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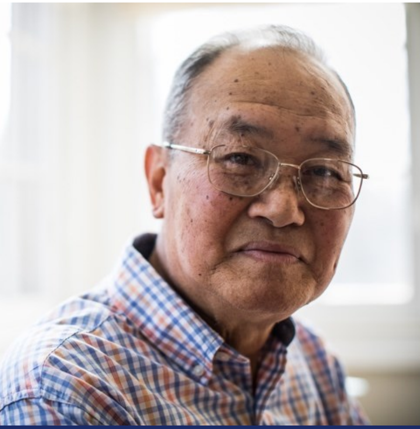

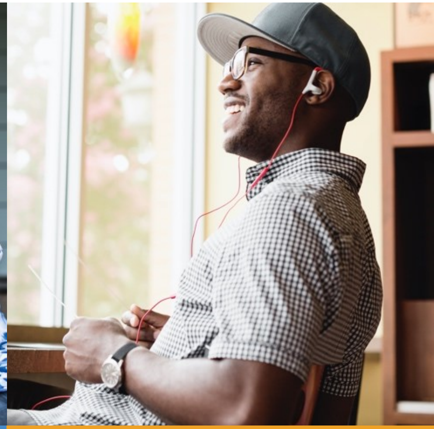

CMS National Rural Health Day Webinar

November 19, 2024

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Agenda

- Welcome & Opening Remarks – Ashley Peddicord-Austin, CMS OMH
  - CMS Office of Minority Health
  - CMS Resources and Reports
- CMS Health Equity Award – Jessica Dawson, CMS OMH
  - 2024 CMS Health Equity Award Winners
- Augusta Health – Isaac Izzillo and Krystal Moyers, Augusta Health
- Moderated Q & A – Jessica Dawson, CMS OMH

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CMS Office of Minority Health

- **The Centers for Medicare & Medicaid Services (CMS)** is the largest provider of health insurance in the United States, responsible for ensuring that more than 150 million individuals supported by CMS programs (Medicare, Medicaid, Children's Health Insurance Program, and the Health Insurance Marketplaces).

- **The Centers for Medicare & Medicaid Services Office of Minority Health (CMS OMH)** is one of eight offices of minority health within the U.S. Department of Health and Human Services. CMS OMH works with local and federal partners to eliminate health disparities while improving the health of all minority populations.

CMS Office of Minority Health

Mission

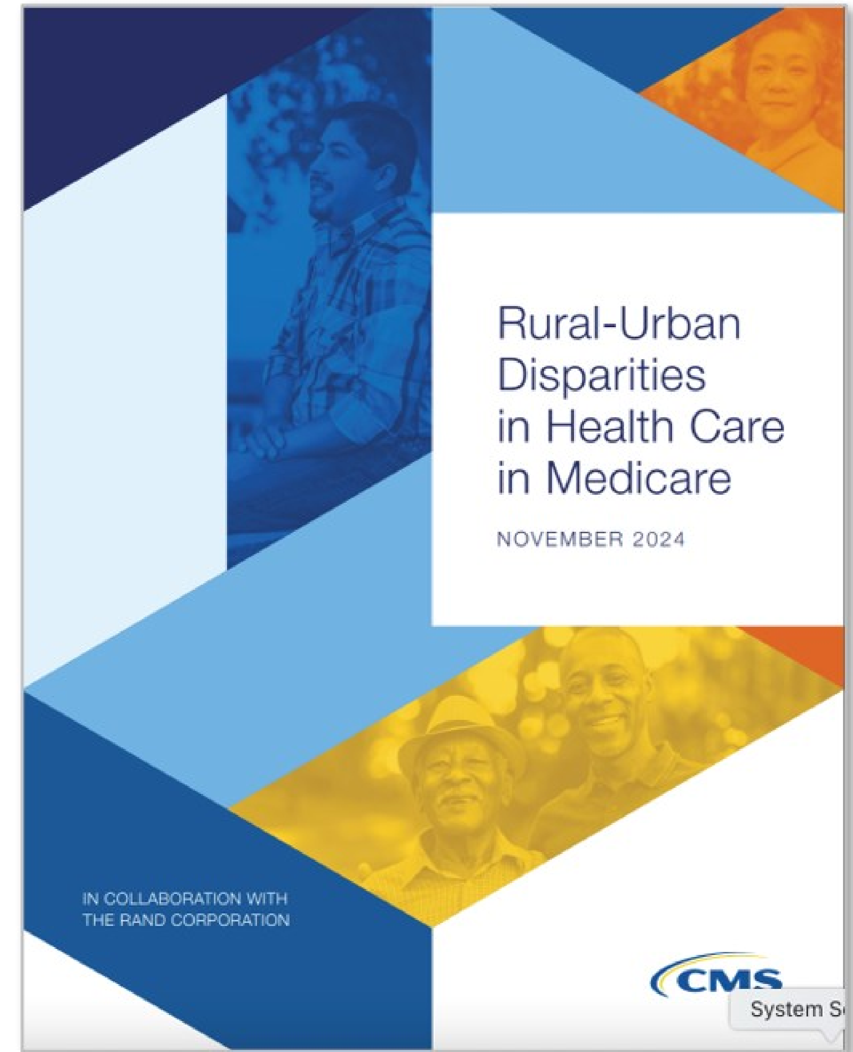
CMS OMH will lead the advancement and integration of health equity in the development, evaluation, and implementation of CMS's policies, programs, and partnerships.

Vision

All those served by CMS have achieved their highest level of health and well-being, and we have eliminated disparities in health care quality and access.

Rural-Urban Disparities in Health Care in Medicare 2024

The Rural-Urban Disparities in Health Care in Medicare 2024 report, summarizes the differences in quality of health care received by people with Medicare in rural and urban areas and how the quality of care can vary by race and ethnicity.



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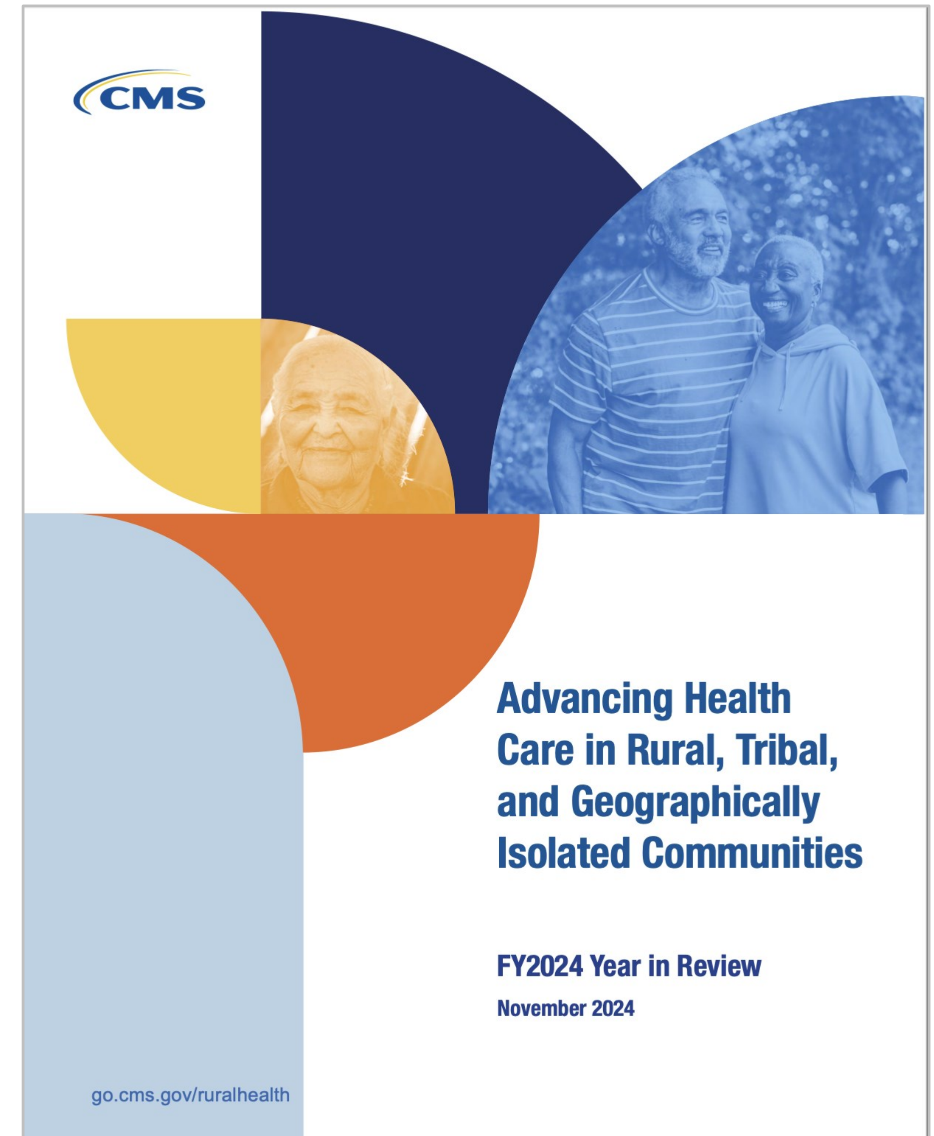
Advancing Health Equity in Rural, Tribal, and Geographically Isolated Communities: FY 2024 in Review

The Advancing Health Equity in Rural, Tribal, and Geographically Isolated Communities: FY2024 Year in Review annual summary report to learn how CMS has met the needs of these communities throughout 2024.



