COMMUNITY HEALTH IMPROVEMENT PLAN RECAP

2014-2016

Premier Health

ATRIUM MEDICAL CENTER

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

Atrium Medical Center (Atrium) is part of Premier Health, the largest health care 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 Atrium 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 Clearcreek Township. Local residents are able to interact with representatives through information booths.

Identified Priorities

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

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 third leading ER 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%, respectively). It is the third most common inpatient discharge diagnosis and the sixth most common ER discharge diagnosis. Discharge diagnosis rates have increased from 2004 to 2012. There is also an increase in kidney and renal cancer, both of which are associated with type 2 diabetes.

Priorities Addressed Through Collaboration (Excluded from the Plan)

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 maternal and infant issues. The hospital shares the goals and objectives collaboratively developed with these groups for program implementation and measurement.

Centering at Atrium Medical Center: Atrium Medical Center has been approved to receive Medicaid funds to begin a centering pregnancy program in an effort to decrease infant mortality in Warren and Butler counties. After a two-year process, Atrium was awarded funds to conduct centering on the AMC campus in the Maternal Child Health Center. The collaboration with local health departments and community agencies PRIM (Partnership to Reduce Infant Mortality) was essential to securing the funding to help combat infant mortality.

Ohio Perinatal Quality Collaborative: Atrium is a non-charter member of this organization as a maternity hospital. The mission of the collaborative is as follows: "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 unnecessary elective scheduled births before 39 weeks gestational age, thereby reducing infant mortality and low birth weights.
- 39 Weeks Dissemination and Birth Registry Accuracy Project – to address inaccuracies in birth certificate data within the quality improvement framework.
- Obstetrics Antenatal Corticosteroids Project – to increase the use of antenatal corticosteroids to reduce mortality and morbidity among preterm infants.
- Progesterone Project – to 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. The plan includes:

- safe sleep
- eliminating elective deliveries before 39 weeks
- progesterone for high-risk mothers
- eliminating health disparities
- safe spacing (also addresses low birth weight)
- access to prenatal care (also addresses first trimester care and low birth weight)
- promoting breast milk

Primary and Chronic Diseases

1. Alcohol and drug dependence

The Butler County Ohio Alcohol and Drug Addiction Services Board coordinates services for the county. Its strategic plan shows goals to reduce the number of overdose deaths, integrate behavioral health and primary care services, and use a specialized perinatal program to educate 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 the counties' residents. Similar to its Butler County equivalent, it assesses mental health and substance abuse needs in the community and provides funding for services that address those needs.

Priorities Included in the Plan

Through the Community Health Needs Assessment, the following priorities were identified for Atrium, and an improvement plan was put in place. Priorities in the plan are not listed in order of importance. Below are the initiatives and programs instituted in 2014 through 2016 to address health priorities.

1. Hypertension – hypertension rates are higher in the service area than in the state and nation. It is the leading inpatient discharge diagnosis and the third leading ER discharge diagnosis.

2. Breast cancer – the breast cancer rate is 195.3 per 100,000, and the rate is increasing in comparison to historically prevalent cancers.

3. Diabetes – widespread behavioral risk factors, such as obesity and physical activity, and the increasing rate of hospital inpatient diabetes diagnoses, are cause for concern.

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 the arteries when the heart pumps blood. When someone has high blood pressure, also known as hypertension, 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. For most people who are diagnosed with high blood pressure, it 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 third leading ER 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.

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

Priority Area 1: Reduce the proportion of adults with hypertension.
Objective 1.1: Among adults with hypertension, increase the proportion of those 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.
Update: Several community education forums were conducted on hypertension throughout Butler and Warren counties. Over 1100 individuals attended the education sessions and/or received health screenings.

Evidence-based Strategies: Promote lectures about high blood pressure prevention and control in worksites, congregations, senior centers and other community-based venues.
Update: Several educational events were conducted in community centers throughout Butler and Warren counties.
Evidence-based Strategies: Identify or develop an educational brochure targeted to those who already have high blood pressure about the importance of medication adherence and a 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.
Update: Premier Health has several marketing pieces, including high blood pressure handouts related to the management of high blood pressure and resources to assist in its management. The system also has information available online. Through various print and electronic materials (internal and external), Atrium disseminated educational information related to hypertension. Forms of communication included but were not limited to: • Focus on the Details (Weekly hospital/facility internal newsletter) • Premier Health intranet (internal) • Premier Health website (external) • social media sites (Facebook, Twitter, YouTube, etc.) Premier Health makes blood pressure experts available to discuss screening, prevention, treatment and management in both public forums and the media.

