Making Progress Together: Addressing Social Risk Factors Through Cross-Sector Collaboration

Addressing Social Risk Factors Through Cross-Sector Collaboration

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MN Community MEASUREMENT

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Addressing Social Risk Factors Through Cross-Sector Collaboration

CO-CREATING A SHARED APPROACH TO SOCIAL NEEDS RESOURCE REFERRALS IN MINNESOTA

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MN Community MEASUREMENT

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Objectives

- Share progress on Minnesota's efforts to address health-related social needs referrals and social drivers of health to improve health equity
- Illuminate the importance of cross-sector collaboration and leadership in achieving goals
- Offer ideas for taking action

We Make Lives Better

- Lead collaboration and innovation in health care quality and safety, and serve as a trusted expert in facilitating improvement for people and communities.
- Core expertise is designing and implementing improvement initiatives across the continuum of care and with and in communities.
- Stratis Health adopted three organizational strategies earlier in 2024 (see next slide).

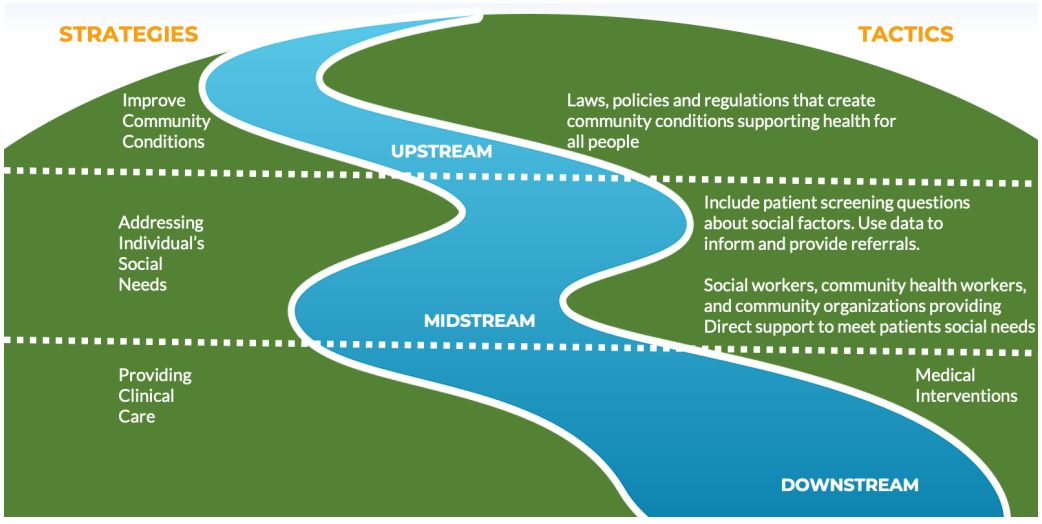
Strategies

Co-design system changes that connect health care and community organizations to improve health.	Advance a safe and compassionate health care environment for those receiving and those providing care.	Accelerate evidence-informed and culturally responsive care and services.

With these strategies, we prioritize improvement efforts that empower those who have been historically marginalized. In implementation, we work in ways that are inclusive, systems oriented, and centered on equity. Our work is broad and inclusive, while highlighting:

- People who are age 65 and older.
- People living in rural places.
- People experiencing substance use disorders.
- People experiencing health disparities.

Social Needs & Social Drivers: Moving Upstream



Source: Time to Look Upstream - Health Endeavour.

Addressing Social Needs: Health Care Systems, Payers, and Community Organizations and Public Health Working Together

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Co-Creation Structure

Guiding Council (leadership and direction) Comprised of 13 community organizations, 8 health care organizations, 3 payers, and two cross-sector organizations
Aligned with the principles of: health equity, culturally and statewide relevant solutions, community leadership fosters meaningful solutions, cross-sector co-design and shared accountability, parity, design for the future, balance of urgency with time for meaningful engagement
Planning phase collaboratively funded by BCBS-MN, Minnesota health plans (BCBS-MN, HealthPartners, Medica, UCare, Itasca Medical Care, PrimeWest, and South Country Health Alliance) collaboratively funded Stratis Health's role as a convener and facilitator through 2023.

