Holmes/Cost: Rural Health Initiatives

Phillip Stokes: [00:00:00] Hello everyone and welcome to Science by the Slice. My name is Philip Stokes, Education Coordinator with the UF IFAS Center for Public Issues Education in Agriculture and Natural Resources. And for today's episode, we are bringing an episode in conjunction with the Southeastern Coastal Center for Agricultural Health and Safety, one of our partner centers. And we're really going to be talking about rural health initiatives. And, um, specifically we're speaking with some experts that were, that attended and spoke at our state of the science meeting earlier this spring, uh, Dr. Mark Holmes and Dr. Holly cost. And I'll give them a chance to introduce themselves in just a second.

Phillip Stokes: Um, but we wanted to, we had some really great conversations at that meeting and we wanted to follow up in a podcast format to share some of their work and really just some of the movement. Um, That we're seeing between, uh, urban audiences and rural audiences and some of the healthcare needs [00:01:00] and differences there.

Phillip Stokes: So, uh, at this point, I just want to let our guests introduce themselves, tell us a little bit about who they are and where they're from, and then we'll, we'll kick off a conversation. So, um, Dr. Holly cost, do you want to just quickly introduce yourself?

Holly Cost: Yes. Thank you so much. I'm Holly cost. I'm the assistant vice president for university outreach and public service at Auburn university. And I lead our rural health initiative here on campus, very committed to health in my previous life. I was the mayor of a city in small town, Alabama, and that's where my passion really for healthy initiatives and healthy lifestyles.

Phillip Stokes: Great. Thank you so much. And Dr. Mark Holmes.

Mark Holmes: Hi, Philip. Thanks. Um, I'm Mark Holmes. I'm a faculty member at the UNC Gillings School of Global Public Health, and I direct the Cecil G. Shep Center for Health Services Research, both at the University of North Carolina, uh, where I lead a, um, rural health research center. This is funded by the Health Resources and Service Administration to conduct [00:02:00] policy relevant research.

Mark Holmes: Like Holly, I have a passion for rural health. I grew up in the thumb of rural Michigan, uh, de tasseled corn growing up and have been committed to rural health ever since.

Phillip Stokes: Great, great. Thank you so much. And my co host for today's episode is Dr. Lisa Lundy, uh, from the University of Florida. We work together in the Southeastern Coastal Center for Ag Health and Safety. So I'm going to let her introduce herself and then kick things off.

Lisa Lundy: Okay, um, like Philip said, I'm Lisa Lundy. I'm a professor in the Department of Agricultural Education and Communication here at Florida, and I'm excited, just excited about this conversation today when we have the state of the science meeting, I thoroughly enjoyed hearing from both of you, and I know that our listeners are going to enjoy hearing what you have to say about rural health care.

Lisa Lundy: So. We're gonna kick it off with a question really for both of you. Um, and thinking about rural health care and local health care. How do you, how do you define that? What [00:03:00] does that mean to you? Um, when you think about local health care and how you talk about it with your stakeholders? Um, and Holly, I'll, I'll let you kick us off and then we can kind of go back and forth a little bit.

Holly Cost: Okay. Thanks so much for this question. Um, I grew up in Alabama. I've always lived in Alabama. It's a two year stint in Texas. But when I think about local health, I really think about my neighbors. I think about the people across our community who really need the health and the support and the access. Alabama, There are so many who are disenfranchised for a number of different reasons.

Holly Cost: A lot of it is distance from health care. We have hospitals that are closing down all over our state right now. Very challenging for someone to go and give birth in a hospital right now if they live in a rural area. So we really drilled down into these small communities. In fact, in one of our communities, the population where we have our health initiative is 75.

Holly Cost: That's the population. Now, the broader population is bigger than that, about 70, 000. 10, 000, but we look at where the needs are, and we also look at where [00:04:00] the access, um, lacks in order to concentrate our efforts and just really getting to know the people in the community. That's what I've enjoyed the most about this and identifying.

Mark Holmes: What I really liked about Holly's answer is the notion of being tailored to the specifics of that particular community. As a policy researcher, we often have to define a community and we'll pick counties or something like that. But people travel across county boundaries all the time, or maybe a county is large enough to in the South counties tend to be smaller.

