Making Families Stronger Through Community Connections

Brittany Brown, Community Engagement Partner

KY System of Care Academy
June 9, 2020

About WellCare Health Plans

WellCare of Kentucky provides government-sponsored managed care services to families, children, seniors and individuals with complex needs primarily through Medicaid, Medicare Advantage and Medicare Prescription Drug Plans. WellCare is a wholly subsidiary of Centene Corporation, a leading multi-national healthcare enterprise committed to helping people live healthier lives.

WellCare's Presence in Kentucky

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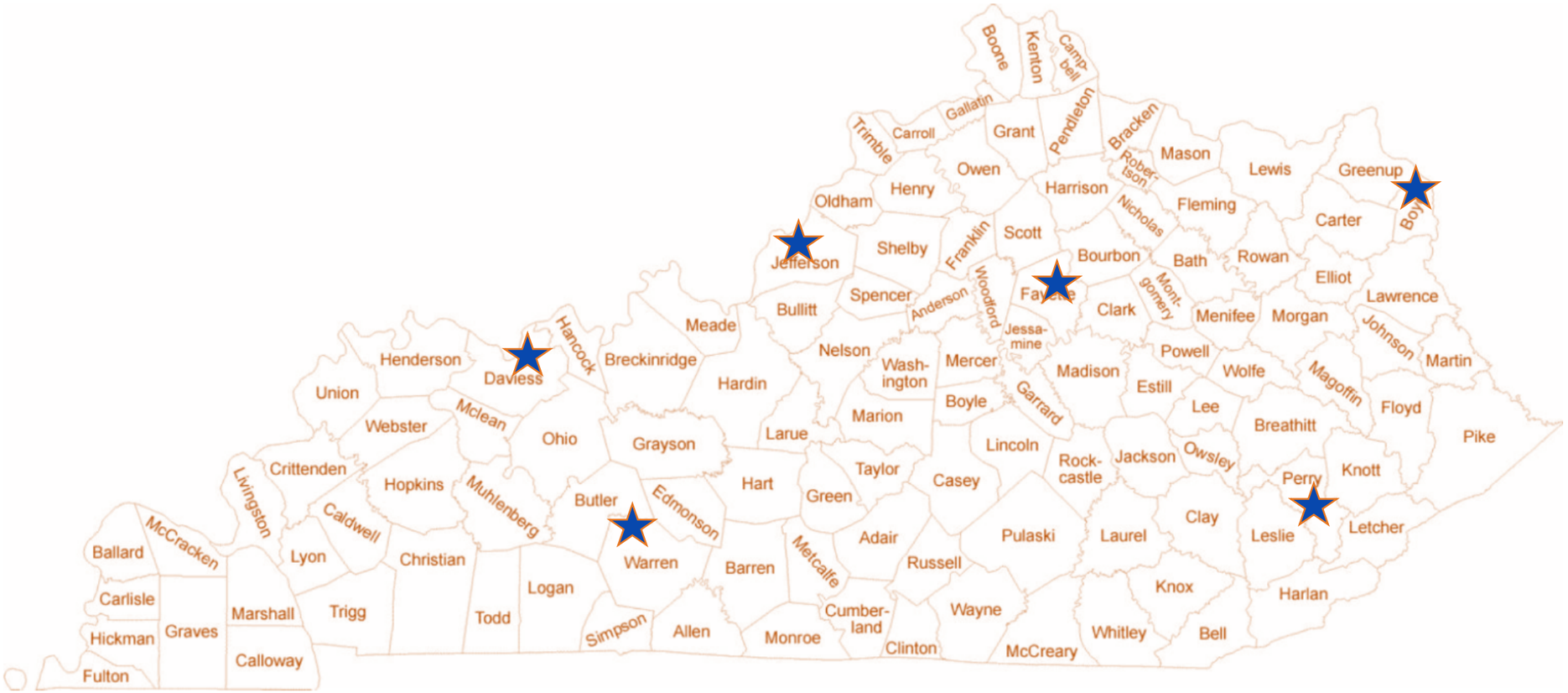

485K	320	6	36K	17K	$5.8B
MEMBERS	ASSOCIATES	OFFICES STATEWIDE	PROVIDERS	FACILITIES	STATE ECONOMIC IMPACT

★ Counties with WellCare offices

*Economic impact based on CY2018 internal projections, including direct, indirect and induced benefits.