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Guiding Council

Guiding Council Membership

Community Organizations

- Alzheimer's Association MN/ND
- CEAP (Community Emergency Assistance Programs)
- Cultural Wellness Center
- Hmong-American Partnership (HAP)
- MN River Area Agency on Aging (MN RAAA)
- Mino-Bimaadiziwin Wellness Clinic at Red Lake Nation
- Pillsbury United
- Recovery Alliance
- Second Harvest Heartland
- START Senior Solutions/ Faith Nurse Network
- The ArcMN
- Volunteers of America (VOA) MN/WI
- Wellshare International
- Youth and AIDS Project: University of Minnesota

Health Care

- Allina Health
- Lakewood Health System
- Children's Hospital & Clinics
- M Health Fairview
- Essentia Health
- MN Community Care
- Knute Nelson
- Canvas Health

Payers

- Blue Cross Blue Shield of Minnesota
- UCare
- PrimeWest
- National health plan (vacant)

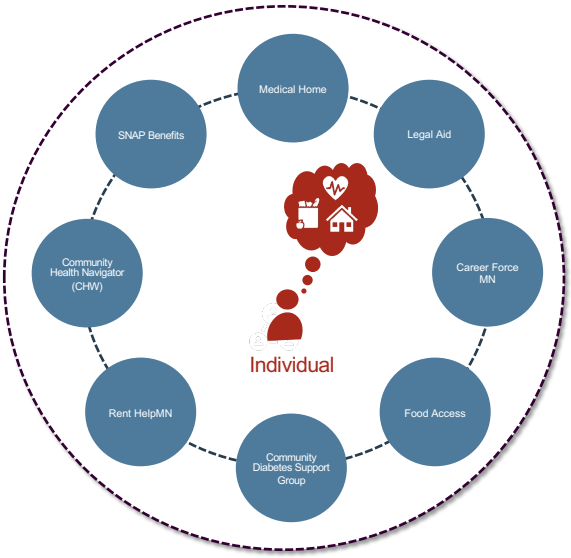
Dual Payer/Health Care Role

- HealthPartners
- MN Department of Human Services

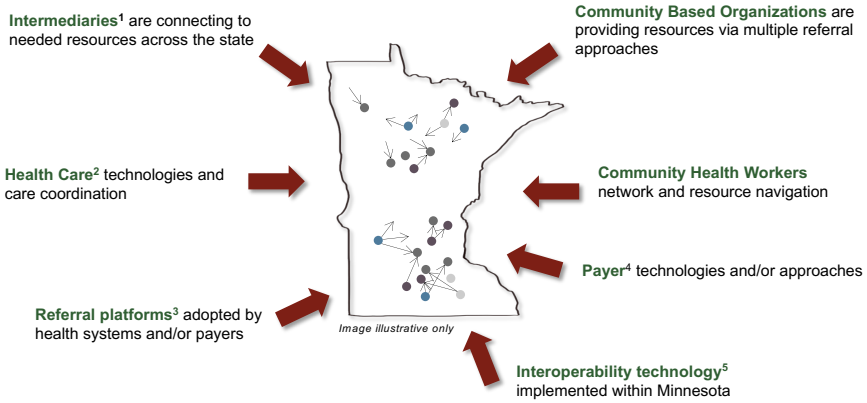
Public Health representative

Overall Goal

- Co-create a shared approach for connecting people in Minnesota with needed and culturally meaningful resources and supports across health care, food, transportation, housing, and more.
- Supported by universal standards, collaborative information directory, interoperable referral technology, human navigation, shared infrastructure, and sustainable financing.