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CMS Resources Rural, Tribal, and Geographically Isolated Communities

- [CMS Framework for Advancing Health Care in Rural, Tribal, and Geographically Isolated Communities]
- [Rural Health Equity One-Pager]
- [Advancing Rural Maternal Health Equity Report]
- [Rural Health Information Hub]
- [CMS Rural Health Clinics Center]

CMS Framework for Advancing Health Care in Rural, Tribal, and Geographically Isolated Communities

NOVEMBER 2022
GO.CMS.GOV/RURALHEALTH

CMS Framework for Advancing Health Care in Rural, Tribal, and Geographically Isolated Communities

Rural Health Overview

Rural communities comprise vast and varied landscapes that encompass micropolitan, frontier, and tribal lands, as well as U.S. territories and other island communities. These communities are increasingly diverse; nearly a quarter of people living in rural areas are from racial or ethnic minority groups. CMS is working to advance health equity across the nation's health system to enable people living and working in rural, tribal, and geographically isolated communities to attain their optimal health regardless of race, ethnicity, disability, sexual orientation, gender identity, socioeconomic status, geography, preferred language, or other factors that affect access to care and health outcomes.

CMS Framework for Rural Health Priorities

Priority 1: Apply a Community-Informed Geographic Lens to CMS Programs and Policies

Priority 2: Increase Collection and Use of Standardized Data to Improve Health Care for Rural, Tribal, and Geographically Isolated Communities

Priority 3: Strengthen and Support Health Care Professionals in Rural, Tribal, and Geographically Isolated Communities

Priority 4: Optimize Medical and Communication Technology for Rural, Tribal, and Geographically Isolated Communities

Priority 5: Expand Access to Comprehensive Health Care Coverage, Benefits, and Services and Supports for Individuals in Rural, Tribal, and Geographically Isolated Communities

Priority 6: Drive Innovation and Value-Based Care in Rural, Tribal, and Geographically Isolated Communities

To receive the latest news on rural health care policy and programs, sign up for the rural health listserv.

To read the CMS Framework for Advancing Health Care in Rural, Tribal, and Geographically Isolated Communities, visit, go.cms.gov/ruralhealth.

The CMS Office of Minority Health offers health equity technical assistance resources, aimed to help health care organizations take action against health disparities. If you are looking for assistance, visit go.cms.gov/healthequityta or email HealthEquityTA@cms.hhs.gov.

August 2023

C2C Resources

Our Coverage to Care (C2C) initiative is intended to support individuals regardless of insurance type. These resources are available in several languages and can help individuals:

- Navigate their coverage
- Access care
- Get preventive care and services
- Manage care for chronic conditions

All of these resources, plus resources for partners and providers is available on our website.

MANAGING DIABETES: COVERAGE & RESOURCES

10 STEPS FOR PEOPLE LIVING WITH DIABETES

ROADMAP TO BETTER CARE TRIBAL VERSION

TELEHEALTH: WHAT TO KNOW FOR YOUR FAMILY

KONSÈY POU W KONPRANN KOUVÈTI ASIRANS MEDIKAMAN W LAN AK MEDIKAMAN SOU PRESKRIPSYON W YO

CMS CENTERS FOR MEDICARE & MEDICAID SERVICES OFFICE OF MINORITY HEALTH

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CMS Health Equity Award

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About the CMS Health Equity Award

CMS recognizes organizations who have demonstrated a strong commitment to health equity by reducing disparities affecting vulnerable populations with its Health Equity Award.

The 2024 CMS Health Equity Award was awarded to Augusta Health and Latino Connection for their work to advance health equity and reduce disparities in health care access, quality, and outcomes.

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Latino Connection

Their Community-Accessible Testing & Education (CATE) initiative was launched in response to the COVID-19 pandemic with the aim of addressing disparities in access to essential resources and education among underserved communities.

Latino Connection is the first Latino and LGBTQ+ organization to launch such a program, CATE represents a groundbreaking effort to provide critical support to populations disproportionately affected by the pandemic, including minorities, low-income individuals, LGBTQ+ communities, and those residing in urban areas.

Augusta Health

Augusta Health was recognized for improving access to health care in vulnerable communities.

The hospital, aiming to be a national model for community-based health care, implemented Augusta Health Neighborhood Clinics, previously known as Primary Care Mobile Clinic, to reach neighborhoods with rural geographic barriers and local cities with high poverty rates and adverse social and health barriers.

Sustaining Our Mission:
Expanding Community Access to Healthcare

November 19, 2024

Care that makes a lifetime.

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Krystal Moyers, M.Ed., CHES
Administrative Director
Community Partnerships and
Communications

Isaac Izzillo, RN MSN
Director of Public and
Primary Care Services,
Augusta Medical Group

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Augusta Health Profile

- Non-Profit Community Hospital
- Located in the Shenandoah Valley of Virginia
- Service area population of approximately 350,000 across rural counties and several small cities
- 255 licensed beds
- 225 active medical staff (Augusta Medical Group)
- 2,500 employees
- 11,000 annual admissions

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Care that *meets you where you are*

Primary Care & Urgent Care Locations

- Physician Offices
- Urgent Care Offices
- New Offices

ROCKINGHAM COUNTY
Weyers Cave
HIGHLAND COUNTY
Churchville
Verona
Staunton
AUGUSTA COUNTY
Fishersville
Crozet
Waynesboro
Stuarts Draft
ROCKBRIDGE COUNTY
ALBEMARLE COUNTY
Lexington
NELSON COUNTY
Buena Vista
Maury River

Augusta Medical Group™

To strengthen the health and well-being of all people in our communities.

What Are Our Communities Telling Us?

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Questions We Asked Our Communities:

- Who is not doing well in our communities?
- Where are the disparities?
- What are the local drivers underlying health disparities?
- Who are our partners in resolving health disparities?

