All right. Good afternoon or good morning, depending on where you are, and hello, everyone. Thank you for joining us today for our CMS National Rural Health Day webinar. And we are joined today by Augusta Health, one of our 2024 CMS Health Equity awardees.

My name is Ashley Peddicord-Austin and I am with the Centers for Medicare and Medicaid Services Office of Minority Health, or as you'll see us note on the slides, CMS OMH. And for those of you who may not be able to view your screen today, I am a White woman with brown hair, blue eyes, I'm wearing glasses and a fall-colored blazer.

So, National Rural Health Day, coming up soon, offers us a unique opportunity to highlight the importance of rural health and critical health challenges that are faced by people in rural, tribal, and geographically isolated communities. So, we're so glad that you can join us today for this important conversation. Let's go ahead to our next slide.

A few housekeeping items. Before we start, we want to note that closed captioning and ASL interpretation are available.

To access closed captioning, here's the instructions. Go to the menu at the bottom of the screen. Click on captions, which will display another menu where you can select show captions. Selecting show captions will allow closed captioning to appear on your screen.

To access ASL or American Sign Language interpretation, go to the menu at the bottom of the screen and click on interpretation icon. Under watch, choose American Sign Language and a window of our interpreter will appear on your screen. You'll note that they will automatically change every few minutes. Next slide.

So, on this slide, we have listed our agenda for today's session. So, following this opening and this welcome, we'll have a few opening remarks about our office, CMS OMH, and some resources that we have available for rural communities.

So, I'll turn it over to Jessica Dawson to discuss the CMS Health Equity Award and our 2024 winners. Following that, we will hand over our virtual microphone to Isaac Izzillo and Krystal Moyers, both with Augusta Health, who will discuss the work they are doing to improve access to health care in underserved communities in Virginia.

Prior to concluding today's forum, there will be time for a moderated Q&A session where we will take questions from attendees using the Q&A feature. And that's one of the boxes at the bottom of your Zoom screen. Let's go ahead to the next slide, please.

So, a little bit about who we are and where in the world we are in the government. So, the Centers for Medicare and Medicaid Service is actually the largest provider of health insurance in the United States. It's responsible for more than 160 million individuals supported by each of our programs. We'll call these the big M's within our office, but it's Medicare, Medicaid, CHIP, and of course, the Marketplaces.

The Centers for Medicare and Medicaid Services Office of Minority Health, our office, is one of eight Offices of Minority Health within the larger US Department of Health and Human Services. And we work with local and federal partners to help eliminate health disparities while improving the health of all minority and underserved populations.

So, we listed the logos of some of our other kind of sister agencies throughout HHS. We work with them frequently, but of course, we are focused on those Medicare, Medicaid, CHIP, and Marketplace work. Let's go ahead to the next slide.

So, our mission here at CMS OMH is to lead the advancement and integration of health equity into the development, evaluation, and implementation throughout CMS policies, programs, and our partnerships.

Our vision is mentioned here on the slide, as well, and I'll read it. "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." It's a pretty broad vision but that really is what we're looking for. And then is it also a very broad definition of our office's population.

So, you'll notice that our name might be minority health, but we're very generally health equity focused, and that's what brings us here for rural, tribal, and geographically isolated communities. Let's go ahead to our next slide.

So, speaking of rural, we just had one of our big reports come out as we wanted to put a slide out there to make sure that you guys knew about it. This is -- we'll have -- highlight a few reports and resources, but this one is particularly focused on rural, tribal, and geographically isolated communities.

It is our "Rural-Urban Disparities in Health Care in Medicare 2024." So, we do this report annually, or have for several years, at least. And it summarizes differences between health care quality and outcomes between rural areas, rural Medicare folks, and those with Medicare in urban areas. And it also examines the quality of care and how that can vary by race or ethnicity.

There's lots of stratified reports on our website if you're interested, but this one we wanted to make sure to mention since it's new. Let's go ahead to our next slide.

Another hot off the press or hot off the Internet report we'd like to highlight is "Advancing Health Equity in Rural, Tribal, and Geographically Isolated Communities, a Year in Review." So as the title might tell you, this is kind of summarizing things that happened at CMS to help these communities in the last year, in 2024.

This is another annual report that we try and come out with in November ahead of National Rural Health Day to make sure people know what's happening here at CMS, and highlight our strategies, initiatives, and outcomes that are focused on equity for underserved communities and how we're meeting the needs of all of these communities throughout the year. And let's go ahead to our next slide.

So, these aren't particularly newer reports, but they are kind of our big buckets. So, if you're looking for a little bit more about what is CMS doing for rural and geographic health care, this is where I would send you.

