ATRIUM MEDICAL CENTER

Community Health Improvement Plan

2014-2016

A comprehensive plan outlining the efforts of Atrium Medical Center to improve the health of those we serve.

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A Message from Premier Health

Dear Colleagues:

Healthcare is experiencing unprecedented changes that affect individuals and the entire community. In particular, the move to focus more fully on building healthier communities is a systemic change we have embraced for a long time at Premier Health and is part of our mission. We are committed to and are excited to support these initiatives that will positively impact so many of the people we serve.

An essential part of knowing how we can improve health in our community is to understand the unique health issues of our community. To that end, Premier Health was part of collaboration in 2013 with the Greater Dayton Area Hospital Association and hospitals throughout Southwestern Ohio to conduct a regional Community Health Needs Assessment. This assessment assisted us in identifying areas of opportunity to improve community health.

This report shares our plan for improving population health in the identified priority areas in our region. As you will see, a task this large cannot be done alone. Premier Health collaborates with numerous organizations, coalitions and other groups to impact these important issues. Just as we strive to offer patient-centered care in our clinical facilities, the majority of activities you see in this plan are community-centered.

This plan is just the beginning. Every three years a Community Health Needs Assessment and subsequent Community Health Improvement Plan will be repeated to help us understand the impact of our strategies as it relates to improving health and to identify emerging issues.

We are pleased to present this Community Health Improvement Plan for your review. We consider it a privilege to serve the people of the greater Dayton region and continue our efforts to impact the health status of the community.

Sincerely,

James Pancoast
President and CEO
Premier Health

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Executive Summary

Atrium Medical Center is part of Premier Health, the largest healthcare system in southwestern Ohio. This Community Health Improvement Plan comes from data gathered by a Community Health Needs Assessment conducted in 2013 on behalf of all the hospitals in the region by the Greater Dayton Area Hospital Association and Wright State University. The service areas identified for improvement by that survey are Butler and Warren counties in Ohio.

The priority areas identified for health improvement are:

Priority Area 1: Reduce the proportion of adults with hypertension.
Priority Area 2: Reduce the female breast cancer mortality rate.
Priority Area 3: To reduce the incidence of diabetes in our area and prevent complications in those who have diabetes.

While some other areas were identified for improvement, because of our involvement in community or statewide initiatives to address those issues, we are not addressing them separately in this report.

For detailed information about county demographics, social determents of health, accessibility of health care facilities and resources, behavior risk factors, maternal and infant health, clinical care indicators, some chronic disease indicators and leading causes of death, please consult the Community Health Needs Assessment.

Atrium Medical Center and Premier Health: Committed to Improving Community Health

Atrium Medical Center (AMC) is part of Premier Health, the largest healthcare system in southwestern Ohio.
It is committed to improving the health of the communities it serves through a variety of prevention, health improvement and engagement programs. As part of its overall commitment to the community, Atrium Medical Center focuses on four areas of service:

- Investing in the community
- Prevention and wellness
- Commitment to the under-served
- Community engagement

Three examples of Atrium Medical Center's community health improvement programs include:

Annual Diabetes Wellness Fair
Each year, Atrium Medical Center partners with the Middletown Area Family YMCA to co-host the Diabetes Wellness Fair. The fair is held in November to coincide with American Diabetes Month. It is free and open to the public. It includes health screenings and educational information from AMC and other local organizations.

Project SEARCH
Project SEARCH provides work experience and education for individuals with significant disabilities. It is administered on-site through Butler Technology and Career Development Schools. Participants are trained in a variety of jobs throughout the hospital, working in each area for 12 weeks at a time for the duration of the school year.

National Night Out
Atrium Medical Center partners with local law enforcement to offer safety information for residents of Middletown, Lebanon and Clear Creek Township. Local residents are able to interact with representatives through information booths.

Premier Health's Commitment to the Community

While Premier Health has a robust community-focused program, it also serves the community in other ways. In 2012, Premier Health:

- spent more than $106 million in 2012 to provide services to low-income residents to assure they got the medial care they needed;
- supported neighborhood development projects in east and west Dayton totaling more than $600,000;
- provides health education and screening services totaling more than $8.4 million;
- offered community and social services that totaled more than $6.7 million.