Current Landscape to Address HRSN in Minnesota



[1] **Examples**: United Way 211, FirstLink, Minnesota Help.info, Senior Linkage Line, Disability Hub MN, Veterans Line, Trellis, Youth Services Network app, HelpMeConnect, BenefitsCheck Up

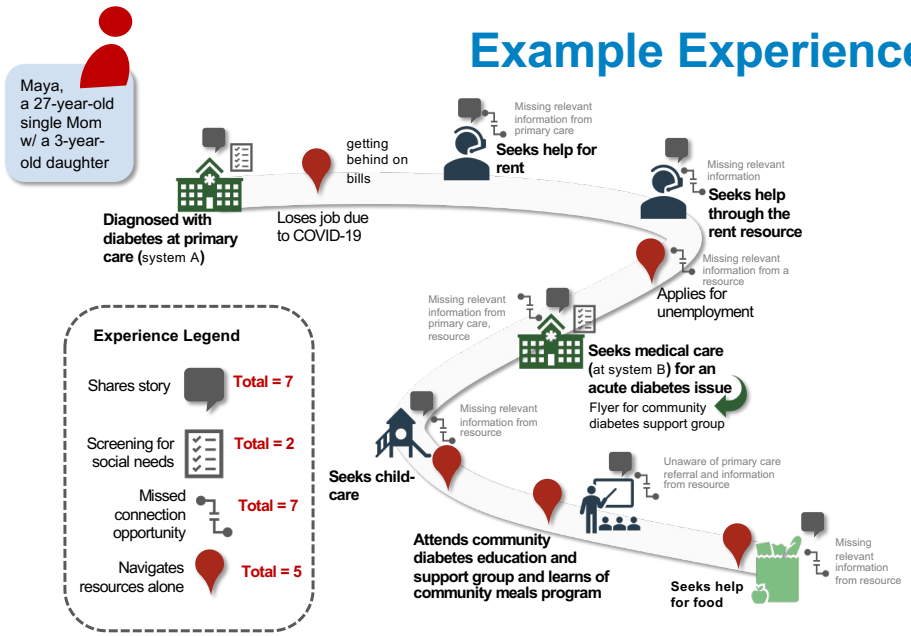
[2] **Examples**: EPIC Compass Rose Module (and other Social Needs Solutions within EHRs), care coordination programs by population and/or condition, value-based contracts with reporting and monitoring of social service supports, medical home referrals

[3] **Examples**: FindHelp, UniteUs

[4] **Examples**: care coordination programs by population and/or condition, value-based contracts with reporting and monitoring of social service supports

[5] **Examples**: ADS system – Audacious Inquiry (AINQ), and HIE - Koble

Example Experience: Maya



National Forces Aligning for Action

- Centers for Medicare & Medicaid Services (CMS) drivers:
  - Quality measure reporting on SDOH and health equity is now mandatory
  - Billing codes in Physician Fee Schedule for Community Health Integration (CHI), Principal Illness Navigation (PIN), and Peer Support (PIN-PS) Services
  - Flexibility for Medicaid agencies through 1115 waivers to address SDOH
- CMMI is testing new models of care and payment
  - Minnesota is one of the test sites for Making Care Primary model
- Health plan (NCQA) and health care accrediting organizations (Joint Commission) now have standards for SDOH screening and referrals

Cross-sector Engagement with Community Organizations

- Health care alone can not address social needs!
- Community organizations have the expertise and built relationships with people seeking social care resources.
- Creating trust and relationship with community organizations is paramount to success.
- Solutions must be comprehensive and integrated, considering that technology is necessary but insufficient - we also need payment, standards, policies, infrastructure, and human navigation.
- Need to align other incentives such as Medicaid waivers, and investments by philanthropy, employers, and others.

Guiding Council: Five Implementation Strategies to Address Social Needs

"Uber" Directory	Standards and Tools	Interoperability	Community Hub Backbone	Amplification
Design and implement shared directory, an "uber" utility for social needs resources to vet and update available resources to ensure comprehensiveness and relevancy for people accessing the information.	Develop standards and tools for health care, community organization and payer engagement which are include viable operational and financial agreements and options for payment.	Develop specifications and workflows for an interoperable information exchange to support multi-directional, closed loop social needs referrals between payers, health care and community organizations.	Advance community care hub backbone organizations to build sustainable, mutually beneficial community organization engagement with health care and payers.	Intensify visibility, momentum, and commitment through a campaign-like approach with pledges, measurement, and reporting.