All numbers are as of Sept. 30, 2019

A Better You

WellCare
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At WellCare, we understand being healthy is affected by so many parts of your daily life.

We provide healthcare that gets you to the right doctors and specialists.

We also connect you with other services and organizations that can help you manage the many challenges of your life.

Because we believe a more integrated approach to your health means ***a better you***.

Community Engagement

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WellCare Community Connections

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Our Mission

Meeting members where they are, to support them in **removing social barriers to improve health outcomes and systemic, organic change** through data-informed decision-making and program evaluation, strategic local community partnerships, industry-leading innovation pilots and a national peer-support team.

Why Community Connections

- The US has unsustainable rising health and social service costs with marginal impact on health and well-being outcomes
- Individuals and families with socio-economic needs **have higher healthcare needs and costs**

What We Do

- Integrate socio-economic solutions into the **whole-person care model**
- **Support community partners** in preparing for more formal integration into the healthcare system

The Points of Light Foundation named WellCare one of the 50 most community-minded companies in America three years in a row.

Solution-Focused Capabilities

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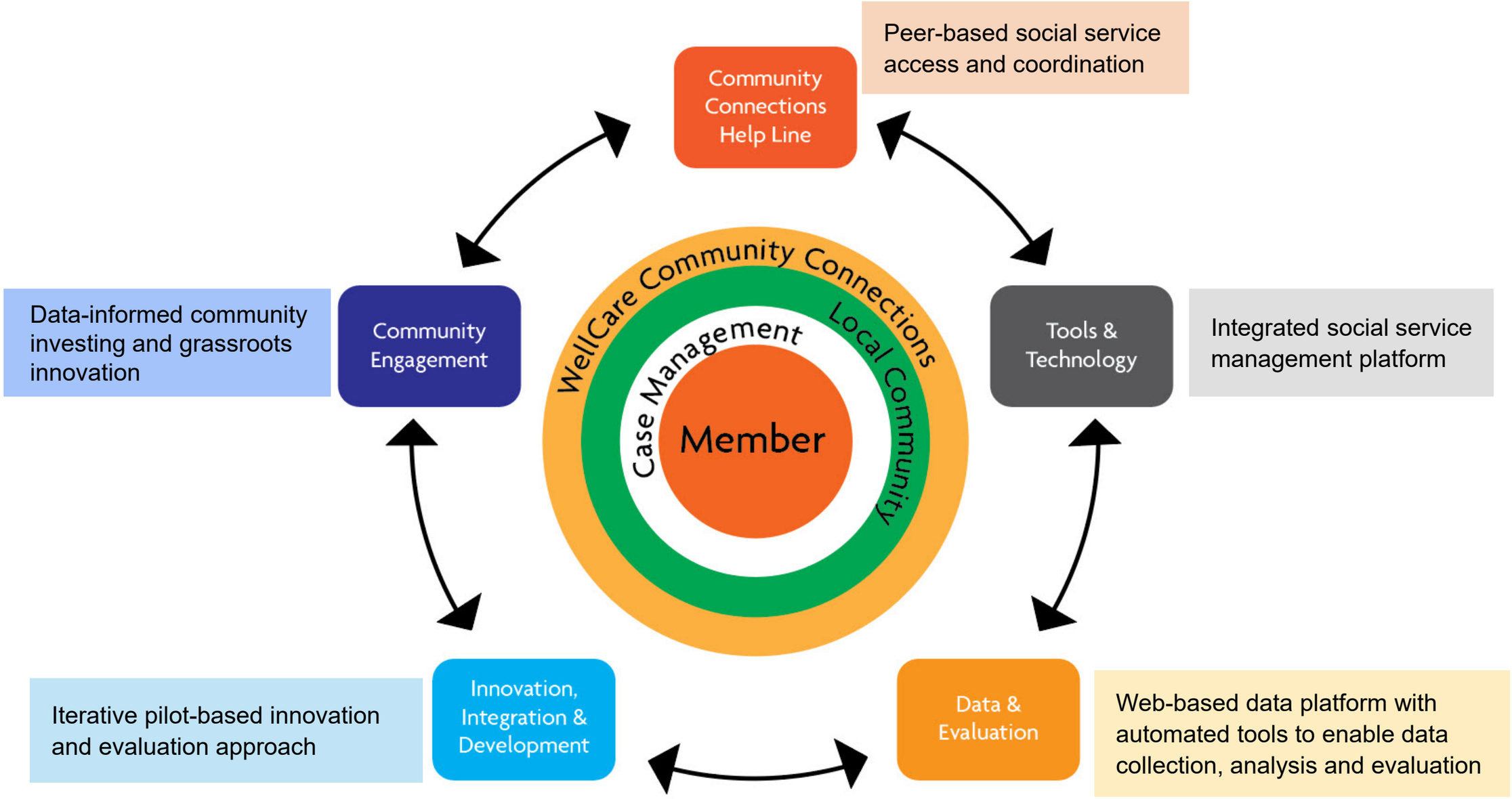

