36TH ANNUAL AHA RURAL HEALTH CARE | LEADERSHIP CONFERENCE

FEBRUARY 19-22, 2023 | SAN ANTONIO, TX

JW MARRIOTT SAN ANTONIO HILL COUNTRY

American Hospital Association™

Advancing Health in America

AHA Events

MERGING THE RIVERS:

Advancing Health Equity in a Rural Community through the Integration of Community Outreach and Population Health

Mary N. Mannix, FACHE, President & Chief Executive Officer

Clint Merritt, M.D., Vice President of Population Health & Executive Director of Augusta Care Partners

Krystal D. Moyers, M.Ed., CHES, Administrative Director of Community Outreach & Partnerships

Augusta Health™

About Augusta Health

About Augusta Health

- Owned by the Community
- $500 Million Net Revenue
- No Debt; 480 Days Cash on Hand
- 325,000 Population (service area)
- 255 Beds
- 2300 Team Members
- 250 Employed Physicians and APP’s
- 55,000 ED Visits
- 260 active Medical Staff
- 1000 Deliveries
- 45 Outpatient Practice Sites
- Member of Mayo Clinic Care Network
- Largest employer in the Primary Service area

About Augusta Health

To promote the health and well-being of our community through access to excellent care

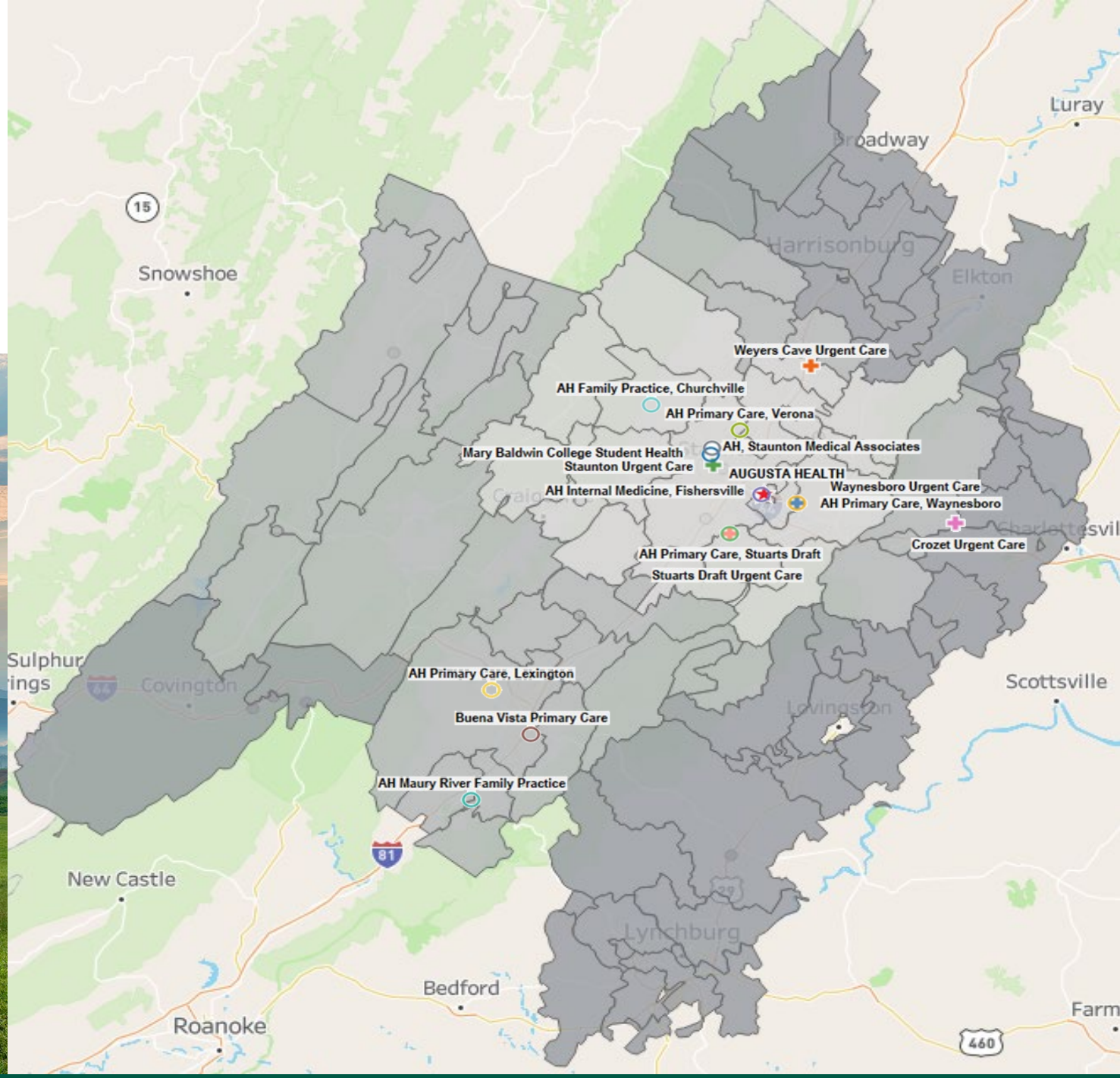
This will be achieved through:

- Unrivaled coordinated care of the highest quality
- Inspired and engaged professionals
- Patient centered services that are recognized for being comprehensive, distinguished, compassionate, and specialized
- A health system in aggressive pursuit of transformation

Our Community

Staunton, Augusta County,
Waynesboro (SAW), Virginia

“Located in the Shenandoah Valley”



Governance Structure

Augusta Health Board of Directors

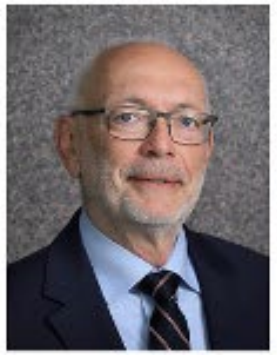
"Community Owned and Governed"


John Bowers


Debra Callison


Robin Crowder, Ed. D.