Guided by the following principles:
equitable, relevant culturally and statewide, community led, meaningful time to engage, co-design and shared accountability, accounts for the future.

Benefits of Leveraging these Strategies

- Comprehensive directory of resource information which ensures that patients are getting to the right place for services.
- Less waste and redundancy in the system; information is shared once and efficiently.
- Systems in place to support providers and multi-sector accountability for outcomes.

Culture Care Connection

Forthcoming Resources

- "Uber" Directory
- SDOH toolkit
- Culturally & Linguistically Appropriate Services (CLAS) Standards

Call to Action

- Talk to others in your organization about the five implementation strategies to address social needs:
  - Which resonates most given where your organization is at and wants to focus on
  - Explore what your organization is doing to implement or advance each strategy
- Share the Culture Care Connection resources with your team
- Learn about the real-life experiences of a collaborative health care and community partnership hub in Winona from my fellow presenters

For More Information:

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Winona's Collaborative Solution to Meet Community Needs

September 25, 2024

Winona Health

Winona's Collaborative Solution:

1) Market area and population
2) Identified Needs & Community Solution
3) Implementation within the Clinics and Community
4) Intervention Sustainability

About Winona Health

Rural, independent, community-owned hospital & clinic:

- Primary & Specialty Care
- Emergency Department & Urgent Care
- 49-bed acute care hospital
- Skilled nursing & memory care residences
- 90+ physicians across 13 specialties
- 900+ employees

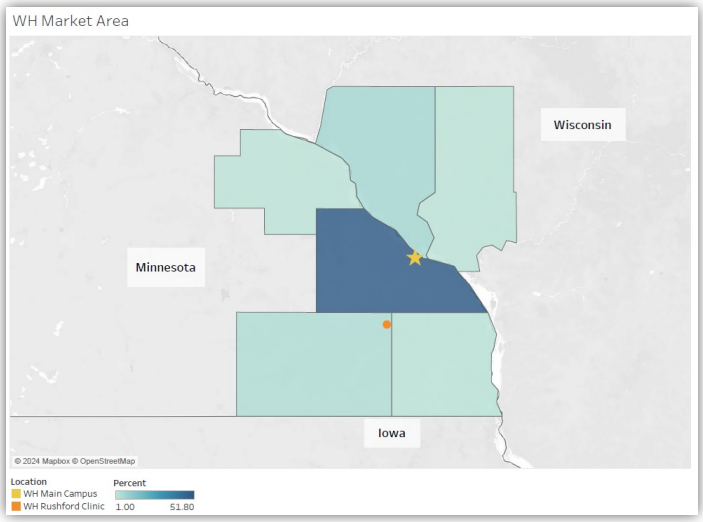
Service Areas

Race & Ethnicity:

- 0.5% American Indian/Alaskan Native
- 1.6% Two or more races
- 2.1% Black/African American
- 2.7% Asian
- 3.9% Hispanic or Latino
- 93% White

Other Important Things to Know:

- 14.3% persons in poverty
- 32% of ED visits are by patients with Medicaid – Regular/PMAP
- 10% food insecure
- 43% poor mental health
- 15% severe housing problems



2023 MN County QuickFacts Tables
Feeding America – MN Food Insecurity
Winona Health, Cerner Millennium

Winona Wellbeing Collaborative

- Winona County & Winona Health - CHNA collaboration
- Findings highlighted food insecurity & significant disparity
- BCBS grant support helped launch the WWC
- WWC conducted deeper analysis of issue/solutions
  - Quantitative/qualitative data gathering and analysis
  - Environmental scan of community resources
  - Gap analysis
- Identified area of impact: *Improve community-based care coordination!*

The WWC decides to pursue development of the Pathways Community HUB Model!