Community Connections Overview

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Community Connections Help Line (CCHL)

National, **peer-based** call center providing member, caregiver and provider support in **removing social barriers through connectivity to national and local resources**. Peer Coaches listen to callers' needs and refer them to existing resources both locally and nationally.

- Represents **diverse cultures** including individuals with disabilities, seniors, caregivers, students, veterans, military families and more
- **First-hand experience** in navigating social services and/or have "lived" the experience
- Expertise in **social needs assessment**, goal setting and action planning to **drive sustainable change and success**
- Fielded an average of **5,075 calls per month** in 2019, yearly total of **69,903 inbound calls** and **45,903 outbound calls**

Community Engagement

Field-based, national reporting team focused on **building grassroots, strategic, and data-informed value-based outcome contracting and community partnerships.** Using the social service data, the Community Engagement Team:

- Identifies when services are needed and then **mobilizes resources to (re)create the needed service**
- Forms **community planning councils** to expand innovative community-based programs or **introduce new programs**
- **Establishes community contracts** to assess impact and pilot new **outcome-focused payment models** with community partners
- Information is **constantly updated and audited** through **local teams** with **boots on the ground**, **deep partnerships** in the community, and **formalized contracts** with community organizations

Community Connections Overview

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Tools & Technology

Integrated social service management platform:

- **Bilateral data exchange** capability allows for **constant-flowing live information**
- Ability to **triage members based on need and risk**
- **Integrated follow-up surveys** help us **gauge participants' satisfaction** with an organization and **ensure closure of needs**

Data & Evaluation

National **data collection and analytics** team focused on:

- Community level data analysis to **help drive decisions around priorities, investment and innovation opportunities**
- Connection to enterprise priorities including **quality outcome data**, **member retention**, **member and provider satisfaction**

Innovation, Integration & Development

National team developing and **implementing innovative pilot programs** focused on **systemic, industry-leading solutions** to drive **social determinant integration** into healthcare. Innovation pilot programs generate the data to **evaluate the impact** in local communities in three ways:

- **Improving health outcomes** and **increasing access to care**
- Reducing avoidable costs by **removing social barriers**
- **Evaluating system effectiveness** leading to social innovation

Programmatic Outcomes: Our Impact

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Improved Access & Health

Compared to demographically similar members, individuals with **social barriers removed through CCHL** are: [1]

4.8x More Likely to Schedule and Attend a PCP Visit

2.4x More Likely to Improve BMI

1.5x More Likely to have Better Diabetes-Related Treatment Compliance

Reduced Cost

Aggregated saving of $2400 per member per year by reducing preventable ER use: [2,3]