So, the first one listed is the "CMS Framework for Advancing Health Care in Rural, Tribal, and Geographically Isolated Communities." You hear me say that phrase a lot. It is long but we want to make sure that we're covering all people everywhere, so that's -- forgive my length. And that describes how CMS is focusing its efforts to advance rural health in all communities. So, that's kind of your big picture, how are we doing this, how are we going about it.

And then if you want something just short or maybe somebody in your office is looking for it or you don't want to read that much, we have the "Rural Health Equity One-Pager." And that outlines those six priority areas in just a little bit less words. I did kind of figure out where we're going.

And then we do have an "Advancing Rural Maternal Health Equity Report." So that one is definitely of interest in a lot of communities, so make sure if you're doing maternal health, that might be of interest.

We also have the Rural Health Information Hub. That one's actually from our colleagues from HHS, but it's a great resource, has lots of information and links for programs in rural communities, and kind of learning a little bit more about what's affecting Americans living in these areas.

Rural Health Clinics Center, another resource hub on the cms.gov page for information on rural health clinics, so that includes the educational resources, policy ideas, regulations, and then also billing and payment fact sheets since there are some nuances for rural health clinics.

All right, those are a bunch of big reports. Let's go to our next one.

Changing gears a little bit, we wanted to highlight our Coverage to Care initiative, also known as C2C. And you'll see that written on the images that are displayed on the screen here.

C2C is essentially health insurance literacy and it applies to anybody, any type of coverage. It offers resources specifically to help understand and use health coverage, so we have a lot of general resources, but there are a few that we wanted to point out for those maybe working in a rural or geographic community that maybe might be a little extra helpful. So, here's a few of those examples.

Essentially, we're talking about helping people access preventative care, utilizing their services for kind of a long-term, chronic care health, and keeping people involved in their care.

Drug coverage, prescriptions, chronic care, and just kind of helping break those down a little bit so people can understand it and know what in the world all these tricky health insurance terms are. So, you'll see one of the ones listed that's specific to tribal communities.

Prescriptions is huge. Telehealth is really important for rural communities. So, we have lots of information there. And then we sometimes get into a little bit more particulars on like chronic care or diabetes. So, there's a lot there on that website and that's go.cms.gov/c2c.

All right, at this point, I am going to turn it over to my colleague, Jessica Dawson, who's going to discuss the CMS Health Equity Award and our 2024 awardees.

Thank you, Ashley. Good afternoon or good morning, everyone. Thank you, Ashley, for your opening remarks and for sharing some of the CMS and C2C resources that are available. Like Ashley mentioned, my name is Jessica Dawson and I'm a Black woman with glasses, brown faux locs, and a tan dress. And I would now like to switch our focus to the CMS Health Equity Award. Next slide, please.

Thank you. So, health equity is defined as the attainment of the highest-level health for all people where everyone has a fair and just opportunity to attain their optimal health regardless of race, ethnicity, disability, sexual orientation, gender identity, social economic status, geography, preferred language, and other factors that affect access to care and health outcomes.

CMS is working to eliminate avoidable differences in health outcomes experienced by people who are disadvantaged or underserved and to provide the care and support people need to thrive.

In previous years, CMS recognized organizations who have demonstrated a strong commitment to health equity by reducing disparities affecting vulnerable populations, such as racial and ethnic minorities, individuals with disabilities, sexual and gender minorities, individuals with limited English proficiency, and members of rural, tribal, geographically isolated communities, the phrase that Ashley mentioned earlier. And other individuals impacted by persistent poverty and inequality.

The 2024 Health Equity Award continues this focus by recognizing Augusta Health and Latino Connection as two organizations that are using the CMS Framework for Health Equity to advance health equity and reduce disparities in health care access, quality, and outcomes.

We'll drop the link to our website in the chat where you can learn more about the CMS Health Equity Award. Next slide, please.

Before I introduce Augusta Health, I want to give some background on our other Health Equity awardee for 2024. And so Latino Connection is a community-based organization that was founded by George Fernandez in 2014, that creates and activates programming in low-income communities to address the social determinants of health.

Their Community-Accessible Testing and Education initiative, or CATE, 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.

The impact of CATE has been profound, reaching thousands of Pennsylvanians with lifesaving resources and education. Between 2020 and 2022, nearly 9,000 COVID-19 tests and over 17,000 vaccinations were administered across the state. Particularly in vulnerable and underserved communities who may not have had access, otherwise.

CATE also provided 500 flu shots and 10,000 personal protective equipment kits, resources, and education in both English and Spanish to the more than 37,000 people that attended all of their community events combined.

Latino Connections' CATE initiative exemplifies the transformative power of community-driven interventions in addressing health disparities. Next slide, please.