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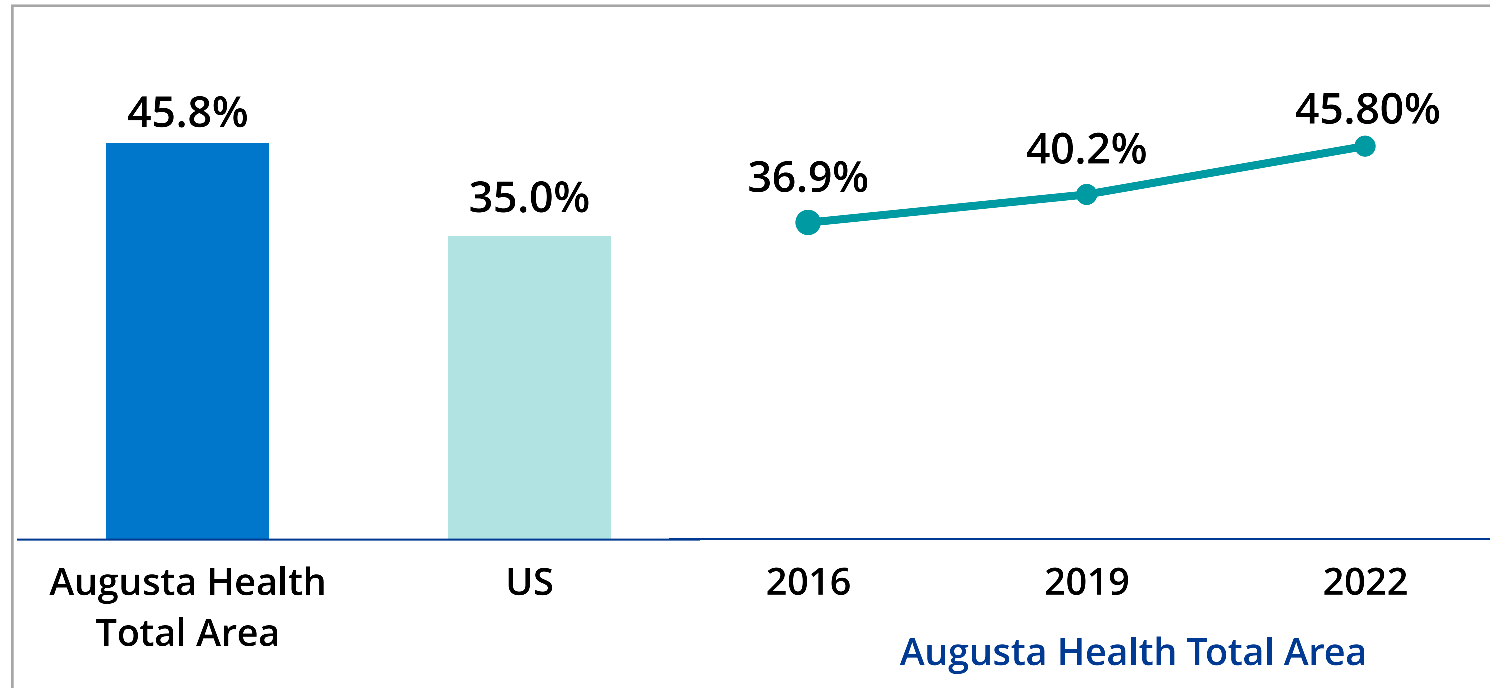
Local Indicators

Challenges to Accessing Care

Aging Population | Rising Patient Complexity | Shrinking Workforce

Experienced Difficulties or Delays of Some Kind in Receiving Needed Health Care in the Past Year



Source: Augusta Health 2022 CHNA

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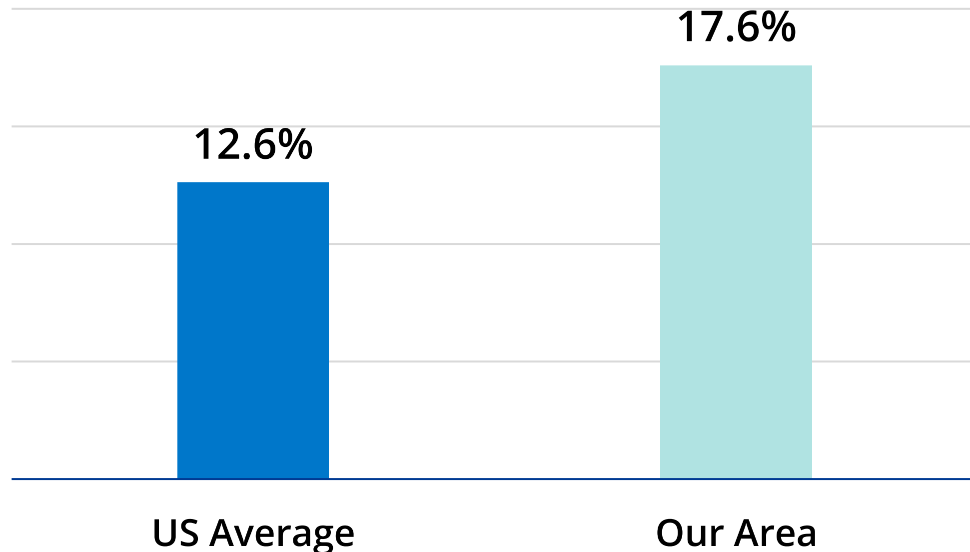
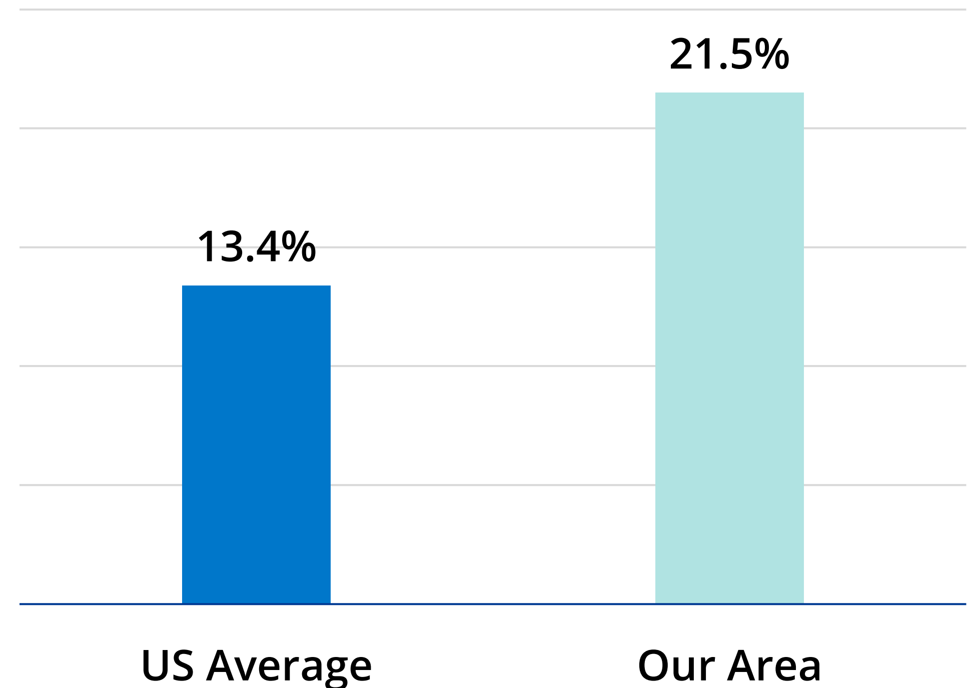
Community Member Health Ratings

Community respondents' self-reported health status worse than national benchmarks





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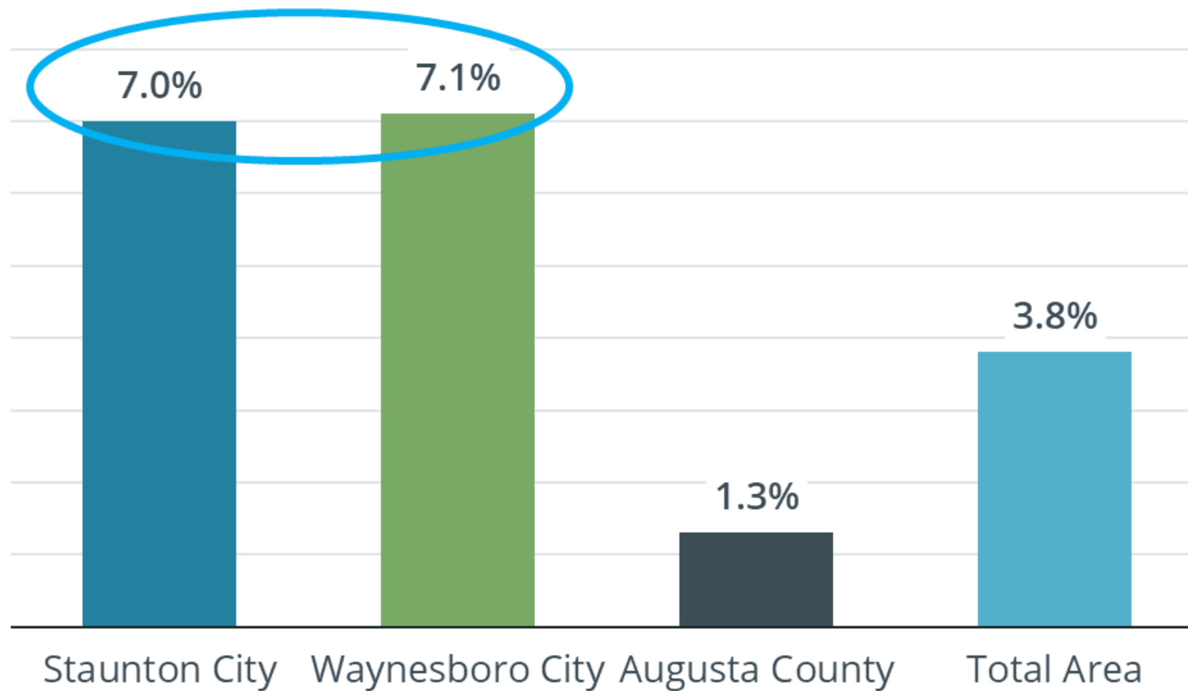
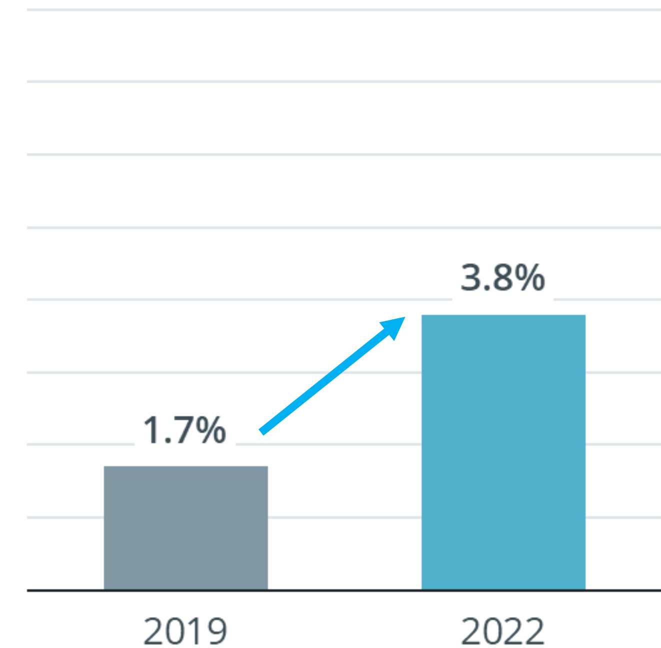
Local Indicators
Sharp Increase in Homelessness

