Atrium Health

Enhancing the Health of Our Communities

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December 2018

Goals

GET INFORMED

GET INSPIRED

GET ACTIVATED

GET UNCOMFORTABLE

Carolinas HealthCare System Is …

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Our Mission:

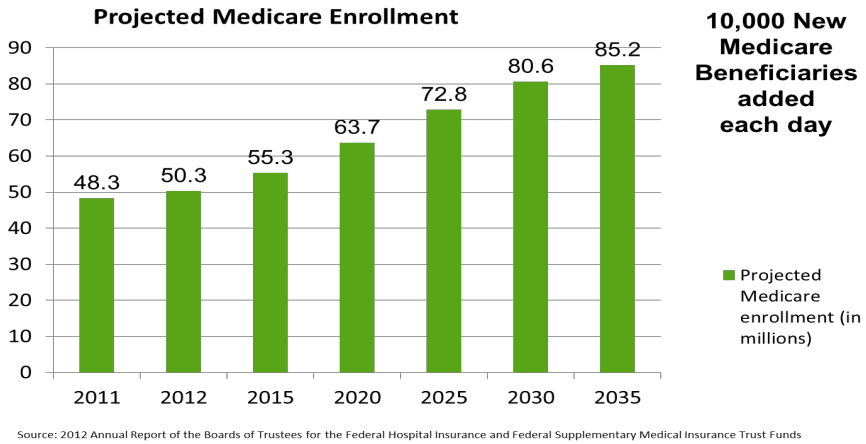
To improve **health**, elevate **hope** and advance **healing** – for all.

Our Vision:

To be the **first** and **best** choice for care.

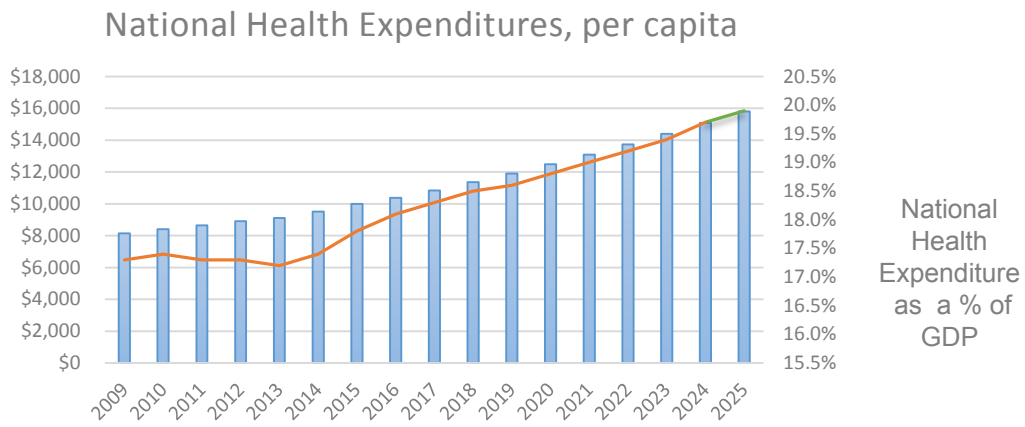
National Landscape – Market Pressures

1. Aging Population

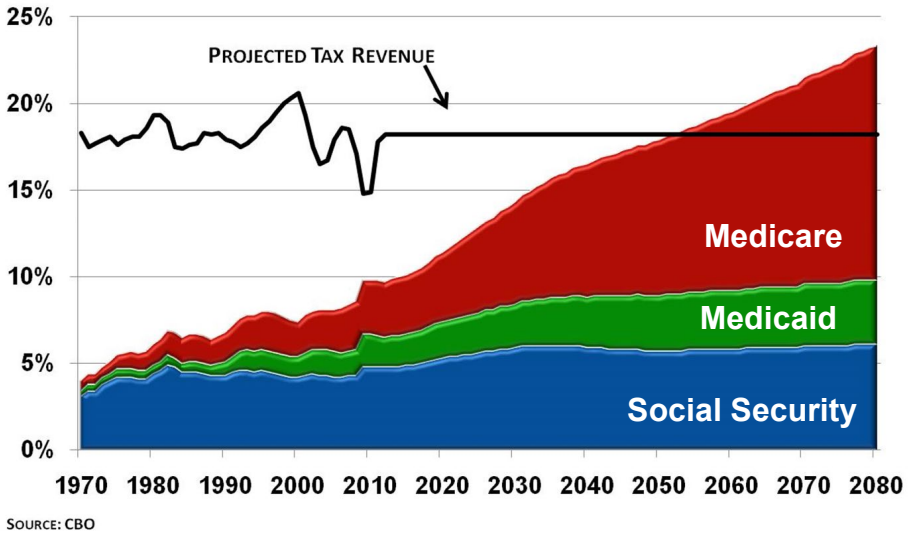


Source: 2012 Annual Report of the Boards of Trustees for the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds

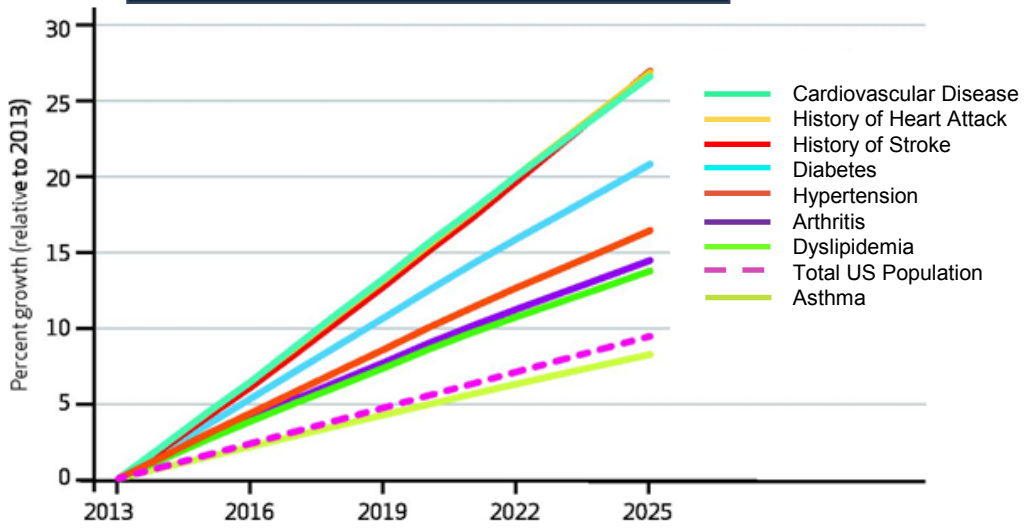
2. Significant Spend Increase



3. Not Fiscally Sustainable



4. Chronic Conditions



Slide Source: Premier

Strategy Map

VALUE

Excelling at delivering **high-value,** person-centered care

Improve the health of at-risk populations

Enhance community health and benefit in partnerships with others

Improve our value for teammates, their families and for employer partners

DESTINATION POINTS
Year-end 2020

Improve 300,000 Lives
in sustainable value-based models

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Community Health Strategic Priorities

