressing first the priorities of the patient before looking specifically at their healthcare needs.

Anticipated Impact:
• Secure four community partners by June 2018 with whom to coordinate resource navigation
• By June 2019, see a 25% increase in accessibility of resources within the top two identified priority areas
• Alignment with State Priorities: Tennessee State Health Plan Goal 1a. People in Tennessee have the necessary support and opportunities for healthy living
• Alignment with State Priorities: Tennessee State Health Plan Goal 1c. Health disparities between and among populations, as well as the underlying causes of these disparities, are eliminated
• Alignment with National Priorities: Healthy People 2020 Objective SDOH-3.1 – Proportion of persons living in poverty
• Alignment with National Priorities: Healthy People 2020 Objective NWS-13: Reduce household food insecurity and in doing so reduce hunger

Strategy 5: Remove the barrier of transportation to increase the needed follow-up care received by patients of the Mobile Health Unit
• The target population is uninsured and underserved residents of Rutherford County who struggle to receive needed medical care due to transportation issues
• This strategy directly targets transportation as a social determinant of health
• This strategy is based upon a strategy utilized by other healthcare systems, such as Partners HealthCare and UK HealthCare

Anticipated Impact:
• Follow-up rates will increase 50% by December 2017 among voucher recipients
• Alignment with Local Priorities: Rutherford County Health Department recognizes 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 – Priority 2 for Consideration includes Transportation

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: Access to Care / Care Coordination

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

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

**Action Plan**

<table>
<thead>
<tr>
<th>STRATEGY 1: Engage state legislators and other key stakeholders to advocate for expanded access to care in Tennessee</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>BACKGROUND INFORMATION:</strong></td>
</tr>
<tr>
<td>• 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.</td>
</tr>
<tr>
<td>• This strategy targets those who are still without access to health insurance and thus are typically medically underserved.</td>
</tr>
<tr>
<td>• This strategy addresses a policy change and has drawn from other states who have proposed a version of Medicaid Expansion to the federal government that the state has specifically designed</td>
</tr>
<tr>
<td><strong>RESOURCES:</strong></td>
</tr>
<tr>
<td>• Saint Thomas Health Executive Representatives</td>
</tr>
<tr>
<td>• Saint Thomas Health Vice President of Advocacy</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. Saint Thomas Health leadership from each district meets with each state legislator who represent their district regarding increasing access and coverage for all Tennesseans</td>
</tr>
<tr>
<td>2. STH VP of Advocacy conducts follow up visits with each state legislator</td>
</tr>
<tr>
<td>3. Engage state legislators on other health policy that affects our health system and the health of Tennesseans</td>
</tr>
<tr>
<td><strong>ANTICIPATED IMPACT:</strong></td>
</tr>
<tr>
<td>I. Increase legislative support by 50% for expanded healthcare access/coverage by January 2018</td>
</tr>
<tr>
<td>II. Expand healthcare access/coverage in Tennessee by July 2018</td>
</tr>
</tbody>
</table>
**STRATEGY 2: Address the outpatient care needs of recently hospitalized vulnerable individuals by going beyond usual discharge planning**

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

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

**COLLABORATION:**
- Community resources

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

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

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

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

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

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

### ANTICIPATED IMPACT:
IV. Annually fill 30,000 prescriptions for unaffordable medications to qualifying individuals who enroll in Dispensary of Hope through medications obtained through the DOH Distribution Center, Saint Thomas Health Safety Net list, or physician donated samples.
STRATEGY 4: Provide a medical home for an increased number of uninsured and underinsured individuals, thus expanding their access to a full range of needed medical care

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

RESOURCES:
• Saint Louise Family Medicine Center
• Saint Thomas Medical Partners – Family Health Center – Eagleville
• PCMH Guidelines
• Saint Thomas – Rutherford Leadership

COLLABORATION:
• Specialist referral network
• University of Tennessee Health Science Center

ACTIONS:
1. Conduct survey to identify patient appointment needs
2. Develop and implement expanded schedules in response to communicated needs
3. Communicate expanded hours into the community
4. Host Family Medicine Resident Physicians at Saint Louise Family Medicine Center to expand practice capacity
5. Develop and annually update a list of specialists willing to see uninsured and underinsured patients
6. Facilitate needed specialist referrals to secure needed specialty care for patients

ANTICIPATED IMPACT:
V. By June of 2017, increase appointment availability for uninsured and underinsured individuals by 10%
VI. By June of 2017, increase access for uninsured and underinsured individuals to specialty care by 10%
**STRATEGY 5:** 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:**
VII. 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
<table>
<thead>
<tr>
<th>STRATEGY 6: Increase access to hospice care and grief support &amp; counseling</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>BACKGROUND INFORMATION:</strong></td>
</tr>
<tr>
<td>• The target population is Rutherford County residents and loved ones in need of hospice care and/or grief counseling</td>
</tr>
<tr>
<td>• Both hospice care and grief support are provided independent of a patient’s ability to pay for the services, thus caring for the underserved and addressing health disparities in access to hospice care or grief support</td>
</tr>
<tr>
<td>• This strategy is evidence-based, upon Alive Hospice’s 40 years of providing hospice care in Middle Tennessee</td>
</tr>
<tr>
<td><strong>RESOURCES:</strong></td>
</tr>
<tr>
<td>• Financial Support</td>
</tr>
<tr>
<td><strong>COLLABORATION:</strong></td>
</tr>
<tr>
<td>• Alive Hospice</td>
</tr>
<tr>
<td><strong>ACTIONS:</strong></td>
</tr>
<tr>
<td>1. Construction of Alive Hospice’s 10-bed respite and residential hospice, which includes grief center care areas</td>
</tr>
<tr>
<td>2. Open hospice facility for on-site care</td>
</tr>
<tr>
<td>3. Expand currently available grief support services</td>
</tr>
<tr>
<td>4. Begin on-site community and clinical education</td>
</tr>
<tr>
<td><strong>ANTICIPATED IMPACT:</strong></td>
</tr>
<tr>
<td>VIII. By December 2017, there will be a 50% decrease in travel time for community members seeking hospice care</td>
</tr>
<tr>
<td>IX. Annually, 90% of Grief Support clients will reach performance targets while under the care of a grief counselor</td>
</tr>
</tbody>
</table>
**STRATEGY 7:** Implement community-wide Medical Missions at Home that integrate medical, dental, vision and behavioral health, along with broader community resources