Increase in Percent Homeless at Some Point in the Past 2 Years





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Local Indicators

Hospital Course for Those Experiencing Homelessness

Average Hospital Length of Stay (Days)
2022 vs. 2023

30-Day Hospital Readmission Rates
2022 vs. 2023

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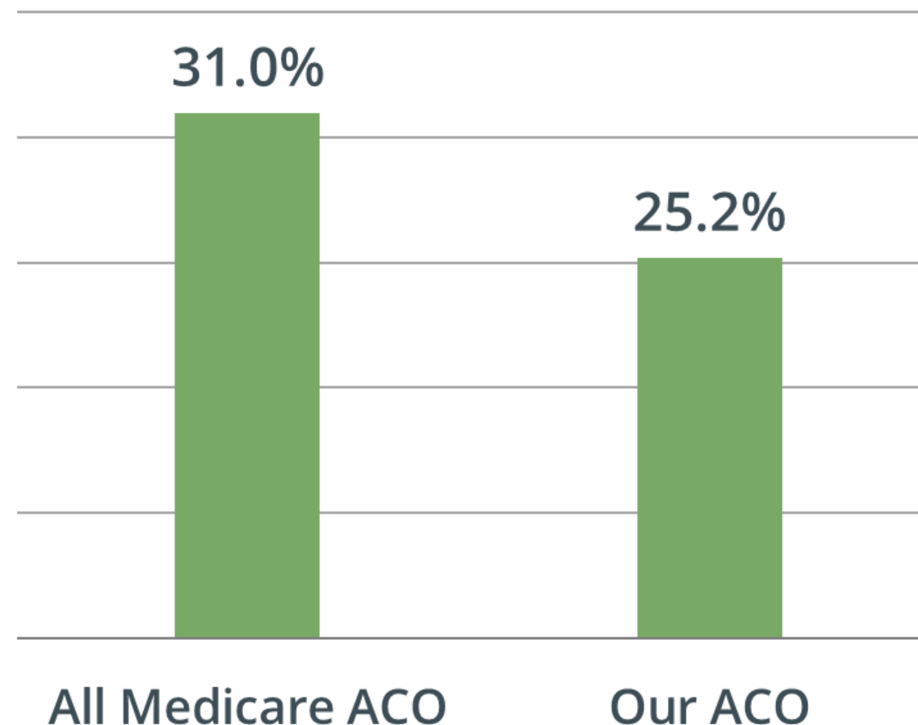
Improving Outcomes with Managed Care Patients

We are seeing success in meeting our community health mission across many health metrics

Hospitalization Rates for Medicare Patients with Multiple Chronic Conditions



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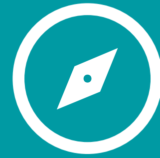

Charting the Course

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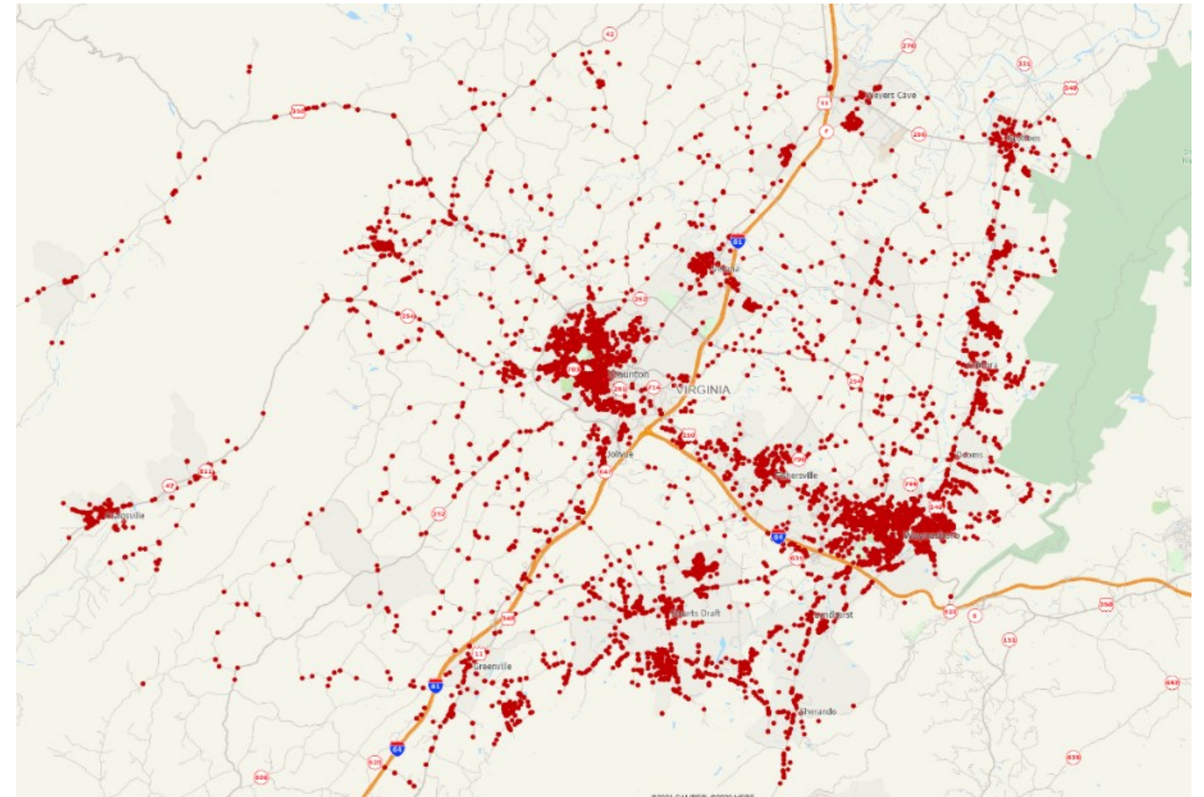
How Do We Select Mobile Clinic Locations?

3 Steps to selecting Neighborhood Clinic locations:

1. Map the lack of primary care connection
2. Plan and implement with a trusted community partner
    - *Identify a church, shelter, community center, or school to set up clinic and frequency*

Mapping Medicaid Beneficiaries and/or Persons with Disabilities Who Lack Primary Care



Each red dot represents a Medicaid beneficiary or disabled person with an ED or Urgent care visit in the past 2 years, but NO primary care in the past 2 years. 13,231 patients were mapped across Augusta Health primary service area.

