Goals

GET INFORMED

GET INSPIRED

GET UNCOMFORTABLE

GET ACTIVATED
Carolinas HealthCare System Is …
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

- Projected Medicare Enrollment
  - 2011: 48.3 million
  - 2012: 50.3 million
  - 2015: 55.3 million
  - 2020: 63.7 million
  - 2025: 72.8 million
  - 2030: 80.6 million
  - 2035: 85.2 million

- 10,000 New Medicare Beneficiaries added each day

2. Significant Spend Increase

- National Health Expenditures, per capita

3. Not Fiscally Sustainable

- Projected Tax Revenue
  - 1970: 20%
  - 2080: 25%

- Medicare
- Medicaid
- Social Security

Source: CBO

4. Chronic Conditions

- Cardiovascular Disease
- History of Heart Attack
- History of Stroke
- Diabetes
- Hypertension
- Arthritis
- Dyslipidemia
- Total US Population
- Asthma

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

**Achieve $300 Million**
in margin growth to fund capital investments

**Improve 300,000 Lives**
in sustainable value-based models

**Realize $300 Million**
in efficiencies by implementing best practices
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
Know What Affects Health

- Physical Environment: 10%
- Health Behaviors: 30%
- Clinical Care: 20%
- Socioeconomic Factors: 40%
Ready to Get Uncomfortable?

A comfort zone is a beautiful place, but nothing ever grows there.
High (red) values show neighborhoods with the highest disparities among the Social Determinants of Health.
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.
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
Time to Get Inspired!

- New Resources
  - DHHS launches statewide resource
    - http://arcg.is/0Xm5yn

- New community partnerships and collaborations

- New Work
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
Obesity

YMCA HEALTH REFERRAL PROGRAM

SMARTER LUNCHROOMS MOVEMENT

Total schools surveyed: 33

Healthier options highlighted
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
Access

Mobile Medicine
• YMCA & Once Charlotte Health Alliance

Dowd YMCA
• Charlotte Internal Medicine & Specialty Group Physical Therapy, and Sports Performance
• Virtual
# Social Determinants of Health

## Hunger Vital Signs

Within the past 12 months we worried whether our food would run out before we got money to buy more?

- Often
- Sometimes
- Never

Within the past 12 months the food we bought just didn’t last and we didn’t have money to get more?

- Often
- Sometimes
- Never

## PRAPARE

### Personal Characteristics

What language are you most comfortable speaking?

- [ ] [ ] [ ]

At any point in the past 2 years, has seasonal or migrant farm work been your or your family’s main source of income?

- [ ] Yes
- [ ] No
- [ ] I choose not to answer this question

Have you been discharged from the armed forces of the United States?

- [ ] Yes
- [ ] No
- [ ] I choose not to answer this question

## Family & Home

What is your housing situation today (ref)?

- [ ] I have housing
- [ ] I do not have housing
- [ ] I choose not to answer this question

Are you worried about losing your housing?

- [ ] Yes
- [ ] No
- [ ] I choose not to answer this question

How many family members, including yourself, do you currently live with?

- [ ] [ ] [ ]
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
Stronger Together Partnerships

LOAVES & FISHES
Groceries for Neighbors in Need

Mobile Health Units

Renaissance West Steam Academy

Read Charlotte

Second Harvest
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
Bringing Health, Hope and Healing for Jerry

- Facilitated connection to Niece for Family Support
- Coordinated transportation to Primary Care and Specialty Appointments
- Advocated for Patient Placement in Mecklenburg County Supportive Housing
- Facilitated applications for Medicaid, Food Stamps, and SSI

- Provided a means of contact for patient care
- Connected Jerry to specialists for his Retinal Detachment and Cataracts
- Provided clothing and connections to services and agencies in the area

Family
Coordination of Transportation
Housing
Government Sponsored Assistance
Lifeline Phone
Services for the Blind
Community Resources
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
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
Network of Partners

What if we could connect all the dots?
Resource Coordination

Support

Assistance

Service

Help

1221 programs serve people in Charlotte, NC (28201)

Type a search term, or pick a

CarolinasHealthCare.org/CommunityResourceHub
Initial Pilot Sites
On Deck Q3-Q4 2018
“For All” Health Equity Strategy

Partnership between Community Health and Diversity & Inclusion

Equity of Care Pledge

Quality metrics

Equality doesn’t mean Equity
# 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
## Colon Cancer Screening Rates: Male

<table>
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<tr>
<th>Ethnicity Category</th>
<th>Colonoscopy Screenings</th>
<th>Eligible Colonoscopy Population</th>
<th>2017/AHA Benchmark</th>
<th>2017 screening rate</th>
<th>% change</th>
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<tr>
<td>Not Specified</td>
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<td>11,423</td>
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<tr>
<td>Pac Islander</td>
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<td>14</td>
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<td>57.1%</td>
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<td>2+ Races</td>
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<td>68.9%</td>
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<td>Hisp/Latino</td>
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<td>AfrAmBlack</td>
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<td>67,938</td>
<td>91,491</td>
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<td>73.3%</td>
<td>(5.0%)</td>
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</tbody>
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**Colonoscopy (Colon Cancer) Screening %**
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 Screenings
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