ENHANCE COMMUNITY HEALTH AND BENEFIT IN PARTNERSHIPS WITH OTHERS:

- Improve Mental Health and Substance Abuse Awareness, Education, and Access
- Impact Reduction in Tobacco Use and Obesity Rates
- Facilitate Improved Access to Primary Care, Mental Health, and Dental Services
- Participate in Improvement of Social and Economic Indicators

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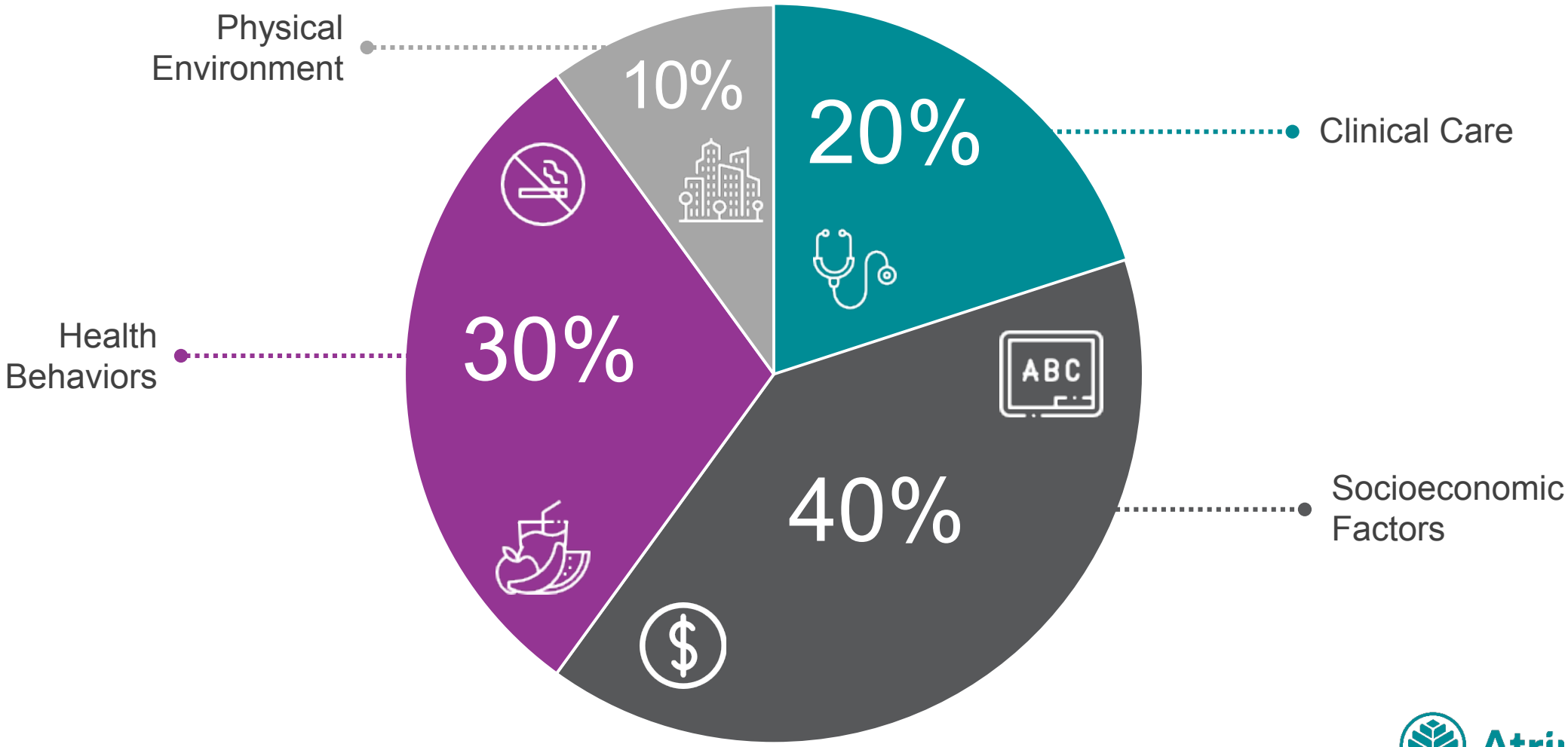
Know What Affects Health



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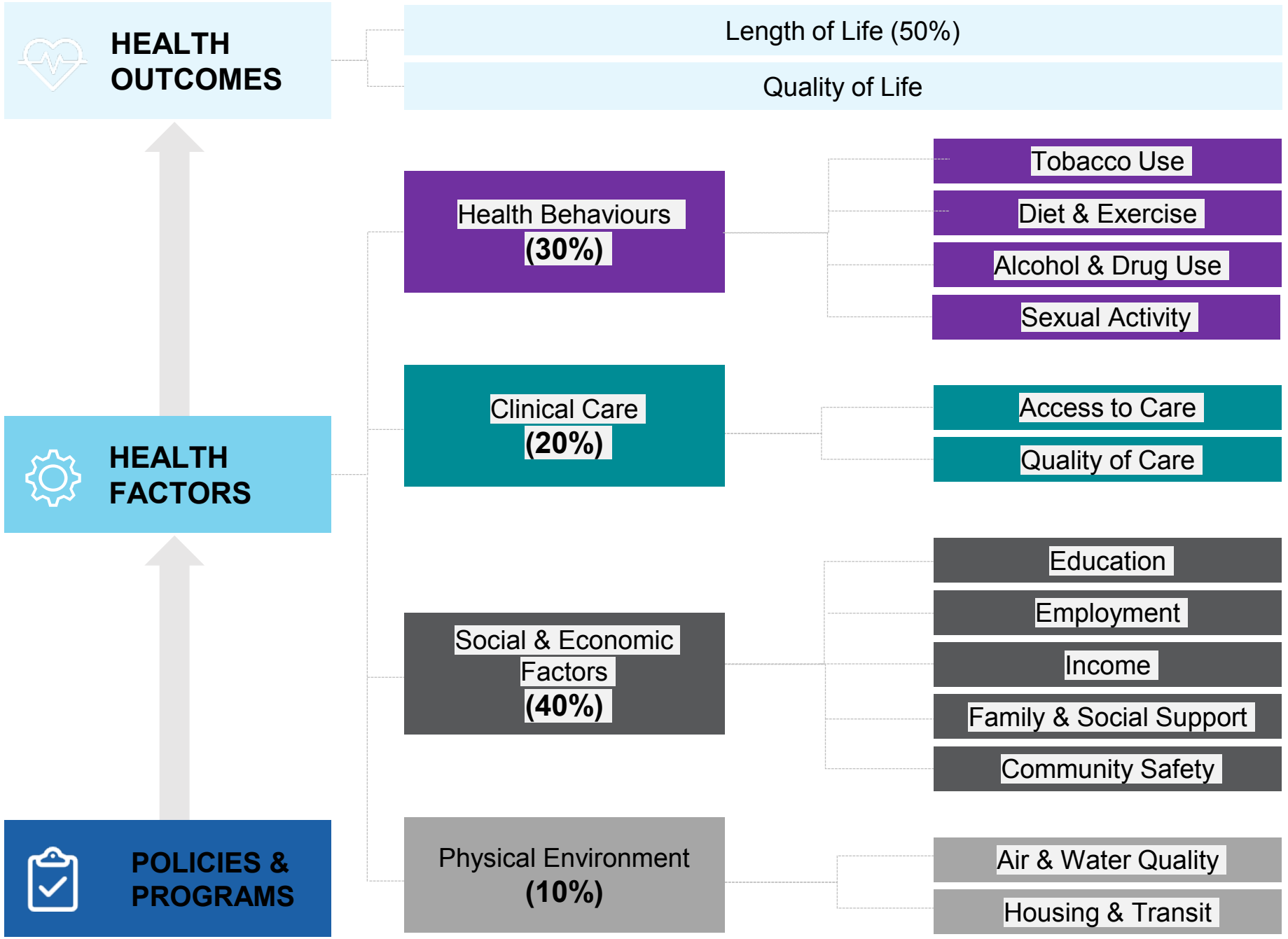
HEALTH OUTCOMES
Length of Life (50%)
Quality of Life
HEALTH FACTORS
Health Behaviours (30%)
Tobacco Use
Diet & Exercise
Alcohol & Drug Use
Sexual Activity
Clinical Care (20%)
Access to Care
Quality of Care
Social & Economic Factors (40%)
Education
Employment
Income
Family & Social Support
Community Safety
Physical Environment (10%)
Air & Water Quality
Housing & Transit
POLICIES & PROGRAMS