Ronald Denney


Richard Evans, MD


David Fosnocht, MD


Christopher Heck, MD


Laurie Landes


Homer Hite


John Peterson


Burnie Powers


Keri Rankin

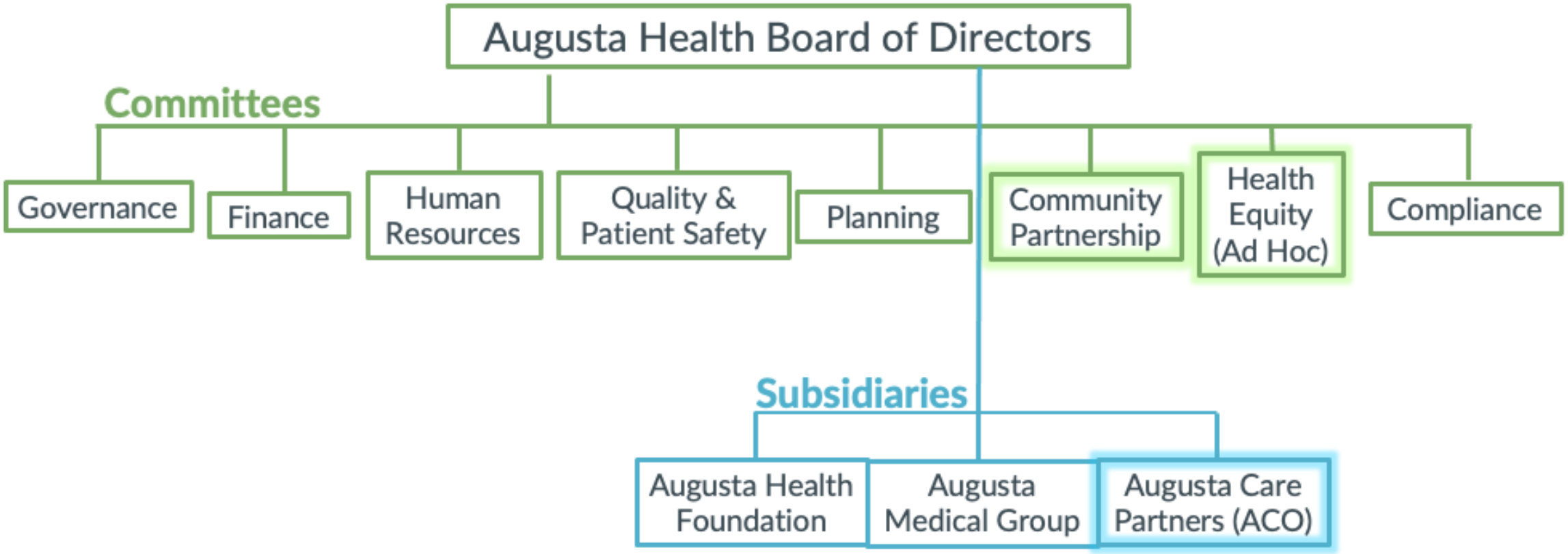

Mary N. Mannix, FACHE


Whit A. Morriss, MD


Jack Otteni, MD


Victor M. Santos

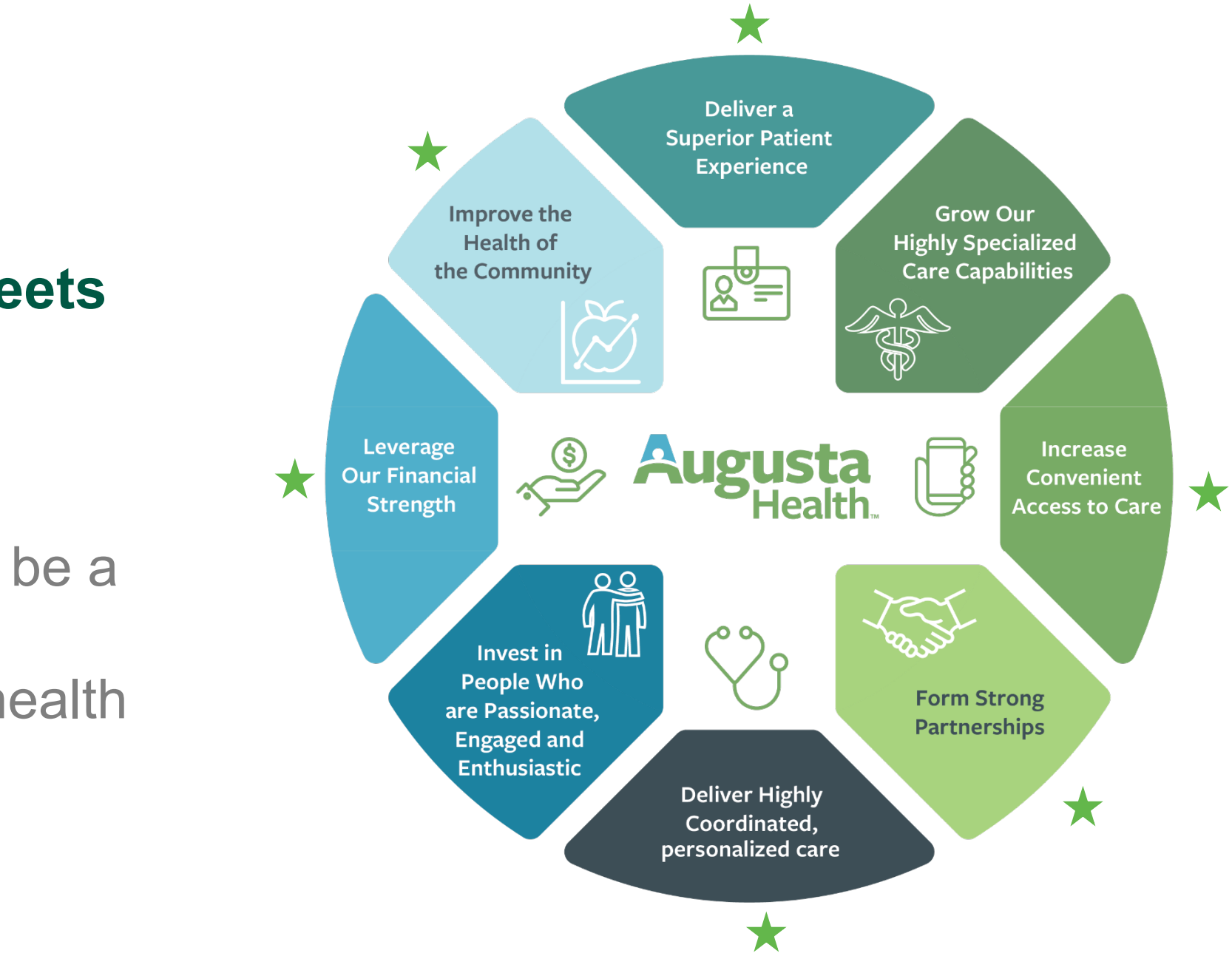
Governance Structure



Journey 2025: Where Mission Meets Strategy

Vision:

Augusta Health will be a national model for community-based health care.



Overall Themes

- Community Outreach & Partnerships and Population Health Teams have alignment in mission. Their initiatives have different histories, tactics, partners and funding models; we work to take advantage of the strengths in both teams.
- Health equity is foundational to our mission– it is how we understand who needs what help, and we are committed to developing a sustainable economic model to support and protect this work.
- Data is both our challenge and a key strength. We will share some of our data that highlighted the priorities identified on the journey, hoping pieces of our work might prove helpful.
- We believe this work differentiates Augusta Health and is part of the journey as a national model for community health, even during these challenging financial times.

Our Journey toward Health Equity

Listen:
CHNA Identifies Health Needs

Community needs: BH, Nutrition, & Access

Find High Risk:
Homeless Healthcare Connection

The great disruptor: **COVID-19**

AH Commitment:
COVID-19 Outreach & Mass Vaccination Clinic

$3M Board Commitment with goal that 20% of served are vulnerable & undeserved

Community Benefit Endowment

Find Partners:
Formed partnership for COVID vaccinating of Spanish Latino Community (Silver lining)

AH Community Outreach kicks into gear

Partnership Commitment:
Latino Health Council leads community programming and Health Disparities

National movement to focus on Health Disparities evolves

More Partners Join:
Latino Health Outreach/ Community Health Fairs (Embrace Community Center)

Expand:
Augusta Health continues to focus on disparities

AH Outreach & Pop Health Team enhance access

Niche Services:
- Mobile Clinic for Primary Care
- Food Access

Plans to grow from 3 to 7 sites

Path One

Access to Care

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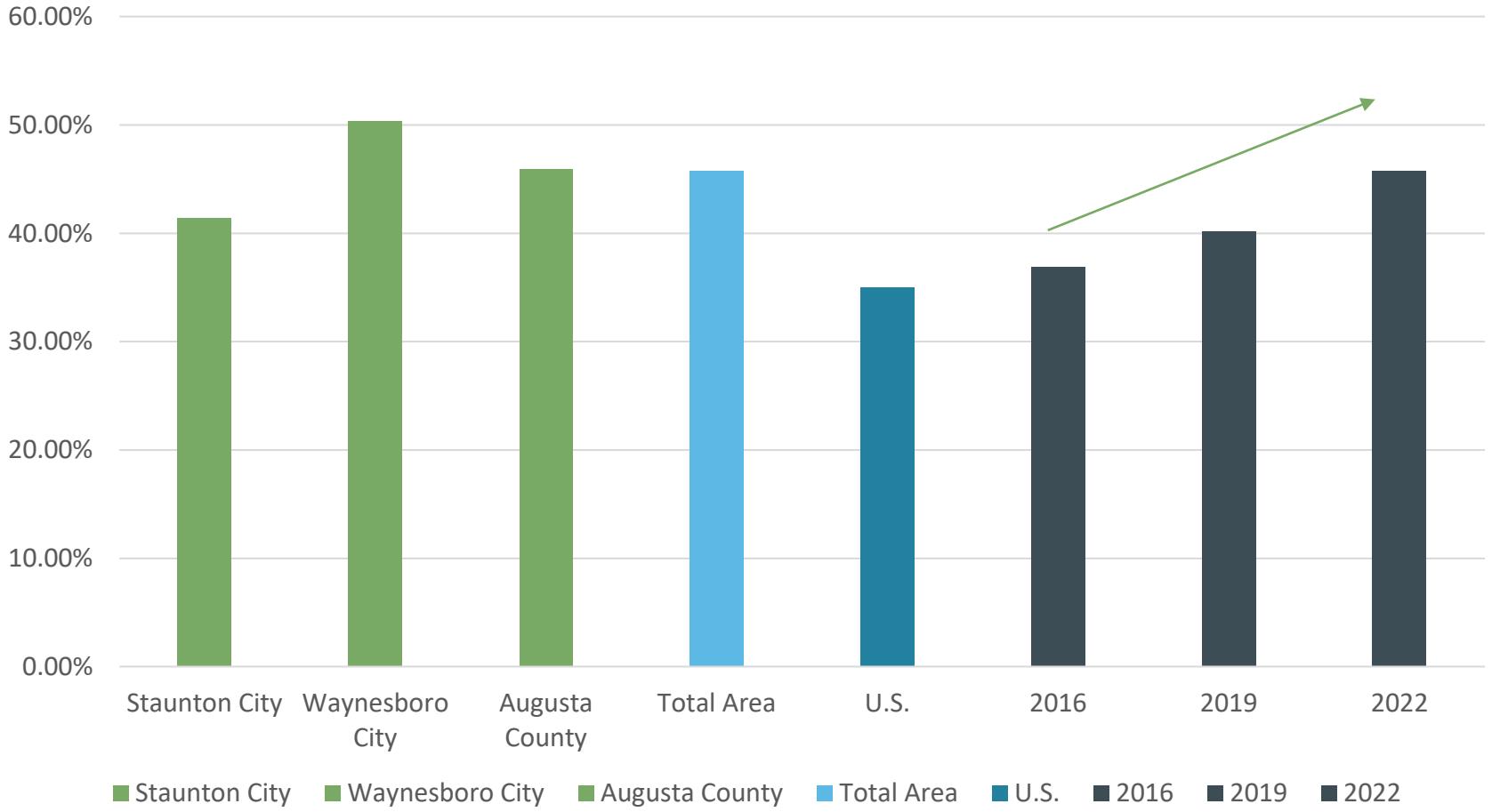
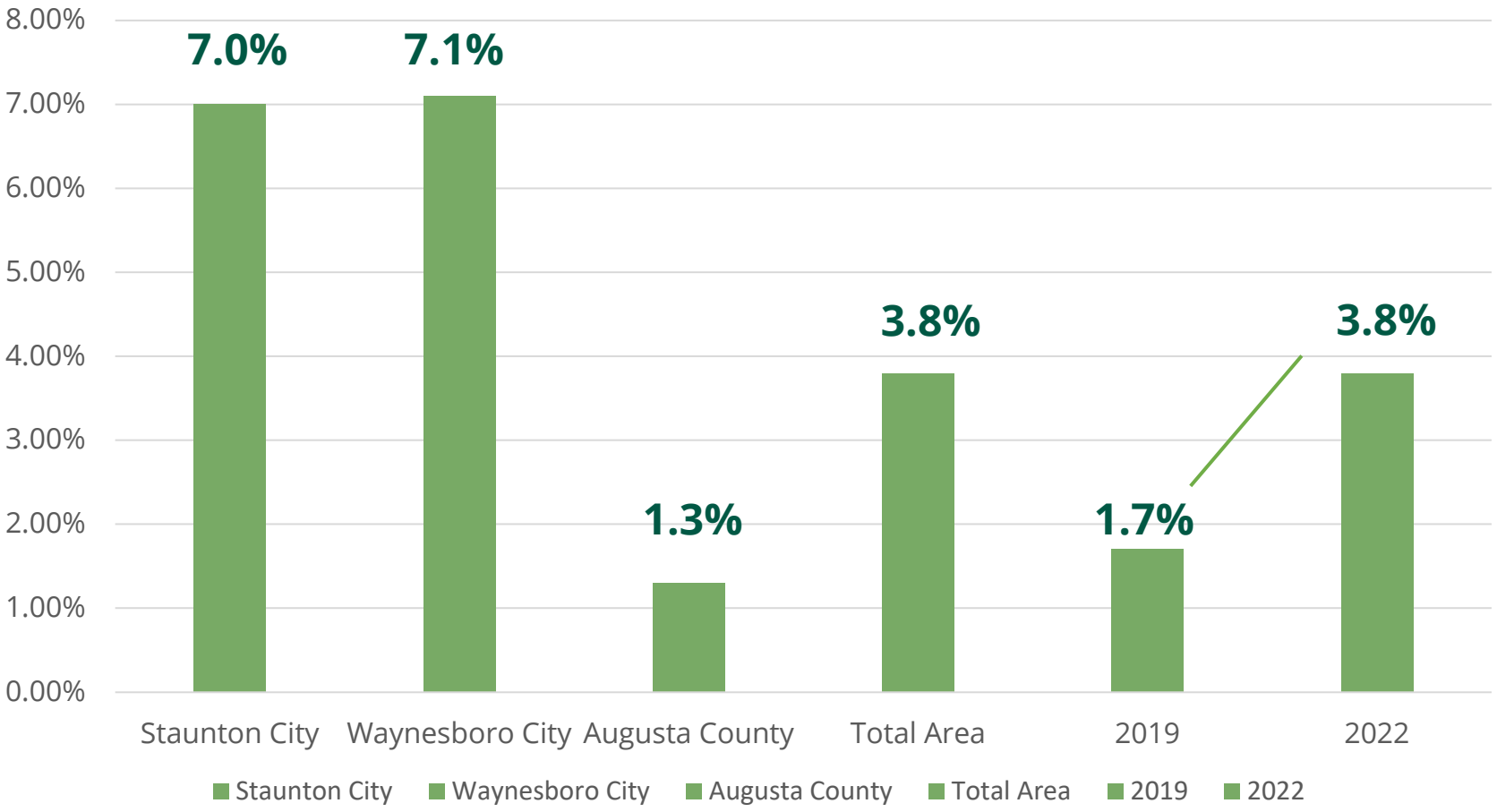
Increase in Percent Experienced Difficulties Accessing Health Care