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

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

**COLLABORATION:**
- Students
- Community Agencies

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

**ANTICIPATED IMPACT:**

X. Increase awareness of and connection to social services and other resources through 300 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 8:** Convene a Middle Tennessee Oral Health Coalition to improve the oral and overall health of the dentally underserved in Middle Tennessee

**BACKGROUND INFORMATION:**

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

**RESOURCES:**

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

**COLLABORATION:**

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

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

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

## STRATEGY 9: Increase access to acute dental care for residents of Rutherford County by providing triage services on the Mobile Health Unit

### BACKGROUND INFORMATION:
- The target population is dentally uninsured and underserved residents of Rutherford County.
- Dental Care Triage via the Mobile Health Unit will assist in removing barriers to access by providing dental x-rays at sites around Rutherford County, assessing which patients are in need of acute dental follow-up and scheduling them for follow-up accordingly. This will both increase accessibility of dental attention to underserved areas of Rutherford County and increase the capacity of the Health Department to care for acute dental needs by screening in advance
- This strategy is supported by free and reduced lunch data in both Murfreesboro City and Rutherford County Schools, Public Transportation access, and centralized locations (walkability) to determine sites of service. Additionally, ancillary support services within the public school system partner with MHU staff to determine pockets of vulnerability and need within the community.

### RESOURCES:
- Mobile Health Unit Team

### COLLABORATION:
- Community Partners/Sites of Service
- Rutherford County Health Department
STRATEGY 9: Increase access to acute dental care for residents of Rutherford County by providing triage services on the Mobile Health Unit

ACTIONS:
1. Coordinate with the Rutherford County Health Department to determine a schedule
2. Purchase and install dental x-ray equipment
3. Conduct a monthly dental triage clinic, in which residents are screened via x-ray for needed dental follow up by the Rutherford County Health Department’s dental team
4. As needed, residents will be scheduled for follow-up at the Rutherford County Health Department to receive their needed acute dental services
5. Evaluate effectiveness of sites of service every quarter
6. Assess potential new sites of service as needed

ANTICIPATED IMPACT:
XV. By June 2017, 90% of patients identified to have a dental follow-up need will have received that follow-up care

STRATEGY 10: Increase access to both primary and mental health care to residents of Rutherford County by providing services on the Mobile Health Unit

BACKGROUND INFORMATION:
• The target population is uninsured and underserved residents of Rutherford County.
• Primary & Mental Health Care via the Mobile Health Unit will assist in removing barriers to access by providing services at targeted locations throughout Rutherford County. Additionally, services can be accessed at a reduced fee or free of charge as needed.
• This strategy is supported by free and reduced lunch data in both Murfreesboro City and Rutherford County Schools, Public Transportation access, and centralized locations (walkability) to determine sites of service. Additionally, ancillary support services within the public school system partner with MHU staff to determine pockets of vulnerability and need within the community.

RESOURCES:
• Mobile Health Unit Team
• Saint Louise Clinic Providers

COLLABORATION:
• Community Partners/Sites of Service
• Guidance Center
## STRATEGY 10: Increase access to both primary and mental health care to residents of Rutherford County by providing services on the Mobile Health Unit

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

**ANTICIPATED IMPACT:**

XVI. Increase awareness of primary health care resources in Rutherford County, with the MHU shared as a resource to 100% of Rutherford County Schools and Murfreesboro City Schools beginning in the 2016 – 2017 school year

XVII. Increase the ability of Rutherford County residents to access primary & mental care by serving 750 residents annually who otherwise would have no access

## STRATEGY 11: 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 Rutherford County.
- Our Mission In Motion Mobile Mammography will reduce barriers by providing access to screening mammography and breast health education to uninsured and underserved women.
- This strategy is informed by evidence found on Healthy People 2020 and Tennessee Cancer Coalition.