Mark Holmes: But if you're in the West, you got this huge county and that's too big to be local. So when you say local, Lisa, I think about, you know, Um, something that's tailored to how the people in that community define it. Um, and think about the assets there and how their, um, what works for that. And for some places that might mean 50 miles, for some it might mean 12 miles. Uh, depends on whether you're in, surrounded by snow covered mountains or in the eastern coastal plain. Um, so it is going to [00:05:00] vary tremendously based on the circumstance of the community and the particular healthcare you're looking for. Local for primary care is going to be a lot different from local for maternity care, for example.

Lisa Lundy: Yeah, and I think that just to follow up on that question, High points or big ticket items in terms of health care needs. What are both of you seeing, um, at the, at the local health care need level in terms of like how you mentioned, um, you know, being able to deliver a child prenatal care. What are some of the other, you know, primary health care needs that you're seeing?

Holly Cost: Yeah, well, we're seeing particularly across Alabama as we have very high rates of diabetes and obesity in particular, so we're looking at those areas, cardiovascular health, we have a high incidence of individuals who have strokes, and so we're really trying to drill down into those areas and identify how can we meet the needs of these individuals, not just through the care, but also through the health and wellness [00:06:00] education.

Mark Holmes: Seeing generally an erosion of specialty services, particularly those based in hospitals, but that. So it's everything from the well documented maternity care deserts that have developing services are getting harder to access oncology services, but also long term care facilities and your nursing homes and even pharmacies are tending to disappear from rural America.

Mark Holmes: And if we want to address these. Uh, one great strategy is to think about training people that are, you know, rural aware, um, and by that I mean, um, we know that, uh, physicians who have a rural upbringing and are trained in rural communities are far more likely to stay and practice in rural communities and, and addressing that gap of, of the services erosion, uh, we, we have some proven policy, uh, approaches that can be taken.

Phillip Stokes: You know, you both touched on something, uh, the fact that it seems like in [00:07:00] healthcare, our professionals, I mean, they work so hard, but they get trained. kind of in a one size fits all approach, right? And you just mentioned that, Mark, uh, that, that if, if they're raised in a rural community, they, they have that perspective and they know what some of the needs are.

Phillip Stokes: And what we talk about a lot in our center is a

Phillip Stokes: of migrant workers. And so, I mean, that's just a you know, people coming from, uh, You know, different countries and working different, you know, language barriers and other types of barriers, their economic barriers. And so, I mean, what, what are some of those, um, what are you seeing between, you know, the health care that is currently being provided and some of the needs in these rural communities?

Phillip Stokes: I'll start with you, Mark.

Mark Holmes: Yeah, um, I think as uh, as distance gets farther and farther, uh, as services are disappearing, um, we have this promise of telehealth, which we saw really kind of help a lot [00:08:00] during Um, but, um, It's only so useful if you don't have reliable broadband. Um, and, you know, for example, one solution that's often given for the dearth of mental health professionals in rural areas as well, we can do telepsych. But if you're Um, if your best broadband or the only reliable broadband in the, in the community, um, is to, is in the parking lot of the local library. That's not really the kind of privacy that most of us want for something like that. And so we have this often this gap between what the needs are and the solutions that, you know, may work in urban settings, but don't always translate to rural. Um, there's this history generally of. Trying to solve rural health care, um, gaps or challenges by taking urban and tailoring that a little bit. And rural is not small urban. It's often a completely different, uh, [00:09:00] approach that needs to be taken by people who understand their community and, and, uh, understand what local means.

Holly Cost: Oh, man, you totally set me up, Mark. This is good. Um, because, uh, what our model is centered around at Auburn University is this telehealth model. And so we've identified these telehealth. There's the opportunity and to increase access. We can use telehealth. But just like Mark said, you go into so many of these homes, they don't, they either don't have good Internet service.

Holly Cost: They can't necessarily afford the Internet. Or they have this resistance to using anything electronic. And so one of the models that we're

looking at is that we have this, um, this telehealth technology called on med, it's a standalone telehealth station that we're able to install in areas where there are these gaps in services.

Holly Cost: And so, Catherine, Alabama, with a population of 75, it's in the shock community center, and that shock community centers where they do the feeding programs. It's where they vote, it's where they do after school programming for kids. from time to time. Um, in Chambers County, [00:10:00] it's in a building that's in Alabama, rural Alabama, East Alabama.

Holly Cost: It's in a building that's a vacated health clinic, but it's right beside the Department of Human Resources in a grocery store. So it's in a location where people can go. But even still, they may not want to go because they get, they get nervous about using telehealth. And so what we do is we do multiple demonstrations in that area.