Worse Than the National Average



Source: 2022 PRC Community Health Survey, PRC, Inc. [Item 140] | 2020 PRC National Health Survey, PRC, Inc.
Note: Asked of all respondents | Percentage represents the proportion of respondents experiencing one or more barriers to accessing healthcare in the past 12 months.

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



Source: 2022 PRC Community Health Survey, PRC, Inc.
Note: Asked of all respondents

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Homeless Healthcare Connection

Augusta Health is having a greater collective impact by partnering with community organizations.

Key Program Partners Include:

Homeless Healthcare Connection

An initiative led by Augusta Health that provides people experiencing homelessness with improved access to healthcare and social services and reduce barriers to care.

Key Program Components:

- Health Screenings
- Education
- Vaccinations
- Coordination of resources and community resource referral (transportation and food access)
- Prescription support through the Medication Assistance Program, and prescription delivery
- Financial Assistance

Through program participation, patients are better able to manage complex chronic disease diagnoses, and in turn reduce Emergency Room utilization.

65% of area homeless population impacted


Augusta
Health

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COVID-19 Outreach… Many New Findings And New Partners

250 Community COVID-19 Clinics Locations

COVID-19 Community Partnerships

- Forged new relationships with community partnerships addressing health equity issues
- Became a trusted partner
- Specifically, those organizations serving Hispanic/Latino community
- Lead to conversations beyond COVID-19
- Fastest growing population in our area
- 4% total population in Staunton, Augusta County, Waynesboro
- Formed the Latino Health Council to the needs of the community

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Latino Health Outreach

Program Purpose

- Address health disparities and reduce the barriers that exist in the Hispanic and Latino community when accessing healthcare
- Offer health promotion and disease prevention services
- Seek to better understand the concerns, values, and culture of the Spanish-speaking community
- Engage community partners to provide culturally competent care

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Latino Outreach Fair

Services Coordinated by Community Outreach, and Offered by Diverse Augusta Health Teams or Our Community Partners

- Blood Pressure Screenings
- COVID-19 Vaccines & Boosters
- Diabetes Education & Screenings
- Every Women's Life
- Food Pantry Bags
- Flu Vaccines
- Medication Assistance Program
- Provider Referrals
- Infant and Maternal Health

Augusta Health Partners at Embrace Community Center

Broad Community Partnerships:

- Sin Barreras
- Latino Futura
- Central Shenandoah Health District
- Just Neighbors
- Valley Community Services Board
- Molina Health
- Blue Ridge Area Foodbank
- New Directions Shelter
- Every Woman's Life
- AH Community Outreach Team
- AH Diabetes Education Team
- AH Population Health
- AH Stroke Team
- Augusta Medical Group

Augusta Health Hispanic Outreach

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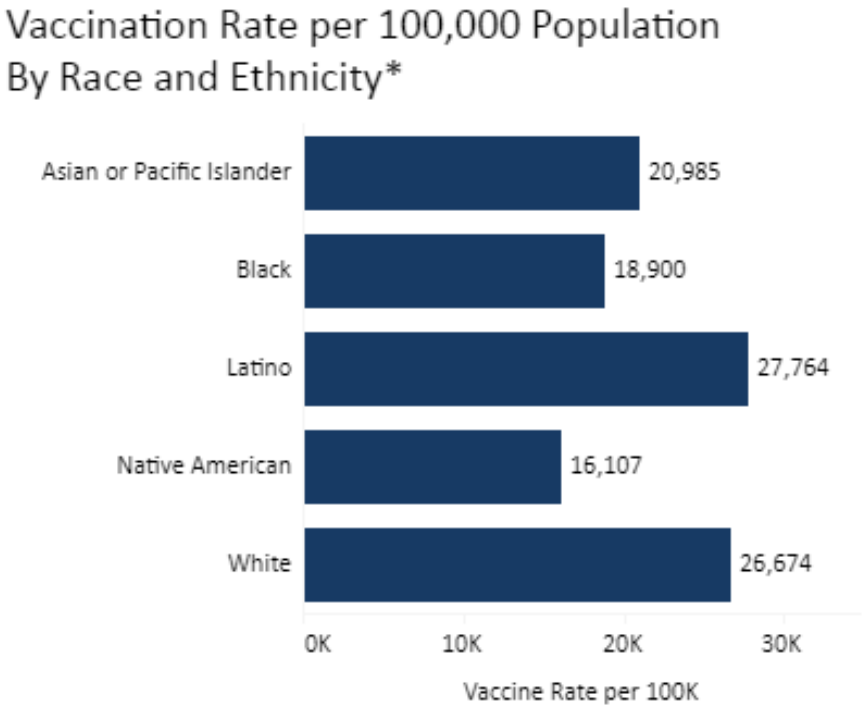
Improving Covid Vaccine Access

Staunton, Augusta Co, Waynesboro



Data pull 4-28-21, VDH

Access to Primary Care in the Preceding Year

4,110 Latino community members in primary service area

239 Individuals coming to our primary care practices

Health System sets 2022 Annual Goal tied to health equity and access to care

2022 Variable Comp Goal to Increase Primary Care Visits for Latino Community Members

Our Next step:

Talk to our community members

The Latino Health Council

What they shared with us:

- Affordable access to primary care
- Services in Spanish
- Independent of citizenship or insurance status
- Promoted by trusted community leaders

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The Mobile Clinic

Our Philosophy:

We bring healthcare to underserved members in our community, independent of social status, disability, income, insurance, citizenship, or preferred language.

We believe that improving the health of our community requires us to take care on the road, to recognize personal and social barriers, to understand disparities, and to connect in neighborhoods with the help of trusted community members.

