Atrium Medical Center (AMC) is part of Premier Health, the largest private, nonprofit, comprehensive health care system in Southwest Ohio. Atrium Medical Center is committed to improving the health of the communities it serves with high quality, cost-competitive health services. AMC serves Southwest Ohio from its Middletown campus. It is Warren County's only Level III Trauma Center and Primary Stroke Center. It is also the only accredited Chest Pain Center in Butler and Warren Counties. It offers a variety of health care services.

Mission

The mission is to improve the health of the communities we serve with others who share our commitment to provide high quality, cost-competitive health services.

Communities Served

The primary service areas identified for Atrium Medical Center include Butler and Warren Counties in Ohio.

Prioritization of CHNA Community Health Needs

Criteria for Prioritizing

In 2021, over thirty hospitals worked collaboratively to conduct a Community Health Needs Assessment (CHNA) for Southwest Ohio. The work was led by The Health Collaborative in Cincinnati, Ohio and the Greater Dayton Area Hospital Association in Dayton, Ohio. Local health departments also collaborated to shape the process and share data. Results in the CHNA report include data from a structured survey, qualitative data from multiple focus groups, an analysis of available secondary data, and findings from health departments. Atrium Medical Center aims to align its priorities with the top community health needs identified in the CHNA, while providing services that aid in addressing the social determinants of health, structural and systemic barriers that impact the surrounding community. Seven health issues achieved consensus as high priorities by the CHNA workgroup and were supported by the secondary data. Like the health priorities identified in the CHNA, Premier Health's approach to community health focuses on substance abuse and mental health; hunger and food insecurity; physical literacy and chronic disease; and infant and maternal health.

Prioritization Process

Results in the CHNA report include data from a structured survey, qualitative data from multiple focus groups, an analysis of available secondary data, and findings from health departments. Hospital leaders met on May 11, 2022, to endorse the priorities identified in the CHNA, and discussed appropriate implementation strategies.

Priorities

Among the health and non-health needs identified in the CHNA, AMC's top priorities include:

- Cardiovascular health
- Mental health and substance abuse
- Arthritis and osteoporosis
- Dental care
- Lung/respiratory health
- Maternal health
- Prevention

Process for Strategy Development

Premier Health's Director for Community Benefits, Lynn Foubert, convened the hospital team to develop the implementation strategies for these priorities. Assisting the team was Between the Lines Consulting, Inc.

Participants invited to the May 11, 2022; meeting included:

- Jennifer Burcham, Site Manager, PR, and Community Relations
- Keith Bricking, Emergency Physician
- Lori Etmans, Operations Director - Primary Care
- Lynn Foubert, Director, Premier Community Health and Care Management
- Dr. Andre Harris, VP OPERATIONS/CMO-AMC
- Kim Hensley, Vice President of Hospital Operations
- Ronda Seidenschmidt, Vice President of Operations at Atrium Medical Center
- Sumayyah Shermadou, Program Coordinator, Community Health Programs
- Mike Stautberg, President of Atrium Medical Center
- Paula Thompson, President & CEO, Fidelity Health Care
- Tomika Hedrington, Consultant
- Robyn Reepmeyer, Consultant
- Tiffany White, Consultant

Description of Strategies Addressing Top Health Conditions Identified in the CHNA