Holly Cost: We want to make sure that people come in and they feel comfortable. So I've actually driven a van load full of people from a church to the telehealth station and to have them go in and press the button and talk to clinicians. And that really increases their comfort level there. Plus, we've also identified that the gaps in, uh, the gaps in internet services, they still apply to us.

Holly Cost: So, in this building in Catherine, Alabama, we thought, great, we have internet service. We go there, it's not strong enough. There's an AT& T tower right beside us. It's not strong enough. we partnered with the university of West Alabama. They have this grant for Starlink internet. And so now at two of our sites, we're using Starlink [00:11:00] and it is killer.

Holly Cost: I mean, the bandwidth is fantastic. We have no problems with that. So we're able to overcome some of the challenges, but then there's still the transportation barrier. Even if it's right down the road, how does some people get there, particularly if you're sick. And a lot of times it's neighbor helping neighbor, but we're creating a network of community health ambassadors.

Holly Cost: So people can go out and then they can help their neighbors to get to these places and they're committed to do it and committed to this healthy lifestyle. So we have a lot of different facets of what we're doing. Um, we definitely haven't mastered it yet. We're constantly learning from others. I really appreciate Mark and that, um, just the comments he's making and I'm learning from him even on this podcast.

Holly Cost: So thank you.

Mark Holmes: And what I really like about the model that Holly's describing is, It recognizes that, um, you know, my, my, um, I have family who lives outside of rural town in rural Michigan, and they could barely get their audio to work. And there's no way they could support video. [00:12:00] Um, and so there's some more centralized location where you can really, you know, boost up that bandwidth to get the connection, but it's not terribly.

Mark Holmes: You know, you're going in the town anyway for groceries and whatnot. what's really attractive about this model is it's surrounded by other supports. And so when you're hanging up, you're not by yourself in your family room or. You know, in the, in the quiet room in the library kind of thing, you walk out and there's a community health, uh, ambassador or worker right there to say, okay, what'd you hear?

Mark Holmes: I said, well, they said this and I don't know what that means. And they said that, you know, I need to cut back on this, but you know, we got the fair this weekend and I really want to go and say, well, what if you substitute this for that? All that kind of stuff that really helps translate, um, um, that, that information. There's a similar model or, um, another telehealth model, uh, that I'm really excited about in southern Georgia, where, uh, it's addressing the maternity care desert and same idea, uh, taking high risk, uh, you know, uh, pregnant people, connecting them with a maternal and fetal medicine [00:13:00] provider, but putting them in local health departments.

Mark Holmes: So they hang up with the physician and then they walk out and the nurses, all right, I've got your notes already. Let's follow up. What did you hear about your blood pressure and what do you have to do so you have that immediate reinforcement rather than hanging up and going on with your day. So I think that's a really exciting development that Holly's model is doing as well as others across the country that I think really has some promising potential.

Lisa Lundy: Yeah, I was going to ask. I'm so glad you said that because I was going to ask, um, in terms of follow up or what comes after. That, um, know, your, your turn with on med is, um, what sort of, do people come away from that with a handout or sort of a next steps cared, you know, of some sort? Because I'm thinking about a lot of our, Agricultural workers that we communicate with, with our center, if there are things that would help them in communicating to their supervisors, [00:14:00] you know, individualized risks and needs that they may have for their health.

Holly Cost: Thanks. That's a really good question. Um, so what happens in our center is we're pretty resource rich. For one thing, we're right next to the

Department of Public Health. And so we have, uh, or to the Department of Human Resources. So we have a lot of resources there as far as health and handouts that folks can have access to as soon as they walk out of that station.

Holly Cost: But what we also have. Is from on men. They provide us with a monthly report. They don't provide us with individual patient information because that's protected and it's private, but they provide us with this information so that we can then host these different community conversations and we can host different workshops surrounding the particular health needs that we see an example, we have nutrition needs.

Holly Cost: So we have different workshops there. To promote healthy living, healthy eating. We also have extension that's closely aligned with us. Um, they, they helped to manage these locations and they end up bringing in healthy foods and we have recipe [00:15:00] cards that teach people how to give them different ideas of how to, how to cook some of these foods they may not be familiar with.

Holly Cost: other thing that I think has been really impactful is if we have somebody with a lot of needs. Um, that come out of that telehealth station, they, because of the state law in Alabama, they can only go into telehealth four times for the same condition before they have to see somebody face to face. So now we have these IPE clinics.