The Mobile Clinic

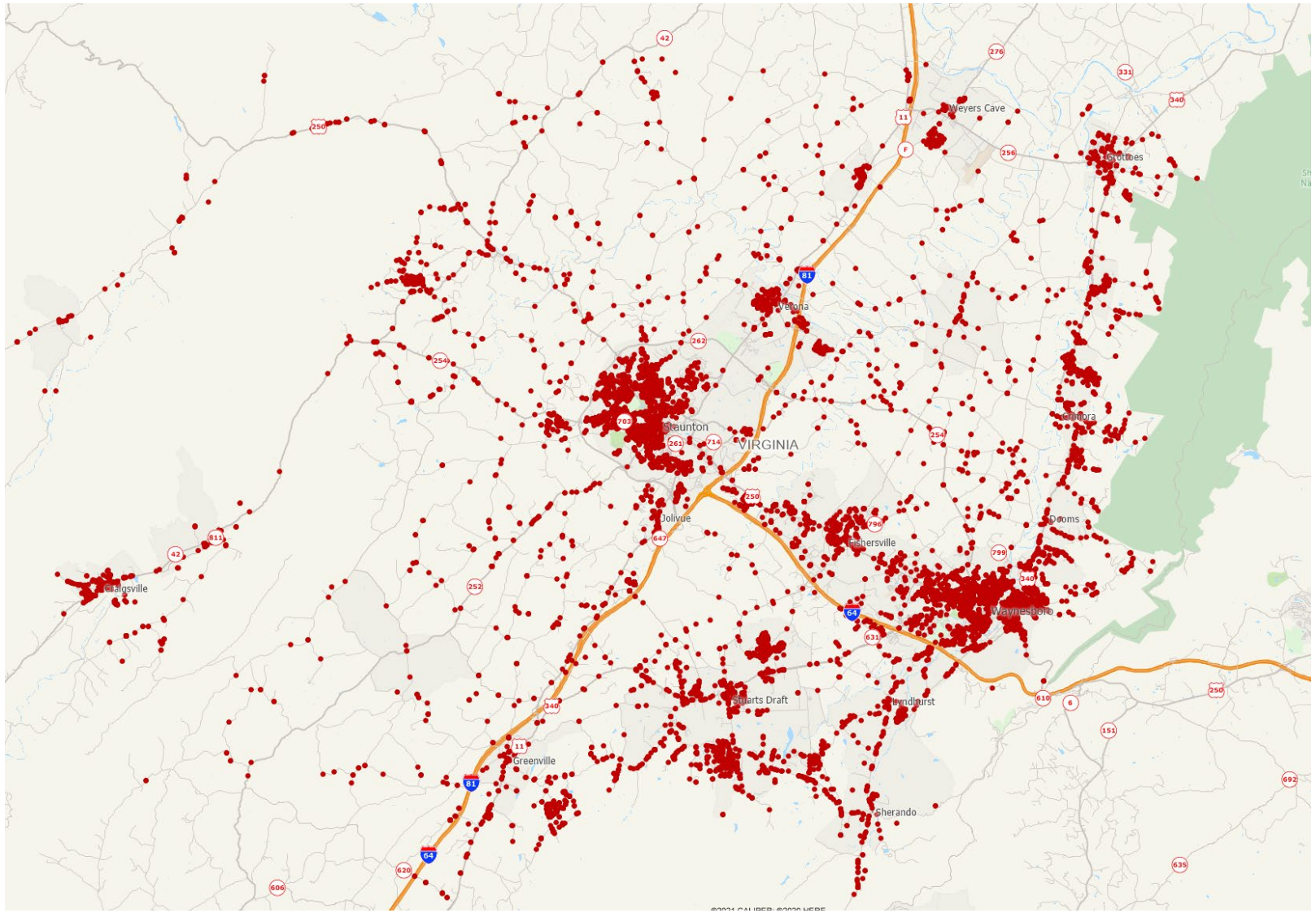
Who are we helping?:

- Those with transportation or mobility barriers
- Latino community members
- Homeless persons
- Dual eligible patients (Medicaid & Medicare)
- Immigrants
- Persons with low income or who are uninsured
- Underserved rural communities

The Mobile Clinic

What services do we provide?

- Primary care
- Chronic disease management
- Basic labs
- Preventive care
- Vaccines
- Case management
- Social services referrals
- Medicaid enrollment
- Financial assistance enrollment



How do we select locations for the Mobile Clinic?

A. Map the lack of primary care connection

B. Have a trusted community partner

C. Find a church, shelter, community center, or school to set up shop

Each red dot is a Medicaid 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 mapped across our primary service area.

Augusta Health Launches a Mobile Clinic

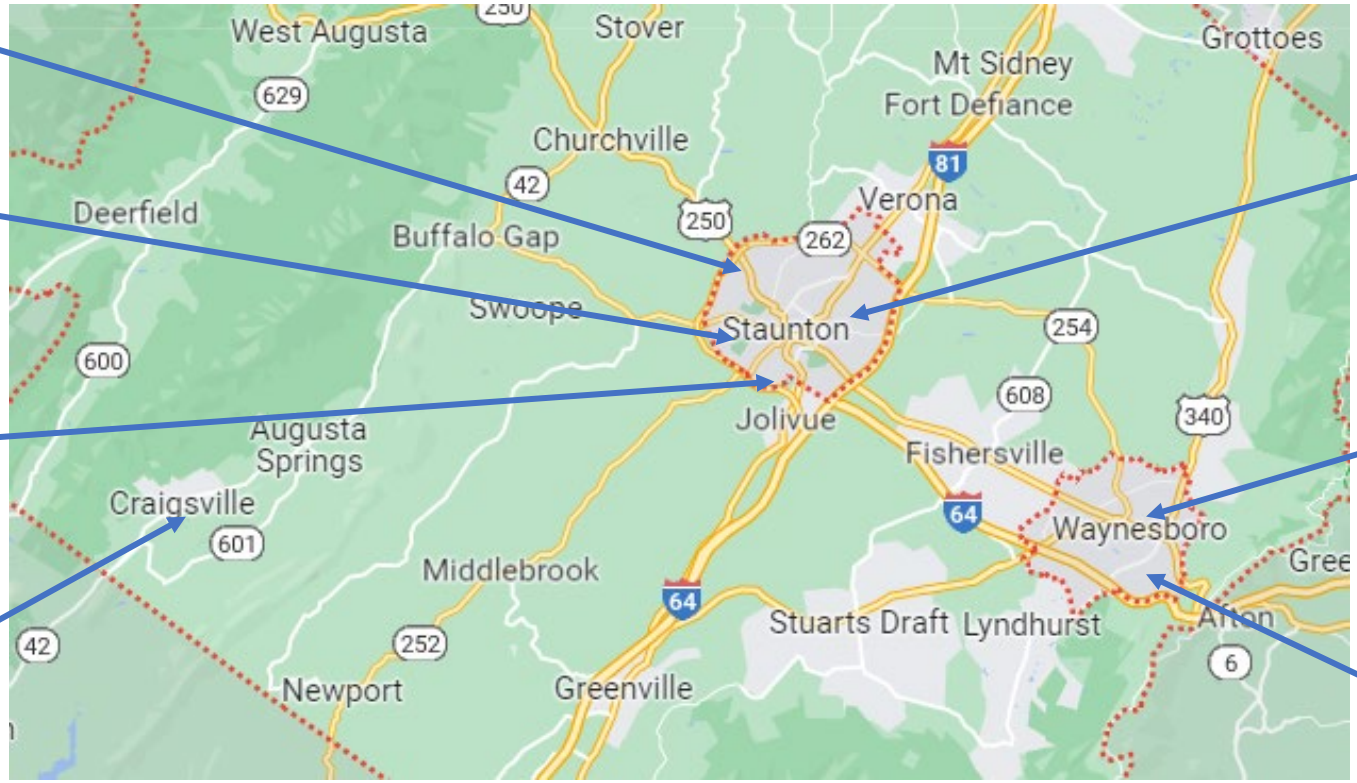
September 2022

Valley Mission Homeless Shelter

Allen Chapel

Plaza Apartments

Craigsville Community Center



Shenandoah LGBTQ Center

Embrace Community Center

YMCA Waynesboro

All locations with community partners supporting our work.

The Mobile Clinic
& Value-Based Care

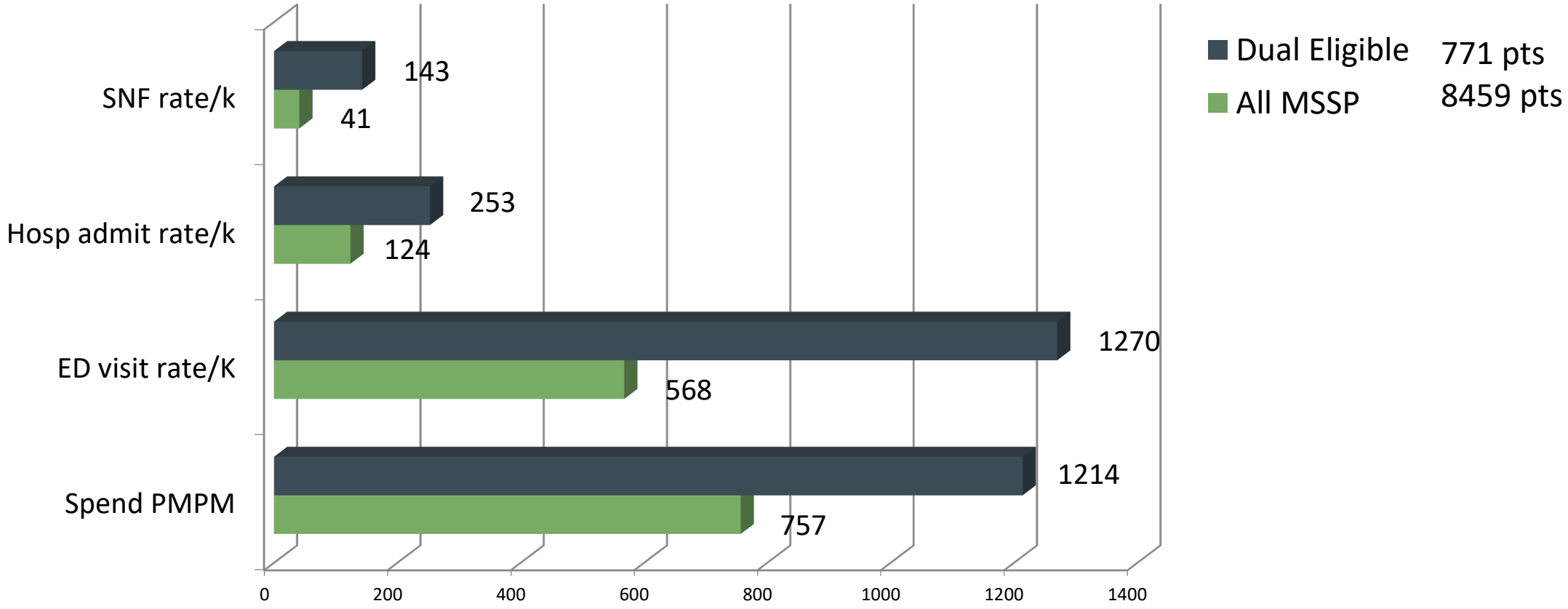
The hope is to reduce the avoidable spend of ED visits, hospitalizations and nursing home stays.