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.
Update: Through various print and electronic material (internal and external), **Atrium Medical Center** disseminated educational information related to hypertension. Forms of communication included but were not limited to: • Focus on the Details (weekly hospital/facility internal newsletter) • Premier Health intranet (internal) • Premier Health website (external) • social media sites (Facebook, Twitter, YouTube) Goal Achieved
Short and Intermediate Term: To conduct at least two lectures per year reaching at least 45 unique individuals.
Update: More than eight lectures on hypertension were conducted in within Butler and Warren counties with more than 400 unique individuals in attendance.
Long Term: Among adults with hypertension, increase the proportion of those whose blood pressure is under control.
Update: Among adults with hypertension, efforts to increase the proportion of those whose blood pressure is under control are ongoing and will continue to be our long-term goal.

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, Atrium will conduct community-based blood pressure screenings on at least 300 individuals per year at a variety of venues throughout the community.
Update: Atrium Medical Center has conducted 1,024 blood pressure screenings on members of the community at local venues, free of charge. Additionally, Atrium has conducted 771 free cholesterol screenings at community-based venues at various locations around the community to local citizens. Goal Exceeded
Evidence-based Strategies: 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.
Update: Follow-up calls are made with all participants who have a stage 2 hypertension result. Contact is then made with each participant's primary care physician. Additional attempts are made to contact participants via mail if telephone communication was unsuccessful.
Evidence-based Strategies: We will successfully contact at least 45 percent of those eligible for follow-up.
Update: Follow-ups are made with participants and then contact is made with the primary care physician.
Evidence-based Strategies: If an individual does not have a primary care provider, we will offer to make a referral to the physician that meets their needs.
Update: Referral lists of primary care physicians within our network were given to participants who do not have a physician.
Evidence-based Strategies: 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 the practice.
Update: Referral lists of primary care physicians within our network were given to participants who do not have a physician.
Evidence-based Strategies: If an individual uses tobacco, we will offer them information about local cessation services.
Update: In August 2015, the Mayo Clinic Nicotine Dependence Center came to Dayton, Ohio and held a tobacco treatment specialist training program, facilitated by Premier Community Health. As a result, Premier Health now has 26 staff members who are certified tobacco treatment specialists and who can assist individuals and patients with quitting tobacco. Dr. Michael Johnson, a plastic surgeon and physician champion, has helped promote the program to patients, physicians and other key leadership along the way. The free, five-week, group tobacco cessation classes hosted by Premier Community Health are designed to help individuals quit smoking. Our certified tobacco treatment specialists have the training needed to provide counseling and support to those who are ready to stop tobacco use.

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.
Update: More than 1,034 people were screened for their blood pressure each year in a variety of community-based venues. Goal exceeded.
Short and Intermediate Term: We will successfully contact at least 45 percent of those eligible for follow-up.
Update: At least 45 percent of people have received follow-up calls and contact has been made to their primary care physicians. If the person did not already have a primary care physician, they were given a referral sheet of physicians within the Premier Health network.
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.
Update: Efforts to 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 are ongoing and continue to be a long-term goal.

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

Women age 40+ who reported they have had a mammogram in the past two years	
	Yes
Ohio	79.10%
Butler County	74.10%
Warren County	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, a 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 and 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, in comparison 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.)
Update: In Butler and Warren counties, Premier Health's mobile mammography unit has enabled us to serve the breast cancer screening needs in our community. This mobile unit has traveled the region, serving more than 230 unique individuals in Butler and Warren counties in 2014-2015. Individuals also received prevention education information, as well as resources to further assist them in preventing breast cancer.
Evidence-based Strategies: 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.

Update: Premier Health educates all patients without insurance about the Affordable Care Act and accessing insurance through Ohio health insurance exchange marketplace. We also inform patients on the many benefits the ACA has provided, including the no co-pay for mammography for women who meet the screening guidelines. Our financial counselors at each facility are important in this role. Additionally, we educate patients on the Breast and Cervical Cancer Project (BCCP) that could potentially waive the cost for eligible women.

Objective 2.2: Increase awareness among women with increased risk due to family history and genetics.
Evidence-based Strategies: Include information about breast cancer genetic risk in existing community focused communications vehicles.
Update: Premier Health has several marketing pieces, including a cancer brochure and handouts related to mammography and high risk breast cancer that mention genetic counselors. The system also has information available online, including the new Women Wisdom Wellness site. When available, Premier Health makes cancer experts available to discuss genetic testing and genetic counseling in both public forums and the media.
Evidence-based Strategies: Offer a simple educational piece that includes how to reach genetic counselors.
Update: Same as previous.