Premier Community Health

The hospitals in Premier Health collaborate to offer Premier Community Health. This organization offers evidence-based community health services to all the communities Premier Health serves. Its mission is to create a healthier community on behalf Premier Health through prevention, early detection and disease self management. Its focus areas are cancer, diabetes, heart, lung health and healthy living. In addition to a robust employer wellness program, it serves the community at congregations, senior centers and other community-based venues.

Premier Health Partners includes:

Miami Valley Hospital
    Miami Valley Hospital South
    Miami Valley Hospital Jamestown Emergency Center
Good Samaritan Hospital
    Good Samaritan North Health Center
Atrium Medical Center
Upper Valley Medical Center
Premier HealthNet
Premier Health Specialists
Upper Valley Professional Corporation
Fidelity Health Care
Samaritan Behavioral Health
Premier Community Health

Identified Priorities

In the Community Health Assessment, researchers identified priority areas for community health improvement using a variety of criteria. The priorities that are included and excluded in the plan.

Priorities Included in the Plan

Through the Community Health Risk Assessment, the following priorities were identified for Warren and Butler counties. These priorities are outlined in this plan.

Primary and Chronic Diseases

1. Hypertension—Hypertension self-reported rates are higher in the service area than in the State and nation (33.8% versus 31.7% and 28.7%, respectively). It is the leading inpatient discharge diagnosis and the 3rd leading ED discharge diagnosis.
2. Breast cancer—The breast cancer rate is 229 per 100,000, and the rate is increasing as opposed to other historically prevalent cancers.
3. Diabetes—The prevalence of diabetes is greater in the service area compared to the state and nation according to self-reports (12% vs. 10.1% and 8.7%). It is the 3rd most common inpatient discharge diagnosis and the 6th most common ER discharge diagnosis. Discharge diagnoses rates have increased from 2004 to2012. There is also an increase in kidney and renal cancer both of which are associated type 2 diabetes.

Priorities Addressed Through Collaboration

All identified priorities are important elements of improving the health of our community. In some instances priorities are already being targeted by collaborative groups of which Atrium Medical Center is a part. Additional strategies will not be developed independent of these efforts. Because of the importance of these community-wide efforts, the following identified priorities are not included in the Community Health Improvement Plan.

Maternal and Infant Priorities

1. First trimester prenatal care
2. Infant mortality rate

Atrium Medical Center is involved in several state-wide initiatives addressing these issues. As part of these collaborations, Atrium Medical Center will share the goals and objectives developed by those groups for program implementation and measurement.

Ohio Perinatal Quality Collaborative. Atrium Medical Center is a non-charter member of this organization as a maternity hospital. The mission of the Collaborative is, "Through collaborative use of improvement science methods, reduce preterm births and improve outcomes of pre-term newborns in Ohio as quickly as possible."

Projects of the collaborative include:

- 39 Weeks Delivery Charter Project – To reduce elective unnecessary scheduled births before 39 weeks gestational age. (Reduce infant mortality and low birth weights.)
- 39 Weeks Dissemination and Birth Registry Accuracy Project – This project was to address inaccuracies in birth certificate data within the Quality Improvement framework.
- Obstetrics Antenatal Corticosteroids Project- This project focuses on increasing the use of antenatal corticosteroids to reduce mortality and morbidity among preterm infants. (Reduce infant mortality.)

- Progesterone Project – This project intends to help raise awareness about the need for screening and intervention for progesterone, provide support to teams to implement screening, identification and treatment, develop the capacity and capability of skilled ultrasound technicians and remove administrative barriers to the administration of progesterone. (Reduce infant mortality and low birth weights.)

Ohio Hospital Association (OHA). OHA has developed a plan to reduce infant mortality (which also addresses low infant birth weight and first trimester care) in Ohio which includes:

- Safe sleep (infant mortality)
- Eliminating elective deliveries before 39 weeks (infant mortality)
- Progesterone for high risk mothers (infant mortality)
- Eliminating health disparities
- Safe spacing (infant mortality and low birth weight)
- Access to prenatal care (First trimester care, infant mortality and low birth weight)
- Promote breast milk
- These program areas also then address increasing first trimester care, improving low birth weight and decreasing infant mortality.

Primary and Chronic Diseases

3. Alcohol and drug dependence

The Butler County, Ohio Alcohol and Drug Addiction Services Board coordinates services for that county. Its strategic plan shows goals to reduce the number of overdose deaths, integrate behavioral health and primary care services and using a specialized perinatal program educating high risk pregnant women about the effects of substance abuse on their baby and how to make healthier lifestyle choices.

