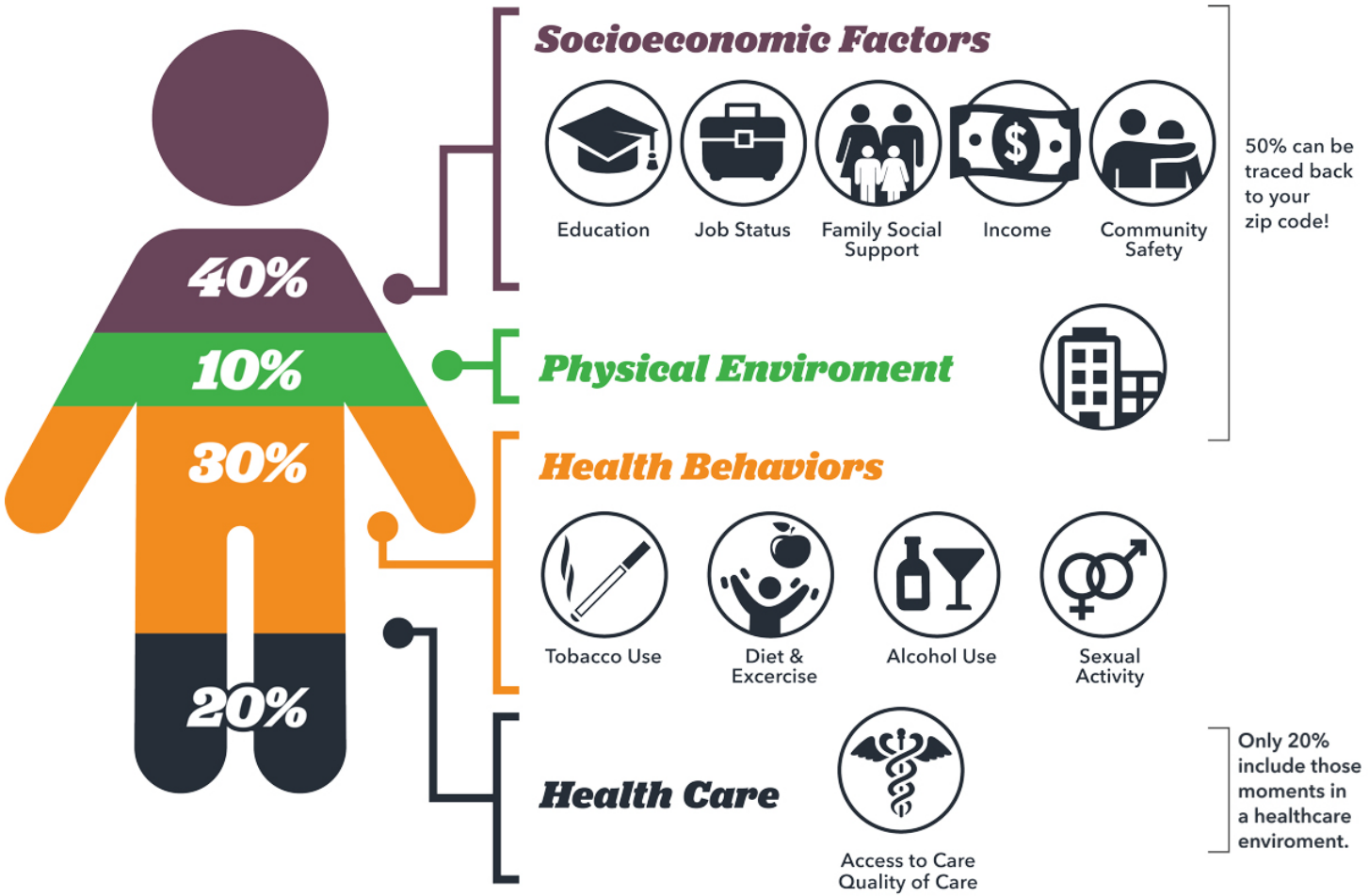
