
KNUTE NELSON

About Knute Nelson:

We are a senior-care provider located in West and Central Minnesota. We provide a full continuum of care founded in 1948 through a generous donation of land from Knute Nelson, former Minnesota governor, and senator. His legacy gave older adults a place to turn to for care and support.

Our mission to enrich the lives of everyone we serve grew out of his vision. It affects all our decision-making – from strategic planning to the services we offer and how we impact the communities we serve.

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BUILD:
Population Health Service Organization

Focus: Standing up a population health service entity focused on comprehensive solutions for better care, lower costs, an engaged workforce, and quality of life for older adults.

Strategy:

Develop infrastructure and capacity to be a stand-alone, risk-bearing organization.

- Develop Care Management and Care Coordination Programming
- Exploring market opportunities and gaps
- Rural Health Network Development
- Connected Communities
- Health Plan Relationships
  - Risk Share-Upside and upside/downside
  - ISNP
  - PMPM Payments

INTEGRATE and ALIGN:
Deploy PH philosophy into existing services and workforce management.

Focus: Integrate population health models of care, technologies, and services into existing KN services and sites of care, as well as consider how we might approach the workforce through a different lens.

Strategy:

- Implementation of technology to support integrated care delivery and the needs of our workforce.
- Ensure equity in our workforce and that workforce is engaged in their interests and to their highest trained skill/certification level.
  - Advanced Care Aide program
- Look for new ways to introduce psycho/social care in partnership with clinical care to improve health outcomes across the care continuum and for our workforce.
- Begin to introduce value-based approaches to care delivery across the care continuum and move towards an enterprise approach to ensure appropriate and whole-person care is delivered.
- Think beyond the box that we feel confined by. We must prove and challenge.

ALOMERE HEALTH
Here for Life

Dancing Sky
Area Agency on Aging

HORIZON
Public Health
Prevent. Promote. Protect.

LAKES AREA
AGE FRIENDLY

LeadingAge
Minnesota

PrimeWest
HEALTH

ucare

WEST CENTRAL MINNESOTA
Communities Action

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Connected Communities Goals

Demonstrate that collaborative planning and intervention by healthcare and community-based organizations can significantly:

Impact the wellbeing of the aging population

Improve whole-person experience

Reduce costs of care

Overcome perceived barriers to rural care delivery

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Pilot Program: Network of Connection & Support

Age Well Community Navigator

Age Well Care Manager

Telehealth Monitoring & Engagement

Personal Emergency Response System

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Contact Information

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Lutheran Family Services

for the well-being of all people

Value-Based Care

LFS Value-Based Care

- Contracting conversations started in 2021
- Contract negotiations – how we would get paid
- Client description – Optum high-cost clients – 400-800
- Per member, per month discussions (PMPM)
- Two visits per month – based on HEDIS measurements
- Goal to reduce the number of ED visits, inpatient utilization, compliance with HEDIS and reduction in readmission rates

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Care & Service Coordination

- How ready were we as an agency? – CCBHC, NOMS, Prevention rather than intervention
- Staffing – How do we staff up and generate revenue?
- How do we engage clients, and ensure two interactions a month?
- How do we ensure HEDIS benchmarks are occurring – wellness exams, diabetes, blood pressure, medication adherence related to health & Behavioral health, and ensure a 7-day follow-up after discharge

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Inter agency collaboration

Where Are We Going?

- Ensure collaboration across the agency
- Internal cross-referral system – increasing resources to clients internally
- External network resources – more resources for clients along the SDOH
- Integration model for full care and service coordination

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Data tracking – integrated approach

- Link to care and service coordination – " It's not what you ask but how you ask it."
- Current tools:
  - HEDIS – measures performance in health care
  - NOMS data – BH Diagnosis, Demographics, Functioning, Employment, Education, Housing & CCBHC specifics
  - DLA 20 – daily living activities including health, housing, financial, communication and others
  - Well RX – economic stability, education, housing, health
  - Self-sufficiency matrix – housing, employment, income, health, communications and other related specifics
  - Social Determinants of Health – what do we do with the info, how do we provide holistic integrated care utilizing the info and data

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