In Warren County, the Mental Health Recovery Services of Warren and Clinton counties coordinate substance abuse and mental health services for its residents. Similar to its Butler County equivalent, it assesses mental health and substance abuse needs in its community and provides funding for services that address those needs.

Key Health Priorities by Objective

Priority Area 1: Reduce the incidence and complications from adult hypertension.

Blood pressure is how hard blood pushes against the walls of our arteries when our heart pumps blood. When someone has high blood pressure, which is also called hypertension, this increased pressure against the arteries causes damage. Hypertension is called the silent killer because usually those who have it do not feel anything. High blood pressure increases risk for heart disease, stroke, heart failure, kidney disease and blindness.

In many cases hypertension can be prevented by maintaining a healthy weight, being active, eating healthy, not using tobacco and limiting alcohol. Most people who are diagnosed with high blood pressure can be controlled. Those with high blood pressure should take the same steps that may prevent high blood pressure. If medication is needed, it is imperative to take it every day.

Self-reported rates of hypertension are higher in the service area than in the state and nation (33.8% versus 31.7% and 28.7%, respectively). It is the leading inpatient discharge diagnosis and the 3rd leading ED discharge diagnosis.

Because of the significant health threat posed by hypertension, a community-focused, population health improvement strategy would benefit all parts of the community.

	The percentage of adults who have been told by a primary care provider that they have high blood pressure
Ohio	31.7%
Warren	33.8%- Only combined data for Butler and Warren counties available
Butler	

Priority Area 1: Reduce the proportion of adults with hypertension.
Objective 1.1: Increase the proportion of adults with hypertension whose blood pressure is under control.
Evidence-based Strategies:
Coordinate a hypertension education health communications campaign that will include communications tactics; free, community-based screenings and free online education.
Promote lectures about high blood pressure prevention and control in worksites, congregations, senior centers and other community based venues.
Identify or develop an educational brochure targeted to those who already have high blood pressure about the importance of medication adherence and healthy lifestyle. Make collateral available through system websites, Facebook pages, at employer and community events and other outlets to be identified. These will include how to get more information by telephone and/or online.

Outcome Indicators
Short and Intermediate Term
To have communications at least once a year in existing hospital communications vehicles that highlights hypertension and how it can be prevented/treated successfully.
To conduct at least two lectures per year reaching at least 45 unique individuals.
Long Term
Increase the proportion of adults with hypertension whose blood pressure is under control.

Objective 1.2: Increase the proportion of adults who have had their blood pressure measured within the preceding two years and can state whether their blood pressure was normal or high.
Evidence-based Strategies:
In addition to the monthly community-based blood pressure screening, AMC will conduct community based blood pressure screenings on at least 300 individuals per year at a variety of community based-venues.
Attempt telephone follow-up with 100% of those who have a stage 2 hypertension result, do not opt out of follow-up and have a working telephone.
We will successfully contact at least 45% of those eligible for follow-up.
If an individual does not have a primary care provider, we will offer to make a referral to the individual that meets their needs.
If an individual has not seen their primary care provider for three or more years, we will educate them about the importance of seeing their physician regularly to maintain themselves as a patient and encourage them to call their physician to become reestablished with them.
If an individual uses tobacco, we will offer them information about local cessation services.

Outcome Indicators
Short and Intermediate Term
In addition to the monthly blood pressure screening program, at least 500 unique individuals will receive a blood pressure screening each year in a variety of community-based venues.
We will successfully contact at least 45% of those eligible for follow-up.
Long Term
Increase the proportion of adults who have had their blood pressure measured within the preceding two years and can state whether their blood pressure was normal or high.

Programs and Resources to be Committed to Implement Plan
To implement the included programs, the hospital and Premier will provide: Program management/coordination/implementation staffing, physical work space, access to computers/telephones/standard office equipment, access to marketing and communications professionals for collateral writing/design/printing, professionals for follow-up calls and heath coaching, maintenance of all data collected and data analysis, primary care referral services, speakers, educational collateral pieces, appropriate social media, meeting space and space for community-focused health programs, screening paperwork and program evaluation.

Intended Collaborative Partnerships
All hospitals in Premier Health Premier Community Health Countryside YMCA- Lebanon

Women age 40+ who reported they have had

Priority Area 2: Reduce the female breast cancer mortality rate.