Connect access via mobile clinic to patients managed in value contracts:

- Medicare Shared Savings Program— Track E, (8700 beneficiaries). 50% return in shared savings
- Anthem MA (700 beneficiaries). 35% shared savings
- UHC MA (1400 beneficiaries)
- Optima Medicaid (3500 beneficiaries)
- Molina Medicaid (250 beneficiaries)
- Self-pay patients
- Self-insured team members (2900)

We use cohort tracking to follow expense and utilization before and after enrollment in the mobile clinic, for patients in value contracts

Connecting Health Equity & Value Based Care



Health Disparities experienced by dual eligible community members, 2022

Creating a Sustainable Economic Model

Billable Services
(Medicaid, Medicare)

Value Contract Shared Savings

Insurer Support

Philanthropy:
Corporate sponsors & individual donors

Grant Funding:

(Federal and state, MAP program Every Woman's Life)

Augusta Health Community Benefit Endowment

(CHW for access, Community outreach programs)

Augusta Health Community Benefit & Community Building

(Financial assistance, uncompensated care)

Operational Budget

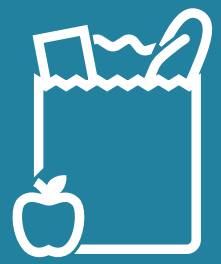
(Goal of Zero)

Take-Aways from Path 1:
Integrating Community Benefit & Population Health

What does this integration look like?

- Members from both teams are on community collaboratives, like the Latino Health Council
- Leaders from both teams are co-leading our health disparities work
- We are co-locate programs from both departments– ex. at the Embrace Community Center
- Members from both teams are on the CHNA initiative workgroups
- Funding from both departments are supporting joint initiatives
- There is a natural continuum from community outreach to clinical services– we want that continuum to be very active– which means lots of referrals in both directions

From our community's vantage point, this looks like Augusta Health helping the community– one large team



Path Two

Promoting Food Security

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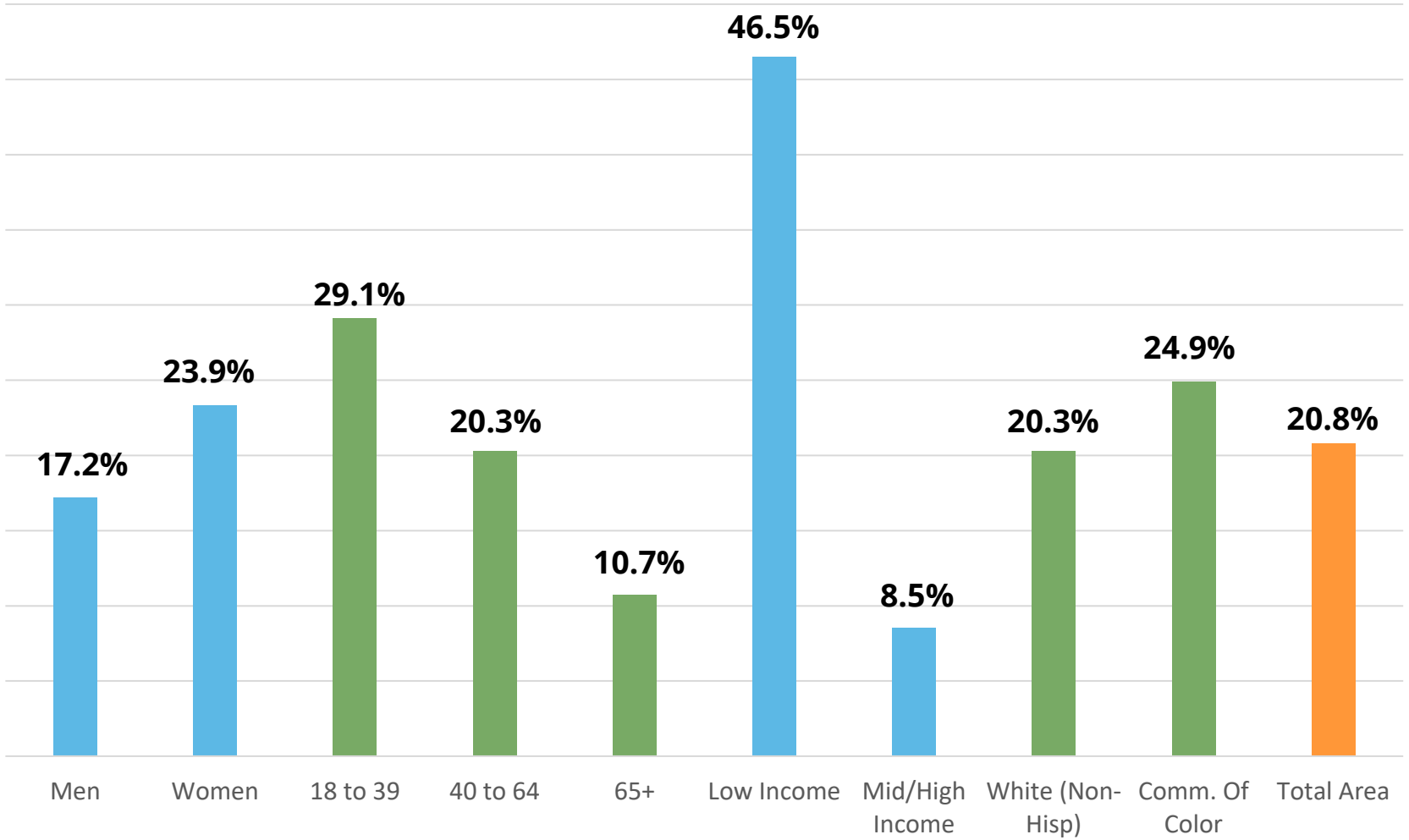
Food Insecurity in our Primary Service Area



Sources: 2022 PRC Community Health Survey, PRC, Inc. [Item 112]
Notes: Asked of all respondents; Includes adults who a) ran out of food at least once in the past year and/or b) worried about running out of food in the past year

Community Outreach Food Access Programs

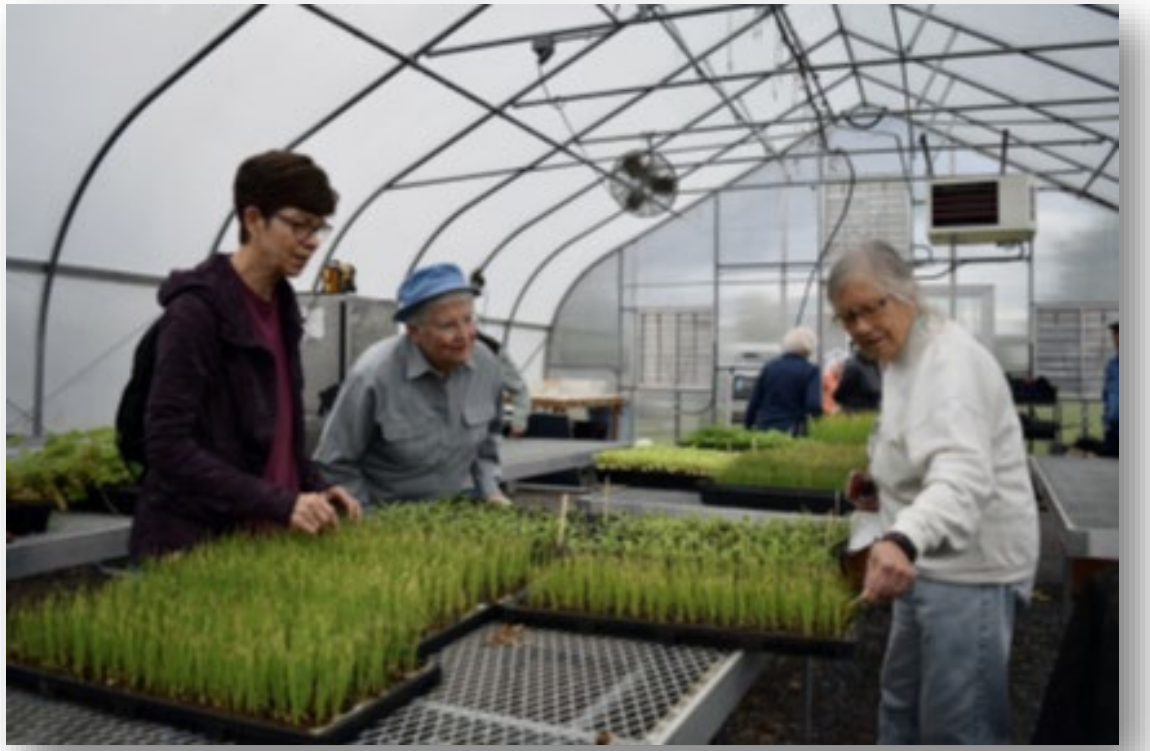
Goal Statement:

Increase education about *access* to healthy foods in Staunton, Augusta County, and Waynesboro.

AMI Farm at Augusta Health

The **AMI Farm at Augusta Health** is a partnership between Allegheny Mountain Institute and Augusta Health to cultivate a 1.25 acre farm on Augusta Health's campus using sustainable agriculture practices.

Food FARMacy



Food FARMacy is a 12-week prescription produce program consisting of nutrition education, cooking demonstrations, and fresh produce shopping.

Food Pantry

Augusta Health **Food Pantry** was designed to increase equitable access to nutritious for patients who have a chronic disease and have screened positive for food insecurity.

Crops to Community

Crops to Community Fresh Food Boxes
A total of 50 boxes containing produce, meat and eggs are delivered bi-weekly to community members who are identified as food insecure.


Y BOX?

- **Home Health & Hospice Food Bags** are fresh produce containers home delivered to patients by nurses.