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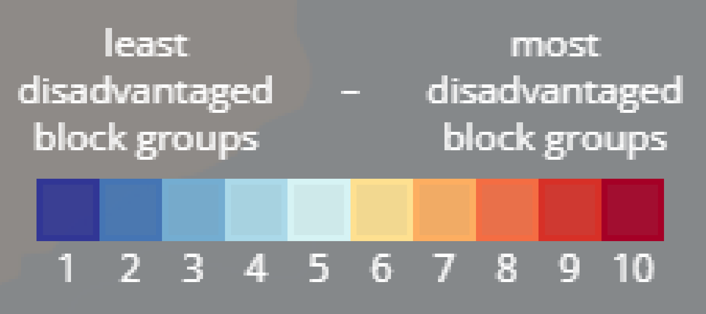
The Area Deprivation Index (ADI)

A Metric for Social Risk

Neighborhood Atlas, University of Wisconsin

Combines 17 metrics on housing quality, employment, poverty and education.

Measured at the level of census block groups→ roughly 1,500 persons. - Close to neighborhood level.



Our region's map of census tract ADI scores, 4/27/23
Source: https://www.neighborhoodatlas.medicine.wisc.edu/mapping

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Do Local ADI Scores Predict Local Clinical Outcomes?

Lack of Primary Care in the Past Two Years

$r = 0.914$ $p = 0.004$

ED Visits for Mental Health

$r = 0.758$ $p = 0.011$

In-Hospital Mortality

$r = 0.831$ $p = < 0.05$

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Augusta Health Neighborhood Clinics

Identifying underserved neighborhoods for primary care services

Augusta Health Neighborhood Clinic Locations 2024 and Regional Area Deprivation Index Map

United States
LEGEND
Augusta Healthcare
AH mobile locations
State ADI
1 (Lowest deprivation)
2
3
4
5
6
7
8
9
10 (Highest deprivation)
No data
0 1.5 3
Miles

Weyers Cave
Grottoes FD
Grottoes
Verona
Verona CC
Gypsy Hill
E Miller Gardens
Valley Mission
Central UMC
LGBTQ Center
Crimora
Plaza Apartments
Jolivue
Dooms
Fishersville
Augusta Health
WARM - Expo
RAM - Expo
Craigsville
Craigsville CC
Embrace
Christ Tabernacle
Disciples Kitchen
Waynesboro YMCA
Calvary UMC
WARM - Springdate
Stuarts Draft
Lyndhurst
81
64

Source: Augusta Health Mobile Clinic Locations and University of Wisconsin School of Medicine and Public Health. 2024 Area Deprivation Index. Downloaded from https://www.neighborhoodatlas.medicine.wisc.edu/

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Augusta Health's Neighborhood Clinics Locations

- Allen Chapel
- Valley Mission Shelter
- Verona Community Center
- Gypsy Hill House
- Grottoes Firehouse
- Plaza Apartments
- Deerfield Community Center
- Warm Shelter
- Craigsville Community Center
- Calvary United Methodist Church
- Central United Methodist Church
- Elizabeth Miller Gardens
- Shenandoah LGBTQ Center
- Embrace Community Center
- Christ Tabernacle Church
- Magnolia Rose HT Shelter

All locations have community partners supporting our work

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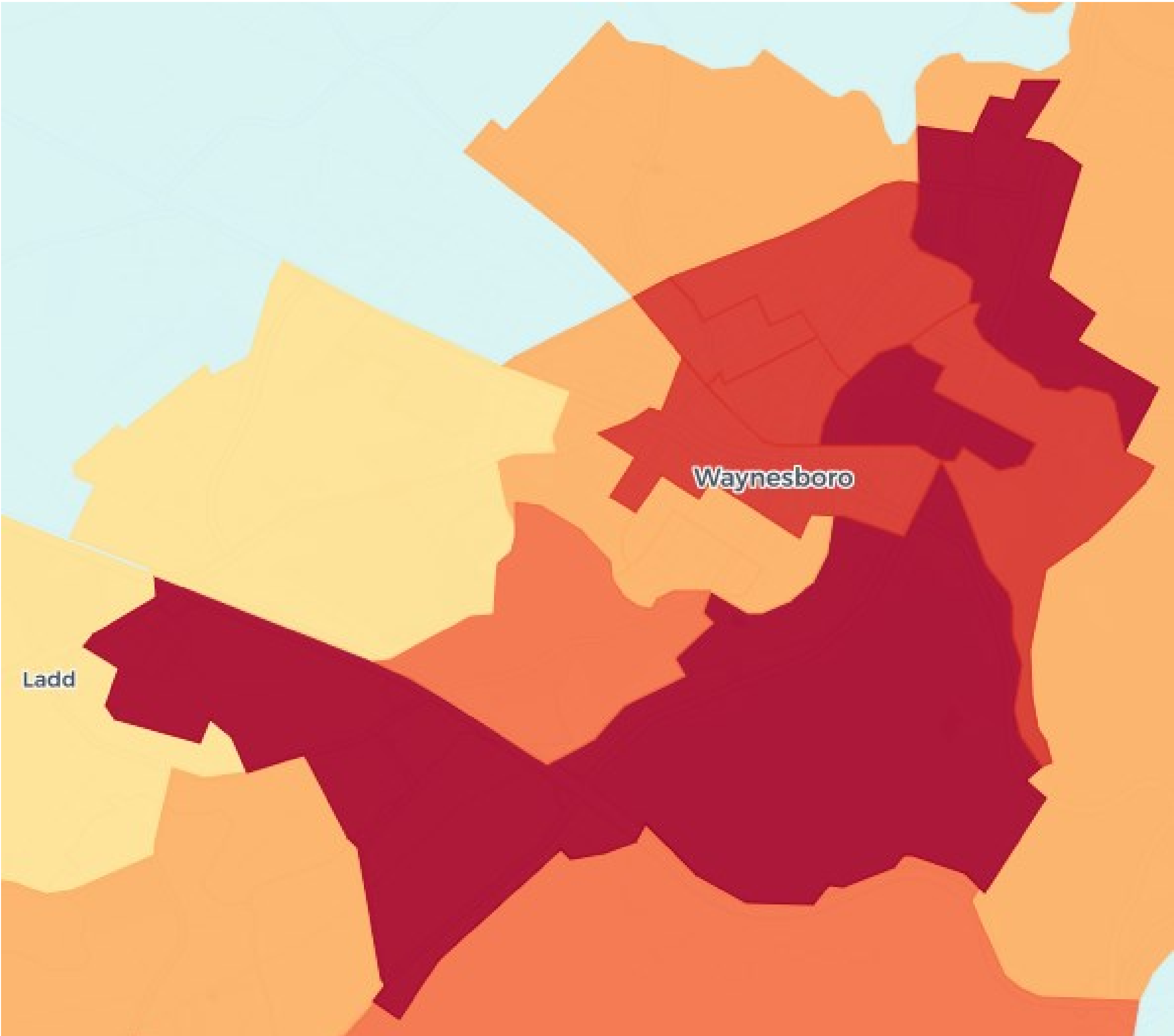
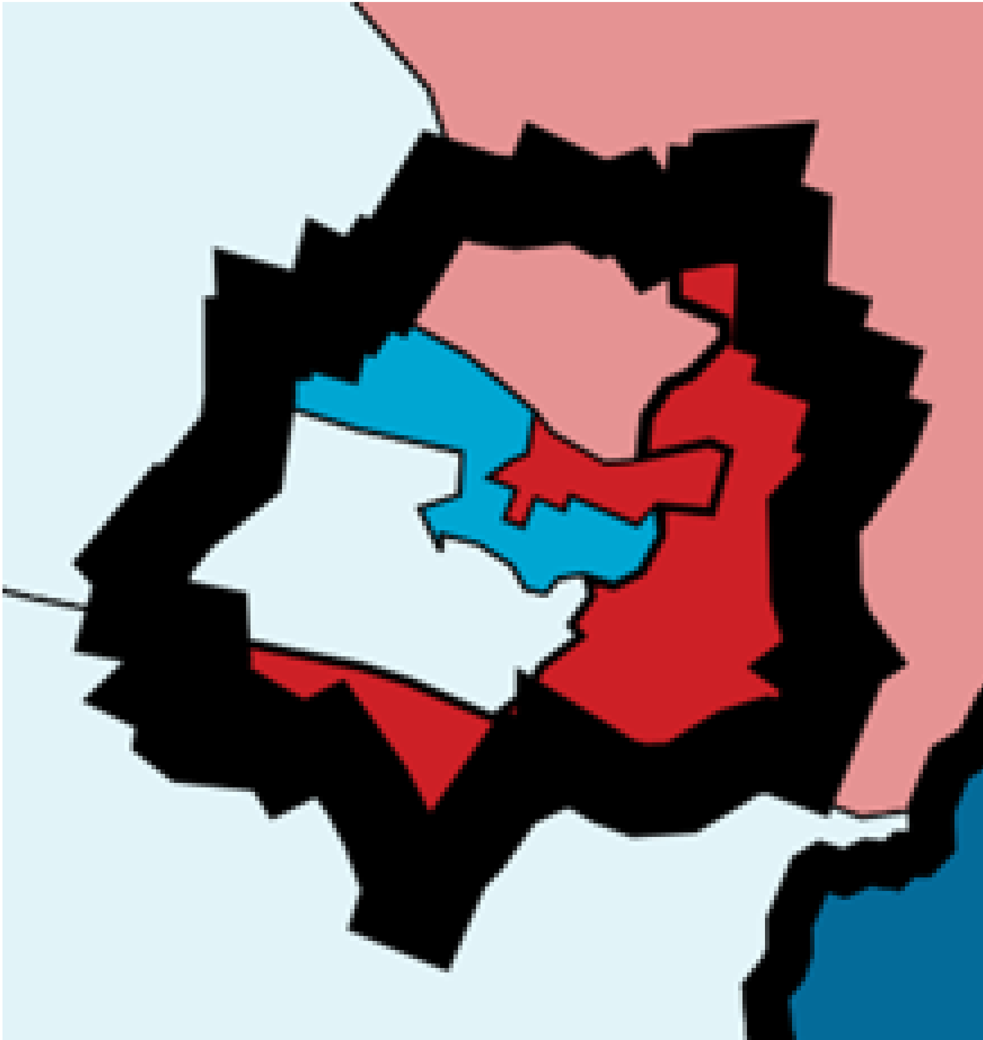
Visual Comparison of the ADI and CDC Lifespan Maps