Ready to Get Uncomfortable?

A comfort zone is a beautiful place,
but nothing ever grows there.

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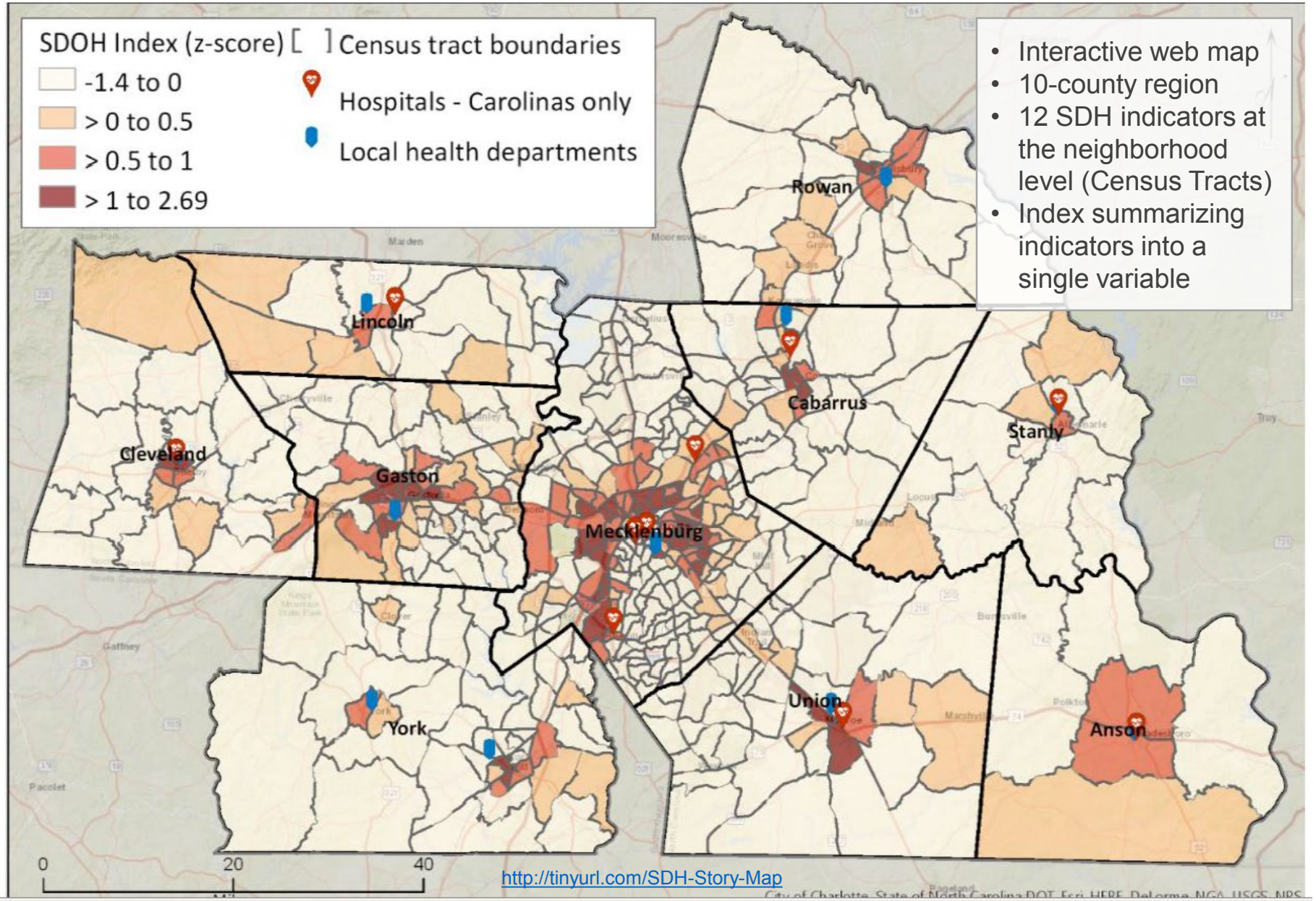
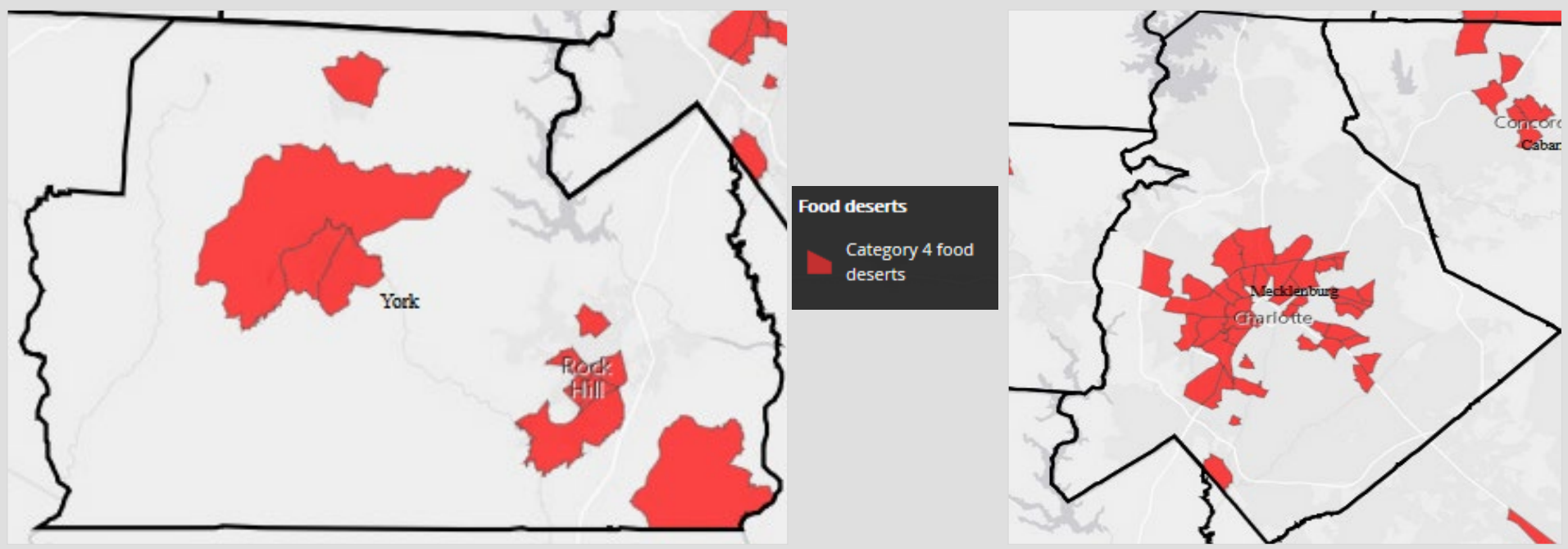
Figure 8. Social Determinants of Health Index Map, CHIS Region