In a few moments, you will hear directly from Augusta Health on the great work that they've been doing but I'd like to briefly introduce you to August Health and what they do.

Augusta Health is a 255-bed nonprofit, independent hospital serving communities of the Shenandoah Valley in Virginia for the past 30 years in a semirural setting. Embracing our vision to be a national model for community-based health care, August Health reaches out to neighborhoods with rural geographic barriers and local cities with high poverty rates and adverse social and health barriers.

One of the ways they respond to acute deficits in access to health care in the community is through the implementation and growth of their primary care mobile clinic program, today, known as the Augusta Health Neighborhood Clinics.

Since its official launch in September 2022, the primary care mobile clinic program has expanded to operate at 14 unique sites each month. Sites have included community centers, churches, a firehouse, the mayor's office, and homeless shelters.

Neighborhood selection is based on identifying communities in the most need through analysis using the University of Wisconsin's Area Deprivation Index, or ADI score, and mapping techniques. Building upon the analytics, the key component for their success is having community partners with local expertise in key social services like housing and food insecurity.

Within the first full year of the program, the primary mobile clinic has provided more than 1,700 primary care visits for 825 patients at 17 different community sites, and services vary by location and are based on community needs. Next slide, please.

And without further ado, it is now my privilege to introduce Isaac Izzillo and Krystal Moyers from Augusta Health who will share more about their impactful work that their organization is doing. And Isaac and Krystal, I will pass it to you now.

Great. Thank you so much, Jessica, for that introduction.

Just to reiterate a few of the stats -- and you can go ahead and flip to the next slide, please, for me. Just to reiterate a few of the things that -- and next slide, again, please. Just one more. There we go.

Thank you. Just to reiterate a few of the things that Jessica mentioned about Augusta Health, we are a nonprofit community hospital. One of the few remaining, independent, community-based health care systems that are located in Virginia.

We are located in the Shenandoah Valley corridor of Virginia. And our service area population serves approximately 350,000 across some very rural areas of Virginia that include several small cities within that rural community. So, just to give you an idea, our primary service area, the county that, that lies within, is the same geographic area of the state of Rhode Island.

We do have licensed beds of 255. Our medical group includes 225 active medical staff where our team members are 2,500 strong and annually admissions, we have around 11,000. Next slide, please.

So, this is just a little bit of a zoomed-in view of the Shenandoah Valley just to give a little bit closer lay of the land. Augusta Health is located in Fishersville, where you can see some of those map dots there. And then our primary care, specialty care, and urgent cares, you can see we have to the north, south, east, and west. So, we are continuing to grow in all directions out from the hospital campus itself. Next slide.

We have recently updated our mission statement, which I believe really speaks to the work that we do in the community to both address social determinants of health, as well as health equity. I think it really shows that we believe in the work that we're doing and not just talk the talk but also walk the walk.

So, we updated our mission statement to say to strengthen the health and well-being of all people in our communities and added that plural onto community. Next slide, please.

So, on this slide in just a moment, we're going to play a video that was produced earlier this year by Virginia Public Media or VPM. And we'll go ahead and let it play.

[Video Plays]

[Video] With a few hands hard at work and some quick unpacking, it takes just minutes to turn this church classroom into a popup neighborhood clinic.

-How was your visit today?

-Really good. It's always good when I come see you people.

-This happens about three times a week in different locations around Augusta County.

Augusta Health provides free care to anyone who shows up.

-We really just want to do what's best for our community.

-Isaac Izzillo was part of the team partnering with organizations around this rural county. The goal is to provide free health care services to the un and underinsured.

-You know, they're going to have a lot more challenges, more negative outcomes, higher cancer rates, right? And they're not the ones getting screenings. They're not going to the physicians. Whether their challenge was financial limitations, accessibility, transportation limitations, or even a gap in health literacy.

-Patients like Johnathan say the care he's received here has been life-changing.

-Everyone that I came in contact with here, I could feel a genuine desire just to help.

-He says he was living in a tent and managing a painful infection when he heard about the clinic.

-I wasn't really expecting much. I just was showing up because I was in need.

-He received treatment for his dental infection and a pair of new glasses.

-It is absolutely a Godsend. Anything that they can help you with, you're going to be helped by.

-Providers also offer ongoing preventive care. They're keeping an eye on Johnathon's blood pressure, monitoring his levels to determine if he'll need medicine.

-So, we take a real comprehensive approach to managing our patients' care and leveraging all those partnerships inside our organization and out in our community to help.

-Care providers have treated more than 1,000 patients at about 230 clinics since 2022.

-When we looked at our patients a year before they saw us versus a year after and emergency room visits were down over 20%, 22%, if I remember exactly. Urgent care visits are down 41% and hospitalizations are down 66%.