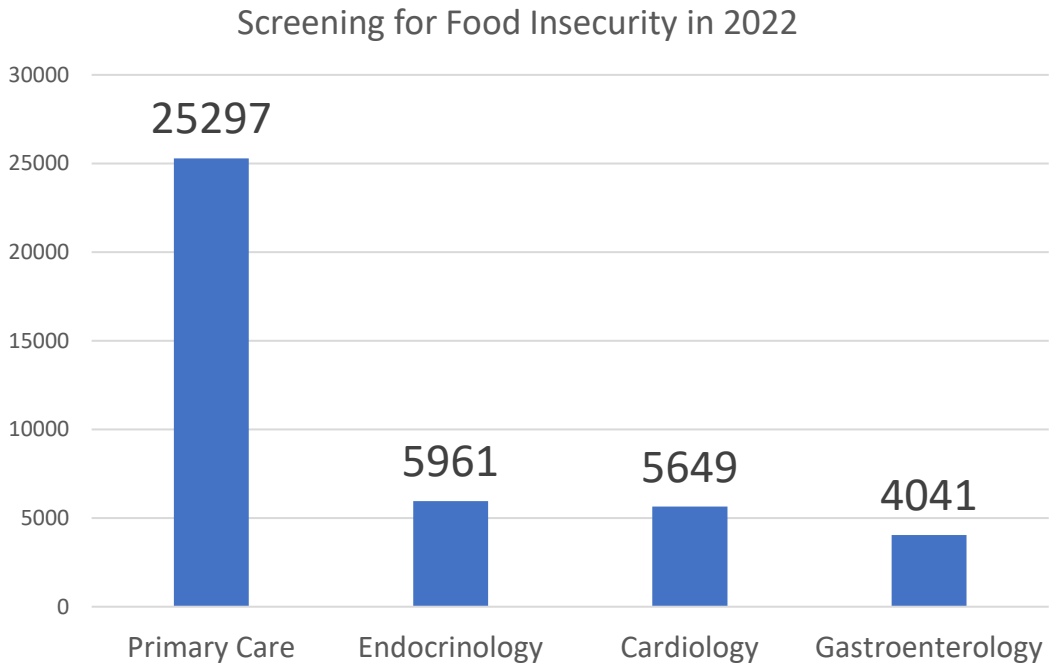
Get Fresh

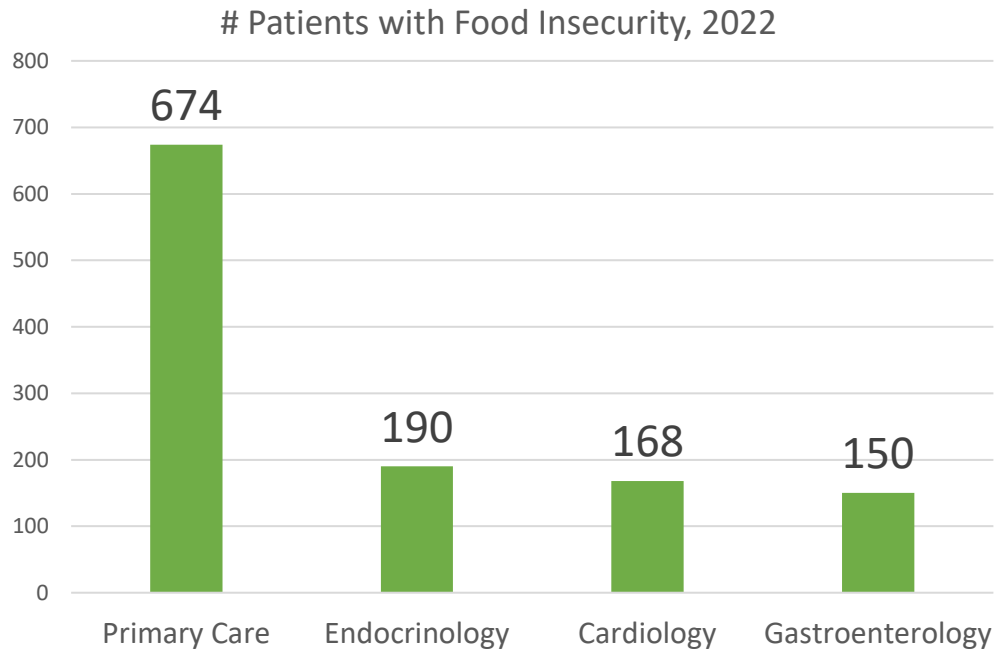
Get Fresh targets elementary school students and consists of nutrition education, fresh food tastings, field trips to local farms, cooking lessons and afterschool nutrition programming for the entire family.

Latino Food Access Initiative

Through the **Latino Food Access Initiative**, provide Hispanic/Latino community members with culturally appropriate food items at outreach events.

Data Elements for SDOH Work





UNITE VIRGINIA

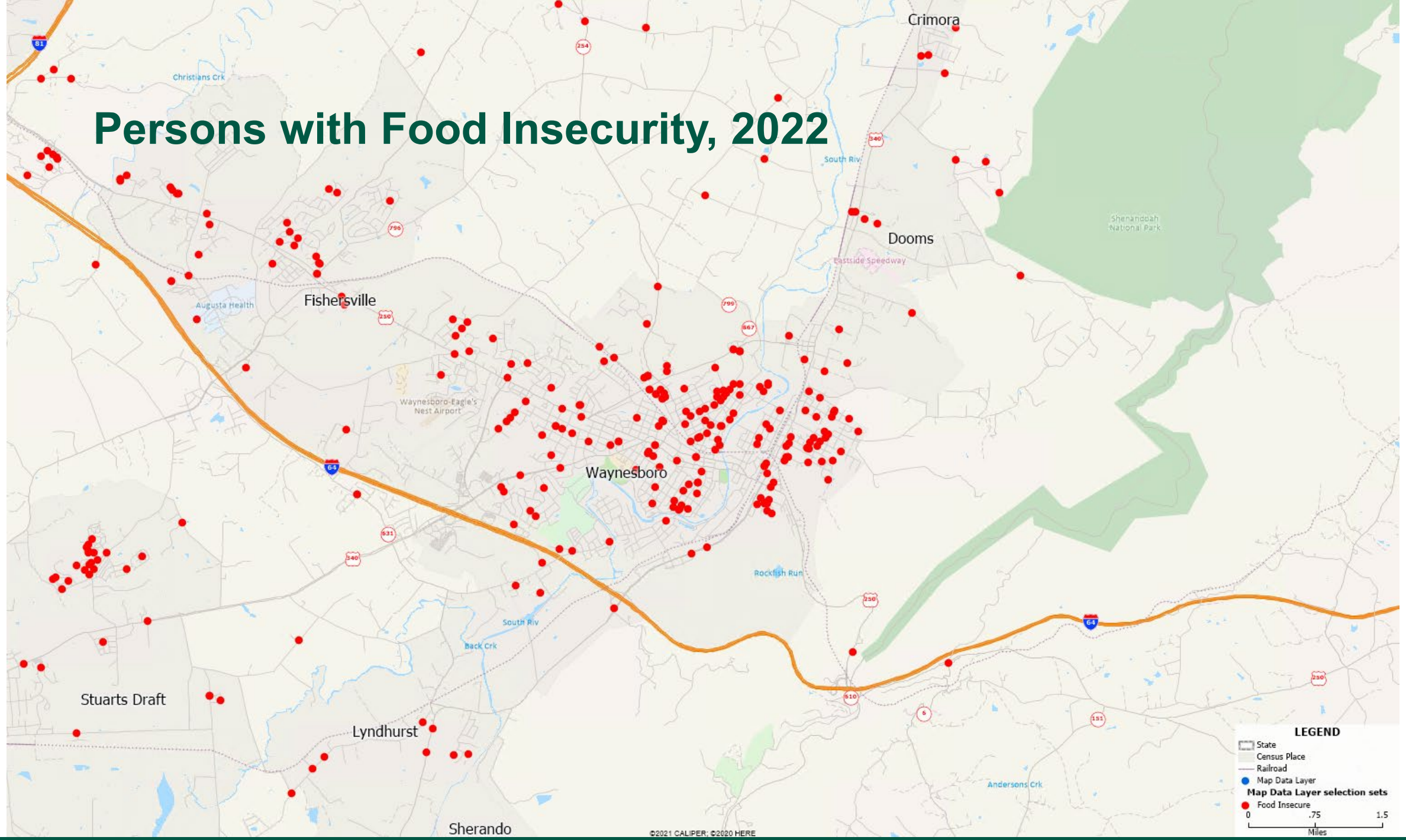
Best Practices for SDOH Screening

1. Maintain privacy and confidentiality
2. Ask in the setting of a trusted clinical relationship
3. Be ready to explain WHY we ask
4. Honor the patient with time
5. Be non-judgmental
6. Always have an immediate referral process in place when a screen is positive
7. Choose the right settings and times for screening
8. Provide opportunities to self-report social needs privately
9. Ask in the person's primary language, and without the requirement of literacy
10. Ask using standard questions, so we can aggregate data