**RESOURCES:**
- Saint Thomas Medical Partners
- Saint Thomas Rutherford Hospital
- Our Mission In Motion Mobile Mammography staff
- Premier Radiology Center for Breast Health

**COLLABORATION:**
- TN Breast and Cervical Cancer Screening Program
- Susan G. Komen Central Tennessee
- Murfreesboro Radiology Inc.
STRATEGY 11: Increase breast cancer screening compliance through Our Mission In Motion Mobile Mammography

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

ANTICIPATED IMPACT:
XVIII. Conduct 12 community outreach visits annually in Rutherford County to provide free mammography services
XIX. Increase the number of women screened with the recommended frequency by 10%

STRATEGY 12: Pharmacist-driven improvement in medication management through Community Education Sessions and Patient Specific Pharmacotherapy Clinic Appointments

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

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

COLLABORATION:
- N/A

ACTIONS:
1. Increase access to Pharmacotherapy Clinic services for St. Louise Clinic patients
2. Deliver education to clinic providers about Pharmacist’s abilities and the Pharmacotherapy Clinic’s services
3. Educate patients regarding their disease, long-term complications, and self-monitoring techniques
<table>
<thead>
<tr>
<th>STRATEGY 12: Pharmacist-driven improvement in medication management through Community Education Sessions and Patient Specific Pharmacotherapy Clinic Appts</th>
</tr>
</thead>
<tbody>
<tr>
<td>4. Educate patients on importance of adherence, self-care, and close follow-up</td>
</tr>
<tr>
<td>5. Provide periodic community education/support groups for various chronic disease states (for example, heart failure and diabetes)</td>
</tr>
<tr>
<td>6. Deliver Pharmacotherapy services by improving access to care, use of evidence-based medicine, and adherence</td>
</tr>
</tbody>
</table>

**ANTICIPATED IMPACT:**

XX. By June 2017, increase the number of patients that are able to receive Pharmacotherapy Clinic services from 6 per week to 50 per week as reported through AthenaNet

XXI. By June 2017, achieve a 25% improvement in the number of patients that attain goal disease state-specific parameters as reported through AthenaNet

XXII. Annually provide 12 community education events on chronic disease management and self-monitoring as reported through program records that result in a 50% increase in attendee knowledge.

<table>
<thead>
<tr>
<th>STRATEGY 13: 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.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>BACKGROUND INFORMATION:</strong></td>
</tr>
<tr>
<td>- The target population is victims of sexual assault in Rutherford County age 13 and older</td>
</tr>
<tr>
<td>- This strategy works to eliminate barriers of sexual assault victims receiving the care they need</td>
</tr>
<tr>
<td>- 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</td>
</tr>
</tbody>
</table>

**RESOURCES:**

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

**COLLABORATION:**

- SANE Training – International Association of Forensic Nurses
**STRATEGY 13:** 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.

**ACTIONS:**
1. Expand the staff certified in SANE by identifying additional associates to attend the training
2. Conduct ongoing training with ED staff to increase awareness of SANE program
3. ED staff refers patients who are victims of sexual assault to the on-duty SANE nurse
4. Provide comprehensive medical-forensic exams to victims
5. Refer patients to other needed resources
6. Attend community events to raise awareness of sexual assault and the SANE resources

**ANTICIPATED IMPACT:**
XXIII. By June 2017, increase the % of presenting victims who are referred to SANE by 10%
XXIV. By June 2017, increase referrals provided to victims by 100%
XXV. By June 2017, increase patient call-backs by 100%, to assess further needed resources

---

**STRATEGY 14:** Improve access to care via telemedicine consultations when acute stroke symptoms are present

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

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

**COLLABORATION:**
- N/A

**ACTIONS:**
1. Increase system use to conduct telemedicine consultations in response to possible stroke symptoms
2. Increase physician and staff telemedicine education participation for competency in NIHSS use, Stroke Telemedicine use, and Stroke ID/Triage
3. Collect peer evaluations and responses from physicians and staff on the benefits of conducting
### STRATEGY 14: Improve access to care via telemedicine consultations when acute stroke symptoms are present

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

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

### STRATEGY 15: Provide community-based organizations with financial support toward their work in one of the Prioritized Need areas

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

**RESOURCES:**
- Financial Support

**COLLABORATION:**
- Community Organizations

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

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

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<tr>
<th>OBJECTIVE:</th>
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<th>“HEALTHY PEOPLE 2020” (or OTHER NATIONAL PLAN):</th>
</tr>
</thead>
<tbody>
<tr>
<td>I – XXVII</td>
<td>Rutherford County Health Department recognizes Access to Care / Care Coordination as a Priority Health Need</td>
<td></td>
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<tr>
<td>I, II</td>
<td></td>
<td></td>
<td>Healthy People 2020 Objective AHS-1 – Increase the proportion of persons with health insurance</td>
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<tr>
<td>I, II, IV, X, XI</td>
<td></td>
<td>TN State Health Plan Principle 2, Access to Care – People in TN should have access to healthcare and the conditions to achieve optimal health</td>
<td></td>
</tr>
<tr>
<td>III, V, VI, VII, VIII, IX, XVI, XVII</td>
<td></td>
<td>TN State Health Plan Goal 2d. People in TN are able to obtain appropriate quality healthcare services to meet their needs</td>
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<tr>
<td>III, IV, VII, VIII, IX, X, XI</td>
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<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, XVI, XVII</td>
<td></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>V, VI</td>
<td>Safety Net Consortium of Middle TN – Alignment on their objective to increase public awareness and use of safety net services and available insurance options</td>
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<tr>
<td>Priority for Consideration 5 within Goal 2d. of the TN State health Plan – Access to appropriate health and dental clinics impacts people’s ability to obtain appropriate services, especially for underserved populations</td>
<td>Healthy People 2020 Objective AHS-6.3 - Reduce the proportion of persons who are unable to obtain or delay in obtaining necessary dental care</td>
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<tr>
<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>
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<tr>
<td>Healthy People 2020 Objective RD-11 – Reduce hospitalizations for chronic obstructive pulmonary disease</td>
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<tr>
<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>
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<tr>
<td>Healthy People 2020 Objective IVP-40 – Reduce sexual violence</td>
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<tr>
<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>
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</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