High (red) values show neighborhoods with the **highest disparities** among the Social Determinants of Health.

Food Deserts

Food deserts are communities with **limited access** to affordable fresh fruit, vegetables, and other healthy foods.



*Low access to healthy food is defined as living **more than ½ mile (urban areas) or more than 10 miles (rural areas)** from the nearest supermarket, supercenter, or large grocery store.*

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Food Insecurity

ADULTS

- Higher rates of Obesity in women, DM, HTN, Depression
- In pregnancy, low birth weight, preterm birth, gestational DM
- Elderly, reduced independence

CHILDREN

- More frequent infections
- Increased use of mental health services
- Increased rates of hospitalizations
- Poorer academic performance

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Time to Get Inspired!

- New Resources
  - DHHS launches statewide resource
    - http://arcg.is/0Xm5yn
- New community partnerships and collaborations
- New Work

Mental Health

MENTAL HEALTH FIRST AID AT “NO GREASE!” BARBERSHOP

- All “No Grease” students will be required to take MHFA
- Trainings are open to all community members
- Training all YMCA employees

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Obesity

YMCA HEALTH REFERRAL PROGRAM

SMARTER LUNCHROOMS MOVEMENT

Total schools surveyed: 33

Healthier options highlighted

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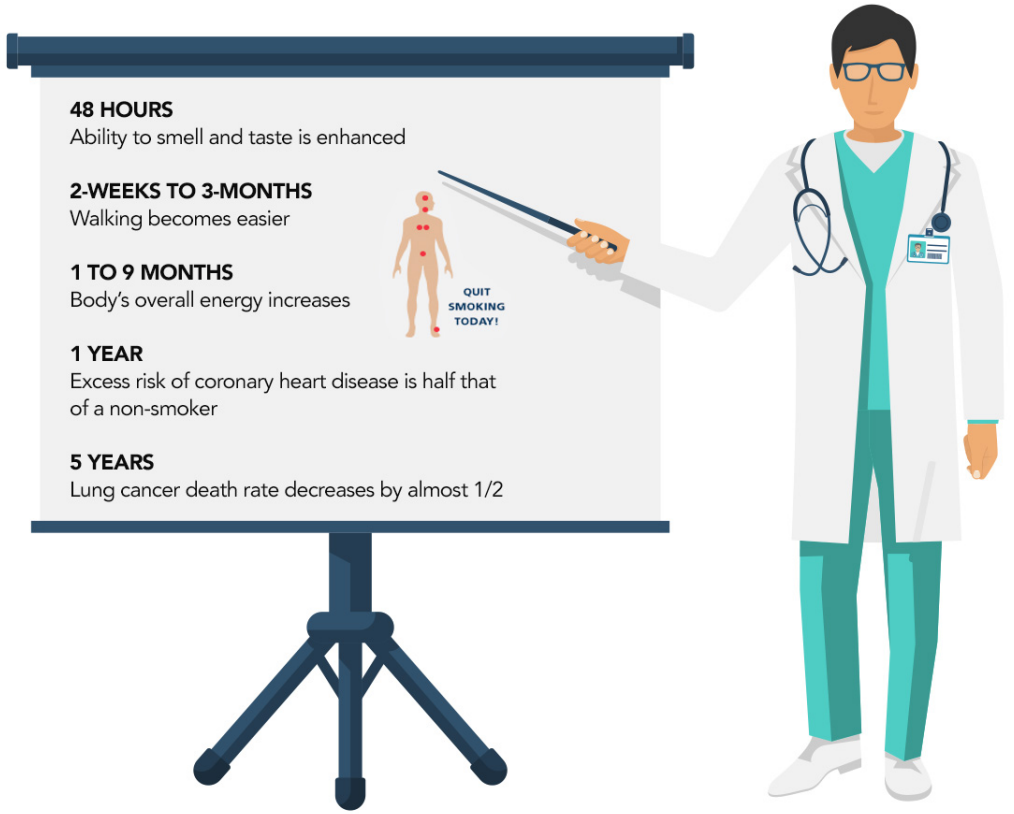
Tobacco Use

TOBACCO TREATMENT SPECIALIST TRAINING

- 4 days of face-to-face training
- Combines findings from the most current evidence-based research on:
  - pharmacotherapy
  - population-based issues
  - guidance on running a practice
  - targeted skills in tobacco dependence counseling



50
people registered

- 17 from Atrium Health
- 17 from Novant Health
- 16 from Mecklenburg Public Health

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Access

Mobile Medicine

- YMCA & Once Charlotte Health Alliance

Dowd YMCA

- Charlotte Internal Medicine & Specialty Group Physical Therapy, and Sports Performance
- Virtual