Reducing the impact of breast cancer in our area will require a diverse strategy because there are several issues to address:

1. More women are diagnosed with later stage breast cancer in our area
2. Mammography rates are lower in our area

a mammogram in the past two years	
	Yes
Ohio	79.10%
Butler	74.10%
Warren	73.80%
BRFSS SMART Data from Premier Oncology Assessment.	

Some identified risk factors for breast cancer are:

- Genetic alterations. (including BRCA1 and BRCA2 genes)
- Close family history. Having a mother, sister, and/or daughter diagnosed with breast cancer, especially before age 50. Having a close male blood relative with breast cancer.
- Race. While white women are diagnosed with breast cancer more than any other race, African American women die from breast cancer more than any other race.

(National Cancer Institute, Breast Cancer risk in American Women.)

According to research, major barrier for screening mammography has been a lack of health insurance. In 2010, only 32% of women age 40 and older with no health insurance had a mammogram in the past two years compared to 71% of those with insurance. Other barriers identified include the lack of a nearby mammography center, lack of transportation, lack of a primary care provider, no recommendation from a provider to get a screening, lack of awareness of breast cancer risks of screening methods, cultural and language differences. Studies have also identified a lack of time and perception of pain as barriers.

In Butler and Warren counties, the breast cancer rate is 229 per 100,000, and the rate is increasing, opposed to other historically prevalent cancers.

Priority Area 2: Reduce the female breast cancer mortality rate.
Objective 2.1: Increase the proportion of women who receive breast cancer screening based on the most recent guidelines.
Evidence-based strategies
Offer free mammograms and related services to uninsured, low-income women in our service area. Related services include transportation to and from appointments and help securing a primary care provider. (This may shift to paying some co-pays for insured women if we see a substantial decline in uninsured women.)
During October, which is Breast Health Month, include information about the importance of mammography for women in communications campaigns.
Educate women about the provision in the Affordable Care Act that provides screening mammography with no co-pay or deductible for women who meet screening guidelines.
Expand the "Brake for Breakfast" program to Atrium Medical Center. This program offers educational information about the importance of mammograms and breast risk factors with a free breakfast.

Objective 2.2: Increase awareness among women of increased risk due to family history and genetics.
Evidence-based strategies
Include information about breast cancer genetic risk in existing community focused

communications vehicles.
Offer a simple educational piece that includes how to reach genetics counselors.

Outcome Indicators
Short and Intermediate Term
To provide assistance to at least 20 women in Warren County and 30 women in Butler County to receive a screening mammogram, diagnostic mammogram, ultrasound, clinical breast exam and/or breast biopsy.
In its first year (2014) serve at least 100 people at the Brake for Breakfast program.
Long Term
To decrease the number of women in our area who are diagnosed with later stage breast cancers. To increase the number of women age 40 and older who have annual mammograms.

Programs and Resources to be Committed to Implement Plan
To implement the included programs, the hospital and Premier will provide: Program management/coordination/implementation staffing, physical work space, access to computers/telephones/standard office equipment, access to marketing and communications professionals for collateral writing/design/printing, professionals for follow-up calls, maintenance of all data collected and data analysis, primary care referral services, speakers, educational collateral pieces, appropriate social media, meeting space and space for community-focused health programs, screening paperwork and program evaluation.

Intended Collaborative Partnerships
All hospitals in Premier Health Premier Community Health Cincinnati Area Breast and Cervical Cancer Project The Ohio Fraternal Order of Eagles

Priority Area 3: To reduce the incidence of diabetes in our area and prevent complications in those who have diabetes.

Type 2 diabetes is a major public health issue that has reached epidemic proportions worldwide. According to the CDC, 25.8 million people in the United States have diabetes. Of these, 7 million do not know they have it. If continues, one of three US adults will have diabetes by 2050. Diabetes is the leading cause of blindness, kidney failure and amputations of feet and legs not related to accidents or injury. The majority of people who have type 2 diabetes also have heart disease.

Research shows making small lifestyle changes can help prevent diabetes. And, if a person has been told by a physician they have diabetes, it can be controlled.

The prevalence of diabetes is substantially greater in the service area compared to the state and nation. It is the 3rd most common inpatient discharge diagnosis and the 6th most common ER discharge diagnosis. Discharge diagnoses rates have increased from 2004 to2012. There is also an increase in kidney and renal cancer-- type 2 diabetes is significantly associated with an increased risk of renal cell cancer.