-Augusta Health is receiving national recognition for this initiative, winning the 2024 Health Equity Award from the Centers for Medicare and Medicaid Services. But Izzillo says the work isn't about awards.

-Being able to share our message and our playbook to others, I just hope that they can help influence them to make differences in their communities, as well.

-And Johnathon's advice?

-Just come in, and get taken care of, and get on to being your best self.

-For "VPM News," I'm Adrienne McGibbon. [Video Ends]

So, as I mentioned, that video was produced by VPM, or Virginia Public Media, as part of a news story and we just felt like that was important to show today to showcase the community work and the services that we are doing out in the community to give a good snapshot.

So, when we start new initiatives like this, we start by listening to our community. And some of the questions that we ask is who is not doing well and what are the disparities. What are the social drivers underlying health disparities? Who could our partners be in this work?

And we ask these questions through a variety of different avenues, things like formal listening sessions or screening for social determinants of health. And by conducting surveys like our triannual community health needs assessment. Next slide, please.

So, our most recent community health needs assessment or our CHNA was conducted in 2022, and it showed an increase in difficulties accessing care. For our community, you can see an increased trend line from 2016 increasing through 2019 up through 2022. From that time, there's about a 10% increase in the experiences of difficulties or delays that our community has had in receiving health care.

This could be for a variety of reasons such as aging population, increased patient complexity, or even the shrinking workforce that we have in the health care field. But what we can also see is that our immediate service area is trending about 10% higher in this area than the national average. Next slide, please.

And at the same time, our community is self-reporting that both their physical health and their mental well-being is worse than our national benchmarks. So, obviously, they're needing that access to care even more. Next slide.

And we're also seeing a sharp increase in some of our most vulnerable populations. One example of that is those that are experiencing homelessness. So, from 2019 to 2022, we saw more than double in the percent of those that are experiencing homelessness in our local area. Next slide.

What we know about vulnerable populations such as those experiencing homelessness is that their average length of stay for those that are experiencing homelessness in the hospital is on average ten days longer and that their chance of a 30-day readmit is about 15% more likely. And this is just an example of one of the vulnerable populations in our community that we really want to help address. Next slide.

So, this is all kind of sobering news, right, in looking at our needs assessment and talking with community partners. So, there is good news out there and that is that we're seeing success in meeting our community health mission across some of our health metrics. And this is one that I want to share with you, one of those data points.

And that is that hospital rates for Medicare patients with multiple chronic health conditions our Augusta Health Accountable Care Organization, our ACO, is trending about 6% less in hospitalization rates than the average Medicare ACO performance data across nationally.

And so, I'm going to leave it there on that good news slide, on that happy data point, and I'm going to turn it over to Isaac to talk in detail about the mobile clinic. And you can go ahead and advance to the next slide, please.

Thank you, Krystal. Thank you, everyone, for having me here today. I'm always excited to talk about the great work going on in our community. As you have seen, we have a case to build to help improve the health and well-being of our community or communities that are out there, as Krystal had presented. Next slide, please.

So, how do we go about selecting places to go to implement our mobile primary care clinic. And I think there's two valuable methods to go about this, is one, we need to understand where there's a lack of primary care, where is the highest need. So really trusting data and understanding data that's intentional in selecting these locations.

And number two, we need to understand who in our community. What partnerships can we develop, whether it's churches, or community centers, or homeless shelters, to help us stand up the clinic.

As you saw in the video, we don't have a true mobile primary care clinic on wheels, at this time. We physically go to brick-and-mortar locations. So, we really needed to have trusted community partners that are aligned with the same mission and vision that we have to help all in our community.

This map here is a heat map of one of the data points we use is this heat map. We looked at patients who were in the emergency room or urgent care over the past two years who had no primary care assigned to them. So, it kind of created some highlights of locations that we needed to go. Another -- next slide, please.

Another thing we use is the Area Deprivation Index developed by the University of Wisconsin. They take 17 measures from housing quality, poverty, education, food and nutrition. And they help develop these heat maps to understand -- for us to understand where the highest need locations are within your community. And I really urge you to go and check this out within your communities. Next slide, please.

We do know in our local communities that we can use the Area Deprivation Index. Next slide -- or next click. It should come up.

We do know that we can understand and predict outcomes in terms of where people live, their actual physical address. So, we know there's a higher correlation to poverty and readmissions and to decreased age life expectancy if -- on these locations.

So, we have some really high R values of understanding people in these locations terms of ER visits frequency, lack of primary care. And one more click. And hospital mortality. So, we feel very comfortable in using this data to select our locations. Next slide, please.