Waynesboro Virginia





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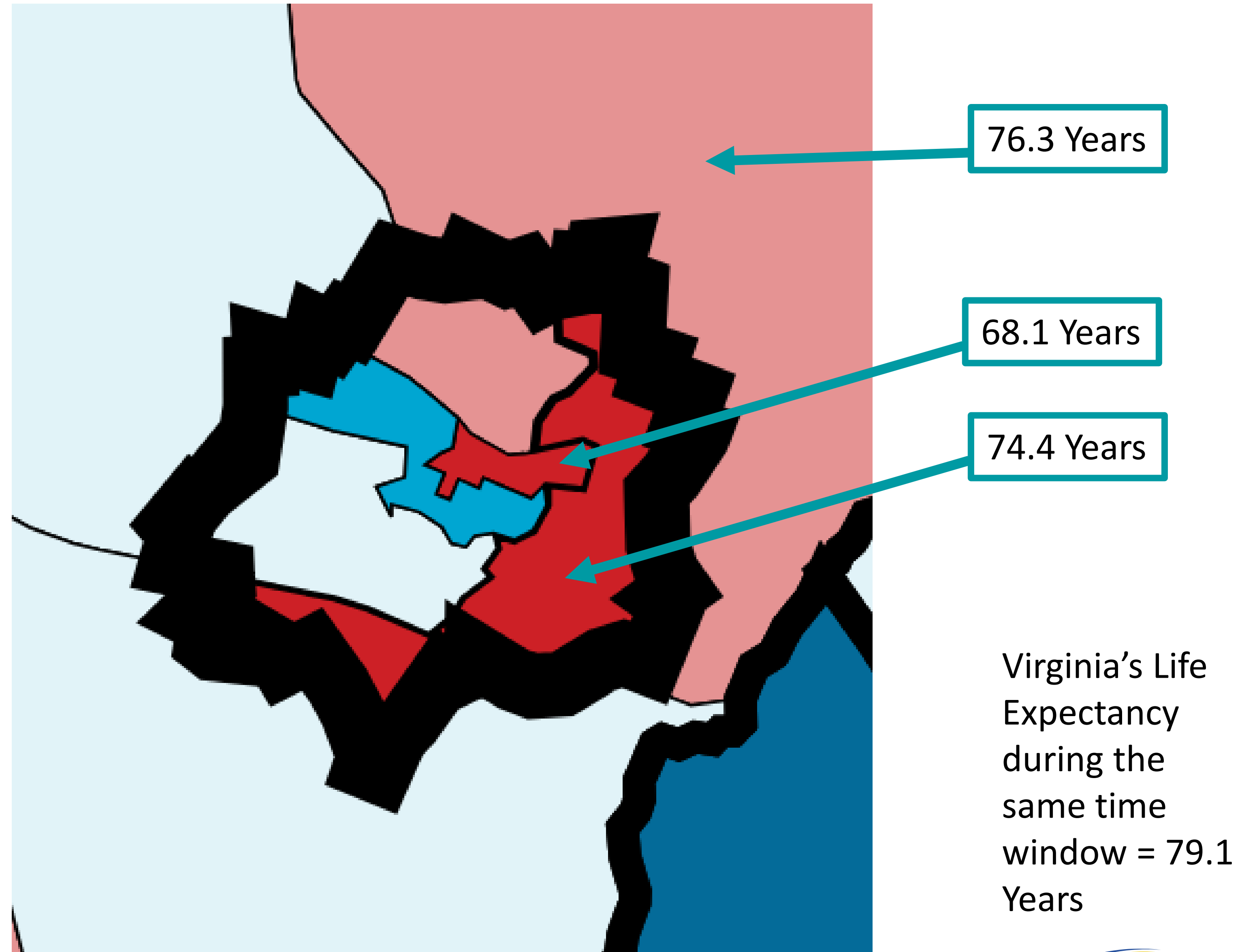
Life Expectancy at Birth Waynesboro, Virginia

At the Census Tract Level, 2010 – 2015

CDC National Center for Health Statistics

https://www.cdc.gov/nchs/data-visualization/life-expectancy/index.html



Virginia's Life Expectancy during the same time window = 79.1 Years

Robert Wood Johnson Foundation
US Life Expectancy, 2022

Virginia = 79.1 Years
Waynesboro = 75.5 years

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What Services are We Providing and Who Benefits?

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Who Are We Helping?

People in our community who:

- Face **mobility** barriers
- Face **transportation** barriers
- Are experiencing **poverty**
- Live in **remote** rural locations
- Are **dual eligible**
- Live with **substance use disorders**
- Are from a **marginalized** minority
- Are **immigrants**
- Are experiencing **homelessness**
- Are **LGBTQ**
- Are **pregnant** and facing social and/or personal **barriers to healthcare**

lic Consumption or Distribution

Augusta Health Neighborhood Clinic Services

- Primary Care
- Management of chronic diseases like hypertension and diabetes
- Vaccines
- Preventative screenings
- Case management
- Maternal health navigation
- Financial assistance enrollment
- Every Women's Life Cancer Screening Program
- Medication assistance program
- Addiction screening and referral
- Referrals for needed specialty care
- STI prevention, testing and treatment
- Food Pantry & Food Farmacy Program

umption or Distribution

Who are we helping?

Neighborhood Clinic Visits

Median age = 55
Age Range: 13 – 97 (5)
60.1% Female, 39.3% Male

0.5% American Indian, Alaskan
11.8% Black
30.6% Hispanic, Latino
53.1% White

1112 Unique Patients Seen

2797 Patient Visits
260 Unique Clinics

38% Uninsured
27.7% Medicare
17.5% Medicaid
17% Private Insurance

September 2022 – August 2024

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Chronic Conditions of Patients Seen

Neighborhood Clinic

Other psychoactive substance abuse
Other stimulant abuse
Depression
Coronary Artery Disease
Chronic Kidney Disease
Cardiovascular Disease
Hypertension
Cataracts
Cirrhosis
Heart Failure
Alcohol abuse
Frailty
Diabetes
COPD
Amphetamine Use Disorder
Cocaine abuse
Advanced Chronic Kidney Disease
Opioid abuse
Cannabis abuse
Stroke
Dementia

Mobile Clinic Visits 9/1/22 through 8/13/24, 1112 Unique Patients

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Food Insecurity, Diabetes & Neighborhood

What are we seeing in the neighborhoods around Augusta Health in 2023 & 2024?

Group	What % have Food Insecurity?
Primary Care Clinics **Patients with Controlled Diabetes** What % Have Food Insecurity?	4%
Primary care Clinics **Patients with Uncontrolled Diabetes** What % have Food Insecurity?	7%
Neighborhood Clinic **Patients with Controlled Diabetes** What % have Food Insecurity?	18%
Neighborhood clinic **Patients with Uncontrolled Diabetes** What % have Food Insecurity?	32%

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Neighborhood Clinic Growth and Trends

PATIENT VOLUME TO DATE

- We have seen a over 1,250 patients in the neighborhood clinic since launching in September 2022.