Holly Cost: It's interprofessional education. And so then we'll have a number of different professionals that will meet with them for primary care. Um, and then we have some folks in there from pharmacy. We'll have people in there from, From, um, physical therapy, also speech and hearing, also nutrition, dietetics, and that we schedule those appointments.

Holly Cost: And so I think the last time we had one of these clinics, we had 30 people signed up, but then they're not just meeting with one primary care provider. They're meeting with a whole team that they're to support them. And it seems a little intimidating at first, but we're. We have these relationships form and these [00:16:00] relationships developed.

Holly Cost: And I think what you said about the folks who may be non English speaking, we have great relationships in the communities. Also going out to, for example, the folks at the Mexican restaurant, they are some of our best customers best patients that they're also sharing the information with the people that come in, letting them know this is a safe space to go.

Holly Cost: And as far as the barrier for, um, paying, uh, for the funding needs, we, we don't charge anything for folks to come in and use the services in the telehealth station. That's all sponsored, but then for the IPE clinics, there may be a sliding scale fee for some of the services if they're connecting with primary care.

Lisa Lundy: I think back to something that Mark said at the beginning of our conversation about students that are rural aware. Um, has there been any, um, Has there been any incorporation of this into medical training? I'm thinking especially of maybe medical students that are training for, you know, internal medicine, [00:17:00] primary care that this would be a really amazing opportunity to interact with patients and, and, and, you know, do some rounding, so to speak.

Holly Cost: Now Auburn University, we don't have a medical school here, but we are affiliated and closely associated with a college of osteopathic medicines called BCOM. And so those students do come over regularly for oral medicine. For training, so they are able to get out there and do the training in the community and they're part of these at the clinics as well.

Phillip Stokes: So, Mark, I did want to ask you a question because I know a lot of your research, um, goes back to some of the disparities and outcomes and health outcomes. And maybe we I'm taking kind of a step back. Um, but I was just wondering if you could share, um, about what some of these are, maybe provide some examples about, um, Um, Um, you know, you know, we've been talking about all this great development and addressing some of these needs, which is fantastic.

Phillip Stokes: Um, and, and Holly, you've, [00:18:00] uh, the work that you're doing there is just phenomenal. But like, what are some of these disparities and what are some of these differences in outcomes that we're seeing among patients? yeah,

Mark Holmes: um, that question is a very depressing one because if you have 100 different outcomes, probably about 95 of them, uh, rural populations, um, have lower outcomes, worse performance, higher risk picket. Um, it's rare that there's, um, many places where many areas where rural populations, um. Are having better outcomes. Um, and that sort of outlines the challenge. Um, and it's multifaceted and the causes are things, uh, as basic as, uh, the social economics of the community and what we've seen over the last, you know, 2, 3 decades in particular is a real changing of the economic circumstances facing a lot of rural America. Uh, with some exceptions, obviously, but overall, um, and, um, health

care, uh, [00:19:00] health care providers. So, I mean, by that, you mentioned, I guess Holly mentioned, uh, you know, hospital closures. We talked about the erosion of services. We've talked about gaps in access to primary care providers and pharmacy and nursing facilities, all those kinds of, and home health. Um, you're, you know, you have two people who to the same condition, one to an urban hospital, one to a rural hospital, the urban patient is more likely to get home health care and have an easier transition to home, whereas the rural is often kind of sent home. There's no home health that can get out there often. They're sort of left to figure it out by themselves. Um, probably their follow up care with their provider that they saw in the hospital, um, might be harder to get to. And so they're missing that follow up visit, uh, which puts them at higher risk for readmission. Um, and so they're back in the hospital, they're more likely to be back in the hospital. Um, One where, you know, the couple places where populations end up doing better. And one is something that if you grew up in rural areas, you're probably not surprised by, and that [00:20:00] is the social connectedness. Uh, we can measure that in a lot of different ways, but it's people looking out for each other. It sounds, uh, pretty Americana and apple pie kind of stuff, but that is a real fundamental issue.

Mark Holmes: The smaller communities, um, that local means, um, a number of advantages. It's, um, easier to rally community support around something. If you have, uh, an issue, like we've heard, some communities, you know, have three, uh, drunk driving deaths by, you know, adolescents in a two year period or something like that.

Mark Holmes: And that's it. We've had enough. And within three days, they can get basically everyone in the community together at the hospital boardroom on a Tuesday night and start, you know, rolling up their sleeves and making a difference. And to make that work in larger areas as well. So understanding that and really leveraging the ability of rural communities to be nimble, um, and, um, you know, not listening to those who tell them it can't be [00:21:00] done, um, is one of the, uh, real strengths of rural, um, communities and their ability to make a difference.