This gives you an area map of the area deprivation index and also some of the locations that we go to. As you can see in these locations, our clinics are heavily grouped with inside the darker areas, which are areas scoring highest on the Area Deprivation Index.

So, these are those people that are really experiencing health disparities in underserved communities that are underinsured, uninsured, the working poor that are really challenged in accessing health care. And so, these -- this -- the heat map and Area Deprivation Index has really been a useful tool to us selecting our tools.

Then we went into those areas. We understood some of our partners. We reached out to them, had fantastic conversations and make sure that our missions aligned, the access, and that they wanted to help improve the health and well-being of all of our communities together. Next slide, please.

These are the locations when -- within Staunton and Waynesboro in Augusta County, are very rural areas that we go to. It's a really a mixed bag of locations. We go to churches, African American churches. We go to LGBTQ centers. We have ethnic-specific, Latino-specific clinics that we really bring all the resource to them.

Very rural areas such as Craigsville and Deerfield that don't have access to many goods or services. Subsidized housing locations, fire house, community centers, and everywhere in between. Next slide, please.

We also have also incorporated, just to validate that we're going to the right place, the CDC Lifespan models and maps and overlaid them on top of the ADI maps. Next slide.

Which has been helpful for us is to once again reinforce the places that we're going. From the CDC life expectancy models, we know, once again, if you live in the areas of darker color, you have a significant less life expectancy and you can see that can be over eight years.

So, we really made an organizational decision to start small, get started in 2022, and really leverage this data to start helping care for these underserved communities. Next slide, please.

So, what is the neighborhood clinic, formerly known as the mobile primary care clinic, doing? What services are we providing? Who benefits?

And as Krystal said, when we went in and did some planning at each one of these locations, it's important first to have conversations with those community partners because they really leveraged the trust within that community to build positive relationships for people who have been reluctant or who hasn't wanted to access primary care.

So, it's important to go in and have lessoning sessions with them. And let them lead the type of work and the work that's needed in terms of health care and meeting those health care needs within those community partner locations. Next slide.

We're really helping individuals that are underserved, right? They have mobility barriers, transportation, financial barriers. They may be remote and not be able to make it. They have some people that are insured or may -- dual eligible, that have Medicare, Medicaid. A lot of our patients don't have any insurance at all.

We help manage substance abuse disorders. We work with immigrants, the homeless, the LGBTQ. We also have a maternal health navigator who goes out and helps address some of those mother-baby social determinants of health as well and challenges to accessing health care.

So -- and this is not really comprehensive of everything we do because we do much more, also, but this is a good starting point. Next slide, please.

So, we offer basic primary care, and when I say basic, primary care entitles a lot of things. A lot of these people can't go to specialists. They can't get out to see them. So, our primary care team, first I want to say we've done some extensive training with them with trauma-informed care.

And we really believe in the mission to help our communities and communities, but we really believe in the model that providing the care that brings us closer to the community and community closer to us.

We really try to help manage those chronic diseases. Like many of you, the number two chronic diseases that most individuals may encounter in primary care is diabetes and hypertension. We're not any different from that.

Through philanthropy and the great support of our Augusta Health Foundation, we're able to provide vaccines with no cost. We do a lot of preventive screenings and help navigate them to those. We work very closely with our population health and case management team.

I told you already, we have a maternal health navigator. We bring actually our financial assistance team comes to events and helps sign up individuals for financial assistance within our organization. Everything they encounter is no out-of-pocket cost at our clinics, but in case they need some advanced imaging and such, we go ahead and sign them up for that.

We do special pap clinics for women, women cervical exam screenings. We have a medication assistance program we get them. We do addiction screenings and referrals and connect them directly, this hand off. We have a group called Valley Community Services Board. They actually come to multiple clinics with us to help manage addiction.

We do referrals to special care. We do sexually transmitted infection screenings and prevention, testing, and treatment. That's a big thing in the LGBTQ community. And also, we have a wonderful food pantry program, a Food Farmacy Program, that Krystal's going to talk about a little later.

So, we really help bring our patients to the coordinated services offered not only in our organization but within our community, as well. Next slide, please.

This is just a little breakdown of the patients that we have. We've seen over 1,000 unique patients. We've had working closer now to almost 3,000 visits since September 2022.

And I urge, as you listen to us, this didn't start overnight. In September 2022, we started with just four clinics that month and then that turned into 2023, the beginning, and eight clinics, to ten, to 12, to 14, to 16. So, it just takes time to build, guys. Don't let being great in 16, 20 clinics a month, be the antithesis of starting and being good. So really start, and get in, and leverage people that are passionate about this work within your organization.