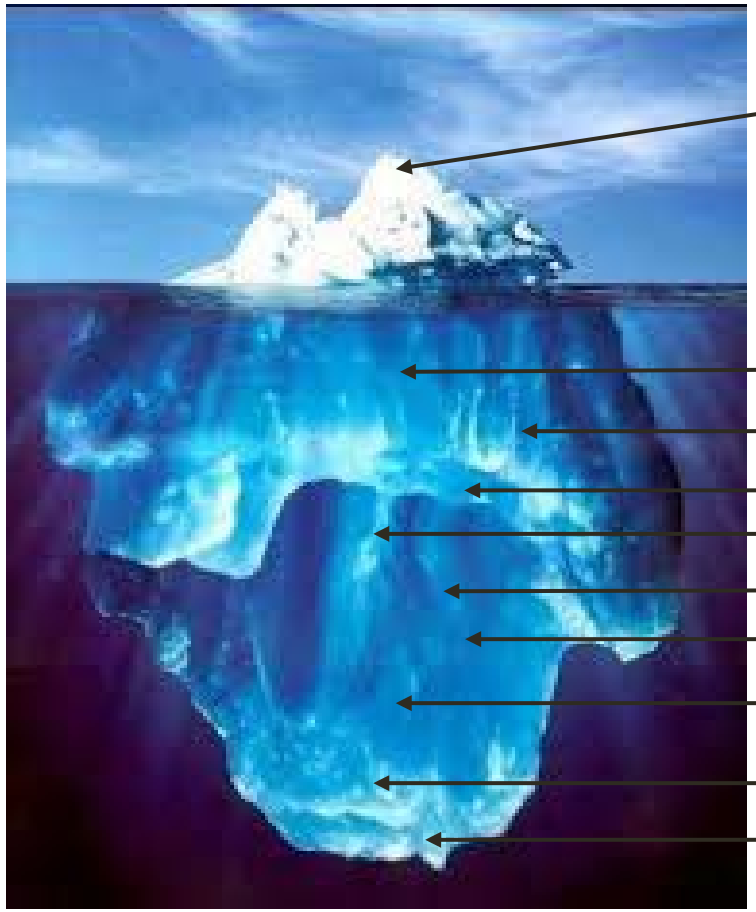
WINONA COMMUNITY HUB