Phillip Stokes: and I'll just follow up. Um, Um, you know, one of the things, uh, Mark that you highlighted, um, at the state of the science meeting, um, and I'll open it up for both of you, but of course the COVID 19 pandemic had pretty drastic impacts on healthcare. Um, Holly, you mentioned hospital closures, uh, but what, I mean, what has changed since the pandemic, good or bad or neutral for healthcare?

Mark Holmes: Holly and I are both playing chicken. I guess I'll go first. Um, I, I think, um, what we really understood from that was the fragility of the healthcare system writ large, and it's everything from how the one respiratory [00:22:00] therapist that was working in the rural hospital when, um, Her family member got sick.

Mark Holmes: All of a sudden, there was no care being done at the hospital that depended on that R. T. Um, it showed the, um, of the system in many states. What we were seeing where the urban hospitals getting overcrowded, um, particularly during peaks and the rural hospitals often saying we have excess capacity and they would work together to manage that, um, that surge. And the rural would, in some places, took COVID positive, uh, patients and sort of specialized in, in managing COVID and others took the lower risk, um, or the, the more, um, you know, pneumonia, for example, and, and, um, uh, and brought them into the rural so that the urbans could do the more complex, um, um, uh, care.

Mark Holmes: So it was a, it was a really nice example of how Um, the healthcare system, I guess that's a big S or smallest, I [00:23:00] don't know, but probably a big S writ large could really, uh, work together and, and understand, you know, often under the guidance of state health departments, um, and community health directors to, to roll up their sleeves and figure out how to get it done. Unfortunately, I think we saw a real spike in the distrust of science that we're still sort of recovering from. Um, and I think there were a lot of lessons learned from that about messaging and how we can, um, uh, do better next time. And, uh, we can't say if there is a next time, but we'll say when, um, you know, we, I think as we understand that there were, um, You know, the likelihood of similar events is probably higher than it was in the past due to a number of circumstances, and we have to be ready for it. Um, and there are investments, um, that states and federal partners are putting in to be better prepared. Um, for example, CDC has invested in creating, um, Uh, an infrastructure that [00:24:00] is already working to figure out how can we communicate better to all our stakeholders, including rural populations, rural health directors, um, so that we're better able to tailor the message and, and understand, um, how all, all parties can, uh, get on board with the interventions that need to be done in the face of the next pandemic or other public health emergency.

Holly Cost: I think Mark covered it. You really, you really nailed it. Um, I think as far as with Auburn, what we identified is that this is a space that we want to be in. Not necessarily to deliver health care, but as far as to look at the innovations out there. I mean, we found a telehealth technology that we felt like could work.

Holly Cost: And because of covid people are a little more open to trying new things now, and they understand that there is no such thing. status quo anymore. Um, we have to think outside the box and that's, that's one positive outcome is that we, we realize there are other ways to bring [00:25:00] healthcare to the person that people don't necessarily have to come to the healthcare.

Holly Cost: So what are, what are our opportunities for healthcare delivery? So we may have telehealth in these areas, but also we have telemetry kits that we'll be able to send home to these patients. And then these patients can then share their, share their health statistics and, um, uh, their numbers with their clinician.

Holly Cost: And so people seem to be a little more open to that as long as they have the guidance and they have the quality of care and the continuity of care. So that's what we've seen around here. And it's, um, I'm happy that Auburn University is willing to get into this space. And then also we leverage our relationship with the extension system.

Holly Cost: We have one office in every single county. In the community and people already have relationships with extension. You think extension, you think, um, they, they go to them already. And so they're able to really communicate with the campus at large about what they see as the needs in the community. And then the community is willing to trust them because they have been there.[00:26:00]

Holly Cost: Like there's to the test of time, really.

Mark Holmes: Yeah, those are great points, Holly. Um, I think glad you mentioned telehealth because there's two things I want to say about that. The first is, um, pre pandemic, I was always using the phrase the promise of telehealth because I think it, you know, it was exciting, but we hadn't really seen it take off as much as we had thought it should, um, and then during the pandemic, paradoxically, and ever since, I think we still see this, that urban, uh, populations are using telehealth more regularly than rural.