<table>
<thead>
<tr>
<th>STRATEGY 1:</th>
<th>Implement a Faith Community Wellness Program, partnering with faith communities, to provide state of the art wellness promotion and health care that embodies physical, psychological, social and spiritual care for individuals.</th>
</tr>
</thead>
</table>
| BACKGROUND INFORMATION: | • The target population is faith leaders and their congregants across Rutherford County  
• The collective energy and commitment of all collaborating in this strategy (physicians, Nurse Navigators, FCNs, clergy and faith community care teams) brings together an integration of services that imparts great benefits to many populations, with focus on the underserved and uninsured. This strategy aims to extend access to supplementary services to many individuals who otherwise would have limited or no access  
• This strategy is evidence-based, upon the model for congregational health developed by the Methodist Health System in Memphis, Tennessee |
| RESOURCES: | • Saint Thomas Rutherford Hospital  
• Saint Thomas Rutherford Foundation  
• Saint Louise Family Medicine Center  
• Saint Thomas Rutherford Mobile Health Unit  
• Saint Thomas Rutherford Hospital Wellness Center |
| COLLABORATION: | • Over 30 Rutherford County faith communities who will comprise the Inter-Faith Council |
| ACTIONS: | 1. Hire a Manager of Faith Community Wellness  
2. Assess and determine current Faith Community Nurse network in Rutherford County  
3. Work with faith community partners to cultivate volunteer congregation care support teams  
4. Revise Saint Thomas – Rutherford Hospital workflow so that Nurse Practitioner Navigators, chaplains, transitional care coordinators and physicians seek patient approval to connect them to a Faith Community Nurse and volunteer congregation care support teams  
5. Begin discharging patients with a connection to a FCN and volunteer congregation care support team in the patients’ community  
6. FCN and volunteers follow up with patients, offering a full range of support including pastoral care |
**STRATEGY 1:** Implement a Faith Community Wellness Program, partnering with faith communities, to provide state of the art wellness promotion and health care that embodies physical, psychological, social and spiritual care for individuals.

7. Engage with clergy to enroll them in a discounted Clergy Wellness Program through the Saint Thomas Rutherford Hospital Wellness Center
8. Provide clergy with resources, tools and staff support to help inspire and facilitate their congregations to more fully engage in wellness

**ANTICIPATED IMPACT:**
I. Annually serve 1,000 individuals with Saint Thomas Rutherford Hospital congregational nurse navigation
II. Annually reach 30,000 individuals through FCNs, congregational care team support, and education

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

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

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

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

**ACTIONS:**
1. Appropriately screen each patient as dictated by PCMH guidelines or Behavioral Health guidelines.
2. Review the screening tool and refer to Behavioral Health as needed.
3. Initial appointment with Behavioral Health team for counseling and/or medication.
4. As appropriate, patient will remain under the care of Behavioral Health until patient/Behavioral Health team decide patient no longer needs Behavioral Health Care Management.

**ANTICIPATED IMPACT:**
III. By July 2017, 90% of PCMH patients in the respective practice will be screened for behavioral health needs
IV. By December 2017, 90% of patients with a positive screen will be receiving needed behavioral healthcare

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

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

**RESOURCES:**
- Saint Louise Chaplain
- Saint Louise Staff
- Saint Louise Behavioral Health Providers

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

**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:**
V. By June 2017 and after, 70% of patients referred to Behavioral Health by Chaplaincy will seek follow-up care, ensuring an increased proportion of patients with mental and emotional health needs receive needed care

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**STRATEGY 4:** Increase access to hospice care and grief support & counseling

**BACKGROUND INFORMATION:**
- The target population is Rutherford County residents and loved ones in need of hospice care and/or grief counseling
- Both hospice care and grief support are provided independent of a patient’s ability to pay for the services, thus caring for the underserved and addressing health disparities in access to hospice care or grief support
- This strategy is evidence-based, upon Alive Hospice’s 40 years of providing hospice care in Middle Tennessee

**RESOURCES:**
- Financial Support

**COLLABORATION:**
- Alive Hospice

**ACTIONS:**
1. Construction of Alive Hospice’s 10-bed respite and residential hospice, which includes grief center care areas
2. Open hospice facility for on-site care
3. Expand currently available grief support services
4. Begin on-site community and clinical education
STRATEGY 4: Increase access to hospice care and grief support & counseling

ANTICIPATED IMPACT:
VI. By December 2017, there will be a 50% decrease in travel time for community members seeking hospice care
VII. Annually, 90% of Grief Support clients will reach performance targets while under the care of a grief counselor

STRATEGY 5: Increase access to both primary and mental health care to residents of Rutherford County by providing services on the Mobile Health Unit

BACKGROUND INFORMATION:
• The target population is uninsured and underserved residents of Rutherford County.
• Primary & Mental Health Care via the Mobile Health Unit will assist in removing barriers to access by providing services at targeted locations throughout Rutherford County. Additionally, services can be accessed at a reduced fee or free of charge as needed.
• This strategy is supported by free and reduced lunch data in both Murfreesboro City and Rutherford County Schools, Public Transportation access, and centralized locations (walkability) to determine sites of service. Additionally, ancillary support services within the public school system partner with MHU staff to determine pockets of vulnerability and need within the community.