You see most of the people coming right now are women, over 60%, versus male. Next click, please. Average age is 55. And, you know, it's been really alarming is seeing the aging population in homelessness. That has been really alarming in our community.

You see the majority of people we see are White but we have a large population of Hispanic and Latino. And we've been really intentional leaning into connecting with our Black African American community.

You see over a third of our patients are uninsured. We have a solid mix of Medicare and Medicaid patients. And that really comes from our subsidized housing and homeless communities. Next slide.

As you can see, this is just a basic word cloud of some of the chronic diseases that we are managing. Once again, hypertension and diabetes are the number two things. We do a lot of substance use disorder management. We have a lot of mental health that we try to address and connect with our communities. But it's not -- the greatest challenge is, you know, in primary care, you can manage hypertension and diabetes. But our patients not only have these issues but they have, you know, encountered many social determinants of health issues.

Whether it's housing, or nutrition, or the inability to buy medications to treat these things. So, they have much more complexity in being managed in these chronic disease arenas. Next slide.

We looked at our -- I'm going to get into some data here, some exciting things. Next click.

We looked at food insecurity and diabetes in our clinics and we wanted to see, again, how many people are experiencing whether they have controlled or uncontrolled diabetes. Next click, also.

We know that people with uncontrolled diabetes are experiencing in our primary care clinics more food insecurity. One more click.

Also, you will see in our neighborhood clinic, you can see the tremendous amount of increase of people with uncontrolled diabetes that also encounter food insecurity. So, we've been really leaning in with some work to help address some of these things.

So, we are very grateful to partnerships that we have within our community, but definitely our Food Farmacy Program. Next click.

We wanted to see what kind of impact, and this is really we've leaned in this since we've won the award. We wanted to see what kind of impact are we making in our community in regards to outcomes. And this is an update since you heard me on the video talking earlier.

We knew out of our 1,200 patients, 800, almost 850 of them, have had a touch within the organization. And that's not necessarily with primary care. It could have been in the ER, or urgent care, or any of our other specialty clinics. So, we wanted to look and see what kind of impact. Next slide.

That they had two years before we had the clinic versus two years now that the clinic's been going. Next slide, please.

Oh, there we go. This shows the growth that we've had since we started. You see September 2022 to where we're at now. We've just had continued growth when our -- in our neighborhood clinics in terms of volumes.

Key to success of people coming is consistency. So, we go to each -- most of these clinics, we go to once a month, all right, because we go through all of our counties. It's important to be present and consistent for extended period of times before changing up and going somewhere else.

You think about it, if we go to five clinics, it takes five minutes -- I mean, five months for us to develop relationships within those communities. In that time period, there's a lot of marketing, a lot of work, a lot of hand-delivering, a lot of reaching out to community partners within those areas, to let people know how to access this care and how to set up a joint relationship.

So, we've had continued growth, and we continue to do so. All of our clinics are extremely busy these days, which is great hard work that we've been intentionally trying to do. Next slide, please.

We've looked at the percentage of individuals by chronic disease, once again, hypertension and diabetes, a third of them have hypertension issues and 17% a lot of depression.

A lot of people have some mental health issues that we need to address. We've partnered with a local agency called the ARROW Project that we bring them in and help them do some counseling actually at our clinic several days a month. So, we've been excited about that work and hopefully we look to expand it. Next slide, please.

So, when we looked at the two patients, okay, the patients, there's 848 patients. We looked at them two years beforehand and that's -- this is urgent care visits. What kind of impact have we had on that and why is this important? Because if we really want people, we know people that access primary care on a continual basis.

We know that the management of their chronic diseases are much better than seeing ER and urgent care visits. They're just helping address that emergent need in time but not help addressing it over long periods of time.

The left are two years are patients beforehand. And you see on the right, we have a 49% reduction in urgent care visits after seeing our neighborhood clinic. So that tells me that we're -- access is not -- is an improved thing for these patients and that they feel comfortable in coming.

I feel that's a very significant drop and we're very proud of that within our communities. It's a lower-cost access for these underserved communities. Next slide.

What kind of impact do we have in the emergency room? Well, once again, we looked at two years beforehand and two years after, and we have a 15% drop, and I feel that's very statistically significant, also, and very appro. Once again, trying to provide the right care, at the right location, at the right time. Next slide, please.

We want to look at hospitalizations, and this one we're quite proud of. Patients have become moderately comfortable in connecting with us and talking to us prior to reaching and a higher level of care. And we have helped -- the neighborhood clinic has helped drop hospital admissions by 31%. And that's a lot of out-of-pocket expense time when you're out of, you know, you're out of clinic or in the hospital, you can't go to work. And it just compounds all the social determinants of health that they may be experiencing, already.

So once again, we're very, very proud of this work and the work the team's doing. Next slide, please.

