Welcome!
2017 Health Summit
Logistics/Acknowledgements

- **Health Summit Planning Committee**
  - Matthew Bersagel Braley – Viterbo University
  - Dan Duquette – UW-La Crosse
  - Lori Freit-Hammes – Mayo Clinic Health System
  - Robert Lynn – Gundersen Health System
  - Aaron Rasch – Western Technical College
  - Brenda Rooney – Gundersen Health System
  - Joanne Sandvick – La Crosse Medical Health Science Consortium
  - Paula Silha – La Crosse County Health Department
  - Vanessa Southworth – Family & Children’s Center
  - Teri Wildt – Mayo Clinic Health System

- **Population Health Committee**
  - Liz Evans – Great Rivers United Way
  - Matthew Bersagel Braley – Viterbo University
  - Dan Duquette – UW-La Crosse
  - Lori Freit-Hammes – Mayo Clinic Health System
  - Betty Jorgenson – Mayo Clinic Health System
  - Catherine Kolkmeier – La Crosse Medical Health Science Consortium
  - Barbara Krieg – Western Technical College
  - Jen Rombalski – La Crosse County Health Department
  - Brenda Rooney – Gundersen Health System
  - Joanne Sandvick – La Crosse Medical Health Science Consortium
  - Paula Silha – La Crosse County Health Department
  - Vanessa Southworth – Family & Children’s Center
  - Teri Wildt – Mayo Clinic Health System
La Crosse Medical Health Science Consortium - Partnership

• Formed in 1993
• Partners:
  – Gundersen Health System
  – Mayo Clinic Health System
  – University of Wisconsin – La Crosse
  – Viterbo University
  – Western Technical College
  – School District of La Crosse and La Crosse County Health Department added in 2009
• Population Health Committee formed in 2005
Summit History - 2009

Seeking interest on further collaborations

Align initiatives towards same goal
Summit 2010

Shared the plan

“Health in all Policy”
Summit 2011

“Making the healthier choice together”

Communication
Summit 2012

“Awakening the Power in Our Community”
Summit 2013

Wicked Problems

- Seemingly intractable with chronic policy failure
- Sit astride organizational boundaries and responsibilities
- Difficult to define
- Involve changing behavior
- Interdependencies and multi-causal
- Solutions can lead to unforeseen consequences
- No clear solution

Socially complex

By Greg Lister, PhD

La Crosse Medical Health Science Consortium
Summit 2015

Building a Culture of Health

Adverse Childhood Experiences (ACES)
Summit 2016

Pink Zones
County Health Rankings Model
La Crosse County Rankings
out of 72 counties in WI

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County Health Rankings Model
La Crosse County Health Factor Rankings out of 72 counties in WI

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What We Need Is Here
What We Need Is Here
"It is said that no one truly knows a nation until one has been inside its jails.

A nation should not be judged by how it treats its highest citizens, but its lowest ones –
INTERGENERATIVITY
“The immensely powerful capacity to IMAGINE something new and to devise new ways to bring it into being marks our live as HUMAN and not merely biological.”

~ Gary Gunderson and Jim Cochrane
ENTROPY TO ENSEMBLE
Leading Causes of Life™
Write down an example of at least one area in your life that connects back to one of the LCL
Coherence

The many ways:

• We make sense of life
• Life makes sense to us
• We see our life journey as intelligible and neither wholly random nor victim to inexplicable forces
Community Partnerships

- La Crosse County Jail
- La Crosse County Justice Support Services
- WI DOC
- Workforce Connections
- YWCA
- Attic Corrections
- CouleeCap
Education
• GED
• Credit courses

Employment
• Career Pathways
• Meaningful
PROVEN Ideology

- Strengths perspective
- Empowerment
- Cognitive Behavior Skill Development
Video

Jordan Holter: A non-linear path to success
Stories
Everybody is a genius but if you judge a fish by its ability to climb a tree, it will live its whole life believing that it is stupid. —Albert Einstein
Agency

Sometimes agency is the only cause of life you have to work with.