RESOURCES:
• Mobile Health Unit Team
• Saint Louise Clinic Providers

COLLABORATION:
• Community Partners/Sites of Service
• Guidance Center

ACTIONS:
1. Deliver physical health services at six sites of service, twice per week, utilizing Saint Louise Clinic providers and resident physicians
2. Deliver mental health services at three sites of service, twice per week, through on-site resources from the Guidance Center
3. Screen for substance abuse during mental health care provision, providing referrals as needed
4. Strengthen relationships with staff at MHU sites of service to ensure community partners understand the scope of our services and how to connect families with the MHU
5. Evaluate effectiveness of sites of service every quarter
6. Assess potential new sites of service as needed
STRATEGY 5: Increase access to both primary and mental health care to residents of Rutherford County by providing services on the Mobile Health Unit

ANTICIPATED IMPACT:
VIII. Increase awareness of primary health care resources in Rutherford County, with the MHU shared as a resource to 100% of Rutherford County Schools and Murfreesboro City Schools beginning in the 2016 – 2017 school year
IX. Increase the ability of Rutherford County residents to access primary & mental care by serving 750 residents annually who otherwise would have no access

STRATEGY 6: Pharmacist-driven improvement in medication management through Community Education Sessions and Patient Specific Pharmacotherpay Clinic Appointments

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

RESOURCES:
• Pharmacist with needed supplies and dedicated space
• Saint Louise Clinic Providers & Staff

COLLABORATION:
• N/A

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

ANTICIPATED IMPACT:
X. By June 2017, increase the number of patients that are able to receive Pharmacotherapy Clinic services from 6 per week to 50 per week as reported through AthenaNet
XI. By June 2017, achieve a 25% improvement in the number of patients that attain goal disease state-specific parameters as reported through AthenaNet
XII. Annually provide 12 community education events on chronic disease management and self-monitoring as reported through program records that result in a 50% increase in attendee knowledge

STRATEGY 7: Empower victims of sexual assault through the provision of SANE care and advocacy, ensuring that victims receive trauma-informed care and are connected to appropriate resources.

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

RESOURCES:
• Saint Thomas – Rutherford Hospital Providers
• SANE Exam Space and Materials

COLLABORATION:
• SANE Training – International Association of Forensic Nurses

ACTIONS:
1. Expand the staff certified in SANE by identifying additional associates to attend the training
2. Conduct ongoing training with ED staff to increase awareness of SANE program
3. ED staff refers patients who are victims of sexual assault to the on-duty SANE nurse
4. Provide comprehensive medical-forensic exams to victims
5. Refer patients to other needed resources
6. Attend community events to raise awareness of sexual assault and the SANE resources
STRATEGY 7: Empower victims of sexual assault through the provision of SANE care and advocacy, ensuring that victims receive trauma-informed care and are connected to appropriate resources.

ANTICIPATED IMPACT:
XIII. By June 2017, increase the % of presenting victims who are referred to SANE by 10%
XIV. By June 2017, increase referrals provided to victims by 100%
XV. By June 2017, increase patient call-backs by 100%, to assess further needed resources

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

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

RESOURCES:
- Financial Support

COLLABORATION:
- Community Organizations

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

ANTICIPATED IMPACT:
The work of community organizations working to meet the Priority Needs will be furthered through a partnership with Saint Thomas Health. Specific objectives will be dependent upon the specific actions and interventions of each selected partner organization. Each organization will submit its anticipated impact in its request seeking financial support from Saint Thomas Health.
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<tr>
<td>I, II</td>
<td>TN Department of Health’s Faith-Based Health Initiative</td>
<td>Healthy People 2020 Objective ECBP-10 – Increase the number of community-based organizations providing population-based primary prevention services</td>
<td></td>
</tr>
<tr>
<td>I – XV</td>
<td>Rutherford County Health Department recognizes Mental and Emotional Health / Substance Abuse as a Priority Health Need</td>
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<tr>
<td>III, IV</td>
<td>TN State Health Plan Goal 1c. Behavioral Health cited as a Priority</td>
<td>Healthy People 2020 Objective MHMD-5 – Increase the proportion of primary care facilities that provide mental health treatment onsite or by paid referral</td>
<td></td>
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<tr>
<td>III, IV</td>
<td></td>
<td>Healthy People 2020 Objective MHMD-9 – Increase the proportion of persons with mental health disorders who receive treatment</td>
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<tr>
<td>III, IV</td>
<td></td>
<td>Healthy People 2020 Objective MHMD-11 – Increase depression screening by primary care providers</td>
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<td>V</td>
<td>Spiritual health cited as a component of the TN State Health Plan’s targets toward moving TN residents toward optimal health</td>
<td>Healthy People 2020 Objective HRQOL/WB-1.2 – Increase the proportion of adults who self-report good or better mental health</td>
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<tr>
<td>VIII, IX</td>
<td></td>
<td>Healthy People 2020 Objective MHMD-9 – Increase the proportion of persons with mental health disorders who receive treatment</td>
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<tr>
<td>VIII, IX</td>
<td></td>
<td>Healthy People 2020 Objective MHMD-12 – Increase the proportion of homeless adults</td>
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<td>with mental health problems who receive mental health services</td>
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<tr>
<td>X, XI, XII</td>
<td>Healthy People 2020 Objective TU-1 – Reduce tobacco use by adults</td>
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<tr>
<td>XIII, XIV, XV</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>
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Prioritized Need #3: Wellness and Disease Prevention