WHAT INFLUENCES HEALTH



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

SOCIAL DETERMINANTS OF HEALTH



Health Outcome

Race/Ethnicity

Social Connectedness/Isolation

Environment

Language

Education

Employment

Transportation

Housing/Neighborhood

Food

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

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.

Catholic Charities of Southern Minnesota
PROVIDING HELP. CREATING HOPE.

ENGAGEWINONA

Family & Children's Center
Better Tomorrows Start With Us

Habitat for Humanity® serving Winona County

Hiawatha Valley MENTAL HEALTH CENTER

HEALTHY HABITS • BETTER LIVES
LiveWell winona

Miller Mentoring
Planting a Seed to a Better Future
ESTABLISHED IN 2000

Project FINE
Focus on Integrating Newcomers through Education

WINONA AREA PUBLIC SCHOOLS
Welcoming All Learners

WH Winona Health

Winona County

the YMCA
FOR YOUTH DEVELOPMENT®
FOR HEALTHY LIVING
FOR SOCIAL RESPONSIBILITY

WINONA FAMILY YMCA

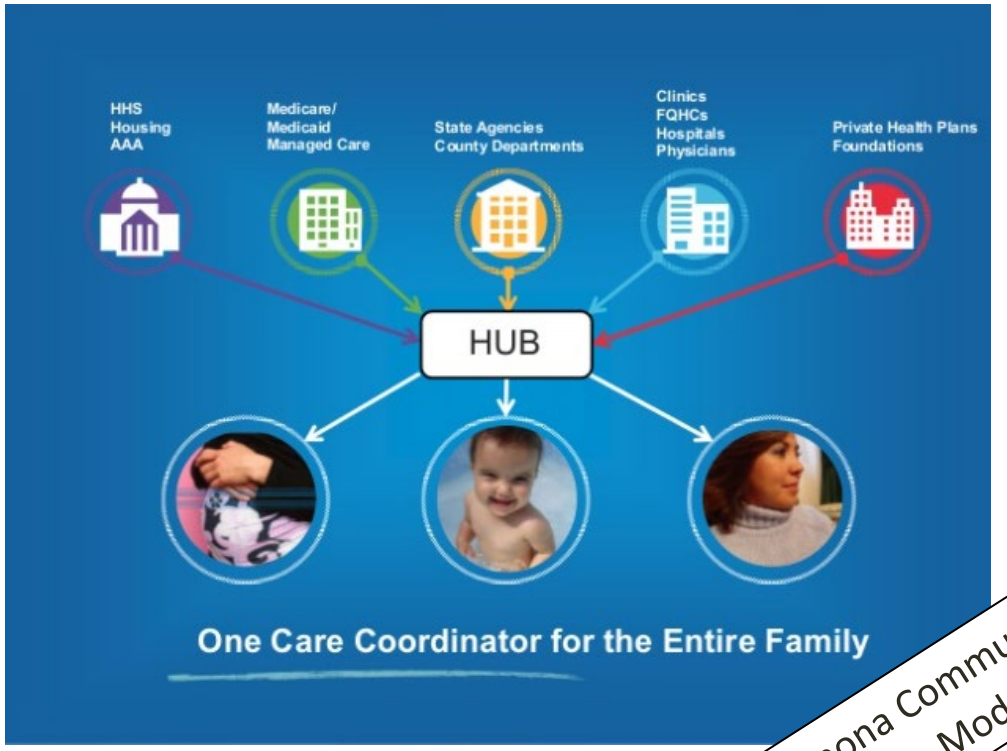
Winona Volunteer Services

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

WINONA COMMUNITY HUB

Traditional Community Model

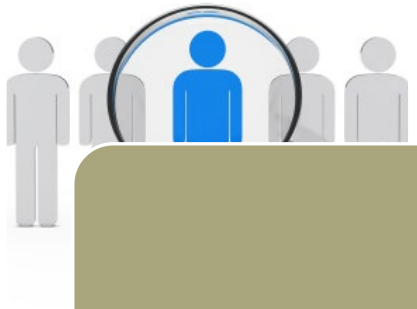


Winona Community HUB Model

COMMUNITY CONNECTOR/COMMUNITY HEALTH WORKER (CHW)

- Monthly check-ins in the home or community setting
- Way finding in health system and social service system
- Health education and goal setting for behavior change
- Support patient in self-management of chronic disease
- Support patient in medication adherence
- Depression screens including PHQ-9 and Edinburgh
- Support patients in building capacity to achieve wellness
- Address Social Determinants of Health via referrals

BASIC PRINCIPLES OF THE MODEL



FIND

Identify individuals/families at greatest risk and provide a comprehensive assessment of health, social, and behavioral health risk factors.

TREAT

Ensure each identified risk factor is assigned to a specific pathway ensuring that risk factors are addressed with an evidence-based or best practice intervention (e.g., parenting education, housing, food, clothing)

MEASURE

Completion of each pathway confirms that risk factors have been successfully addressed. Measurement includes other outcomes that involve multiple risk factors (e.g., improvement in chronic disease, reduction in emergency department visits, stable housing, and employment).