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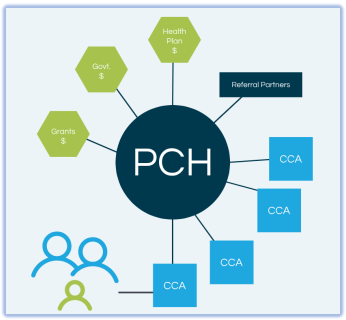
Pathways Community HUB Institute (PCHI) Model

- The Pathways Community HUB Institute's (PCHI) Model provides the framework to build a robust, complete network of care that removes barriers and improves systems while also reducing duplication of services and aligning payment with achieving positive outcomes.



How the model works

- Local community health workers engage community residents at risk for poor health and social outcomes and connect them to social and medical services
- Services are designed to remove barriers and address risk factors across 21 standardized Pathways, such as lack of housing or inadequate access to specialized health services
- Pathways are completed when the barrier or risk has been removed, and payment for services is tied to the completion of Pathways rather than the delivery of the services themselves

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Evolution of Referral Criteria

Winona Community HUB referral criteria are based on priority areas identified through the CHNA and continue to evolve.

Program Implementation (2019): Food insecurity

→

In response to COVID-19 (2020-22): Food insecurity, housing insecurity, mental health challenges

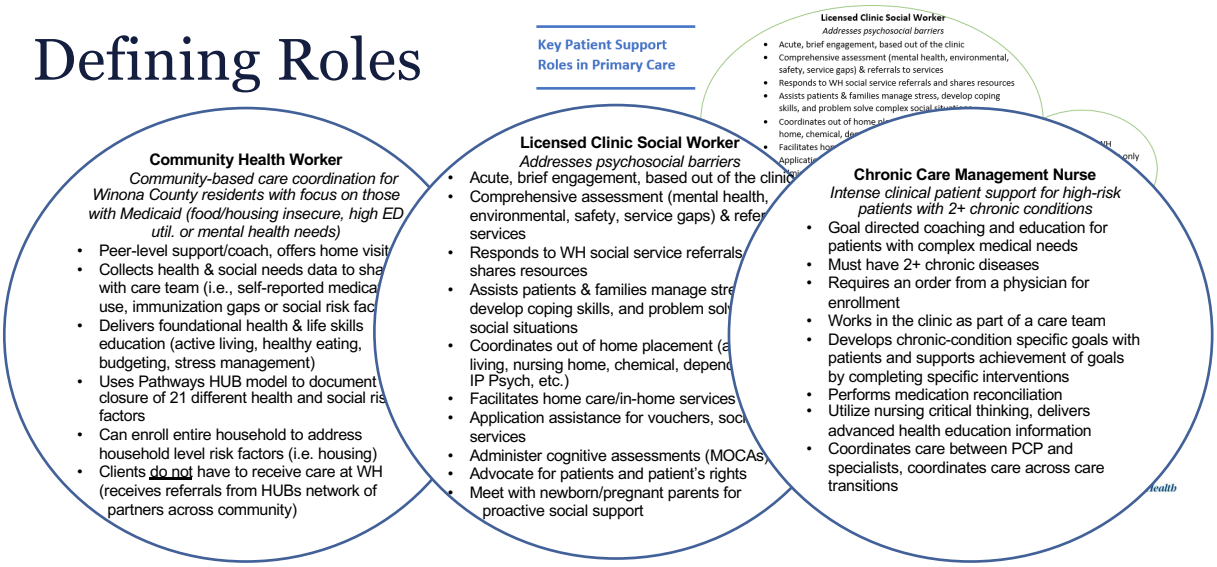
→

2022 CHNA (2022-present): Food insecurity, housing insecurity, mental health challenges, high emergency dept. utilization

Team Integration

- Co-location in clinic settings
- Use of EMR and CHR
- Pharmacist secure communication via CHR
- Developed dot phrase for quick in-chart referral
- CHWs attends morning huddles
- CHWs meet with SWs and RNs periodically
- Attend provider visits with participants when requested
- Relay findings in the field back to team

Defining Roles



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Sustainability – Program & Workforce Development

Program:

- HUB Support for Supervisors/CHWs
- Quality control of whole structure
- Contracting with Payors
- Invoicing/Claims billing
- OBU reports