Mark Holmes: And we've talked about the broadband, uh, limitation for that. I mean, when I transitioned, it was easy to fire up my, uh, or to pull up my laptop and launch zoom. I'm on zoom eight hours a day. What's it's easy to connect with your provider that way. Um, and I am on Google fibers. So the connection was valid.

Mark Holmes: But, you know, take that away and it's a much harder gap. And so I am. Concerned, wary, [00:27:00] notwithstanding the wonderful project of

OnMed and others like it that, you know, Holly's been speaking about nationally, we still, we have this reversal, which is paradoxical. And I would love to figure out, I mean, we know some of the barriers, but address these barriers and find the solutions to giving that telehealth option to more, uh, rural members. Holly also mentioned, um, telemonitoring, which I think is, uh, really exciting. Um, we're, we have a project at my center that is, um, remote monitoring blood pressure using cuffs that link to the cell, uh, system. So rather than the past, it used to be, you know, that that's a next generation. A lot of the existing work had been, you have the cuff and then you have to Bluetooth it to your phone and, I can never get my headphones to connect on the first three tries.

Mark Holmes: But, um, so that was a challenge and now it's just done, you know, without even knowing about it and the light blinks and it's already uploaded. And so imagine again. You're a, uh, provide healthcare provider. [00:28:00] You wake up in the morning, you fire up your patient panel and there are three people who have a red line or red shaded, uh, row from that morning's data. much better are we able to address that? You know, um, in near real time as close as we'll ever get, uh, without asking them to come in and get checked out. We can have a risk based model and say, all right, we're Let me call these three people on the phone and figure out what we need to do about this and how, what's going on, you know, take it again, uh, what were you doing when you took it?

Mark Holmes: Did you have pizza last night? Which has all which assault or whatever it is. Um, and again, that's a way to really, uh, lower those access barriers that we have.

Phillip Stokes: So I, um, I want to ask a question to Holly, um, but what I'm getting at is, um, I'm hearing about all these changes. And sometimes change is hard and comes with, uh, a bit of, uh, kind of an aversion to, to going into something new, but also, kind of to counter that a little [00:29:00] bit, we've heard about how rural communities have a, a strong sense of community and, and really, um, you know, they, they can uh, I'll, I'll take all this out, but they can, uh, they can, uh, kind of harmonize quickly around challenges.

Phillip Stokes: Right. So what I want to ask Holly is what have you seen with the OnMed program? As far as it's, it's change, it's new, but it's also, are you seeing community members reaching out and saying, no, actually this is really helpful. Like this is great. Uh, this is something that's new and, and kind of this word of mouth that's happening.

Holly Cost: You know, it's funny because when we first started introducing this in the communities, uh, people were saying, Oh, the older people won't want to do it. They're going to be resistant. And, and what we found is it's been the opposite. They love it. They go in and it's this private environment where they meet face to face with this clinician.

Holly Cost: The clinician is lifestyles and all they have to do is press a button. So they go in, they press this button says start [00:30:00] and then the clinician actually fills out all of the paperwork for them. They don't even have to fill out any paperwork. So we have to sign things on the screen, but then on to type in their name and type in their address 100 different times.

Holly Cost: It's really, um, much more efficient for people. But what we also realize is you. You have to, um, you know, what is the, you can lead a horse to water, but you can't make him drink. You have to, you have to make a drink to a certain extent. So we have it out there. It's free. It can do 85 percent of what you can do in an office.

Holly Cost: But still, if someone, I mean, I'd be nervous if I'd never been in. So what we're doing with these demonstrations, as I mentioned, we bring the churches in. So we go out, we take the van and we bring people to the center and have them Try it out. So we have the, we've had senior center, um, individuals come before they're sick.

Holly Cost: That's when you need to catch them. Don't wait till they're sick. I mean, you don't want to go to a new place when you're sick. You want to already feel comfortable going into this place. So we've had Rotary club, Civitan club, our main street organization. We've had a county [00:31:00] commission members, city council members, um, I mentioned senior center nurses, uh, uh, a nursing group.

Holly Cost: And then also, um, the. Uh, just any kind of churches, but so that's been really helpful in it. But what we're finding is you have word of mouth. We've just added another question on our survey that folks use when they come in about the quality of their services, asking how they heard about us. I don't have the data for you yet, but we're, I'm interested.

Holly Cost: What is, what is working in my guess will be word of mouth. I think one of the most impactful things we've done is we've created this network of health ambassadors. And I mentioned them earlier, we have 33 health ambassadors in Chambers County, in the city of Lafayette. And these are mainly, it's kind of interesting.