We also want to know what aren't we doing well and we looked at our two most common chronic management diseases: hypertension and diabetes.

We know we looked at, as you can see on the left-hand side, those are the 848 people that were diagnosed with hypertension beforehand. And on the right, we looked at controlled and uncontrolled, and you can see we brought a lot more uncontrolled people with hypertension.

But we also have made some gains, about 6%, and we're quite proud of that, especially with people with social determinants of health issues. On the right, we looked at uncontrolled and controlled diabetes and we really haven't made a great pathways in improvement within that. And that's leaning to some work that we're going to do in 2025 here to really help hand-hold some people through this diabetic management pathways, medication, and monitoring.

With that being said, I'm going to hand it right back to Krystal and she's going to talk about some of the great work they're doing.

Thank you so much, Isaac. So, we can go to the next slide.

There we go. Thank you. And so, we are going to kind of try to tie this up now.

So, we're going to touch on some of the community benefit initiatives that we have in place. And go into a little bit more detail on some of those programs that Isaac has alluded to about how we're addressing these needs from a community benefit perspective.

So, Isaac -- both of us have mentioned community partners. So, you hear that reoccurring theme and how important we feel that is.

As a national model for community-based health care, one of Augusta Health's critical success factors we really believe is strong relationships with our community partners. I've been partnering intentionally and strategically with our local organizations to address our community health needs assessment priority areas.

Which right now are nutrition and physical activity, mental health and substance use, and access to health care. And that allows us to have a larger influence on those social factors that are, you know, really important for us to get at with these vulnerable populations.

So, I just listed out a list of organizations who may not mean a whole lot to you all if they're the ones that are local here. But just to give you an idea about a handful of organizations that we partner with.

We have about 150 to 200 partnerships, depending on when you take that snapshot throughout the year of partners that we have in works with our programming that's happening out in the community. These are just, you know, a segment, a snippet of those related to the programs that I'm just going to provide examples of over the next few slides. So, we can go on to the next slide, please.

So, referencing back to our community health needs assessment, nutrition is identified as a reoccurring priority need through our last several cycles for our area. And under this priority, improving access to, not just to food, but to nutritious food is always one of our top goals.

And so, an example of an initiative under that area is our Crops to Community program. Crops to Community is a food box delivery program that's designed so that food insecure patients who have transportation barriers or are homebound can have access to fresh, nutritious foods. These boxes that are delivered to them contain fresh meat, eggs, and produce. The produce comes from The Farm at Augusta Health, which is our farm on our hospital campus.

Another program that we have in place is our food pantry program. The Augusta Health Food Pantry focuses on equitable access to nutritious foods for our patients who screen positive through our social determinants of health screening for food insecurity.

Guests who receive -- who come to the food pantry receive food from The Farm at Augusta Health and shelf-stable food items that have been prepared from our local food bank. And the shelf-stable items are specifically selected by our hospital's dietitians to make sure that they receive -- the patients receive food that meets certain dietitian standards for chronic diseases. Go on to the next slide, please.

So, just to provide a little bit more details about these programs, our Crops to Community program began in 2022. It was actually a COVID response program for patients that were homebound. But quickly we learned that there was a lot of our patients who had food access and transition -- excuse me, transportation barriers and it became much more than just a pandemic program. It is referral-based through our case management for patients who are food insecure and who have incomes who -- that are less than 200% of the federal poverty level.

We right now are delivering 50 boxes of food biweekly right to the patients' doorstep. Since inception, we delivered over 50,000 pounds of food in total. The produce accounts for about 17,000 pounds of that and that market value of the produce would be about $74,000.

We are continually trying to provide more and more of a whole diet to patients through this program. And make sure that we have a balance not only of nutritious food access, but also the education that's needed to go along with that.

So, providing recipes in the boxes or what we call "What's in your Box" handout that helps identify each veggie that's in that box. Because some may be unfamiliar with the veggies and how to store those or prep those. And as well as, again, I said those recipes. Next slide, please.

So, the Augusta Health Food Pantry began in 2021, in April of that year. We are now up to eight pantry locations across our health system. So, it's very important to us that folks that are in the more rural locations have a pantry location at one of our clinics that are easier for them to access and they don't have to come all the way to our hospital campus.

If you think back to the map I showed at the beginning, those might not have looked far, but from some of our clinic locations to our main hospital campus can be closer to an hour. And we -- and that's not feasible for some folks to drive to or to get from, you know, a local food pantry location to another.

We do have 21 referring practices, but most of the referrals are done through social determinant of health food insecurity screenings. But providers and nurses can refer in to the program just through conversations that they have with patients and somehow that's how folks are identified as food insecure. And patients can also self-refer. And if someone says they're in need of food, we don't turn them away.