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

### Action Plan

<table>
<thead>
<tr>
<th><strong>STRATEGY 1:</strong> Operate a community based breastfeeding clinic to support and educate breastfeeding families</th>
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<tbody>
<tr>
<td><strong>BACKGROUND INFORMATION:</strong></td>
</tr>
<tr>
<td>• The strategy’s target population is breastfeeding families in Rutherford County</td>
</tr>
<tr>
<td>• The clinic addresses health disparities and barriers to care by providing lactation services at no cost, services that otherwise would be out of reach for underserved families.</td>
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<tr>
<td>• Evidence-based lactation consulting practices are utilized in caring for the clinic’s patients. Lactation consultants, certified by the board of lactation, staff the clinic.</td>
</tr>
<tr>
<td><strong>RESOURCES:</strong></td>
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<tr>
<td>• Breastfeeding Outreach Clinic Staff</td>
</tr>
<tr>
<td>• Dedicated clinic space, with needed materials</td>
</tr>
<tr>
<td>• Saint Thomas Health Providers &amp; Staff</td>
</tr>
<tr>
<td><strong>COLLABORATION:</strong></td>
</tr>
<tr>
<td>• Non-Saint Thomas Health Providers</td>
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<tr>
<td><strong>ACTIONS:</strong></td>
</tr>
<tr>
<td>1. Employ certified lactation consultants to provide evidence based practice methods for breastfeeding to support families</td>
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<tr>
<td>2. Designate a space for the clinic, stocked with appropriate materials</td>
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<tr>
<td>3. Open the clinic for 10 hours per week and available for drop-in</td>
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<tr>
<td>4. Saint Thomas maternal/newborn staff refer breastfeeding families</td>
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<tr>
<td>5. Other community physicians refer breastfeeding families to the clinic</td>
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<tr>
<td>6. Advertise the clinic through social media</td>
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<tr>
<td><strong>ANTICIPATED IMPACT:</strong></td>
</tr>
<tr>
<td>I. By June 2017, 70% of mothers who visited the clinic will still be breastfeeding at 3 months</td>
</tr>
<tr>
<td>II. By June 2018, 70% of mothers who visited the clinic will still be breastfeeding at 6 months</td>
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</tbody>
</table>
**STRATEGY 2: Implement a Faith Community Wellness Program, partnering with faith communities, to provide state of the art wellness promotion and health care that embodies physical, psychological, social and spiritual care for individuals.**

**BACKGROUND INFORMATION:**
- The target population is faith leaders and their congregants across Rutherford County
- The collective energy and commitment of all collaborating in this strategy (physicians, Nurse Navigators, FCNs, clergy and faith community care teams) brings together an integration of services that imparts great benefits to many populations, with focus on the underserved and uninsured. This strategy aims to extend access to supplementary services to many individuals who otherwise would have limited or no access
- This strategy is evidence-based, upon the model for congregational health developed by the Methodist Health System in Memphis, Tennessee

**RESOURCES:**
- Saint Thomas Rutherford Hospital
- Saint Thomas Rutherford Foundation
- Saint Louise Family Medicine Center
- Saint Thomas Rutherford Mobile Health Unit
- Saint Thomas Rutherford Hospital Wellness Center

**COLLABORATION:**
- Over 30 Rutherford County faith communities who will comprise the Inter-Faith Council

**ACTIONS:**
1. Hire a Manager of Faith Community Wellness
2. Assess and determine current Faith Community Nurse network in Rutherford County
3. Work with faith community partners to cultivate volunteer congregation care support teams
4. Revise Saint Thomas – Rutherford Hospital workflow so that Nurse Practitioner Navigators, chaplains, transitional care coordinators and physicians seek patient approval to connect them to a Faith Community Nurse and volunteer congregation care support teams
5. Begin discharging patients with a connection to a FCN and volunteer congregation care support team in the patients’ community
6. FCN and volunteers follow up with patients, offering a full range of support including pastoral care and spiritual support
7. Engage with clergy to enroll them in a discounted Clergy Wellness Program through the Saint Thomas Rutherford Hospital Wellness Center
8. Provide clergy with resources, tools and staff support to help inspire and facilitate their congregations to more fully engage in wellness
**STRATEGY 2:** Implement a Faith Community Wellness Program, partnering with faith communities, to provide state of the art wellness promotion and health care that embodies physical, psychological, social and spiritual care for individuals.

**ANTICIPATED IMPACT:**
III. Annually serve 1,000 individuals with Saint Thomas Rutherford Hospital congregational nurse navigation
IV. Annually reach 30,000 individuals through FCNs, congregational care team support, and education

**STRATEGY 3:** Implement a community-wide campaign that integrates education and barrier reduction to increase breast cancer screenings

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

**RESOURCES:**
- Saint Louise Family Medicine Center
- Saint Thomas – Rutherford Hospital
- Mobile Mammography

**COLLABORATION:**
- Women’s Breast Center
- Premier Radiology
- National Breast Cancer Foundation

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

**ANTICIPATED IMPACT:**
V. By June 2017, increase local women’s knowledge of breast cancer resources to 80% as measured by community survey.
VI. By June 2017, increase local women’s self-reported breast cancer screenings from 68% to 73% as measured by W survey.
### STRATEGY 3: Implement a community-wide campaign that integrates education and barrier reduction to increase breast cancer screenings

VII. By June 2018, increase the proportion of women over 40 who receive a clinical breast exam from 79.1% to 85% as measured by BRFSS.