53% Reduction in Inpatient Spending

17% Reduction in Emergency Room Use

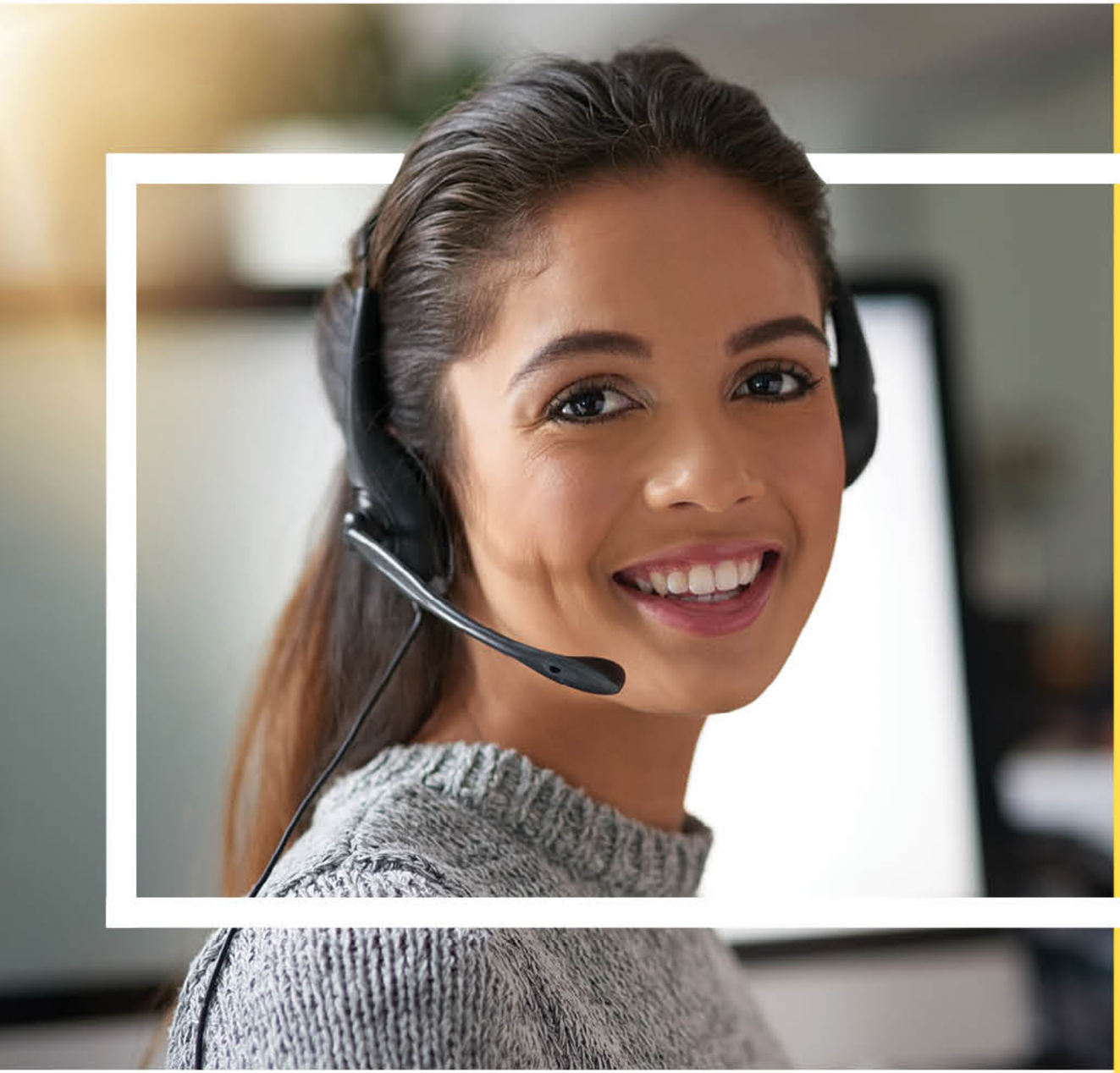
26% Reduction in Emergency Department Spending

Community Innovation

The healthcare savings from removing social barriers are **reinvested back into the community** through **800+** investments designed to increase data-sharing capabilities or sustain critical social services.