PATIENT HISTORY

- 848 patients had a previous encounter with Augusta Health either in an outpatient office, Emergency department, or inpatient setting.

NEW PATIENT VOLUME

- 32% growth in new patients to the Neighborhood clinic and organization.

IMPACT ANALYSIS

- We analyzed the 848 established patients to determine what kind of impact was experienced by the patients two years before the implementation of the Neighborhood clinic and two years after, in regards to emergency room visits, urgent care visits, inpatient admissions, inpatient costs, hypertension diagnosis and management, and diabetes diagnosis and management.

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Neighborhood Clinic Visits Growth

Patients Visits by Month at a Neighborhood Clinic
September 2022 – July 2024

Month	Visits
Aug 2022	
Sep 2022	29
Oct 2022	52
Nov 2022	49
Dec 2022	31
Jan 2023	86
Feb 2023	79
Mar 2023	91
Apr 2023	110
May 2023	137
Jun 2023	125
Jul 2023	99
Aug 2023	110
Sep 2023	218
Oct 2023	178
Nov 2023	176
Dec 2023	114
Jan 2024	153
Feb 2024	163
Mar 2024	140
Apr 2024	163
May 2024	127
Jun 2024	124
Jul 2024	114
Aug 2024	

Two communities of interest are **individuals experiencing homelessness** and the **Latino population**

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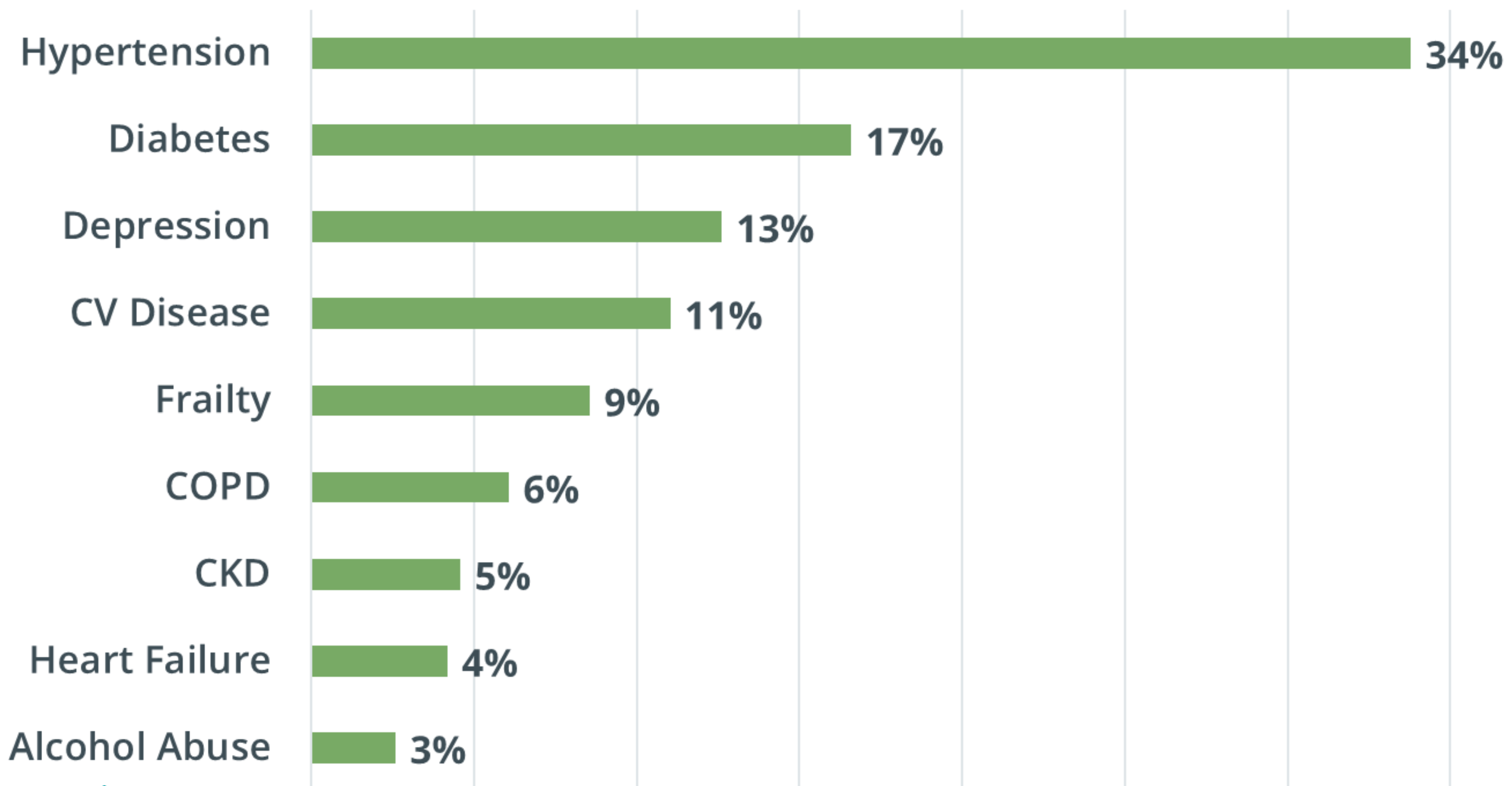
Most Common Conditions Seen & Payer Mix

Neighborhood Clinic Patient Mix by Chronic Condition



Neighborhood Clinic Payer Mix

Payer	% of Total
Commercial	13%
Medicaid	18%
Medicare	33%
Self pay	36%

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Impact of Clinic Connection on **Urgent Care Visits**

49% reduction in Urgent Care visits before & after 1st clinic visit

Urgent Care Visits Pre-Clinic Visit

Urgent Care Visits Post-Clinic Visit

↓49%

visits

30
25
20
15
10
5
0

1st visit

-25 -20 -15 -10 -5 0 5 10 15 20 25

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Impact of Clinic Connection on **ED Visits**

15% reduction in ED visits before & after 1st clinic visit

ED Visits Pre-Clinic Visit **ED Visits Post-Clinic Visit**

↓15%

visits

50
40
30
20
10
0

1st visit

-25 -20 -15 -10 -5 0 5 10 15 20 25

Months

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Impact of Clinic Connection on **Hospitalizations**