Holly Cost: We have youth, high school students, and we have retirees. So they're both out there spreading the gospel and they're getting their friends to come in and they're making it feel like a safe space. And they're out there promoting [00:32:00] all the good things. So that's what it takes. It doesn't take Holly costs from Auburn university saying this is a good thing.

Holly Cost: They don't know me and trust me yet. but it really takes the people in the community. And that's what I've been pleasantly surprised about. it takes a lot of work. It doesn't just happen overnight. You have to really get out there. that's been, it's worked.

Phillip Stokes: Yeah, no, that's, um, that's really cool to hear. And, um, yeah, I can, uh, I can hear kind of the, the excitement and the passion when you're sharing that, which is, is really great. Cause you know, I, I know that there's a, just a huge impact that's being made. Um, I, I really, I think we're kind of starting to wrap up.

Phillip Stokes: I know we can, uh, kind of have one more question for both of you, but, uh, Lisa, did you have anything you wanted to add?

Lisa Lundy: Well, I was just thinking as you were talking, Holly, that a lot of the things that I hear you saying about, you know, we go get [00:33:00] them, we provide transportation, we work with the churches. lot of those are things that we've talked about, uh, in terms of community health with agricultural workers in so many different ways. Um, so I can see a lot of crossover in terms of what you all are offering and the approach that you're taking and how that we Um, try to think about how we can just make sure that those opportunities are, are something that agricultural workers know about and, um, can take advantage of, uh, and especially as, as those networks grow across the South. Um, and they, a lot of our agricultural workers don't necessarily stay in 1 place throughout the year. And so hopefully that that would be a way that as you maybe move through a growth through growing seasons, you might. Develop trust with this, with this way of getting healthcare. And then when you find yourself in a new location, you think, okay, yeah, I know.

Lisa Lundy: I know about that. I already did that before. And, [00:34:00] and I know that that's trustworthy place to go. So that's great.

Mark Holmes: Can I ask Holly what might be a softball question?

Holly Cost: Please!

Mark Holmes: you know,

Holly Cost: I

Mark Holmes: Holly, I'm really interested in, um, the OnMed model and how you, um, what, how you've been tailoring it, or maybe not the model itself, but how you've been tailoring the talking about it, uh, for rural populations. And what have you learned and what have you had to adjust in order to, uh, increase its acceptability, uh, by your target population?

Holly Cost: think the best way I could answer that question is to say we wade into the water gently. And so when we're looking at communities, you know, talk about this health outcomes and those health factors. I'm looking at these maps right now of Alabama, and I see the dark counties. They're all really rural.

Holly Cost: They're in West Alabama. And so what we do is we identify communities that have that we know have the health needs. They have the poor health outcomes. Core health [00:35:00] factors. And then we start by talking to their community leaders. And these are the official leaders. We'll talk with the county commissioners, we'll talk with the um, hospitals, we'll talk with the, um, the city council members, and we bring 'em in, all in as a group.

Holly Cost: Talk to them about. our model is, and then we ask them, what do you see as your needs and your priorities? And is this something you'd want to partner with us on? And if they do, then our next step is to have a community conversation. So then we bring in a broader group of stakeholders, about 20 to 30 say again, what are the barrier?

Holly Cost: What are your health priorities? What are your barriers to access? This is this health care station. Who's going to use it? you interested in using it? Do you want to jump on a van and go and see an existing care station? Um, and we'll go check that out. And so just introducing it over and over to multiple groups and then, and being real open to whatever questions or hesitancy they do have.

Holly Cost: But I [00:36:00] guess that's my best answer is just, we do wait into it, but we have a pretty lockstep model because meet with these leaders. They like it. We meet with the community members. We find out where we want. Where's the best place to locate this? How are they gonna have to buy in and then from there we do the implementation that it's continual improvement.

Holly Cost: We're always evaluating and assessing Just the the patient satisfaction and then the impact what we are hoping is to see these Better health outcomes, but you know, that's going to take a while to see

Phillip Stokes: Yeah, and actually, Mark, you kind of, uh, asked a really great question to sorta, uh, as, as we're wrapping up. Um, I did want to ask, uh, both of you and, and Holly, I think you kind of addressed it here, uh, recommendations, uh, that you have for novel or adapted healthcare delivery models. And it sounds like from what you said, it's really, um,

Phillip Stokes: uh, you know, going in slowly. Getting [00:37:00] community feedback, evaluating, uh, adapting as needed, right. Addressing some of those concerns as needed. Um, but yeah, do either of you have any other recommendations for, uh, just, just ways to, to reach some of those, um, populations that have previously not been reached as much? Mm

Mark Holmes: I think that as some of the work that I've done is really shown unsurprisingly that local leadership is usually the secret sauce and what makes a difference and and empowering them to address their priorities rather than coming in and saying, hey, I'm from UNC and I've got the solution for your behavioral health needs.