### STRATEGY 4: Implement a community-wide campaign to provide nutrition counseling that will improve food choices.

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

**RESOURCES:**
- Saint Louise Family Medicine Center

**COLLABORATION:**
- N/A

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

**ANTICIPATED IMPACT:**
- VIII. By February 2017, increase number of obese patients receiving dietary counseling by 10%.
- IX. By September 2017, decrease average BMI by 5% for patients receiving dietary counseling.
**STRATEGY 5:** Improve maternal and infant health through offering prenatal education and lactation consulting

**BACKGROUND INFORMATION:**
- The target population is community members who are either pregnant or new mothers
- This strategy addresses health disparities and cares for the underserved by increasing access to prenatal care and lactation consulting available to un/underinsured patients, including the Hispanic and African American populations
- This strategy is in line with national recommendations for prenatal care and utilizes evidence-based lactation consulting practices

**RESOURCES:**
- Saint Louise Family Medicine Center

**COLLABORATION:**
- N/A

**ACTIONS:**
1. Hire a Prenatal Educator/Lactation Consultant
2. Conduct visits with female patients in which pregnancy is confirmed
3. Refer pregnant patients to the practice’s insurance application enrollment specialist for CoverKids
4. Conduct and schedule the prenatal visits for each pregnant visit
5. Complete a post-partum visit 6-8 weeks after the patient delivers
6. At this post-partum visit, lactation consultant assesses breastfeeding success and counsels as needed

**ANTICIPATED IMPACT:**
X. By December 2017, 90% of patients will be completing the full prenatal course of care
XI. By December 2017, 40% of patients will be exclusively breastfeeding at 3 months
### STRATEGY 6: Pharmacist-driven improvement in medication management through Community Education Sessions and Patient Specific Pharmacotherapy Clinic Appointments

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

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

#### COLLABORATION:
- N/A

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

#### ANTICIPATED IMPACT:
- **XII.** By June 2017, increase the number of patients that are able to receive Pharmacotherapy Clinic services from 6 per week to 50 per week as reported through AthenaNet
- **XIII.** By June 2017, achieve a 25% improvement in the number of patients that attain goal disease state-specific parameters as reported through AthenaNet
- **XIV.** Annually provide 12 community education events on chronic disease management and self-monitoring as reported through program records that result in a 50% increase in attendee knowledge.
<table>
<thead>
<tr>
<th>STRATEGY 7: 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><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>XV. 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 8:** Increase the physical activity of youth by constructing outdoor walking tracks at three Rutherford County Middle Schools

**BACKGROUND INFORMATION:**
- The target population is students (and staff) of Smyrna Middle, LaVergne Middle, and Buchanan Middle Schools.
- This strategy addresses health disparities by expanding opportunities for physical activity for students who are disproportionately obese and qualifying for free and reduced lunch.
- This strategy is evidence-based, as tracks have been implemented in Rutherford County elementary schools; data has shown increased physical activity and decreased rates of overweight and obese students at these schools. This is an environmental change, resulting in the permanent placement of a track to promote physical activity.

**RESOURCES:**
- Financial support

**COLLABORATION:**
- Coordinated School Health

**ACTIONS:**
1. Develop a plan for the track’s location and construction
2. Receive School Board approval on track construction
3. Construct walking track
4. Integrate walking track into school day activities
5. Conduct annual BMI measurement of students

**ANTICIPATED IMPACT:**
XVI. Observe an annual decrease in overweight and obesity among students by 0.5%
**STRATEGY 9:** Provide community-based organizations with financial support toward their work in one of the Prioritized Need areas

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

**RESOURCES:**
- Financial Support

**COLLABORATION:**
- Community Organizations

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

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

<table>
<thead>
<tr>
<th>OBJECTIVE:</th>
<th>LOCAL / COMMUNITY PLAN:</th>
<th>STATE PLAN:</th>
<th>“HEALTHY PEOPLE 2020” (or OTHER NATIONAL PLAN):</th>
</tr>
</thead>
<tbody>
<tr>
<td>I, II, X, XI</td>
<td>By 2020, increase the number of infants who have breastfed</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I, II</td>
<td>Healthy People 2020 Objective MICH-3.1 – Reduce the rate of deaths among children aged 1 to 4 years</td>
<td></td>
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</tr>
<tr>
<td>I – XVI</td>
<td>Rutherford County Health Department recognizes Wellness and Disease Prevention as a Priority Health Need</td>
<td></td>
<td></td>
</tr>
<tr>
<td>III, IV</td>
<td>TN Department of Health’s Faith-Based Health Initiative</td>
<td>Healthy People 2020 Objective ECBP-10 – Increase the number of community-based organizations providing population-based primary prevention services</td>
<td></td>
</tr>
<tr>
<td>V, VI, VII</td>
<td>By 2018, increase the proportion of early-stage diagnoses of breast cancer among all women by 25%</td>
<td>By 2020, reduce the female breast cancer death rate from 23% to 20.7%</td>
<td></td>
</tr>
<tr>
<td>V, VI, VII</td>
<td>TN State Health Plan Goal 1c. Health disparities between and among populations, as well as the underlying causes of these disparities, are eliminated</td>
<td>Healthy People 2020 Objective C-3 – Reduce the female breast cancer death rate</td>
<td></td>
</tr>
<tr>
<td>VIII, IX</td>
<td>Obesity is cited as one of the TN Department of Health’s four priorities</td>
<td>Healthy People 2020 Objective NWS-8 – Increase the proportion of adults who are at a healthy weight</td>
<td></td>
</tr>
<tr>
<td>XII, XIII, XIV</td>
<td>Healthy People 2020 Objective HDS-21 – Increase the proportion of adults with a history of cardiovascular disease who are</td>
<td></td>
<td></td>
</tr>
<tr>
<td>XII, XIII, XIV</td>
<td>Healthy People 2020 Objective D-13 – Increase the proportion of adults with diabetes who perform self-blood glucose monitoring at least once daily</td>
<td></td>
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<tr>
<td>Physical inactivity is cited as one of the TN Department of Health’s four priorities</td>
<td>Healthy People 2020 Objective PA-2 – Increase the proportion of adults who meet current federal physical activity guidelines for aerobic physical activity</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Obesity and physical inactivity are cited as two of the TN Department of Health’s four priorities</td>
<td>Healthy People 2020 NWS-10 – Reduce the proportion of children and adolescents who are considered obese</td>
<td></td>
<td></td>
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<tr>
<td>using aspirin or antiplatelet therapy to prevent recurrent cardiovascular events</td>
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</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
### STRATEGY 2: Provide resource navigation support to community members in need, recognizing how critical economic stability and social environments that promote good health are to improve an individual’s and a community’s health.