Workforce:

- Hiring landscape in rural region
- "Start-up" grant dollars for each position needed
- Apprenticeship to attract candidates

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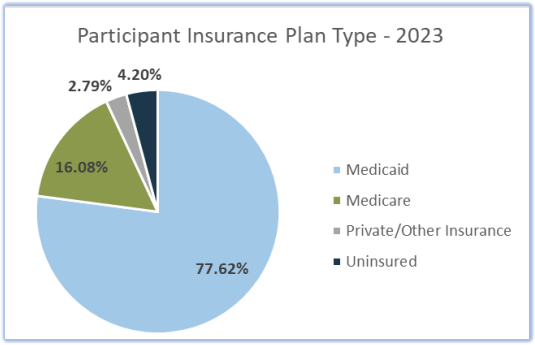
Winona Community HUB Sustainability

- Pathways Community HUB Institute (PCHI) certification
- Contracts with two health plans to reimburse for Pathways = reduced dependency on grant funding
- Braided funding
- Increased volume to support onboarding of new CCAs and new hires of CHWs
- Expanded referral criteria to maximize impact



Infrastructure Support for CCAs

- Certified software vendor
- Supervisor training/monthly meetings
- Support onboarding in tandem with CCAs (model training, CCS training)
- Quality improvement
- Grant writing
- Monitoring of caseloads and referrals/waitlist
- Relationships with Referral Partners
- Billing and agency payouts
- Expansion

Looking into the Future

- Intentional Growth
- Lived Experience Leaders
- Expansion of CHW Workforce
- New Revenue Opportunities

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Thank you!

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Winona Health

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Health-Related Social Needs & Medicaid

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MEDICAID MEDICAL DIRECTOR | MINNESOTA DEPARTMENT OF HUMAN SERVICES

Health-Related Social Needs (HRSN) & Medicaid

- HRSN refers to an individual's unmet social needs that contribute to poor health outcomes.
  - Centers for Medicare & Medicaid Services (CMS) 2021 State Health Official Letter (SHO#21-001): Encouraged states to use Medicaid and CHIP to address Social Drivers Of Health.
- 2023 - CMS released guidance allowing states to address HRSN within Medicaid programs through Section 1115 Demonstration authority.
  - Informational Bulletin (2023): Outlines services that can be funded, including housing and food support.

HRSN Federal Guidance Highlights

- Services can include housing, non-medical transportation, employment, education, and home-delivered meals.
- States can use federal authorities such as Section 1915 and Section 1115 waivers to support these services.
  - Section 1905(a): Optional services to address SDOH, such as rehabilitative services and case management.
  - Section 1915(i) and (j): Home and community-based services (HCBS) to support independent living.
  - Section 1115: Demonstration authority to test innovative approaches addressing SDOH

CMS Principles for HRSN Programs

- Services must be based on individual needs assessments.
- Medicaid is the payer of last resort.
- Services should be cost-effective and high-quality.

HRSN Service Examples

- Housing-Related Services & Supports
  - Home Accessibility Modifications: Temporary or permanent changes to improve individuals' ability to stay in their homes.
  - Community Transition Costs: Helps individuals transitioning from institutional living to the community with costs like security deposits or utility fees.
  - Housing and Tenancy Supports: Rent assistance, pre-tenancy services and tenancy sustaining supports.
- Non-Medical Transportation
  - Medicaid can cover transportation to access community resources like grocery stores and employment.
- Nutrition Supports
  - Medically tailored meals, fruit/vegetable prescriptions, pantry stocking.
  - Home-Delivered Meals: Delivered to individuals who face difficulties preparing meals due to functional limitations, identified in a person-centered care plan.