References:

1. Quality Data Analytics and Reporting team (QDAR) in Population Health, WellCare; Analysis based on 2017 STAR measures and completed August 2018
2. Expenditure Reductions Associated with a Social Service Referral Program, Pruitt, 2017
3. *Social linkages to cost savings*. Robert Wood Johnson Foundation's Center for Public Health Systems and Services Research at University of Kentucky, Mays, 2016



Community Connections Help Line

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Community Connections Help Line

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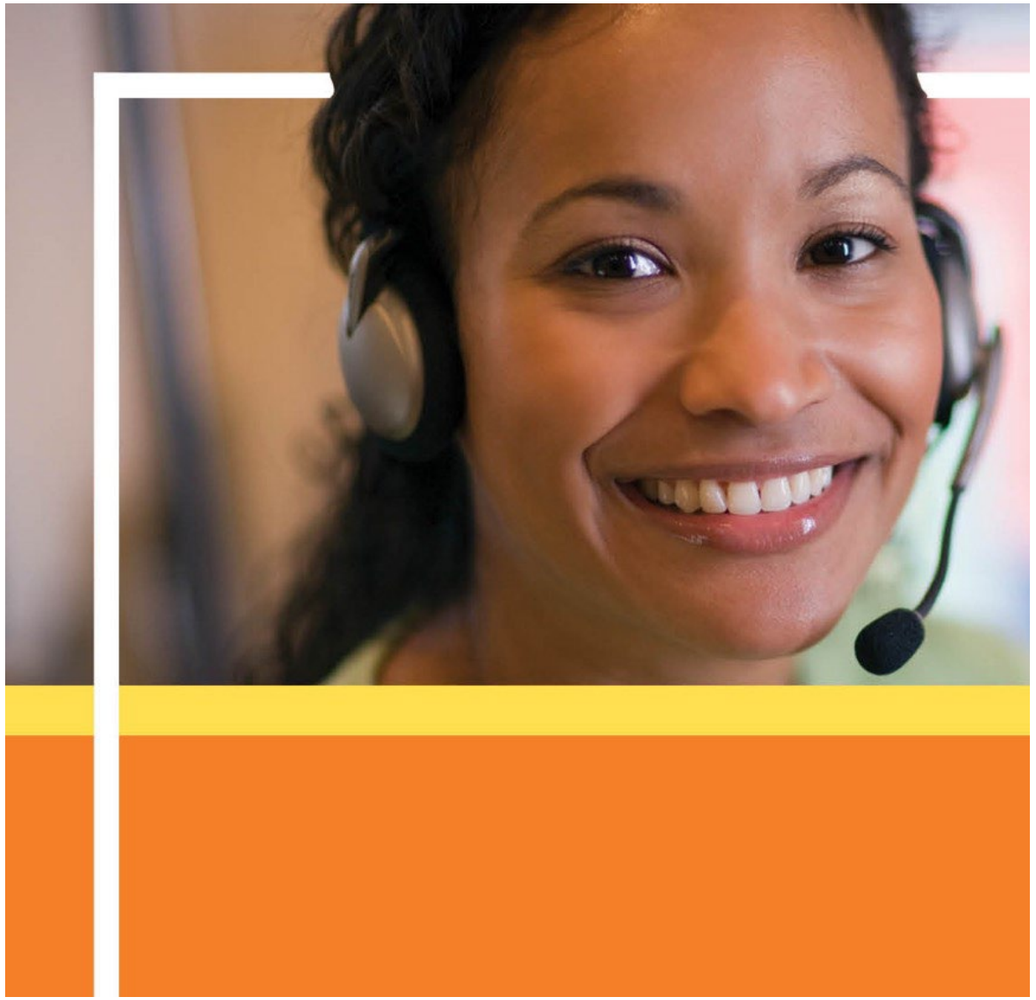
Through WellCare Community Connections, you can connect to a wide range of services that help you live a better, healthier life.

Everyone deserves to live their vest life possible. Yet a lot of things can affect your ability to do that. A phone call to our Community Connections Help Line cab connect you with services. Plus it's here for WellCare members, non-members and caregivers. Our Peer Coaches will listen to your needs and refer you to existing resources all over the country or right in your local area.