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

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

#### COLLABORATION:
- N/A

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

#### ANTICIPATED IMPACT:
- II. 80% of callers receiving at least one referral to a community resource by June 2019
- III. 70% of callers receiving assistance from the referral by June 2019
STRATEGY 3: Implement community-wide Medical Missions at Home that integrate medical, dental, vision and behavioral health, along with broader community resources

**BACKGROUND INFORMATION:**
- The target population is low income, uninsured, underinsured, and underserved in the selected communities.
- This strategy addresses social determinants of health, health disparities and the challenges of the underserved by providing access to free medical, dental, vision, behavioral health care and social services.
- This strategy has been developed over the past 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 3: Implement community-wide Medical Missions at Home that integrate medical, dental, vision and behavioral health, along with broader community resources

**ANTICIPATED IMPACT:**

IV. Increase awareness of and connection to social services and other resources through 300 encounters with community agencies annually

V. 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 4: Formalize community partnerships to pilot a model for better meeting the resource needs of residents of a specific geography

**BACKGROUND INFORMATION:**

- The target population is residents of Rutherford County zip code 37128 who are in need of socioeconomic resources
- This strategy is aiming to address social determinants, to provide the underserved with resources needed, which in turn will reduce health disparities across socioeconomic divides
- This will be a pilot program seeking to develop an evidence base as well as seeking to expand to other geographies. This strategy is a system change as Saint Thomas Health seeks to holistically serve members of the community, addressing first the priorities of the patient before looking specifically at their healthcare needs.

**RESOURCES:**

- Saint Thomas Medical Partners – New Salem

**COLLABORATION:**

- Organizations serving the New Salem community

**ACTIONS:**

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

**ANTICIPATED IMPACT:**

VI. Secure four community partners by June 2018 with whom to coordinate resource navigation

VII. By June 2019, see a 25% increase in accessibility of resources within the top two identified priority areas
### STRATEGY 5: Remove the barrier of transportation to increase the needed follow-up care received by patients of the Mobile Health Unit

#### BACKGROUND INFORMATION:
- The target population is uninsured and underserved residents of Rutherford County who struggle to receive needed medical care due to transportation issues.
- This strategy directly targets transportation as a social determinant of health.
- This strategy is based upon a strategy utilized by other healthcare systems, such as Partners HealthCare and UK HealthCare.

#### RESOURCES:
- Mobile Health Unit Team

#### COLLABORATION:
- Rutherford taxi companies

#### ACTIONS:
1. Identify patients for whom, due to limited public transportation operating hours, transportation will be a barrier to the patient receiving medically necessary follow-up care.
2. Provide the patient with the needed referral.
3. Provide a taxi voucher for the intended purpose of returning home after the follow-up visit.
4. Measure follow-up rates among patients provided with a voucher.

#### ANTICIPATED IMPACT:
- VIII. Follow-up rates will increase 50% by December 2017 among voucher recipients.
**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 Rutherford County served by identified partner organizations
- All organizations will be assessed on the basis of the attention they pay to issues of health disparities and the needs of the underserved
- The evidence base will be dependent upon the specific work of each community organization but is one of the selection criteria that is reviewed and considered in determining partners

**RESOURCES:**
- Financial Support

**COLLABORATION:**
- Community Organizations

**ACTIONS:**
1. Make publicly available a Program Proposal form, through which community organizations can request a financial partnership from Saint Thomas Health
2. Receive Program Proposals from community organizations who seek support for a program working to meet one of the Priority Needs
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</tr>
</thead>
<tbody>
<tr>
<td>I</td>
<td></td>
<td></td>
<td>Healthy People 2020 Objective IVP-1.8 – Increase the proportion of the population residing within the continental United States with access to trauma care</td>
</tr>
<tr>
<td>I – VIII</td>
<td>Rutherford County Health Department recognizes Social Determinants as a Priority Health Need</td>
<td></td>
<td></td>
</tr>
<tr>
<td>II, III, VI, VII, VIII</td>
<td></td>
<td>TN State Health Plan Goal 1a. People in TN have the necessary support and opportunities for healthy living</td>
<td></td>
</tr>
<tr>
<td>II, III, VI, VII</td>
<td></td>
<td>TN State Health Plan Goal 1c. Health disparities between and among populations, as well as the underlying causes of these disparities, are eliminated</td>
<td>Healthy People 2020 Objective SDOH-3.1 – Proportion of persons living in poverty</td>
</tr>
<tr>
<td>II, III, VI, VII</td>
<td></td>
<td></td>
<td>Healthy People 2020 Objective NWS-13 – Reduce household food insecurity and in doing so reduce hunger</td>
</tr>
</tbody>
</table>