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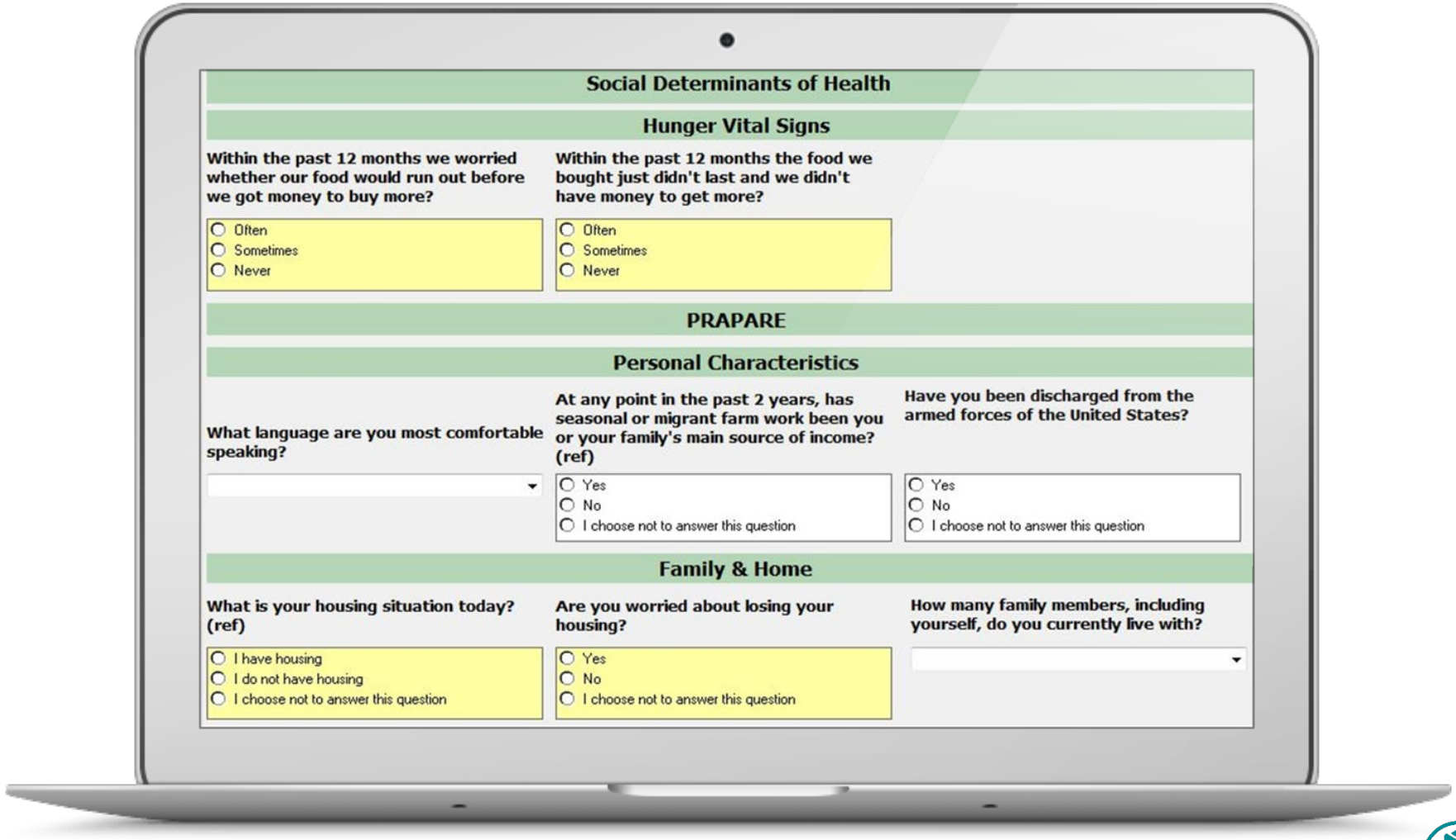
Social Determinants



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NO ONE CAN THRIVE ON AN EMPTY STOMACH

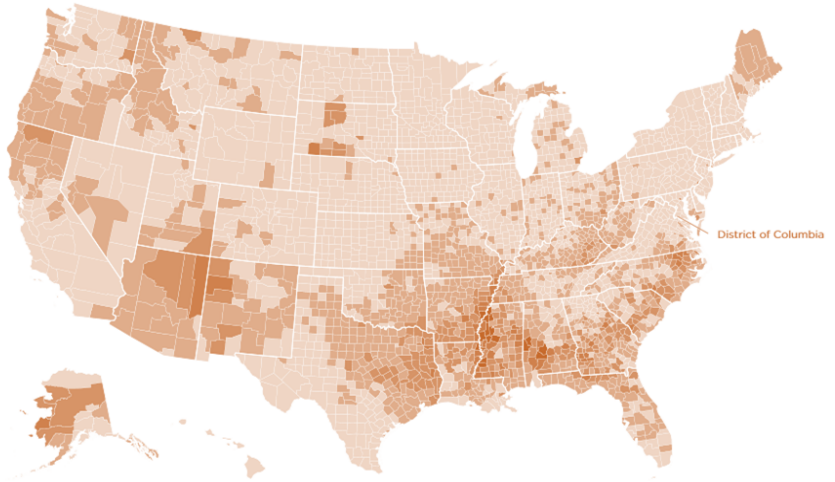
ATRIUM HEALTH PILOT: HUNGER VITAL SIGNS

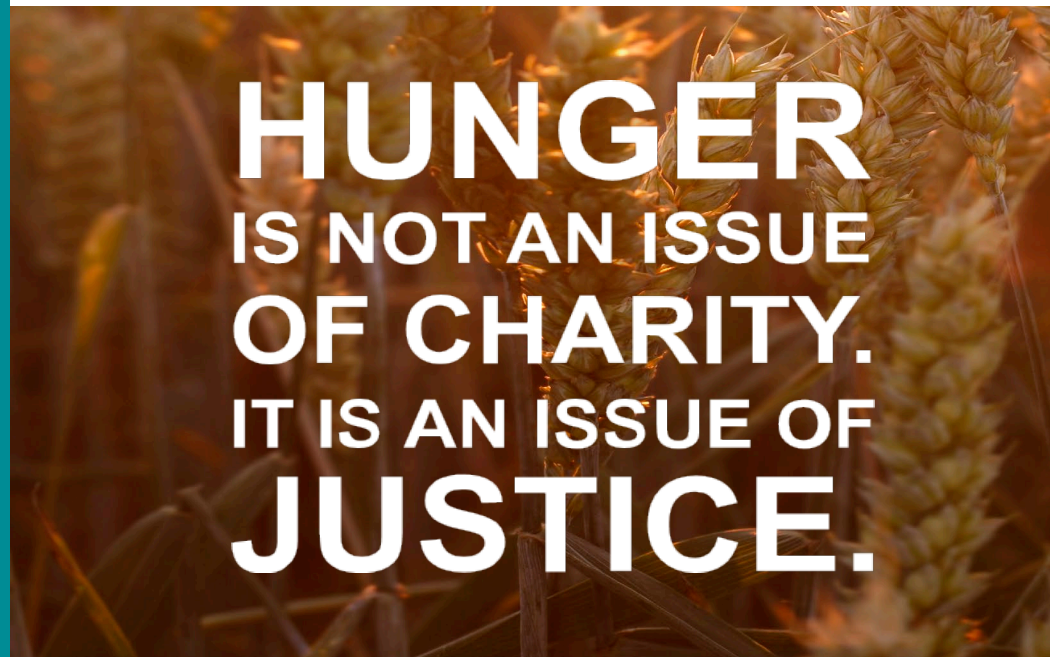
WITHIN THE PAST 12 MONTHS:

- We worried whether our food would run out before we got money to buy more
- The food we bought just didn't last and we didn't have money to get more

AVERAGE ASSISTANCE: **$200/MONTH**

ACROSS OUR REGION, **ONE IN SIX** EXPERIENCE FOOD SHORTAGES





Summer of Opportunity

CMPD

the YMCA

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Stronger Together I ONE CHARLOTTE Health Alliance

NOVANT HEALTH

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Public Health

HEALTH ALLIANCE

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Stronger Together Partnerships

LOAVES & FISHES

Groceries for Neighbors in Need

Mobile Health Units

Renaissance West
Steam Academy

Read Charlotte

Second Harvest
FOOD BANK
of Metrolina

Second Harvest

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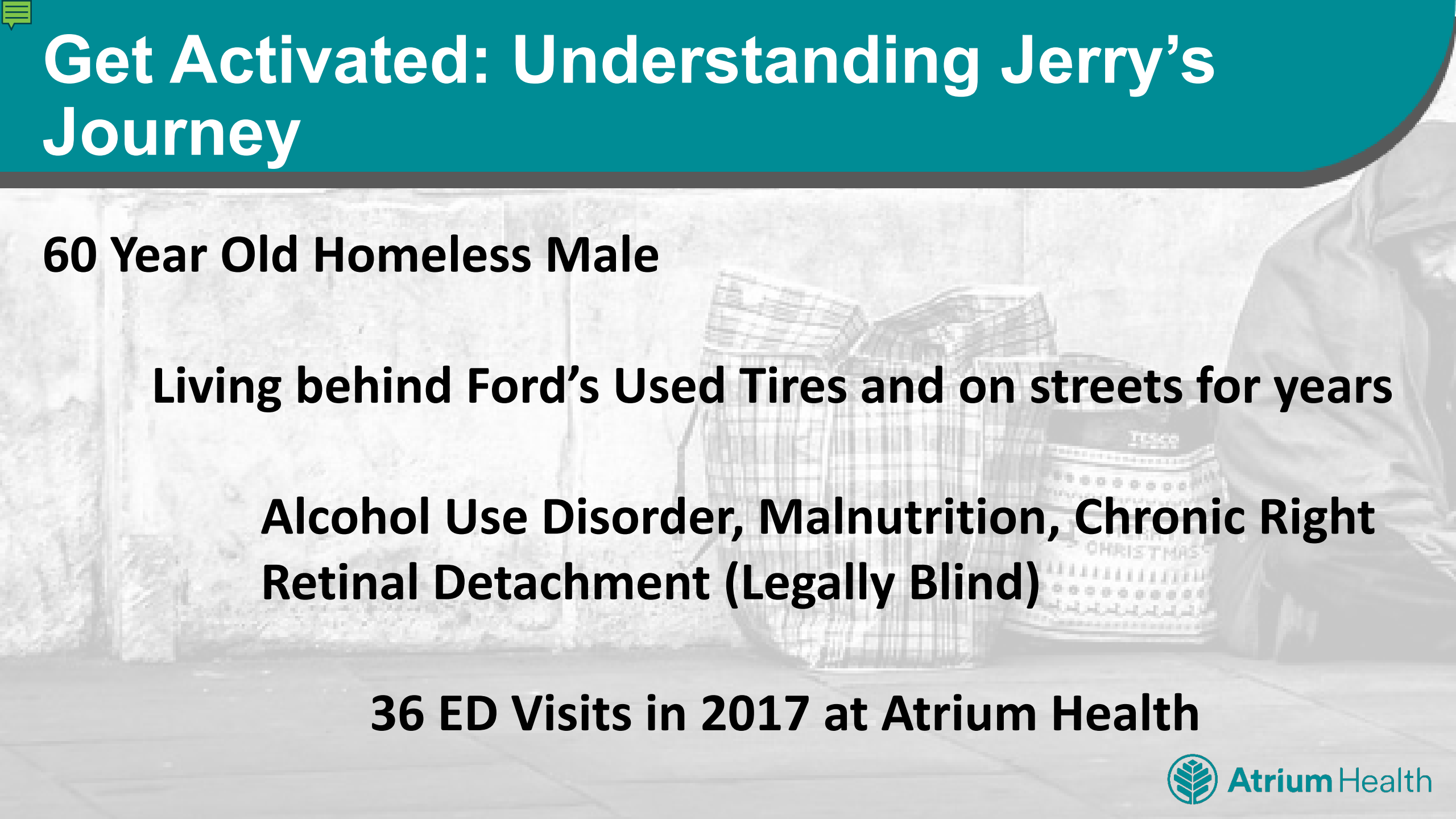
Get Activated: Understanding Jerry's Journey



60 Year Old Homeless Male

Living behind Ford's Used Tires and on streets for years

Alcohol Use Disorder, Malnutrition, Chronic Right Retinal Detachment (Legally Blind)

36 ED Visits in 2017 at Atrium Health

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Bringing Health, Hope and Healing for Jerry

- Facilitated connection to Niece for Family Support

Family

- Coordinated transportation to Primary Care and Specialty Appointments

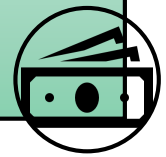
Coordination of Transportation

- Advocated for Patient Placement in Mecklenburg County Supportive Housing

Housing

- Facilitated applications for Medicaid, Food Stamps, and SSI

Government Sponsored Assistance



- Provided a means of contact for patient care

Lifeline Phone

- Connected Jerry to specialists for his Retinal Detachment and Cataracts

Services for the Blind

- Provided clothing and connections to services and agencies in the area

Community Resources

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Bringing Health, Hope, and Healing for All

Facts about the Community Care Bridge Team and our Patients

Total enrollment of 97 patients in 2017

40 Graduated Patients

(defined as achieving maximum goals of the program and/or obtaining insurance)

Financial Savings of over $1M in Emergency Department Charges

43% decrease in Hospital and ED Utilization

Additional Patients Pending for Enrollment into Program

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SDOH Food Insecurity

Kids Eat Free at CHS University

- Summer Food Service Program, USDA
- First hospital facility to offer program in NC
- Started June 14th
- The program operates Monday through Friday, 7am-9am for breakfast and 11am-2pm for lunch.
- Summer of 2018- 3400 meals served

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Network of Partners

What if we could
connect all the dots?