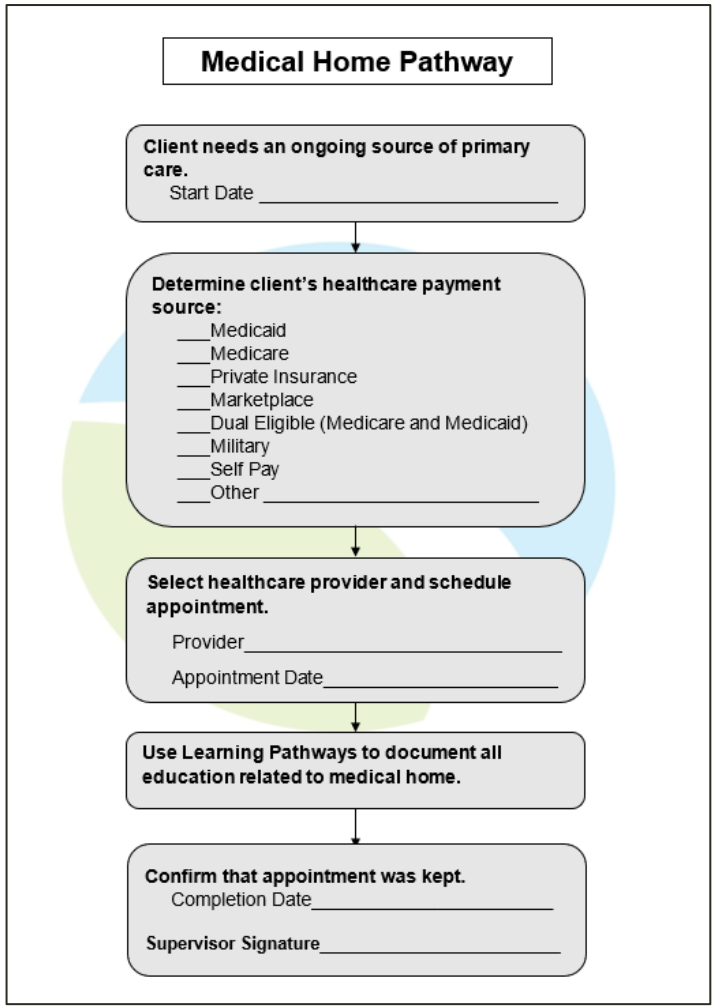
FIND

- 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 Visit Forms 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

TREAT: EACH RISK FACTOR = PATHWAY

21 Standard Pathways

- One risk factor at a time
- Completion = Payment
- Finished Incomplete Pathway = Gaps



Pathways:
Adult Education
Developmental Referral
Employment
Family Planning
Food Security
Healthcare Coverage
Housing
Immunization Referral
Learning
Medical Home
Medical Referral
Medication Adherence
Medication Reconciliation
Medication Screening
Mental Health
Oral Health
Postpartum
Pregnancy
Social Service Referral
Substance Use
Transportation

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

HUB REFERRAL PARTNERS

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
Catholic Charities: 1 CC

HUB PATHWAYS TRACKING: ALL PWS FOR 2021

Pathway	Initiated	Finished Incomplete	Completed	Median Duration Days	Clients with PW	% Clients with PW	% Completed
Social Service Referral	276	142	119	16	95	36.4	46
Medical Referral	171	78	70	23	75	28.74	47
Education	145	1	144	1	65	24.9	99
Tobacco Cessation	38	44	1	115	35	13.41	2
Medical Home	40	36	12	60	38	14.56	25
Housing	39	25	13	104	37	14.18	34
Behavioral Health	38	20	17	70	32	12.26	46
Health Insurance	19	16	9	24	19	7.28	36
Employment	35	18	12	37	35	13.41	40
Adult Learning	25	18	2	119	24	9.2	10
Pregnancy	8	2	3	163	8	3.07	60
Medication Assessment	5	4	0	2	5	1.92	0
Postpartum	4	1	2	15	4	1.53	67
Developmental Referral	0	0	0	39	0	0	0
Family Planning	4	2	1	26	4	1.53	33
Medication Management	0	0	0	-	0	0	0
Immunization Screening	0	0	0	-	0	0	0

FUTURE STATE OF THE HUB

- 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

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 OR
- Anyone who has been to an Emergency Department more than 5 times in the last 12 months

HOW TO MAKE A REFERRAL

If you are a referral partner, enter referrals directly into Care Coordination Systems (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.

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/