Call to get the help you need: 866-775-2192

Get connected with the right social services, including:

- Financial assistance (utilities, rent)
- Medication assistance
- Housing services
- Non-medical transportation
- Support groups
- Food assistance
- Affordable childcare
- Job/education assistance
- Family supplies – diapers, formula, cribs, and more



Community Connections Help Line

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Abuse Support Service
Adult Day Activity Center
Advocacy
Affordable Child Care
Area Agency on Aging
Cancer Support Services
Cardiology-specific Support Service
Center for Independent Living
Child Welfare-related Service
Clothing Assistance
Community Center
Community Service / Volunteers
Community-based Prenatal Program
Condition-specific Support Services
Health Department
Disability Housing

Disability-related Advocacy
Disability-related Service
Domestic Violence
Drug Addiction / Substance Abuse
Early Intervention
Education Assistance
Elder Assistance
Emergency Response / Emergency Preparedness
Employment Assistance
Endocrine-specific Support Service
Faith Based General Support Service
Family Support Service
Financial - Rent assistance
Financial - Utility assistance
Financial Assistance
Food Pantry / Mission / Food Program

Free / Reduced Health Care - Dental
Free / Reduced Health Care - Equip
Free / Reduced Health Care - Hearing
Free / Reduced Health Care - Medical
Free / Reduced Health Care - Vision
Free Cell Phone Program
Health Literacy Program
Healthy Start Program
HIV/AIDS-related Service
Home Health Care
Homeless Service
Housing
ID/DD-related Support Service
Legal Assistance
Literacy
Local Government

Mental Health - Adults & Children
Parenting Service
Pulmonary-specific Support Service
Respite - Home based
Respite - Site based
School based supports
SNAP/WIC
Teen Pregnancy-related Education
Thrift store
Transitional Housing
Transportation Support - General
Transportation Support - Medical
Veteran's Service
Youth Support Service

Community Impact in KY

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In 2019, **12,507** community members in Kentucky received **51,813** social service referrals through the Community Connections Model.

Top Referral Categories:

1. Food Pantry
2. Medical Transportation
3. General Transportation
4. Utility Assistance
5. Clothing Assistance

Among the community members who received social service referrals:

- 11.6% were WellCare Medicare or PDP members
- 77% were WellCare Medicaid members
- 12.2% were not WellCare members

Community Connections Outcomes

When compared to demographically similar members in Kentucky, those individuals with their social barriers removed are more likely to improve their health and access care across several key areas, including:[#]

5.5X More Likely to Have an Annual PCP Visit

1.4X More Likely to Improve HbA1C Results

1.7X More Likely to Improve their Functional Status

Of the Kentucky members with a CCHL interaction surveyed, 50% stated that they would recommend WellCare to a friend or family member. Among the general Kentucky membership, this rate was 54%.

*2019 Kentucky Member Analysis; [#]2017 Star Measures preformed by WellCare's Quality Data Analytics and Reporting Team; WellCare members with identified social needs were compared to a sample of WellCare members within the same demographic groups and geographic area who had no identified social needs.

Community Collaborations

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HOTEL INC
Helping Others Through Extending Love In the Name of Christ

COMMUNITY SHIELD
Reducing the Impact of Violence on Children.

safetynet alliance™ OF NORTHERN KENTUCKY

SP CK Suicide Prevention Consortium of Kentucky

Dare to Care Food Bank

ORSPC Owensboro Regional SUICIDE PREVENTION Coalition, Inc.

OCA

COALITION FOR THE HOMELESS

Eastern Area Community Ministries

WELCOME HOUSE NORTHERN KENTUCKY
HOMELESS TO HOME

Housing Development Alliance, Inc.

