WINONA COMMUNITY HUB

Winona Community HUB

Pathways to wellbeing

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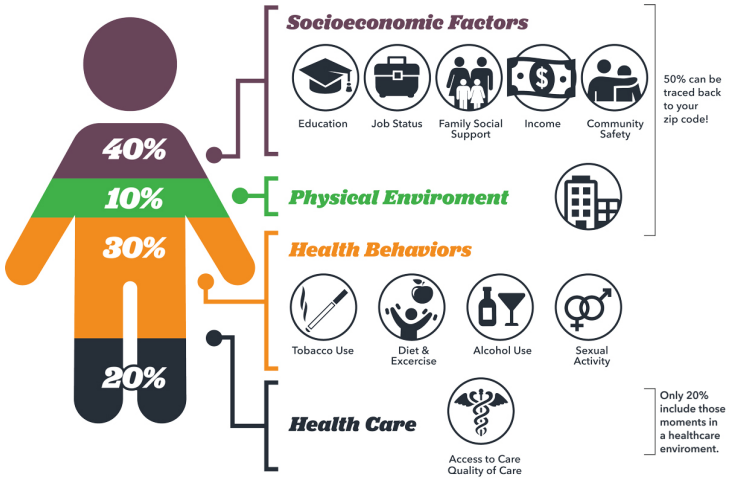
WHAT INFLUENCES HEALTH



Source: Institute for Clinical Systems Improvement, Going Beyond Clinical Walls: Solving Complex Problems (October 2014)

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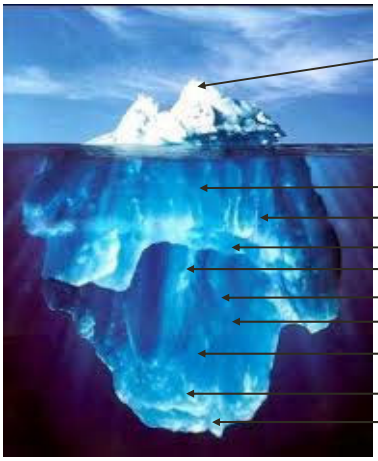
SOCIAL DETERMINANTS OF HEALTH



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How do we remove barriers to health, to create a community of wellbeing?

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WINONA COMMUNITY HUB PARTNERS:

- Community agencies working to break down silos and bridge gaps
- Developed a framework for a community approach to addressing **social determinants of health**
- Under taking a systems level change; with work done collectively to better understand the barriers and work together collaboratively to identify a solution to impact those at greatest risk

Advocacy Center of Winona
Bluff Country Co-op We know good food.
ENGAGEWINONA
IFC Family & Children's Center Better Tomorrows Start With Us
LiveWell winona
Habitat for Humanity serving Winona County
Hiawatha Valley Mental Health Center
Miller Mentoring Planting a Seed to a Better Future
Project FINE Focus on Integrating Newcomers through Education
Winona Area Public Schools Welcoming All Learners
WH Winona Health
Winona County
the Y FOR YOUTH DEVELOPMENT® FOR HEALTHY LIVING FOR SOCIAL RESPONSIBILITY
WINONA FAMILY YMCA
Winona Volunteer Services

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PATHWAYS COMMUNITY HUB MODEL

- A centralized community resource that utilizes Community Health Workers to link individuals to health and social services
- Uses existing community resources more efficiently and effectively
- Focuses on common metrics to identify and track risks (risk reduction)
- Provides holistic community care coordination→ one worker for the whole family
- A sustainable structure of payments for outcomes (pathway completion)
- Is owned by the community, directed by community

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PATHWAYS COMMUNITY HUB 101

https://www.youtube.com/watch?v=4-JE0xvTGvM&feature=emb_title

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WINONA COMMUNITY HUB

Traditional Community Model

Winona Community HUB Model

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COMMUNITY CONNECTOR/COMMUNITY HEALTH WORKER (CHW)

- Create connections between vulnerable populations and healthcare systems
- Facilitate healthcare and social service system navigation
- Manage care and care transitions for vulnerable populations
- Determine eligibility and provide assistance enrolling in public assistance
- Educate health system providers/stakeholders about community health needs
- Provide culturally appropriate health education
- Advocate for underserved individuals
- Collect data and relaying information to care team members and community decision makers
- Provide informal counseling, health screenings, and referrals

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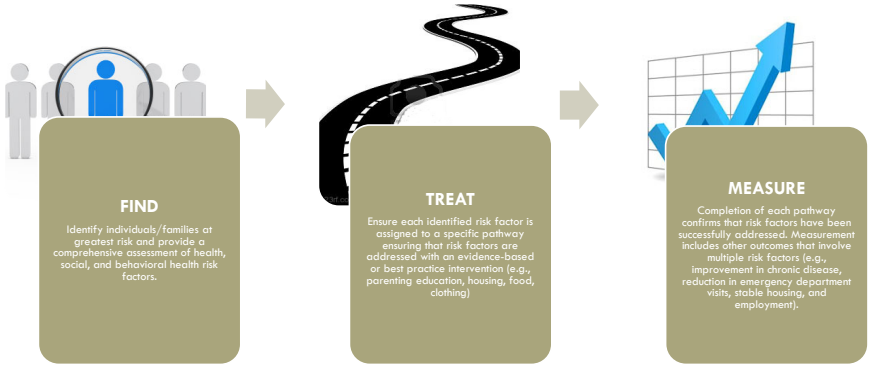
BASIC PRINCIPLES OF THE MODEL