CARDIOVASCULAR HEALTH

Barbershop Health Initiative

Sponsor	Sumayyah Shermadou, Program Manager, Community Health Programs
Metrics	About 100 preventative screenings per year through the Barbershop Health Initiative.
Budget	$28,700 per year
Intervention Goal	The goal is to increase awareness of chronic health conditions and promote healthy lifestyle choices within African American communities.
Description	There are health disparities, especially for chronic diseases, in the African American community. According to the CDC, "new analysis shows that younger African Americans are living with or dying of many conditions typically found in white Americans at older ages. Chronic diseases and some of their risk factors may be silent or not diagnosed during these early years. Health differences are often due to economic and social conditions that are more common among African Americans than whites. For example, African American adults are more likely to report they cannot see a doctor because of cost." Barbershops are a frequently visited location for the target population. There are often trusted relationships created between the barbers and their clients. These opportunities allow barbers to serve as wellness champions and encourage their clients to be more involved in their health and practice healthy lifestyle behaviors. The Barbershop Health Initiative is a community-based program designed to provide free health screenings and education to community members who may not have access to healthcare and/or a physician. Premier Community Health partners with local barbershops and provides these services in the Mobile Clinic at each barbershop location. Partnering with the local health department, Public Health-Dayton & Montgomery County, will help expand services for the community. Barbers (and salon owners) have a close bond with their clients. They can serve as models of good health and/or help connect their clients to health services. The program provides free, voluntary, and convenient health screenings at the shops. Health fairs, events, and fun challenges also occur.
Partners	X-Quisite Cutz School of Barbering and X-Quisite Cutz Barbershop

MENTAL HEALTH AND SUBSTANCE ABUSE

OneFifteen

Sponsor	Elisabeth Esposito, President and CEO, Samaritan Behavioral Health
Metrics	Annual Number of Patients Served: 2021: 2,891 2022: 2,477
Budget	$2 million per year for the five-year period of 2020-2024 for a total of $10 million contribution
Intervention Goal	The goal is to remove barriers to treatment regardless of payor source; provide on-demand services 24/7; and refer to ongoing treatment based upon the assessment process following the ASAM (American Society of Addiction Medicine) criteria.
Description	One Fifteen is a beacon of hope for people suffering with substance abuse issues. Substance Abuse services provided by SBHI are designed to provide a seamless continuum that flows from the assessment through mental health and Substance Use Disorders levels of care designed to integrate and meet the needs of the client in developing a recovery-based lifestyle. Access can be via a referral from the area hospitals and emergency rooms, EMTs, walk-ins or via police escort. In addition, planning and implementing an inpatient setting that dedicates a portion of beds to medically complicated clients in need of detox treatment from alcohol, benzodiazepines, and opiates. In the Crisis Stabilization Unit, the patient receives a diagnosis and is then referred to outpatient treatment at SBHI that includes individual and group therapy and Medicated Assisted Treatment. The physicians prescribe Vivitrol and Suboxone. All substance use disorders are treated. Appropriate levels of care are based on *The ASAM Criteria: Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Conditions*. The criteria provide research-validated standards for outcome-oriented care in addiction treatment.
Partners	ADAMHS, GDAHA, Kettering Health Network, Samaritan Behavioral Health, Inc.

LUNG/RESPIRATORY HEALTH

Smoking Cessation Program

Sponsor	Sumayyah Shermadou, Program Manager, Community Health Programs
Metrics	Number of people enrolled and number of people that completed the program.
Budget	$40,000 for the 3-year period
Intervention Goal	The goal is providing counseling and support to patients, to help them quit smoking.
Description	In 2020, the CDC reported that 19.3% of adults in Ohio smoked compared to the national rate of 15.5%. The CDC estimates 47.9% of daily adult smokers in Ohio quit smoking for one or more days in 2019. The Smoking Cessation Program focuses on supportive conversation revolving around the health issues related to tobacco use, how to pinpoint and deal with personal triggers and overall well-being during the quit journey. The program meets in a group setting, once a week for five weeks.
Partners	Premier Health Physician Network, Community Health Centers

