Partnering to Improve Health and Wellbeing via Community Based Care Coordination in Rural Minnesota

Winona Health

Winona Health is an independent, community-owned, and vertically integrated healthcare system designed to care for people through all stages of life. Located in Winona, Minnesota, a beautiful, rural area nestled among the bluffs of the Mississippi River, Winona Health delivers care to residents of southeastern Minnesota, and Trempealeau and Buffalo counties in Wisconsin. The system is one of the area's largest employers, with nearly 1,100 staff members including more than 90 physicians and associate providers across a 49-bed hospital, primary and specialty care clinics, urgent care, assisted living and long-term care residences.

Community Health Needs Assessment + Community Listening Sessions

Conducting a Community Health Needs Assessment (CHNA) is an important step in monitoring and improving community health, a goal Winona Health shares with various community stakeholders. The assessment opens doors for greater collaboration among community partners by strengthening relationships and promoting a more efficient use of resources.

Research has shown that a person's health is, to a great extent, determined by factors outside the traditional walls of healthcare. Early community discussions and findings on the 2016 CHNA identified gaps in health equity, social determinant of health needs (SDOH), and concerning trends with obesity, mental health, and alcohol and substance abuse. Food insecurity in families rose as one singular area of focus, recognizing that early gaps may lead to downstream economic, health and social consequences and other inequities. For example, results from the 2016 CHNA revealed that 14% of the population who completed the mailed randomized survey compared to 56% of the immigrant and refugee population worried about food running out. Another significant discovery found 28% of Winona County children were eligible for free lunch, but only a fraction received free or reduced-price lunches, which indicated a service gap to more vulnerable students. Accompanying studies showed that 35-37% of Winona kids reported they had to skip meals because of insufficient family money, 11% of Winona residents were food insecure, and 19.5% of people in Winona lived below the federal poverty level. Equally concerning trends expressed during listening sessions included chronic stress related to financial pressures and locating affordable housing; the difficulty of finding and navigating support services; societal stigmas; and the hopeless feeling of being stuck in an endless cycle.

The Winona Wellbeing Collaborative + Winona Community HUB

The Winona Wellbeing Collaborative (WWC), established in 2016, is a group of partner organizations working to positively impact social determinants of health (SDOH) by removing barriers for residents experiencing health inequities.

After a year of research and analysis, the WWC focused its efforts on addressing the fragmentation and silos between agencies and providers via implementation of a community HUB model. The Pathways Community HUB emerged as the most advanced evidence-based framework for community-based care coordination, and the model for the Winona Community HUB.

The Pathways Community HUB model has a three-step process for mitigating risks for participants:

1. **Find** at-risk individuals within their community/home setting and determine risks.
2. **Treat** each identified risk with individual care procedures (e.g., parental education, housing, food).
3. **Measure** the outcome/result for each issue.

Community connectors perform a vital function in the HUB, implementing person-centered care coordination as they:

1. **Connect** with at-risk individuals within their community/home setting.
2. **Collect** client information to determine risks.
3. **Coordinate** client care using the Pathways' procedures to help reach a positive outcome/result.

How it Works

HUB referral partners use a standard set of criteria to determine a potential participant's eligibility for the HUB. In addition to being a Winona County resident, if someone in the household has screened positive for food insecurity, or someone in the household has been diagnosed with or has self-reported mental health concerns, or they are experiencing homelessness, they are eligible to enroll in the HUB. Due to the growth of the program and the COVID-19 pandemic, these criteria were extended beyond the original goal to impact food insecurity. As the HUB continues to grow and evolve, referral criteria will as well.

Referrals are made through a web-based portal, and HUB staff at Live Well Winona confirms referral criteria and assigns the participant to a care coordination agency that best reflects the participant's needs. Once assigned, a community connector arranges to meet with the participant, conducts a comprehensive SDOH screening that identifies gaps in up to 21 risk areas, and initiates pathways for each identified risk factor. The community connecter then works on closing each pathway by linking the participant to needed resources and services.

The HUB does not employ any community connectors or serve as a care coordination agency, but instead enters into agreements with

other community care agencies that employ community connectors. The HUB performs multiple administrative functions, including monitoring community connector caseloads and performance, as well as training and supporting community care agencies and referral partners. Live Well Winona also plays a very important role in developing a sustainable funding model for the HUB. The goal is to sustain the HUB through outcome-based units billed for closed pathways.

Today, there are five full-time community connectors from four different community care agencies addressing health risks through completed pathways to solutions. There are 21 pathways including medical services, mental health, employment, housing, pregnancy, learning, social services and more. To close an identified pathway, an evidence-based outcome must be documented. This can include things such as establishing a provider visit, tracking behavioral health appointments, the patient achieving 30 days of stable housing or employment, a healthy birth weight for a newborn, and much more, depending on the established pathway.

Video: How it works, Winona Community HUB recognized as a Trailblazer

Improving Access and Engagement to the HUB

A sustainable and distinct feature of the HUB model is the growing investment from health plans that provide contracted reimbursement for pathways closure. One of the national standards to achieve HUB certification includes securing a minimum of two multi-year health plan contracts. One of the largest regional Medicaid health plans is set to be the Winona Community HUB's first contracted payer for early 2022, and other payers are in conversation. Health plan investment depends on the HUB's ability to demonstrate a positive return on investment for this model and will require exploration and comparison with various care coordination models as well as outcomes evaluation.

Meanwhile, the HUB is adapting to model enhancements that allow for even better engagement with participants. These changes increase the person-centered approach with an emphasis on having the participant identify their priority needs at each contact with a community connector. A deeper understanding of pathways closure, including those that are challenging to close, provide important information about resources that are unavailable or difficult to access. This information will be incorporated into the next CHNA for further solution planning.

Results + Next Steps

Since its inception, there have been 292 participants referred to the HUB. As of January 2022, there are 75 active participants with more than 700 open pathways. Success is measured in the short-term through participant engagement, in the mid-term through learning pathways, and in the long-term via closed pathways. Success in terms of sustainability will be focused on quality outcomes paired with appropriate outcomes-based payment. Relevant data collection and ongoing discussions with payers will provide important information to solidify a sustainable payment model that supports fidelity to the Pathways Community HUB model.

The Winona Community HUB was recently accepted into the 2021-2022 Pathways Community HUB Certification Program (PCHCP) and has completed submission of all required pre-

requisites for certification. The next step is submission of proof of compliance with all PCHCP national standards by June, 2022.

Building Intercultural Capacity at Winona Health

At the same time the above activities are underway, Winona Health expanded its existing diversity, equity and inclusion (DEI) work alongside its care transformation work to ensure efforts to address health inequities are effective. An outside consultant is providing ongoing training and coaching to clinicians, front line staff members, and leadership to build the organization's intercultural skill level.

With this, Winona Health aims to build a sustainable infrastructure that underpins DEI principles throughout the organization, from hiring and human resource management to policy development, community engagement, patient care practices and more. This key component to a long-term care transformation journey dovetails with growing awareness of SDOH and efforts to continue building and refining the delivery of equitable, coordinated, and person-centered care.

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