Since the program has started, we have served about 4,000 patients with about 10,000 bags of food. Looking into the future, staffing, either with through team members or volunteers, the food pantry to a place that we can be open from 8:00 to 5:00 five days a week is our ideal. And that we can have produce available at all clinic locations.

Right now, we only have produce at our main hospital locations just from a perishability perspective, would be the goal moving forward in the future.

One of the main reasons that patients say they come to our location is, one, they're able -- they're screened food insecure. They don't have to leave the hospital campus without food, which is our goal. But the other is the availability of the fresh produce and our hours right now that exist longer than some of the other food pantries in our community which may be, one, you know, one Friday morning a month.

We have longer hours than that. So, the accessibility and the availability of fresh produce is the differentiators for our food pantry and we want to continue to expand on those differentiators. Next slide, please.

So, the last program I'm going to speak on is an alignment with the "Rural Maternal Health Equity Report" that was talked about at the beginning of the webinar. And Isaac has mentioned our Infant and Maternal Health Navigator program a few times, as well. And this program really works with women before, during, and after they deliver to provide education, resources, and baby supplies.

It targets our more vulnerable populations, teens, women dealing with substance abuse or mental health disorders, women that are incarcerated, or just any more complex case where there may be additional resources that are necessary.

This program began in late-2023 based on several data points. One from our community health needs assessment that was very alarming where we were seeing that our infant mortality rate was doubling in our community and kind of really caught us off-guard. But made us really stop, and reflect, and try to understand what we needed to do in our community. And as we probably all know that, that statistic isn't just an Augusta Health statistic. We're seeing that across the country, unfortunately.

Since we started this work, we've partnered with a lot of community partners. In this year alone, in 2024, one maternal health navigator has had 220 referrals. And so, this is a body of work that we could in just about a year and a half, could instantly have one or two more people in this position. If it's really once we opened the can of worms, it's quickly growing to a huge body of work. And now I will send it back to Isaac to finish us up.

Yeah, we just wanted to highlight some of the great outcomes that patients are talking about us. You know, I can't say enough about our team, the conveniency that people are experiencing, the work that they're going out and doing. It's just been very well received within these underserved communities. Next slide.

I did want to talk to you, and I'll just highlight briefly over it, about what's barriers. What are the next steps? And we want to continue to evaluate and use data to analyze what we're doing and what we're doing well.

We've really got to continue to work on our funding sources. And through our striated approach to we hope that Medicaid, Medicare will help and some commercial payers will see the impact that we're doing and help get onboard to help sustain work like this.
Also look at maybe having some contracts with some payers and I can't say enough about our foundation. They have raised hundreds of thousands of dollars to help this make this work possible.

We want to really strengthen our mental health service. Expanding that, that's what we're looking for in 2025 and beyond. And we want to have a true medical mobile unit so we can go to places that do not have the brick and mortar to help us presently. Next slide.

And this is a demonstration actually of what we're looking at for a true medical mobile unit moving forward. So, if you feel so moved to do so by the work that we're doing, we'd love to have any reach in your pockets, get with your hearts, and be able to donate with our true medical mobile unit.

With that being said, I would like to open up the floor now to any questions that we could help answer. I'm sorry we just a couple minutes left.

Yes, thank you. First, I want to say thank you very much, Krystal and Isaac, for that thorough presentation.

I want to take a moment to acknowledge that we did have some questions that were asked about; access to CMS services, what will be covered through the end of the year. We also collected some comments to be shared with our CMS Rural Health Committee to inform their work. But most of the questions in our chat box were answered by our technical director, Ashley. So, thank you very much for answering those questions.

And since we're almost at time, I'm going to go ahead and close us out and just say thank you to Isaac and Krystal for the very thorough presentation. I think that you preempted a lot of the questions that I would have asked as follow-up with regards to your long-term goals and any challenges that you have addressed, and how you plan to address them going forward. So just really looking forward to seeing the great work that you guys have to do in the future. And next slide, please.

On this last slide, we just have our contact information. So, if you have any questions for the Office of Minority Health or you're interested in learning more about rural health, you can subscribe to our listserv. You can reach out to us via e-mail. Also, our Coverage to Care e-mail address is on screen and our Office of Minority Health e-mail address.

And I don't know, I can't say thank you enough to Isaac and Krystal for taking time out of their busy schedule. I know this is the week of National Rural Health Day, so I'm sure you all have other rural health initiatives to focus on. So, thank you for taking time to be with us here today. And I will close us out.

Thank you for having us, Jessica.

Yes, thank you so much for having us. We appreciate it. Thank you all for tuning in.