Lung Nodule Evaluation Program

Sponsor	Amanda McClure, MHA, BSN, RN, Director of Nursing, Upper Valley Medical Center; Jennifer Hauler, D.O., Chief Operating Officer, Miami Valley Hospital
Metrics	Number of patients evaluated, enrolled in registry program for lung nodule surveillance, and referrals for advanced evaluation by a Pulmonologist. -Stage shift to earlier stage diagnosis of lung cancer for the community. -Decreased length of time between first nodule detection and Treatment initiation.
Budget	$338,000 annually for 3 years earmarked to support program initiation and expansion, IT infrastructure, Advanced Practice Nurse, RN Navigator, and Medical Director
Intervention Goal	The goal is to build a foundation for a robust lung cancer screening program to impact: Timely capture of incidental lung nodules, cohesive care between practitioners, and streamlined referral process through a multidisciplinary "virtual clinic" with Advanced Practice Provider to coordinate care.
Description	An estimated 19% of incidental pulmonary nodules need follow up care ranging from follow-up surveillance imaging to referral for immediate diagnostic intervention and potential treatment. Successful programs have been shown to markedly increase compliance with evidence-based best practice surveillance. Lung Nodule Evaluation Program will ensure that all patients aged 18 or greater who have an incidental finding of a pulmonary nodule at a Premier Health facility or who are referred to the program, receive the proper evaluation and treatment for lung nodules in accordance with the Fleischner Society guidelines for lung nodules and recommended best-practice by the American Academy of Cardiothoracic Surgeons. Services provided are communicated via EPIC in-basket, MyChart patient communication, telephone or mail communication and coordinated with the patient's care team (Primary care and other specialties) by the APP or pulmonologist. Patients are followed until they have met criteria for completion of recommended surveillance, begin treatment for malignancy, or opt out of the program. The Lung Nodule Evaluation Program provides and is not limited to providing the following services: Imaging Study orders and associated follow up, referral to pulmonologist for nodule management, education on Lung Health, Smoking Cessation, and Lung Cancer Prevention, and Goals of Care as appropriate
Partners	Future partnerships between Fidelity Health Care and Community Employers for program growth to support lung wellness are anticipated.

MATERNAL HEALTH

Help Me Grow Brighter Futures

Sponsor	Roberto Colon M.D. Chief Medical Officer, VP of Operations Miami Valley Hospital
Metrics	Caseload of 1,770 families. 100% receiving home visit services receive education and assessment of a safe sleep environment. 100% of all moms, prenatal to age 1 of the child, are screened for depression. 100% of healthy infants survive to their first birthday. More than 80% of moms enrolled prenatally initiate breastfeeding. 54% are still breastfeeding at 6 months. Expansion to serve at least one more geographic area.
Budget	Premier Health supports salary and benefits expenses, projected at $969,995 annually.
Intervention Goal	In 2022, 11% of all infants born were born preterm in Butler County, 2016-2022 32% of Butler County infants who died were born preterm. By race, Black infants were 2.5 times more likely than white infants to be born less than 37 weeks gestation. In 2022, the infant mortality rate for non-Hispanic Black infants was 5 per 1,000 live births. The goals are to reduce infant mortality through home visits from birth to age 3 and to reach a caseload of 1,770 families for 2023-2025.
Description	Home visits include education about safe sleep, smoking cessation, reducing child maltreatment and injury, and encouraging mothers to breastfeed. Making connections to recruit pregnant first-time moms early in pregnancy is critical. One of the Fort Hamilton staff has transitioned to serve Montgomery and Preble Counties. Two staff are available to serve Preble County, expecting a growth of 25 clients. Miami County has added the Nurse Family Partnership to their services. Help Me Grow Brighter Futures utilized existing staff to support Miami County. In 2018 and 2019, Help Me Grow Brighter Futures received increased funding through Medicaid to expand home visiting for reducing infant mortality. Enrollment in home visiting increased by 200%. In 2017 the African American infant mortality rate was 15.1 in Butler County and in 2022 it decreased to a rate of 5. In 2022, 2,171 young children or pregnant moms were provided home visit services by the Help Me Grow Brighter Futures program. There were 28,124 home visits completed with families. The Nurse Family Partnership expanded into Butler County, adding staff at Atrium Medical Center and Fort Hamilton Hospital, to serve 100 first time pregnant women. The program expanded to 10 counties, adding Clark, Darke, Shelby and Warren Counties in 2022. Help Me Grow added a new program, Parents as Teachers, for families who missed eligibility for other programs but still have needs for parenting support and school readiness. Help Me Grow has 84 home visiting staff including 35 nurses, 24 Social Workers, and 25 teachers.
Partners	Greater Dayton Area Hospital Association, Kettering Health Network, Life Stages Centering, Five Rivers Health Centers, Southview Women's Center, Grandview Women's Center, Public Health, physician offices, and a variety of community programs such as the Wesley Center, Elizabeth New Life, Miami Valley Child Development Center, Promise to Hope, Life Resource Center, and Family Service Agency.