• Life may be incoherent; you may be disconnected, but you still can get up in the morning and move.
• It’s a fundamental capacity to choose to move toward life.
• It’s not resisting death, it’s an expression of a seeking of life.
• It’s a positive choosing.
15 minute break
Intergenerativity

Passing wisdom up and down through the generations:
• Quality of knowing our relationship to those who have come before us and those after us who will benefit from our life.
• It’s concern for those beyond our family.
Addressing Chronic Homelessness
in La Crosse

April 7, 2017

Kim Cable, Couleecap
Mary Jacobson, Catholic Charities
Key Players

Design Team
• Combination of front-line and senior staff who work with persons who are homeless
• Intimate knowledge of current systems
• Ready to innovate and improve the system

Leadership Team
• Community leaders and influencers committed to “clear the path” on policy, resources, and buy-in
• Ready to support the Design Team
• Support changes to ensure sustainability of gains

La Crosse Collaborative to End Homelessness
- The organizational “home” for this and future initiatives

Franciscan Sisters of Perpetual Adoration
- Community conveners; the “heart” of this community-wide effort

Facilitation Team (Erin Healy Consulting)
- Co-design, launch, facilitate collaborative efforts to end homelessness
- Share/transfer expertise re: rapid cycle systems change and improvement
- Sponsored by Gundersen Office of Population Health
Team Dynamics

**Design Team**
- Needs to focus energy on designing and implementing a new system

**Leadership Team**
- Deflects counter-productive forces (politics, media, naysayers) to ease path for Design Team
- Puts their own credibility and reputation on the line
- Empowers Design Team
- Not in it for the glory; wants spotlight on Design Team
- Advocates to lock in and sustain system improvements
FIRST CYCLE: Ending Veteran Homelessness in the City of La Crosse

Sprint Cycle:
A fast-paced, focused, short-term implementation cycle, to innovate and “pressure test” new system and pursue ambitious goals

Day 1:
Sept. 15th
Action Lab
Sept. 13 – 14, 2016
Design intensive: current system assessment, redesign, goal-setting, work-planning to test new prototype

Mid-point Review:
Nov. 2nd

Day 100:
Dec. 25th
Goal!! Reached Functional Zero!

Momentum Lab
Jan. 25, 2017
One day review of Sprint outcomes. Includes: celebration of success, identify barriers, new discoveries, strategies to sustain the gains, next steps

WEEKLY TEAM MEETINGS

“100 Day” Model developed in partnership with Community Solutions and the Rapid Results Institute
La Crosse – Veterans: Monthly Housing Placement - 2016

Total Housed During 100 Day Sprint: **16!**

400% Increase!
This is What Improvement Looks Like

* A partnership of Community Solutions and the Rapid Results Institute

Phoenix

End of 100 days
August 2013

RRBC Launch
May 2013

Monthly Housing Placement Rate
Functional Zero: anyone experiencing a housing crisis will be back in stable housing w/in 30 days

- **Functional Zero?**
  - **NO**
  - **YES**

- **# Current Homeless**: 8 > 6
- **Monthly Housing Placement Rate**: 4 < 6
What Works -

**Unprecedented Collaboration:**
- System Leadership
- Rapid Cycle Innovation, Iteration, Improvement
- Audacious Goals!

**Housing First**
- For *high needs*: low/no barrier to entry
- Supportive services
- Permanent (no program-imposed time-limit)

**Prevention and Rapid Rehousing**
- Early warning system
- RR for *moderate needs*

**Coordinated Entry**
- If no CE, cannot prioritize based on need
- By Name list – know who’s out there

**Know Your Data**
- Performance Metrics
- Shared goal – clear, measurable, time-bound
- Data for improvement, not judgment
- Transparency
It’s about the SYSTEM

To reach and sustain Functional Zero, you must have a system that measures (at minimum):

• Real-time data on currently homeless (by name, de-duplicated)
• Inflow rate
• Outflow rate
• Monthly Housing Placement
• ALL housing inventory
• Universal Assessment (for Prioritization, Triage, Matching)
• Average # of days-in-process
THIS NEXT CYCLE: Addressing Chronic Homelessness

Sprint Cycle:
A fast-paced, focused, short-term implementation cycle, to innovate and “pressure test” new system and pursue ambitious goals