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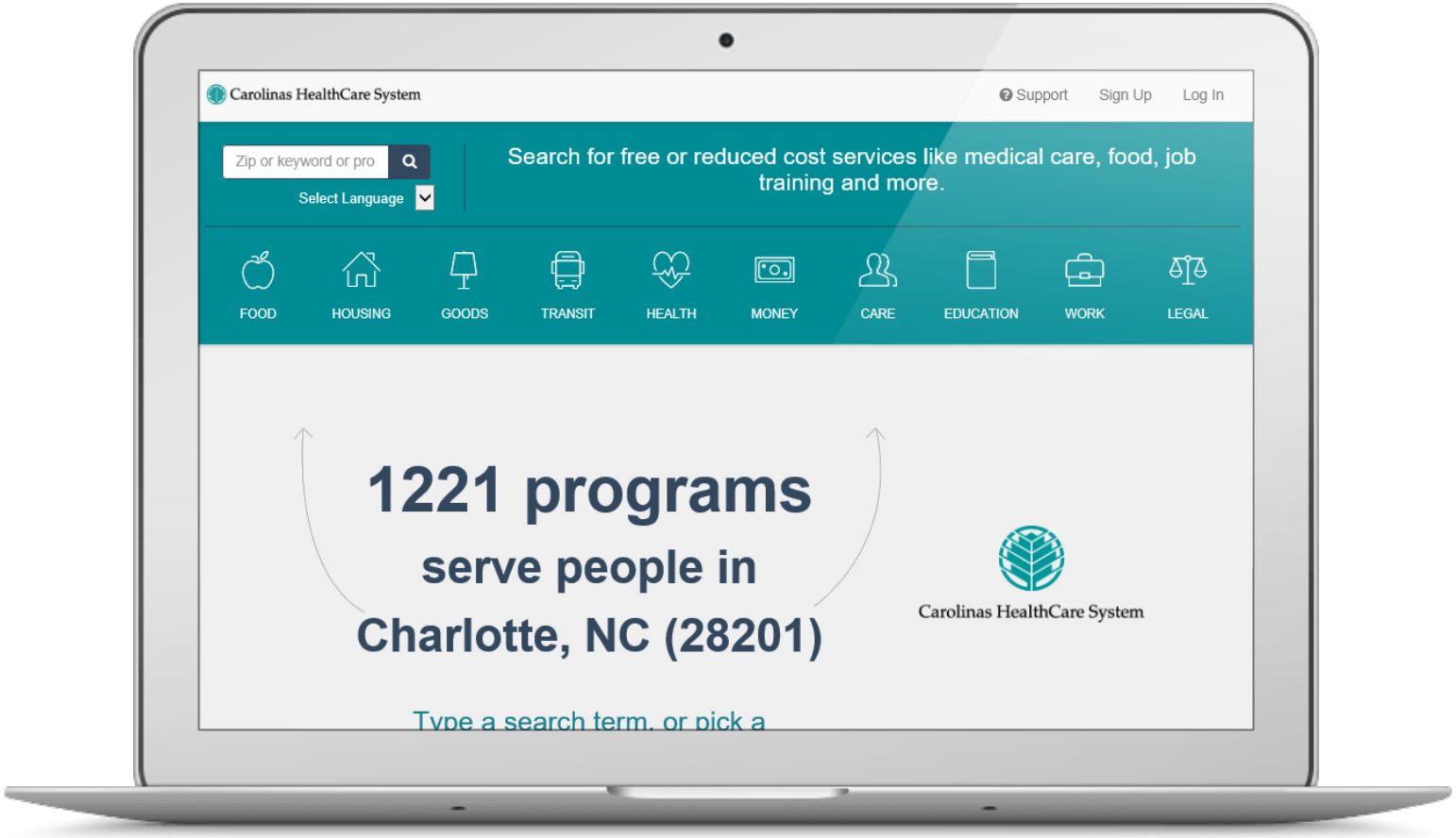
Resource Coordination

Support

Service



Assistance

Help

CarolinasHealthCare.org/CommunityResourceHub

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Initial Pilot Sites

the YMCA

LOAVES & FISHES
Groceries for Neighbors in Need

CARE RING
THE HEART OF COMMUNITY HEALTH

NC MedAssist
Dispensing Hope for the Uninsured

SMITH FAMILY
WELLNESS CENTER

Cardinal Innovations
HEALTHCARE

PROJECT 658

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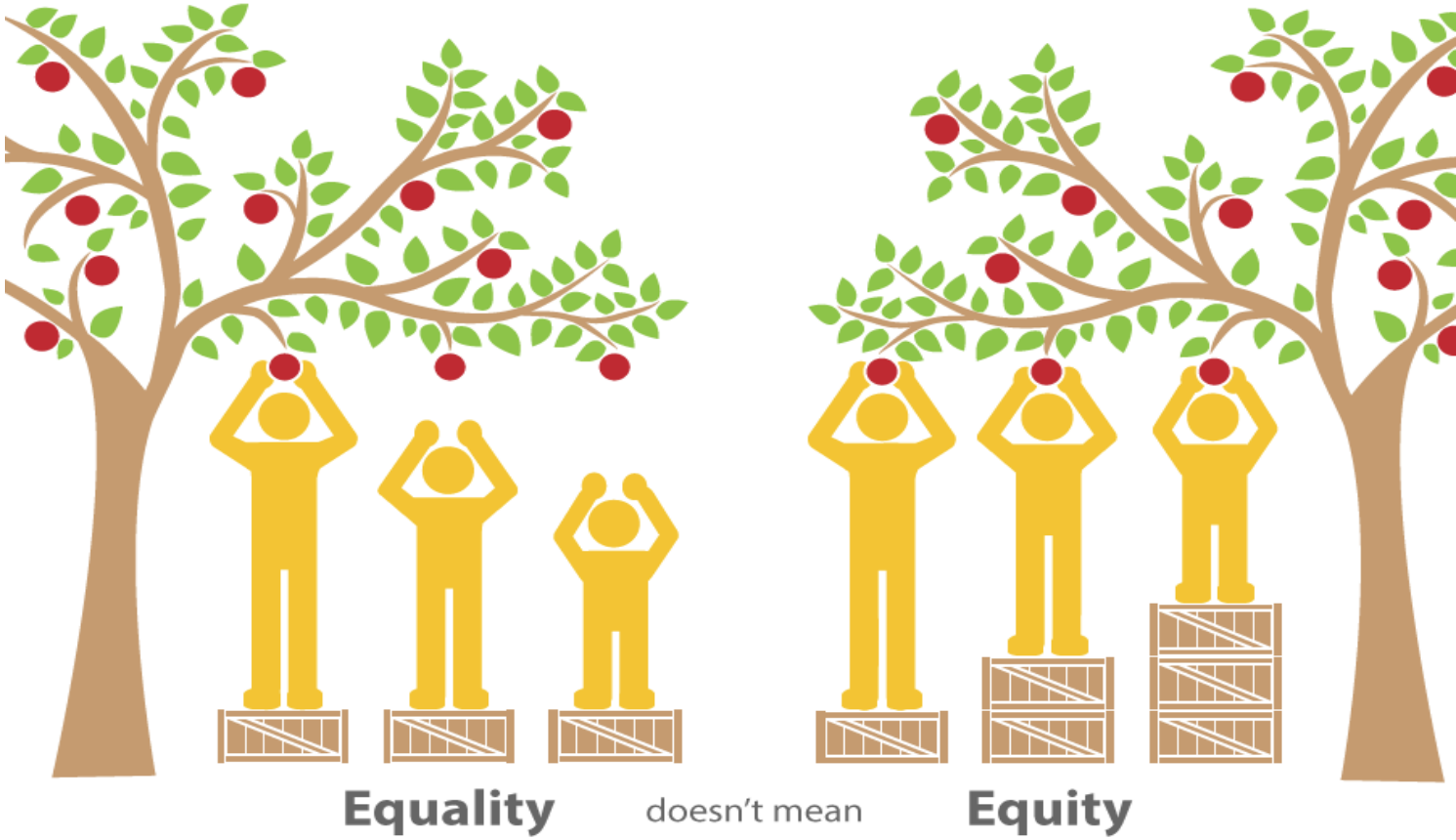
On Deck Q3-Q4 2018