Promise to Hope

Sponsor	Roberto Colon M.D. Chief Medical Officer, VP of Operations Miami Valley Hospital
Metrics	Total clients served per year
Budget	The 2023 budget is $358,000 Promise to Hope has been 100% donor-funded through the Miami Valley Hospital Foundation. This includes funding from individuals, corporations, and foundations and levy dollars through the Montgomery County ADAMHS board. Support for expansion of addressing Substance Use Disorder (and not only Opiate Use Disorder), Miami Valley Hospital in, 2020, funded a second social worker (1.0 FTE), including salary and benefits.
Intervention Goal	To ensure healthy outcomes, pregnant women with substance use disorder or opiate use disorder require a multidisciplinary approach with connection to community resources. The goals are: 1) Decrease the number of unintentional deaths due to substance overdose in Montgomery County, thereby decreasing the maternal and infant mortality rates. 2) Increase the percentage of mothers who can successfully parent their infants following delivery, as opposed to placement by Children Services. 3) Decrease the average hospital length of stay for infants who are diagnosed with Neonatal Abstinence Syndrome (NAS) and/or Prenatal Substance Exposure. 4) Continue to increase the breastfeeding rate for mothers active in recovery at delivery.
Description	A team of physicians, a registered nurse, and a licensed independent social worker work collaboratively to meet the unique needs of pregnant women with opiate use disorder and/or substance use disorder and their infants. Miami Valley Hospital offers the facilities, the highly specialized equipment, and the experienced physicians, nurses, and related staff to provide care for both the mother and infant. To ensure the healthiest outcomes possible for both mother and child, personalized medical care and wraparound social support are provided. Promise to Hope initiates Medication Assisted Treatment (MAT) – (the use of FDA- approved medications, in combination with individual and group therapies, to treat opiate use disorder and/or substance use disorder) and connects the mother with a recovery agency of her choice in the community for ongoing treatment Promise to Hope has served 776 pregnant women with opiate use disorder since its inception in May 2015. It provides treatment during pregnancy and for up to a year after birth. In 2020, Promise to Hope expanded to include pregnant women with any type of substance use disorder rather than just targeting opiates. The Promise to Hope program has joined the Ohio Perinatal Quality Collaborative and is working with hospitals in Cincinnati, Dayton, Toledo, Athens, Cleveland, and Columbus to improve outcomes for moms and infants.
Partners	ADAMHS Board of Montgomery County; Joshua Recovery Ministries; Five Rivers Health Centers; NOVA Behavioral Health; Samaritan Behavioral Health; Recovery Works Healing Center; and TCN Behavioral Health

PREVENTION

Community Health Voucher Program

Sponsor	Lynn Foubert, Director, Premier Community Health and Care Management
Metrics	For the 3-year period, a projected 275 women system-wide will be served by the program. Premier Health is working to establish contracts with providers in the community for cervical services. When this is accomplished, it will increase the capacity for the number of women served.
Budget	$69,000 is projected for the 2023-25 cycle for all hospitals, with $5,000 allocated for Upper Valley Medical Center.
Intervention Goal	The voucher program's mission is to provide financial assistance to detect breast and cervical cancers at the earliest stage to uninsured and under-insured community residents.
Description	This program supplements the State of Ohio's funding to encourage women to be screened for breast cancer and cervical cancer. It provides financial assistance to women who are not eligible for the State program, and it also covers diagnostic testing and biopsies. This program is funded through the Miami Valley and UVMC Foundations as well as other community donations. Clients must be uninsured or underinsured (copayment, deductible, coinsurance) with income at or below 400% of Federal Poverty Level. The following services are covered by this program: screening mammograms; diagnostic mammograms; breast ultrasounds; breast biopsy; surgical consult (breast); Pap tests; clinical breast exams; colposcopies; and educational materials.
Partners	Atrium Medical Center Foundation, Good Samaritan Foundation-Dayton, UVMC Foundation, Miami Valley Hospital Foundation (Help Her Fight), Kroger, Breast Cancer Foundation, Kuhns Brothers and Five Rivers Health Centers