Day 1: April 20th
Day 100: July 28th
Mid-point Review: Early June

WEEKLY TEAM MEETINGS

Action Lab
April 19th
Design intensive: data review, goal-setting, redesign, work-planning to test new prototype

Momentum Lab
August 2017
One day review of Sprint outcomes. Includes: celebration of success, identify barriers, new discoveries, strategies to sustain the gains, next steps

“100 Day” Model developed in partnership with Community Solutions and the Rapid Results Institute
Chronic Homelessness – HUD definition

• A homeless individual with a disability who:
  1. Lives in a place not meant for human habitation, a safe haven, or in an emergency shelter; and
  2. Has been homeless continuously for at least 12 months or on at least 4 separate occasions, separated by at least 7 days, in the last 3 years where the combined occasions must total at least 12 months

• Chronic, or long-term, homelessness is a life threatening condition that shaves an average of 27 years off a person's life.

• WHY FOCUS ON THE CHRONICALLY HOMELESS?
Importance of Housing First & Prioritization

Transitionally Homeless represent 80%, but use only 6% of shelter resources.

Episodically Homeless represent 10%, but use 28% of shelter resources.

Chronically Homeless represent 10%, but use 66% of shelter resources.

Source: Kuhn and Culhane
Saving Lives and Public Dollars

Pre- and Post-Housing Costs for 10th Decile Patients Housed

- Probation
- Sheriff mental health jail
- Sheriff medical jail
- Sheriff general jail
- LAHSA homeless srv.
- GR Housing Vouchers
- General Relief
- Food Stamps
- Paramedics
- Substance abuse srv.
- Mental Health
- County outpatient clinic
- Private hospitals-ER
- Health Srv - ER
- Private hospital-inpatient
- County hospital-inpatient

Source: Economic Roundtable, 2013
Human Costs
Breaking News...!

• March 30, 2017: Bergen County, New Jersey is the first community in America to END CHRONIC HOMELESSNESS

• More than six months at functional zero. Hard proof that with smarter data, improved collaboration, and a refusal to fail, an end to homelessness is possible.

• Bergen's leaders have built a command center model that can identify and respond to any person who falls into homelessness in near real time.

• There is no reason why La Crosse cannot forge the same path—and ultimately achieve an end to ALL homelessness
My other promise to you….  

THE ROLLERCOASTER OF CHANGE℠  
THE ONLY PROCESS TO KNOW  

(IT IS NATURAL, NORMAL...THIS CYCLE OF CHANGE)  

CHANGE MEANS “LETTING GO”  
AND “HANGING ON”!  

Persistence – Persistence – Persistence  

Loss of Traditional Culture  
(“Hold on or let go?”)  

Leap…  

Uncertain New Culture  
(“Grab on and hang in!”)
If organizations in La Crosse take action together as a coordinated team, with one shared goal, we WILL reach functional zero on ALL Homelessness.
Thank you for your commitment to this Team and your community!

Kim Cable, Housing and Community Services Director
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kim.cable@couleecap.org

Mary Jacobson, Assistant Executive Director
Catholic Charities
608-519-8060
mjacobson@cclse.org
Table Activity

Review coherence, agency, and generativity.

How do they align with both your personal and work life?
Connection

As human beings we find life through:

• Complex social relationships and connections to one another

• Building communities of various kinds that enable us to adapt to changing threats and opportunities
Gathering Resources and Aligning Community Engagement

Pathways Community HUB in La Crosse County, Wisconsin
An Innovative Community Systems Change
LA CROSSE COUNTY COMMUNITY HEALTH IMPROVEMENT PLAN 2016-2021

Priority Area #3 – Social Determinants

GOAL: To create social and physical environments that promote good health for all.

PERFORMANCE MEASURES How We Will Know We are Making a Difference

OBJECTIVE

By December 31, 2021, assure that a system exists that connects people in need to available resources in La Crosse County.

*Indicators are data trends. They are not intended to be measures of success.