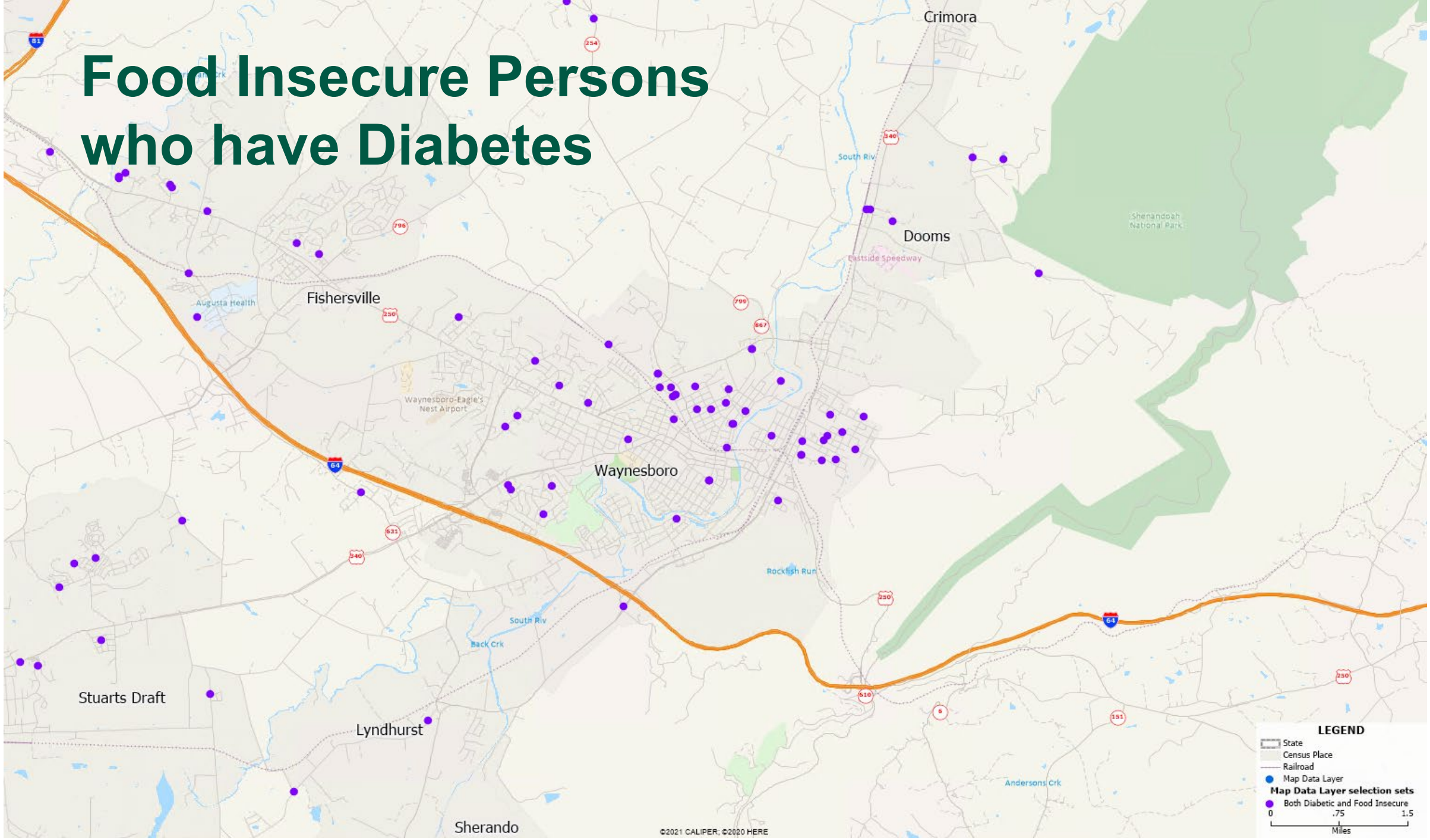
A Conceptual Framework: Cycle of Food Insecurity & Chronic Disease

Source: Feeding America, https://hungerandhealth.feedingamerica.org/understand-food-insecurity/hunger-health-101/

Persons with Food Insecurity, 2022

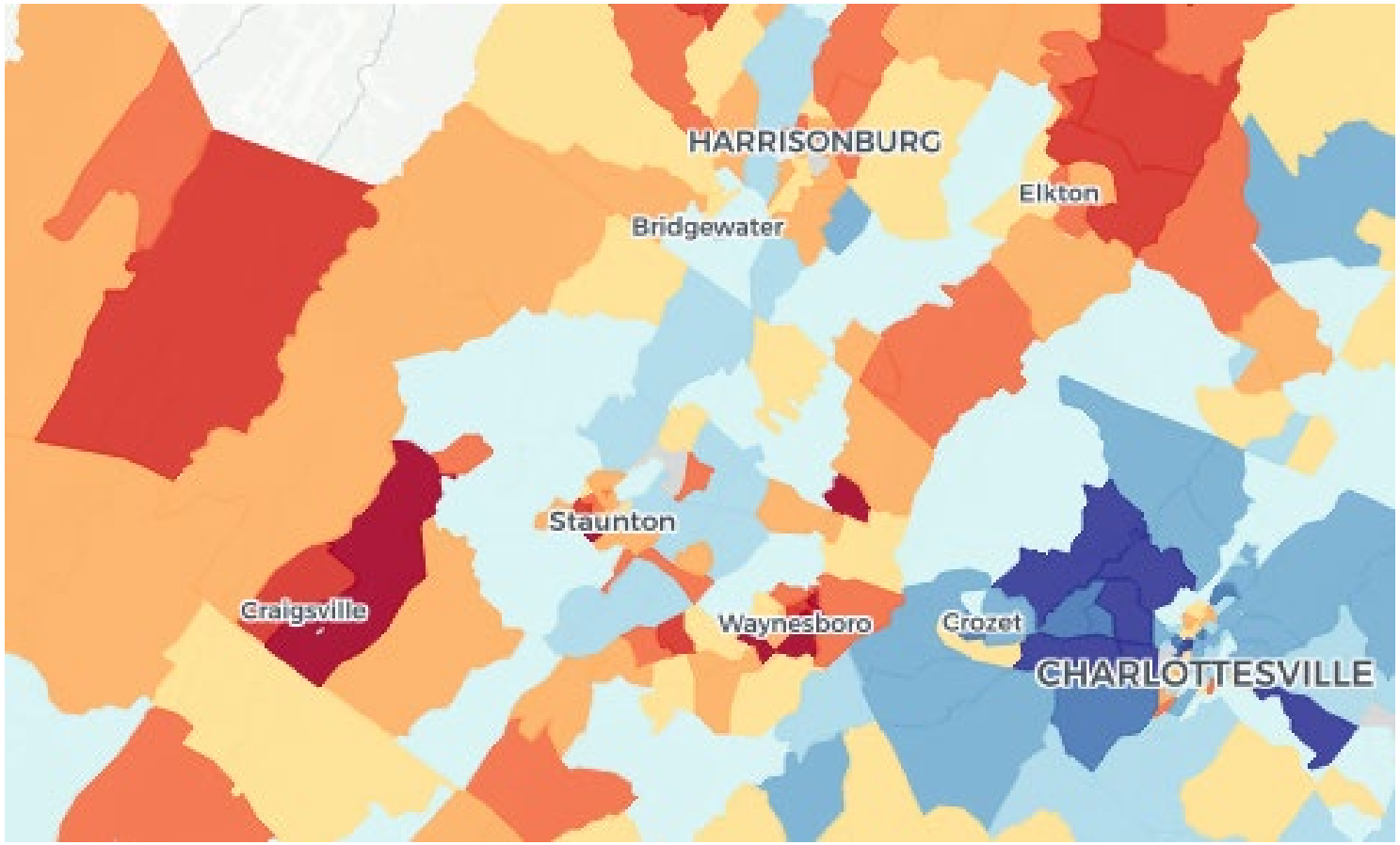


Food Insecure Persons who have Diabetes



Area Deprivation Index

Neighborhood Atlas, University of Wisconsin



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

Census block groups, roughly 1500 persons

We are connecting addresses→ Lat/Long coordinates → Census tract → ADI score

Source: https://www.neighborhoodatlas.medicine.wisc.edu/mapping

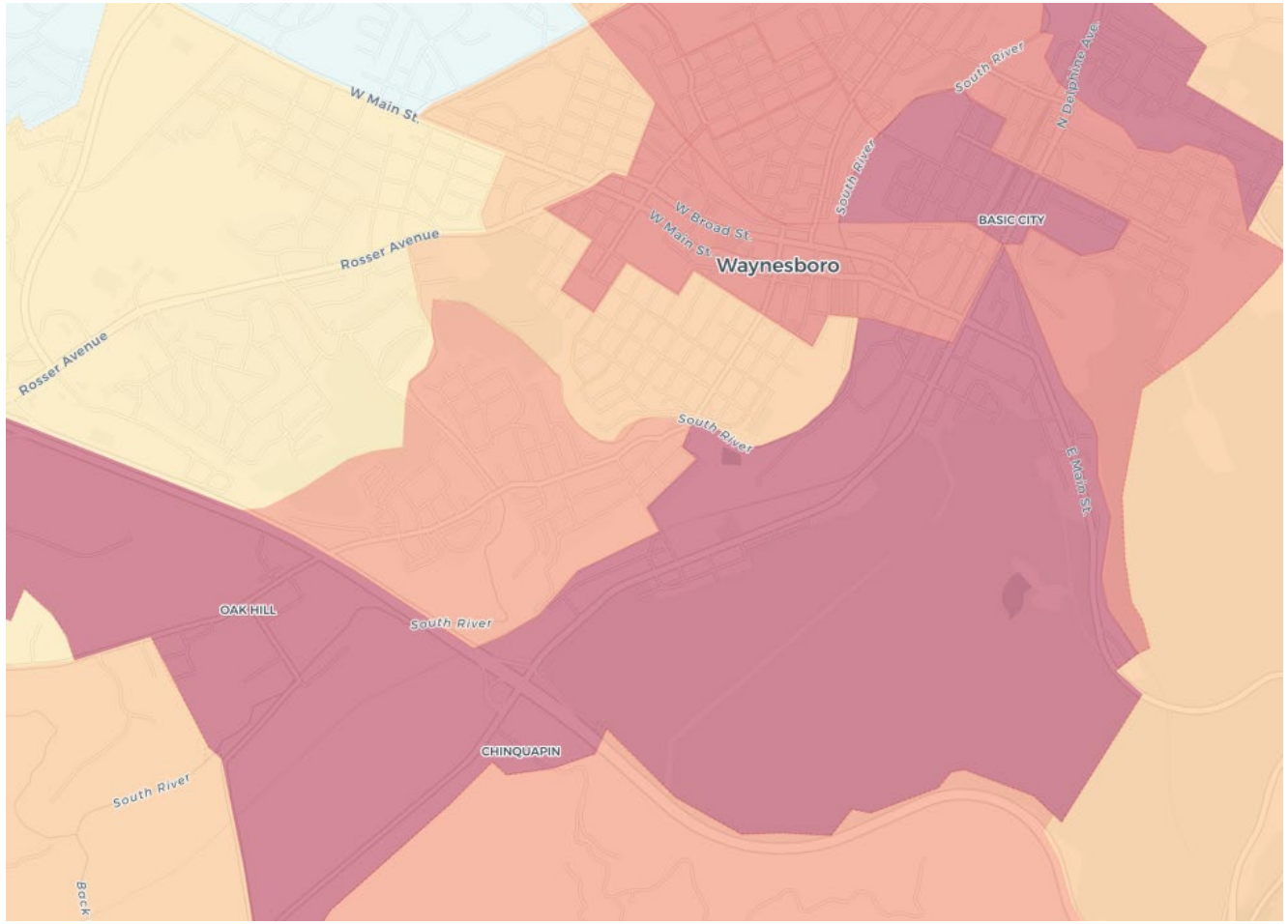
Correlating Local ADI Scores with Clinical Outcomes