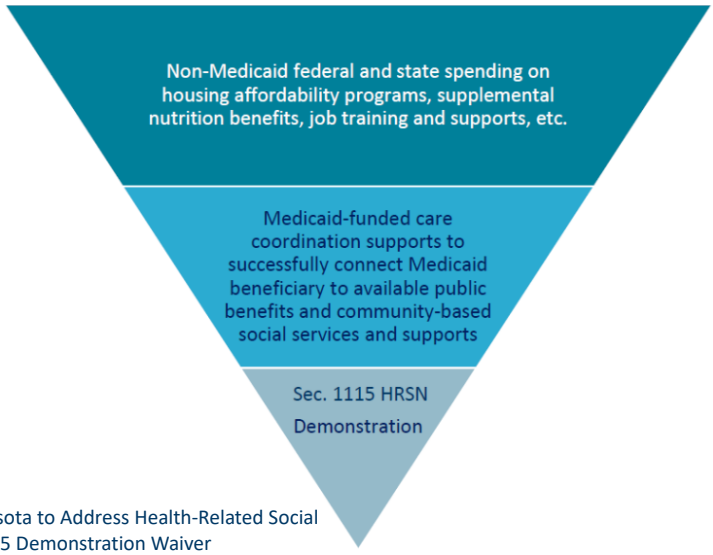
HRSN Service Examples

- Employment Supports
  - Services like job coaching and supported employment to help individuals, especially those with disabilities, gain and maintain employment.
- Community Integration & Social Supports
  - HCBS provide services like public transportation use training and companion services to support social integration.

Infrastructure & Flexibility

- States can receive federal matching funds for administrative infrastructure.
- Flexibility to integrate HRSN into existing Medicaid programs.

Figure 1. Medicaid and Non-Medicaid-Funded Programs to Address SDOH



From: Opportunities for Minnesota to Address Health-Related Social Needs in Medicaid, Section 1115 Demonstration Waiver Opportunity to Support People Overcome Disparities that Impact Health - Prepared by Health Management Associates, February 2024

MN Medicaid HRSN-related Programs & Benefits

- Housing Stabilization Services
- Recuperative Care Program
- Integrated Health Partnerships
- Health Care Homes
- Community Health Workers
- Certified Community Behavioral Health Clinics

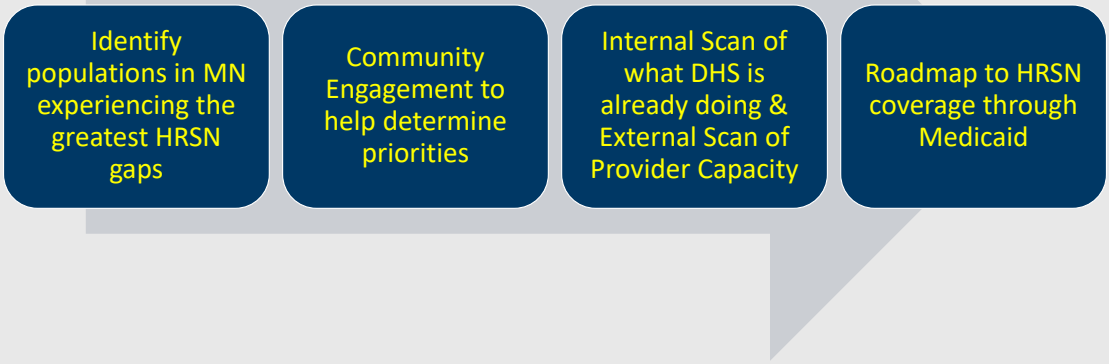
Challenges covering HRSN via Medicaid

- Coordination Efforts
  - Collaboration between healthcare providers and community-based organizations.
  - Funding streams are complex, utilizing both Medicaid and non-Medicaid sources to support SDOH interventions.
- Administrative Challenges
  - Ex. learning costs, compliance costs, and psychological costs make it difficult for Medicaid beneficiaries to access needed services.

Ongoing work in MN DHS to support HRSN

- Minnesota Legislature has commissioned a report from DHS about addressing unmet Health Related Social Needs (HRSN) throughout the state – due March 1st 2025
- Housing Stabilization Services team is conducting Community Engagement to continue improving the administration and impact of the HSS benefit

Evaluating Health Related Social Needs through an Equity Lens



9/23/24

Thank you!

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