31% reduction in Hospitalizations before & after 1st clinic visit*

Hospital Admissions Pre-Clinic Visit | **Hospital Admissions Post-Clinic Visit**

↓31%

admits

1st visit

Months

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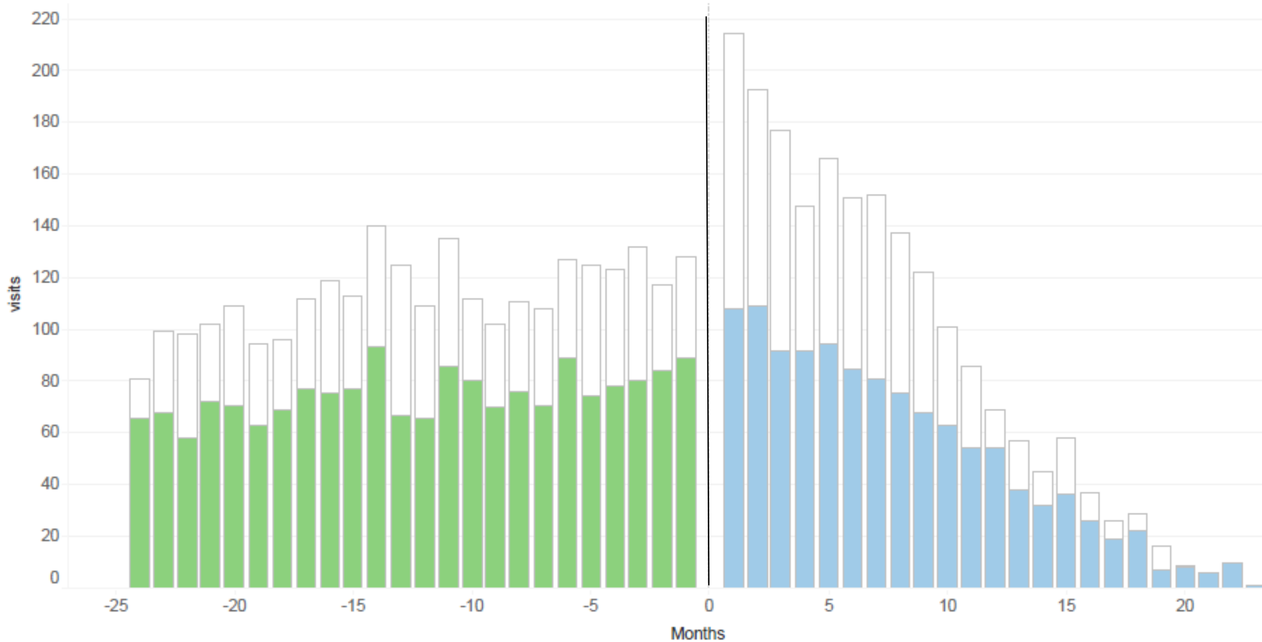
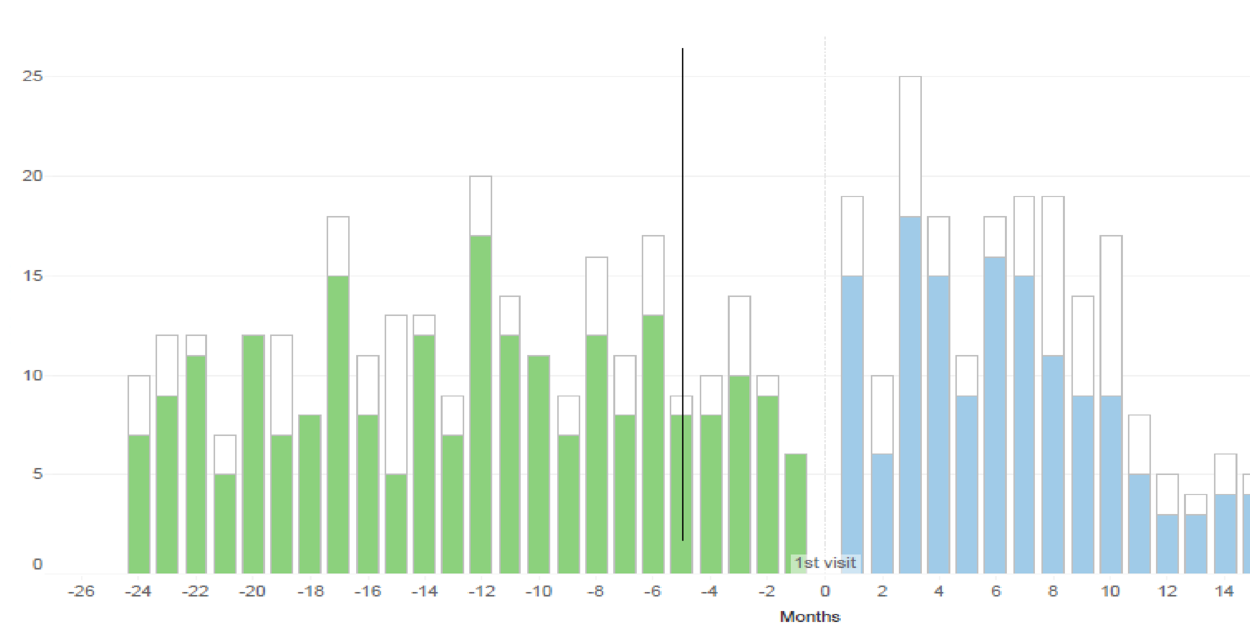
Impact of Clinic Connection on **Chronic Disease**

Focusing on controlling hypertension and diabetes

Reduced uncontrolled hypertension by 6%



No change observed in diabetes control indicators



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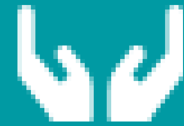

Community Outreach

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Community Partnerships

As a national model for community-based healthcare, on of Augusta Health critical success is our strong relationships with community partners. Partnering intentionally and strategically with area organizations to address the Community Health Needs Assessment priorities allows us to have a larger influence on the social, emotional, and physical well-being of our communities.

- Augusta Pediatrics
- Blue Ridge Area Food Bank
- Child Protective Services
- Comfort Care for Women
- Commonwealth's Attorney
- Cool Breeze Farms
- Dollywood Foundation
- Embrace Center for Community
- Hand in Hand Resource Mothers
- Infant & Toddler Connection
- Magnolia Rose
- Middle River Regional Jail
- New Directions
- Office on Youth
- Polyface Farm
- Strength in Peers
- The Neighbor Bridge
- The Village Prenatal Clinic
- Valley Community Services Board
- Valley Mission
- Valley Pediatric
- Virginia Department of Health
- Virginia Neonatal Perinatal Collaborative
- Waynesboro Area Refuge Ministry

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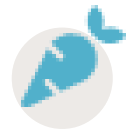

Addressing SDOH: Rural Food Access

In Augusta Health's Community Health Needs Assessment Nutrition is identified as a recurring priority need for our local area. Under this priority, improving access to nutritious food is a top goal.

- Crops to Community: Crops to Community is a food box delivery program designed so food insecure patients, who have transportation barriers or are homebound, can have access to fresh, nutritious foods. Boxes consist of fresh meat, eggs, and produce from The Farm at Augusta Health.

- Food Pantry: The Augusta Health Food Pantry focuses on equitable access to nutritious food for patients who have screen positive for food insecurity. Guests receive produce from The Farm at Augusta Health and shelf stable items from our local food bank, specifically selected by our hospital's dietitians.

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Crops to Community

- Began in April 2020
- Referral-based program through case management for patients who are who are food insecure and whose incomes are less than 200% of the FPL
- 50 boxes of food delivered bi-weekly to patients' doorsteps
- Total pounds of food delivered: 50,000
- Total pounds of produce delivered: 16,651
- Total market value of produce delivered: $73,563
- Total number of unique patients served: 107
- Total number of boxes delivered: 5,150

Consumption or Distribution

Food Pantry

- Began in April 2021
- Eight pantry location
- 21 referring practices
- Patients are referred into the program after screening positive for food insecurity
- Outcomes:
  - Total number of patients serviced: 3,910
  - Total number of bags distributed: 9,576
  - Total pounds of produce distributed: $11,229
  - Total market value of produce distrubited: $49,736
  - Total pounts of shelf stable food distributed: 65,920
  - Total amount of shelf stable food procured: $12,164

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Infant & Maternal Health Navigation

The Infant & Maternal Health Navigator program works with women before, during, and after deliver to provide education, resources, and baby supplies. It specifically targets teenagers, women dealing with substance use disorders, incarcerated women, cases involving complex newborn care, adoption scenarios, and resource insecure women.

Outcomes:

- 220 referrals in 2024
- $2,500 grant from VNPC
- LARC donation for MRRJ
- 1,000+ maternity clothes donations

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Neighborhood Clinic—Patient Perspectives

“When I had insurance and financial resources, I spent a lot of money on healthcare but I have never received such great care and it didn’t cost me anything.”

"Since moving back to my hometown last year, the Augusta Health Neighborhood Clinic at the Verona Community Center has been incredibly helpful in managing my diabetes. Every time I call, they always address my needs, and with various locations, they can make appointments convenient no matter where you live. Having reliable healthcare makes a big difference. From checking in when I arrive to seeing medical professionals, I know they truly care about my health.”

- Augusta Health Neighborhood Clinic Patients, 2024

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Barriers to Success / Next Steps

1. **Evaluation**—Continue to monitor and measure outcomes
2. **Impact Analysis**—Analyze claims data across insurers to demonstrate impact of health equity work and savings
3. **Increase Funding Sources**—Explore and seek funding for Health Equity work through Insurers; Medicaid and any commercially insured patients.
4. **Improve Data Alignment**—Collaborate on social services data for partners; data not collected and/or shared uniformly across sectors/systems
5. **Strengthen Mental Health Services**—Exploring expansions/partnerships for behavioral health
6. **Expand Access**—Pilot Mobile Medical Clinic (Van)

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Future Plans—Mobile Primary Care

Expanding Our Impact

Mobile Van Benefits and Services

- Improved access to remote rural locations
- Can service neighborhoods without a community space to donate
- Has 2 exam rooms
- Provides privacy for physical exams, confidential conversations, women's health
- Can visit occupational health sites
- Provides significant improvements in efficiency of operations—our current model has us loading and unloading supplies and equipment twice a day

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Moderated Q&A

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Thank You!

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