- Percent of adults 18 years and over who report not receiving sufficient social-emotional support (BRFSS)
- Community perception of health, safety, education, quality of life, and economic aspects as well as access to care (COMPASS)
- Calls for resources related to social determinants. (211 Call Data)

ALIGNMENT

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<th>LC HD CHA</th>
<th>Healthiest Wisconsin 2020</th>
<th>Healthy People 2020</th>
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<td>Social Determinants was rated as the third highest concern in the La Crosse County Health Department Community Health Assessment which included data from the COMPASS NOW 2015 survey, key informant interviews, community forums, and community leader rankings.</td>
<td>Health Literacy Objective 2: By 2020, increase effective communication so that individuals, organizations, and communities can access, understand, share, and act on health information and services.</td>
<td>(AHS-6.1) Reduce the proportion of persons who are unable to obtain or delay in obtaining necessary medical care, dental care, or prescription medicines.</td>
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BACKGROUND ON STRATEGY


Policy Change (Y/N) and list policy/link to policy: Yes, Policies to be determined as implementation of system change occurs

Contributing factors and causes (include behavioral risk factors, environmental, social-economic factors, health status disparities, and health equity and health risk population): Those with lower socioeconomic status experience disproportionate health disparities that may stem from unequal access to resources. (LC HD CHA – Access to Care and Social Determinants)
GRACE Hub will implement a system to bridge the gap between health care delivery and the social service sector for cost savings, improved population health outcomes, and increased client experience and engagement.
Same Process for All Agencies:
- intake/assessment
- regular home visits to complete pathways
The HUB model was first developed by the Community Health Access Project in Mansfield, Ohio.
Foundation of the HUB Model

An evidence-based, accountable care coordination delivery system designed to:

- **Find**
  - Comprehensive Risk Assessment

- **Treat**
  - Assign Pathways

- **Measure**
  - Track Results (Connections to Care)
Pathways

- Each Risk = Pathway
- 20 Standard Pathways
- Finished Pathway = Outcome Achieved (Risk Factor Reduced/Eliminated) & Payment
- If outcome not achieved = Incomplete Pathway

- 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
Infrastructure/Governance of Hub

Director
1.0 FTE

Resource Specialist
0.5 FTE

Community Advisory Board
GRACE HUB Flow

- Pregnant Mother
- Family beingEvicted
- Child withAsthma
- ElderlyDiabetic Female

Initial referral agency
- Doctor
- Social Worker
- Hospital

GRACE HUB
Pathways assessment

Agency with Community Care Coordination Services

Agency/Program
Agency/Program
Agency/Program
Sustainability
Pathway Reimbursement/Braided Funding

Health Plans

Payment for Outcome

Pathway Completion

GRACE HUB
Pathways assessment

Agency with Community Care Coordination Services

Long Term & Sustainable Funding

• Health Plans and others pay for completed pathways

• Hub takes % for sustainability

• Remaining goes to agencies for care coordination service (new revenue source)
Indicator for Success

High Emergency Room Usage:

Current data indicates range of 18-67 ER visits from 1/1/15-7/31/16 for highest users
What Does Success Look Like?

**Emergency Room Diversion**
Potential Cost Savings Example
1/1/16-6/30/16
135 users with 377 visits*

377 visits x $1,233 (national average ER visit cost) = $464,841
135 users x $265 (assessment/2 pathways) = $35,775

If decrease visits by 50% with GRACE Hub =
Cost Savings of $268,196
or $536K per Year

*Data from Mayo is for Self Pay EUCC Patients
Summary

- Removes silos and fragmentation
- Uses existing community resources, medical and social, more efficiently and effectively
- Focuses on common metrics to identify and track risks (risk reduction)
- Holistic community care coordination – one for whole family
- Pays for outcomes (pathways) = sustainability
- Owned by the community

“Successful change is about having the right partners working on the right thing at the right time.”

~Nelson
Table Activity

Where do you find community in unexpected places?
Hope

Hope in the deepest sense is not optimism or wishful thinking. It is about:

• Imagining a different, healthier future
• Finding the energy to do something to try to bring that future into being
• Thinking and acting forward

If we can see a positive future this nurtures the life force to make it happen.
Leading Causes of Life™
Thank you!