Community Health and Mobile Clinic Programming

Sponsor	Sumayyah Shermadou, Program Manager, Community Health Projects
Metrics	Number of events scheduled; number of preventative screenings (i.e., health screenings, flu vaccinations, etc.); number of people who received health education; percent of people identified as "at risk" and receiving follow up; and the number of people connected to resources.
Budget	$100,000 per year
Intervention Goal	The goal is to bring healthcare services to underserved communities in Butler and surrounding counties. Many community members in underserved communities do not have easy access to healthcare. The purpose of Premier Community Health's Mobile Clinic program is to make quality healthcare accessible at frequently visited locations to help community members receive care without having to travel long distances. The Mobile Clinic program partners with several locations (i.e., community centers, local schools, non-profit organizations, etc.) to offer healthcare services on a routine basis.
Description	The Mobile Clinic program offers health screenings and assists with physician referrals. The health screenings include blood pressure and blood glucose tests. The screenings are administered by a Premier Community Health nurse who completes the services being requested and uses paper forms to document. The patients receive their results immediately after the screening and discuss their screening values with the nurse. Patients also may undergo screenings for cholesterol evaluations. Services primarily focus on cardiovascular health. Literature about chronic diseases and healthy lifestyle alternatives are provided to patients.
Partners	Madison Local Schools, Gratis Fire Department, Preble County Council on Aging MidPointe Library – Trenton Branch, Central Connections, Robert "Sonny" Hill Middletown Community Center, Preble County Fairgrounds

The Daily Mile

Sponsor	Lynn Foubert, Director, Premier Community Health and Care Management
Metrics	Reengage and expand to at least two additional school districts in the region.
Budget	In-kind donated labor, equivalent to .28 FTE each year for 3 years.
Intervention Goal	The goal is to present physical activity as an important opportunity that shapes health, development, and future physical activity behavior in children. Children will experience higher levels of fitness, lower body fat, and stronger bones and muscles with an increase in physical activity levels.
Description	Regular physical activity benefits the mental and social health of children. The Daily Mile is a wellness intervention developed in Scotland, designed to increase physical activity levels during the school day by encouraging children to participate in a jog or run, at their own pace – with walking kept to a minimum. The Daily Mile objectives coincide with Healthy People 2020 objectives — to target younger children through physical activity in childcare settings. The Daily Mile was developed in 2012 and primarily featured in Scotland and England schools; however, its positive impact on the children resulted in participation from over 10,943 schools and nurseries worldwide and 2,309,784 students. Premier Health and the involved partners introduced the first Daily Mile pilot program in 2018. The pilot program resulted in a 52.7% participation rate in which 80% (of the students participating) demonstrated growth in their level of endurance. The pandemic unfortunately put this program on hold. For the upcoming year, this program's goal is to reengage existing school programs and implement them in 4 new schools over the next 3 years. The success of The Daily Mile can be credited to the partnership between the organizations and the school's educators. Premier and the community agencies involved with the project continue to work to expand the program within local school districts.
Partners	Dayton Children’s Hospital; Public Health Dayton & Montgomery County; Five Rivers MetroParks; Centerville City School District; Miamisburg City School District; and Centerville-Washington Park District