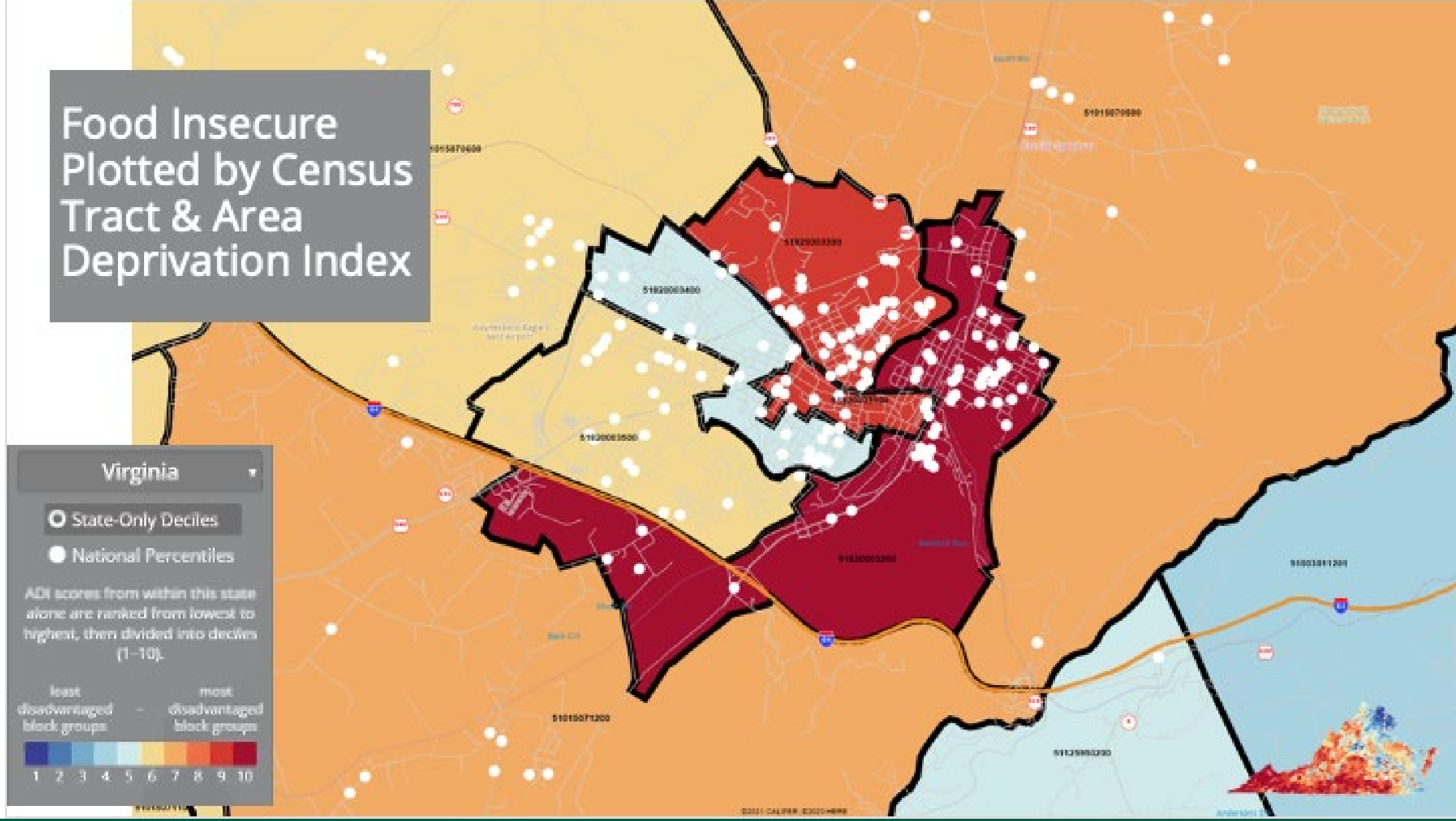
Lack of Primary Care Visits
r = 0.914 p = 0.004

ED visits for mental health
r = 0.758p = 0.011

ED visits for substance use
r = 0.783p = 0.007

Hospital Readmission
r = 0.732p = 0.016




Food Insecure Plotted by Census Tract & Area Deprivation Index
Virginia
State-Only Deciles
National Percentiles
ADI scores from within this state alone are ranked from lowest to highest, then divided into deciles (1–10).
least disadvantaged block groups
most disadvantaged block groups
1 2 3 4 5 6 7 8 9 10

Why these partnerships work so well…

Augusta Health™

Blue Ridge Area FOOD BANK
Everyone should have enough to eat.

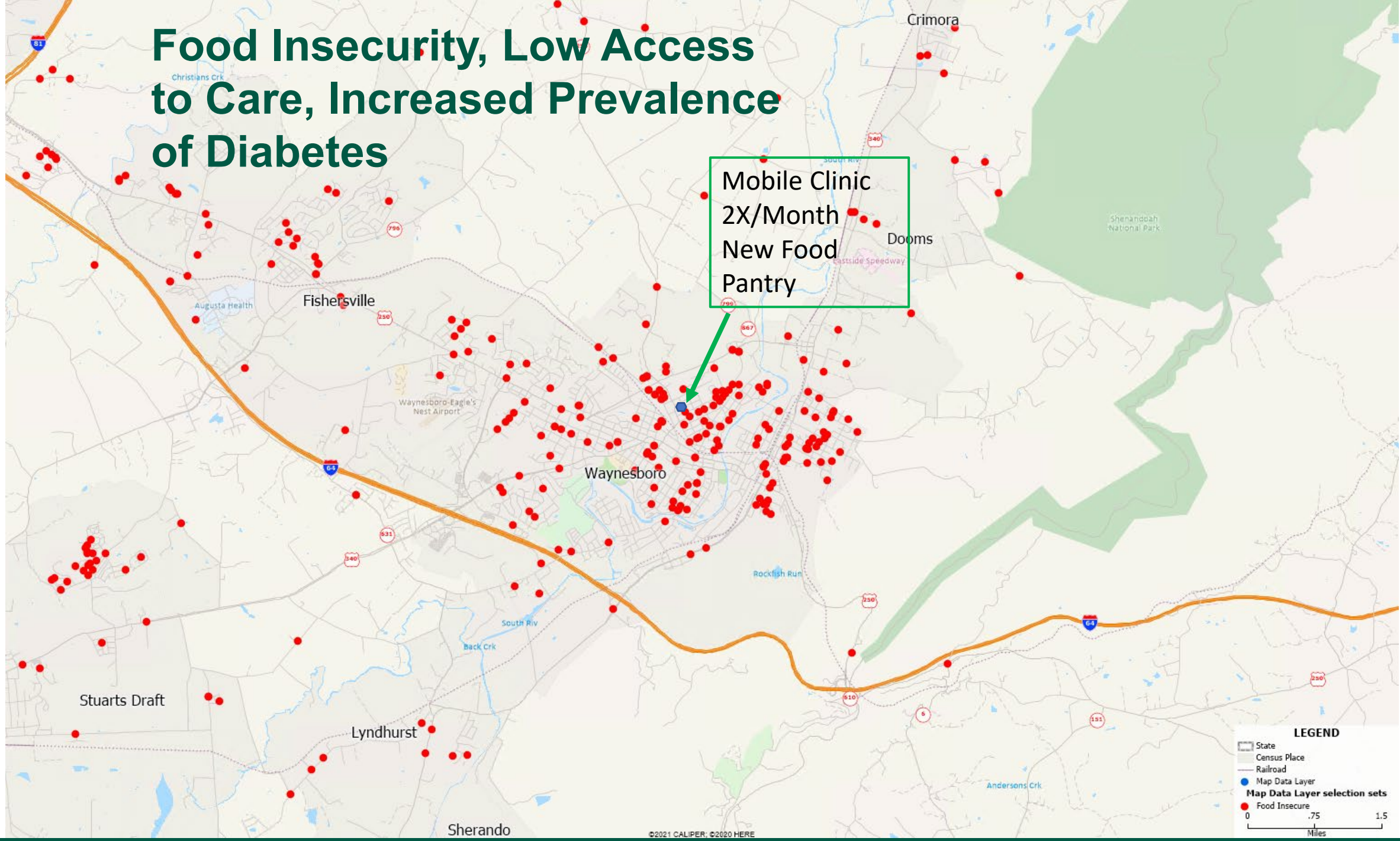
We both have strategic plans that speak to the other organization's strengths:

- The food bank wants their work to improve the health of our community
- The hospital wants to understand and better address social barriers to good health

Does the data from one organization inform the planning and programming of the other?

Where does it make sense to co-locate services?

Food Insecurity, Low Access to Care, Increased Prevalence of Diabetes



The Golden “SDOH Data Path”

Connecting SDOH work to Health Status

1. Screen for Food Insecurity
2. Connect patient to nutritious food that day
3. Connect Food Insecurity to Chronic Diseases & Health Status
4. Follow food services provided to that patient over time
5. Connect food intervention to health status
6. Share data with partner agency

MERGING THE RIVERS:

- Integration of Community Partnerships & Population Health

Each Team Brings Key Strength to This Work:

Our teams are unified by a shared vision for what a healthy community looks like. This is very neighborhood-level work. It is best done locally, listening locally, partnering locally, and measuring outcomes.

Questions?