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.
Update: In Butler and Warren counties, Premier Health's mobile mammography unit has enabled us to serve the breast cancer screening needs in our community. This mobile unit has traveled the region serving over 230 unique individuals in Butler and Warren counties from 2015-2016. Individuals also received prevention education information, as well as resources to further assist them in their journey to breast cancer prevention.
Long Term: To decrease the number of women in our area who are diagnosed with later-stage breast cancers
Update: Efforts to decrease the number of women in our area who are diagnosed with later-stage breast cancers is ongoing and continues to be a long-term goal.
Long Term: To increase the number of women age 40 and older who have annual mammograms.
Update: Efforts to increase the number of women age 40 and older who have annual mammograms is an ongoing long-term goal at Premier Health.

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 this trend continues, one in 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 third most common inpatient discharge diagnosis and the sixth most common ER discharge diagnosis. Discharge diagnosis rates have increased from 2004 to 2012. 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 County	9%
Butler County	10%

(Data are for 2011. County Health 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 percent of non-Hispanic whites age 20 and older have diabetes, both diagnosed and undiagnosed. However, 18.7 percent of all non-Hispanic blacks aged 20 years and older have diabetes, both diagnosed and undiagnosed.

The American Diabetes Association estimates 35 percent of US adults age 20 or older have prediabetes and 50 percent of those age 65 years or older have it. Of the 79 million Americans age 20 or older who have prediabetes, only 7.3 percent 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 to 29.9

	Male	Female	All
Ohio	43.00%	29.40%	35.90%
Butler County	42.1%	26.6%	34%
Warren County	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 County	25.60%	25.60%	25.60%
Warren County	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.
Update: Through various community engagement opportunities, we have served 1,135 people. Those engagements include, but are not limited to, health fairs, group presentations and material distribution. We were able to facilitate more than 1,000 pre-diabetic screenings, 717 HBC1 screenings and 1,000 diabetic risk screenings throughout Butler and Warren counties.
Evidence-based Strategies: A follow-up attempt will be made by telephone to 100 percent of those whose hemoglobin A1C falls out of recommended ranges. To be eligible, the participant cannot opt out of follow-up and must have a working telephone number.
Update: Follow-ups were made with participants, with contact then made with their primary care physician. If the person did not have a primary care physician, they were given a physician referral list, from within our network, free of charge.
Evidence-based Strategies: We successfully reach at least 45 percent of those eligible for a follow-up call.
Update: Follow-ups were made with participants and then contact was made with their primary care physician.
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.
Update: At various community-based venues around Montgomery County, hemoglobin A1C approved-guideline diabetic screenings were given, free of charge, to 716 local citizens.
Evidence-based Strategies: A follow-up attempt will be made by telephone to 100 percent of those whose hemoglobin A1C falls out of recommended ranges. To be eligible, the participant cannot opt out of follow-up and must have a working telephone number.
Update: Follow-ups were made with participants, with contact then made with each participant's primary care physician. If the person did not have a primary physician, they were given an in-network physician referral list free of charge.
Evidence-based Strategies: We successfully reach at least 45 percent of those eligible for a follow-up call.
Update: Follow-ups were made with participants, with contact then made with each participant's primary care physician.

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 two 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.
Update: Premier Health educates all patients without insurance about the Affordable Care Act and accessing insurance through the federally run health insurance exchange in Ohio. We also inform patients of the many benefits the law has provided, including that medical nutrition therapy for people with diabetes is covered with no co-pay or deductible. Our financial counselors at each facility are important in this role.

Outcome Indicators
Short and Intermediate Term: To provide at least 50 hemoglobin A1C screenings in Warren and Butler counties.
Update: Atrium Medical Center has conducted 716 A1C screenings to citizens in Butler and Warren counties, free of charge. The screenings conducted were in accordance with approved guidelines.
Long Term: Increase the number of people who are diagnosed with diabetes but do not know they have this disease.
Update: Efforts to increase the number of people who are diagnosed with diabetes but do not know they have this disease are ongoing and will continue to be our long-term goal.
Long Term: 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 very two years.
Update: The increase in numbers of those who have been told by a primary care provider (PCP) that they have diabetes and attend formal diabetes education classes at least every two years is an ongoing effort and will continue to be a long-term goal for Premier Health.
Ultimate Goal Decrease the number of people who develop diabetes in our market area, and increase the number of people whose diabetes is well controlled and they live healthy, active lives.
Update: Efforts are ongoing to decrease the number of people who develop diabetes in our market area and increase the number of people whose diabetes is well-controlled and they live healthy, active lives. This continues to be a Premier Health goal. However, some strategies are in place with Premier Community Health's collaboration with the Diabetes Coalition, the Center for Global Health and Wright State University on tackling food deserts in West Dayton – specifically within the African American population.

Moving Forward

All the hospitals in Premier Health have a rich history of working with the communities they serve to improve the health of their 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.