Healthy Heroes

Sponsor	Teresa Leeper, Healthy Heroes Manager
Metrics	Serve 24 local fire and police departments – in the process of adding 5 more.
Budget	Program employees 3.5 full time athletic trainers. Each athletic trainer is budgeted for $65,000.00. $65,000 X 3 = $195,000. Budget for supplies, mileage, marketing, etc. = $40,000
Intervention Goal	Premier Health's goal is to improve overall health and wellness by building relationships with first responders and inspiring them to engage in activities that promote improved injury rates and overall awareness of occupation specific healthcare needs.
Description	Healthy Heroes is a comprehensive wellness and fitness program designed to increase the effectiveness, efficiency, and durability of First Responders such as firefighters, EMS, and law enforcement. This program prepares the first responder for the physical readiness of the job and helps fight risk factors for injuries and illnesses associated with first responders. Athletic Trainers provide on-site weekly injury evaluation clinics to assess and treat musculoskeletal injuries common to the first responders. Our goal is to prevent minor injuries from becoming major disabilities. Athletic Trainers also provide education on various health and wellness topics such as nutrition, stress and sleep, and fitness specifics. Healthy Heroes Athletic Trainers are strength and conditioning specialists who can develop individual workouts to help first responders reach their specific health and wellness goals.
Partners	Community Fire/EMT Stations

Community Benefit Grant Program

Sponsor	Lynn Foubert, Director, Premier Community Health and Care Management
Metrics	The size and number of contribution awards.
Budget	$200,000 per year
Intervention Goal	Goal #1: Community Health Improvement: Community activities or programs that respond to community needs and seek to achieve objectives including improving access to health services, enhancing public health, and advancing increased general knowledge. Goal #2: Community-Building Activities: Community-building activities improve the community's health and safety by addressing the root causes of health problems, such as poverty, homelessness, environmental hazards, etc. These activities strengthen the community's capacity to promote the health and well-being of its residents by offering the expertise and resources of the health care organization
Description	Grant-making policy and specific grant decisions for community benefits contributions are made by the Community Benefits Executive Committee (or designees). The size and number of contribution awards are related to the amount of money available each year and vary year to year. Awards are typically in the range of $500 to $8,000. All projects: • Addresses health system priorities: Premier Health's priorities include behavioral health/substance abuse, birth outcomes, and chronic disease management. • Addresses social determinants: Social determinants are all the environmental factors that influence your health, including early childhood development, employment opportunities, food insecurity, air and water quality, transportation, educational attainment, public safety, and housing. • Addresses health equity and disparities: Health equity is achieved when immutable characteristics such as race, gender, sexual identity, and more are not correlated to higher rates of adverse health outcomes. Health disparities are the differences in health outcomes based on race, ethnicity, sexual orientation, and/or socio-economic status. • Upstream approach: An upstream approach addresses the community factors that shape health before any clinical intervention is necessary (also known as social determinants of health). These factors can include fields as diverse as affordable housing, public safety, access to healthy food, and economic opportunity. • Integration: Partnerships that align the practices and perspectives of communities, health systems and public health under a shared vision, establishing new roles while continuing to draw upon the strengths of each partner • Local: Partnerships that engage neighborhood residents and community leaders as key voices and thought leaders throughout all stages of planning and implementation • Data-driven and evidence-based: Partnerships that use data from both clinical and community sources as a tool to identify key needs, measure meaningful change, and facilitate transparency amongst stakeholders to generate actionable insights; mirroring proven strategies that facilitate tangible change.
Partners	None

Accountability

The Executive Community Benefits Committee is responsible for ensuring that strategies occur which meet the community needs, as outlined in this document. The Director for Community Benefits will assist as a community liaison in collaborative efforts and will help coordinate system-wide initiatives.

Significant Health Needs Addressed

Implementation Strategies, listed on the preceding pages, address the prioritized health needs:

- Cardiovascular health
- Mental health and substance abuse
- Lung/respiratory health
- Maternal health
- Prevention

Significant Health Needs Not Addressed

Currently, Atrium Medical Center does not offer any community benefit programs that address arthritis/osteoporosis for the general public. However, the Premier hospital system offers a robust array of services for their patients through their Orthopedic Service Line.

In addition, Atrium Medical Center does not offer any community benefit programs that address oral and dental care for the general public.

Board Approval

Premier Health's Board of Directors approved the Implementation Strategies on April 25, 2023.