Mark Holmes: And they say, yeah, that's great. We're more interested in diabetes

Phillip Stokes: hmm.

Mark Holmes: great. I'm here with a behavioral health solution. Um, and so that, that means listening to them, empowering them. What I really liked about what Holly's model is, is not only is it, um, listening and really engaging [00:38:00] the community, but it's tailoring it. And I can't remember the particular places, but in one place, we put it in a senior center and another place we put it somewhere else because that's what they wanted and that's what they needed. And that's what they thought would, would work best. Um, not super scalable, but it really is the solution to, um, recognize that innovation is going to happen in that, in that local area. Uh, hearse has been doing this. There's a program called our moms, which, um, is designed to let local communities innovate around. Their maternal health solution, uh, and our corp, which is, uh, addressing their opioid, uh, crisis, allowing the communities to come up with what they want to do, um, and what they think their priority is, and then learning from those and building a, you know, here's one general model that you can tailor to, to what's going to work for your, uh, community.

Mark Holmes: That I think is probably the best path forward.

Holly Cost: Yeah, I appreciate that. And one [00:39:00] population haven't mentioned and I did touch on just the health care professionals that we are connecting well with the hospitals. So we're getting input from the hospitals and in one community, a hospital was even hesitant about how what we're doing might impact. Um, just their, their services and their, their patient base that comes in because you know, we don't charge, they do charge.

Holly Cost: And so what we're looking is how can we intersect those? So how could possibly their nurses or their nurse practitioners. Be a part of the on med network so they can deliver services across the county where folks may not necessarily be able to drop all the way to the hospital. But then if they meet their healthcare professionals through telehealth, then they're able, then they say, okay, well, I know you're just 20 miles away.

Holly Cost: Now I'm going to ride there because I met you and you're not scary. And I know you care. And then the other population that we're working well with is, uh, EMS, um, our emergency management services. So in two of our communities, we have the fire chief. Okay. Who is working very closely with us and they're able to tell us, okay, this is what we're seeing from our [00:40:00] frequent flyers, people that call in and that we see them all the time.

Holly Cost: And this is what we need help with. And so we're taking some of that off of them. And again, they're the trusted people in the community, so they can say, all right, Miss Jones, next time you need help with this, you need to go over to this station and I'm going to make you. I'm going to get you to have a visit over there to try it out first and it works.

Holly Cost: People trust chief duty, you know, people trust chief Gibson. So, uh, that's another population that we've really gotten on board as partners. And I really liked what Mark was saying. We do not profess to know all we, we don't know all. And that's one of the first things I say about them. I can't tell you what you need.

Holly Cost: You tell me what you need. We don't have all the answers, but let's figure them out together. So I'm really, I love that, um, just the relationships that have been formed in these communities. It's been fantastic. And yeah, I do get a little excited. Oh,

Lisa Lundy: your tagline for your marketing campaign is, uh, we're not scary. We really [00:41:00] care.

Holly Cost: I like that. Oh, I like it. I'm writing that down.

Mark Holmes: I think I'll use that for our faculty as well.

Holly Cost: Oh, good.

Lisa Lundy: That's right.

Holly Cost: I'm not scary. That's great. I love it. Thank you.

Phillip Stokes: That's great. That's great. Um, well, I want to thank, um. Mark and Holly, I want to thank you both so much for coming on Science by the Slice and sharing today. Um, what a great conversation, uplifting conversation, challenging conversation, but, um, you know, it's so crucial and so critically to have in the work that you're both doing, uh, is amazing.

Phillip Stokes: And of course, uh, Lisa, thank you so much for co hosting and sharing all that you bring in today. So, um, yeah, I, I think we can go ahead and wrap up, but, um, it's, it's been a great episode. Any final thoughts before we close out?

Holly Cost: Appreciate the opportunity.

Mark Holmes: for

Lisa Lundy: Yeah, thank you both.

Mark Holmes: Yeah.

Phillip Stokes: All right. Goodbye.