“For All” Health Equity Strategy

- Partnership between Community Health and Diversity & Inclusion
- Equity of Care Pledge
- Quality metrics



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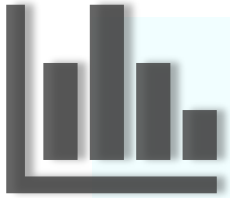
Atrium Health's Pledge

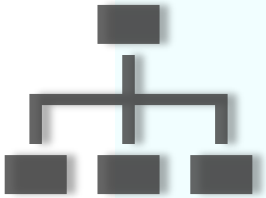


GOAL I
Collection, Stratification & Use of Data

- ✓ Demographic Data Platform
- ✓ For All Health Equity Goal

GOAL II
Cultural Competency Training

- ✓ Physicians & ACPS
- ✓ RNs
- ✓ Other Clinical Professionals
- ✓ Non-Clinical, Patient-Facing Teammates



GOAL III
Diversity in Leadership & Governance

- ✓ Men's Diversity Leadership Program
- ✓ Women's Executive Leadership Program

GOAL IV
Community Partnerships

- ✓ ONE Charlotte Health Alliance

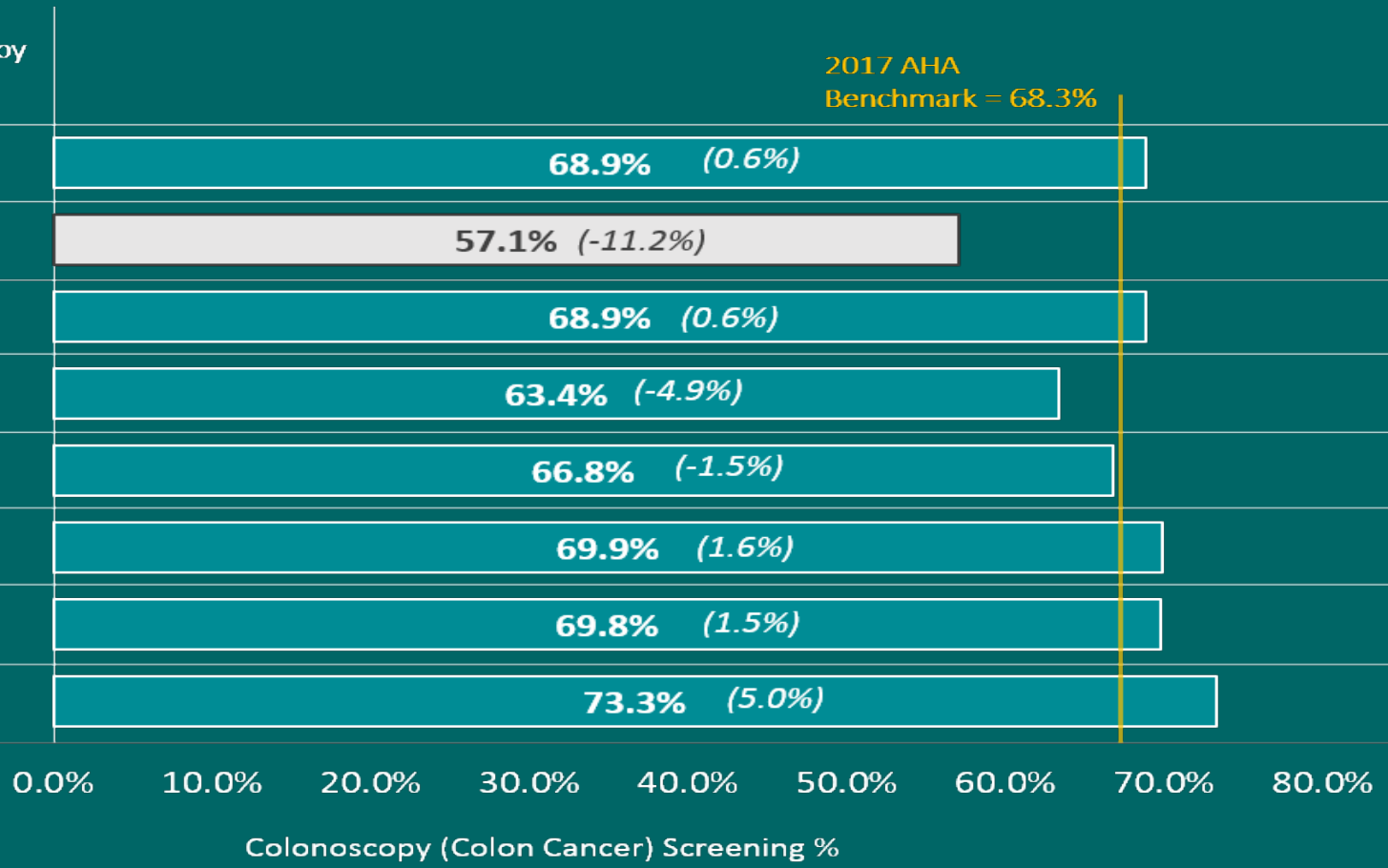
Demographic Data Wall

- Summary
- Mortality-LOS-Readmission
- Population Health
- Patient Experience
- Core Measures
- Teammate Experience
  *limited to HR use only

Colon Cancer Screening Rates: *Male*

> 90 % | 75% - 90% | 60% - 75% | 45% - 60% | 30% - 45% | 15% - 30% | 0% - 15%

Ethnicity Category	Colonoscopy Screenings	Eligible Colonoscopy Population
Not Specified	8,052	11,423
Pac Islander	11	14
2+ Races	45	72
Hisp/Latino	2,006	2,976
Asian	797	1,164
Native Am	67	108
AfrAmBlack	17,917	24,093
White	67,938	91,491



Better Than Expected

Worse Than Expected

The Numbers

2018 ACCOMPLISHMENTS

240
Hispanic Male Patients scheduled/ confirmed receipt of screening

Outreach to
6,400
Hispanic Male Patients (Attempts)

160
Declinations of Colorectal Sscreenings

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What Can You Do?

“Start where you are. Use what you have. Do what you can.”

Arthur Ashe

- *Get Informed*
- *Get Uncomfortable*
- *Get Inspired*
- *Get Activated*

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First & Best