According to the 2014 County Health Rankings and Roadmaps, the percentage of adults aged 20 and older with diagnosed diabetes is:

Ohio	11%
Warren	9%
Butler	10%

(Data are for 2011. County Health camp rankings and Roadmaps collected this data from the National Center for Chronic Disease Prevention and Health Promotion, Division of Diabetes Translation.)

As with other health conditions, diabetes rates are higher among nonwhites. It is estimated that nationally 10.2% of non-Hispanic whites aged 20 and older have diabetes, both diagnosed and undiagnosed. However 18.7% of all non-Hispanic blacks aged 20 years and older have diabetes, both diagnosed and undiagnosed.

The American Diabetes Association estimates 35% of US adults aged 20 or older have prediabetes and 50% of those age 65 years or older have it. Of the 79 million Americans age 20 or older who have prediabetes, only 7.3% have been told they have it. Risk factors for prediabetes include being overweight and having a higher than normal blood glucose.

Adults who are considered overweight- BMI of 25-29.9

	Male	Female	All
Ohio	43.00%	29.40%	35.90%
Butler	42.1	26.6	34%
Warren	42.10%	26.80%	34.60%

Adults who are considered obese- BMI of 30+

	Male	Female	All
Ohio	27.10%	25.60%	26.30%
Butler	25.60%	25.60%	25.60%
Warren	26.20%	26.00%	26.10%

Priority Area 3: To reduce the incidence of diabetes in our area and prevent complications in those who have diabetes.
Objective 3.1: To prevent diabetes in those who have prediabetes.
Evidence-based Strategies:
At community screening events, offer a hemoglobin A1C following approved guidelines to find possible prediabetes.
A telephonic follow-up attempt will be made to 100% of those whose hemoglobin A1C falls out of recommended ranges. To be eligible, the participant cannot opt out of follow-up and have a working telephone number.
We successfully reach at least 45% of those eligible for a follow-up call.
Objective 3.2: Increase the number of people who are diagnosed with diabetes but do not know they have this disease.
Evidence-based Strategies:
At community screening events, offer a hemoglobin A1C following approved guidelines to find possible diabetes.
A telephonic follow-up attempt will be made to 100% of those whose hemoglobin A1C falls out of recommended ranges. To be eligible, the participant cannot opt out of follow-up and have a working telephone number.
We successfully reach at least 45% of those eligible for a follow-up call.
Objective 3.3: Increase the number of those who have been told by a primary care provider that they have diabetes and attend formal diabetes education classes at least every 2 years.
Evidence-based Strategies:
Develop strategies to inform those who have diabetes that under the Affordable Care Act, medical nutrition therapy for people with diabetes is covered with no co-pay or deductible.

Outcome Indicators
Short and Intermediate Term
To provide at least 50 hemoglobin A1c screenings in Warren and Butler counties.
Long Term
Increase the number of people who are diagnosed with diabetes but do not know they have this disease.
Increase the number of those who have been told by a primary care provider that they have diabetes and attend formal diabetes education classes at least every two years.
Ultimate Goal
Decrease the number of people who develop diabetes in our market area and increase the number of people who have diabetes, are well controlled and live healthy, active lives.

Programs and Resources to be Committed to Implement Plan
To implement the included programs, the hospital and Premier will provide: Program management/coordination/implementation staffing, physical work space, access to computers/telephones/standard office equipment, access to marketing and communications professionals for collateral writing/design/printing, professionals for follow-up calls and heath coaching, maintenance of all data collected and data analysis, primary care referral services, speakers, certified diabetes educators, educational collateral pieces, appropriate social media, meeting space and space for community-focused health programs, screening paperwork and program evaluation.

Intended Collaborative Partnerships
All hospitals in Premier Health Premier Community Health

Moving Forward

All the hospitals in Premier Health have a rich history of working with the communities they serve to improve the health of its citizens. With the data gleaned from this Community Health Needs Assessment and having developed a Community Health Improvement Plan, our work continues.

Improving community health is a process of continuing to build traditional and nontraditional partnerships, assuring programs and strategies are evidence-based, building in feedback loops, conducting ongoing evaluation and measuring if what we are doing is having the intended result. We understand these are issues that cannot be solved by a hospital alone- but take the work of all interested stakeholders in the community. We know we need to develop detailed strategies for the identified targeted areas with in-depth work plans and responsible parties.

As the process continues, we will continue to look at new strategies and opportunities, looking for ways to expand beyond the programs here and reach more people with life-improving and perhaps life-saving education and services.

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