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FIND

- Develop a network of Community Referral Partners and shared screening/eligibility criteria to direct at-risk families into the Winona Community HUB
- HUB assigns participant to a community care agency partner (CCA) which houses a Community Health Worker (CHW)
- CHW reaches out to the family *in the community setting*
- CHW uses standardized checklists to systematically identify risks
- Risk factors trigger evidence-based pathways
- CHW works with family to complete pathways and achieve evidenced-based outcome
- HUB monitors performance, and submits claims to health plans for completed pathways
- Care Coordination Agencies are reimbursed for their efforts
- HUB conducts analysis of impact along with regular quality improvement reviews

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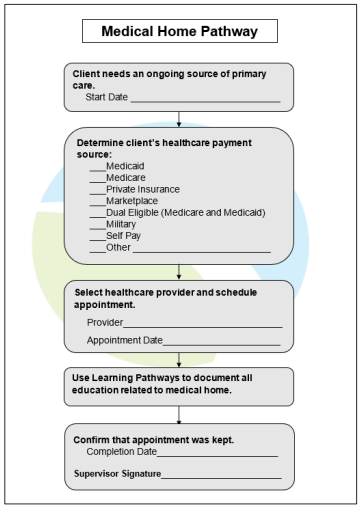
TREAT: EACH RISK FACTOR = PATHWAY

20 Standard Pathways

- One risk factor at a time
- Completion = <u>Payment</u>
- Finished Incomplete Pathway = <u>Gaps</u>



<u>Pathways:</u>
Adult Education
Behavioral Health
Developmental Referral
Development Screening
Education
Employment
Family Planning
Health Insurance
Housing
Immunization Referral
Immunization Screening
Lead
Medical Home
Medical Referral
Medication Assessment Chart/
Medication Assessment Pathway
Medication Management
Postpartum
Pregnancy
Smoking Cessation
Social Services Referral

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MEASURE:

- Database with real-time data on clients
- Track which pathways are completed well in our community and which aren't able to be completed adequately
- See outcomes within each agency
- Share performance data with community partners to guide further action

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HUB REFERRAL PARTNERS

ADVOCACY CENTER OF WINONA

Bluff Country Co-op
We know good food.

IFC Family & Children's Center
Better Tomorrows Start With Us

Hiawatha Valley
MENTAL HEALTH CENTER

Habitat for Humanity
serving Winona County

Miller Mentoring
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Winona Area Public Schools
Welcoming All Learners

Winona Volunteer Services

Winona Health

Winona County

the YMCA
FOR YOUTH DEVELOPMENT
FOR HEALTHY LIVING
FOR SOCIAL RESPONSIBILITY

WINONA FAMILY YMCA

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HUB COMMUNITY CARE AGENCIES (CCAS)

Winona Health: 1 CHW, 1CC
Hiawatha Valley Mental Health Center: 1 CC
Family & Children's Center: 1 CC
Winona Volunteer Services: 1CC

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HUB PATHWAYS TRACKING

Pathway	Initiated	Finished Incomplete	Completed	Median	# Clients with PW	% Clients with PW
Social Service Referral	205	62	57	8	59	62.11
Medical Referral	95	33	28	23	54	56.84
Education	55	4	49	1	30	31.58
Tobacco Cessation	52	22	2	147	48	50.53
Medical Home	49	14	9	25	44	46.32
Housing	36	10	10	85	35	36.84
Health Insurance	29	6	14	11	27	28.42
Medication Assessment	27	1	1	2	20	21.05
Behavioral Health	22	6	5	120	21	22.11
Employment	15	2	4	76	14	14.74
Developmental Referral	6	2	4	39	6	6.32
Adult Learning	6	1	0	-	6	6.32
Postpartum	5	3	2	9	4	4.21
Pregnancy	5	0	2	80	4	4.21
Medication Management	4	2	0	-	4	4.21
Family Planning	1	1	0	-	1	1.05
Immunization Screening	1	1	0	-	1	1.05

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FUTURE STATE OF THE HUB

- Transition to updated model with updated pathways (now 21) and even more person-centered approach
- Secure contracts with payers to reimburse for pathways = reduced dependency on grant funding, long term sustainable model for the "right" work
- Expanded criteria for target at-risk population to maximize impact

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HOW CAN YOU HELP?

- **Referral Criteria:**

- Winona County Resident AND
- Someone in the household has screened positive for food insecurity OR
- Someone in the household has been diagnosed or self-reported mental health issues OR
- Anyone that is experiencing homelessness

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HOW TO MAKE A REFERRAL

If you are a referral partner, enter referrals directly into Care Coordination Services (CCS) Software.

If not a referral partner, anyone can make a referral directly to the HUB by contacting Live Well Winona at 507-474-9825, and we will assist with the referral.

General email for Live Well Winona is info@livewellwinona.org.

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THANK YOU!

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For more information about the Winona Community HUB:
https://www.livewellwinona.org/health-resources/health-management/winona-community-hub/

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