BRIGHT Coalition

Kentucky Homeplace

Prevent Child Abuse Kentucky™

Community Impact Councils

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Community Impact Councils

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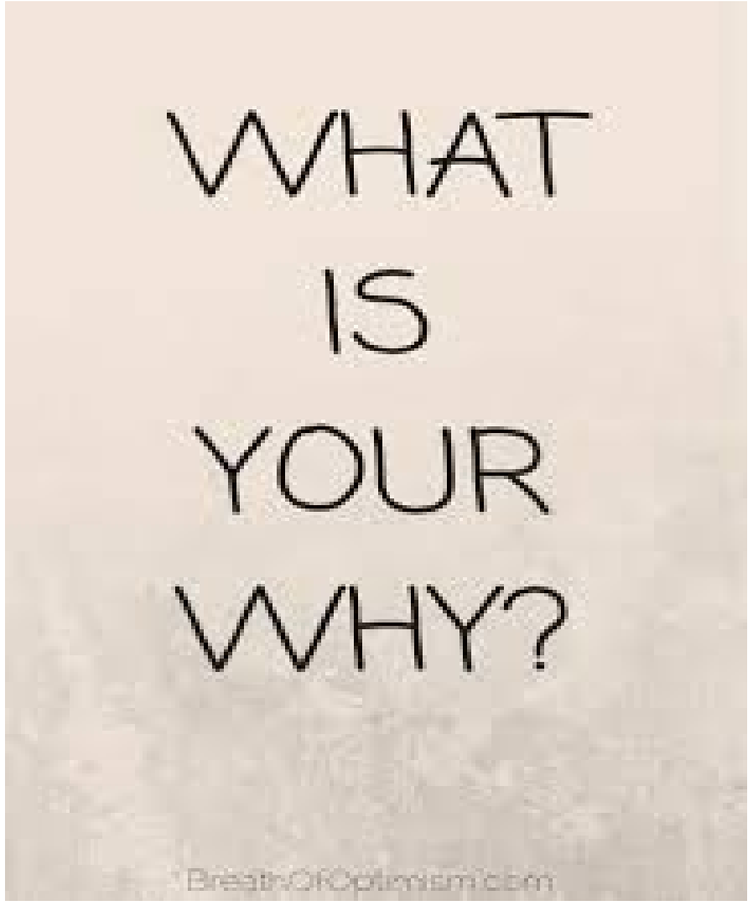
- Bring community members together from diverse sectors to talk about resources and needs
- The group works together to create and implement a project to help fill the gap.
- Collectively and collaboratively work on opportunities for improvement
- Provide community driven solutions to local problems
- Community driven solutions are more likely to create sustainable change



Community Impact Councils

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Meetings 1 and 2 - Understand the community's existing social service and public assistance programs then determine the most urgent needs/gaps in those services by:

- Identifying community strengths and needs/gaps by utilizing available quantitative data (i.e., County Health Rankings) and qualitative data (i.e., knowledge of community partners).

- Identifying current efforts to address community needs/gaps.

County Health Rankings & Roadmaps
A Healthier Nation, County by County

Kentucky - Kenton	KentonCounty	Kentucky	Top U.S. Performers*	Ranking out of 120
Health Outcomes				19
Mortality				29
Premature death	8,076	8,768	5,317	
Morbidity				11
Poor or fair health	16%	21%	10%	
Poor physical health days	3.8	4.8	2.5	
Poor mental health days	3.9	4.3	2.4	
Low birthweight	8.4%	9.1%	6.0%	

Community Impact Councils

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- **Meetings 1,2,3** – Identify need/gap (i.e., transportation, improved nutrition, homelessness).
- **Meetings 2,3** - Identify partnering opportunities to help fill the chosen need/gap.
- **Post CIC** - Development of a project or program to help fill the need/gap.

Community Impact Councils

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CDC Model of Effective Community Planning

Commitment: involves assembling a coalition of members to address key issues and establish partnerships with those other agencies. Coalitions and Partnerships give those members ownership of the process and a give the group a potential pool of resources.

Assessment: involves gathering data and input on what the community needs. Strategies must reflect the needs of the community to have a sustainable impact.

Implementation: executing the plan your team has collectively and collaboratively developed. Implementation requires maintenance of the commitment and ownership.

Evaluation: is woven through the process, whether formal or informal, gathers lessons from what you are doing and provides recommendations that inform key decision making in the future.

Community Impact Councils

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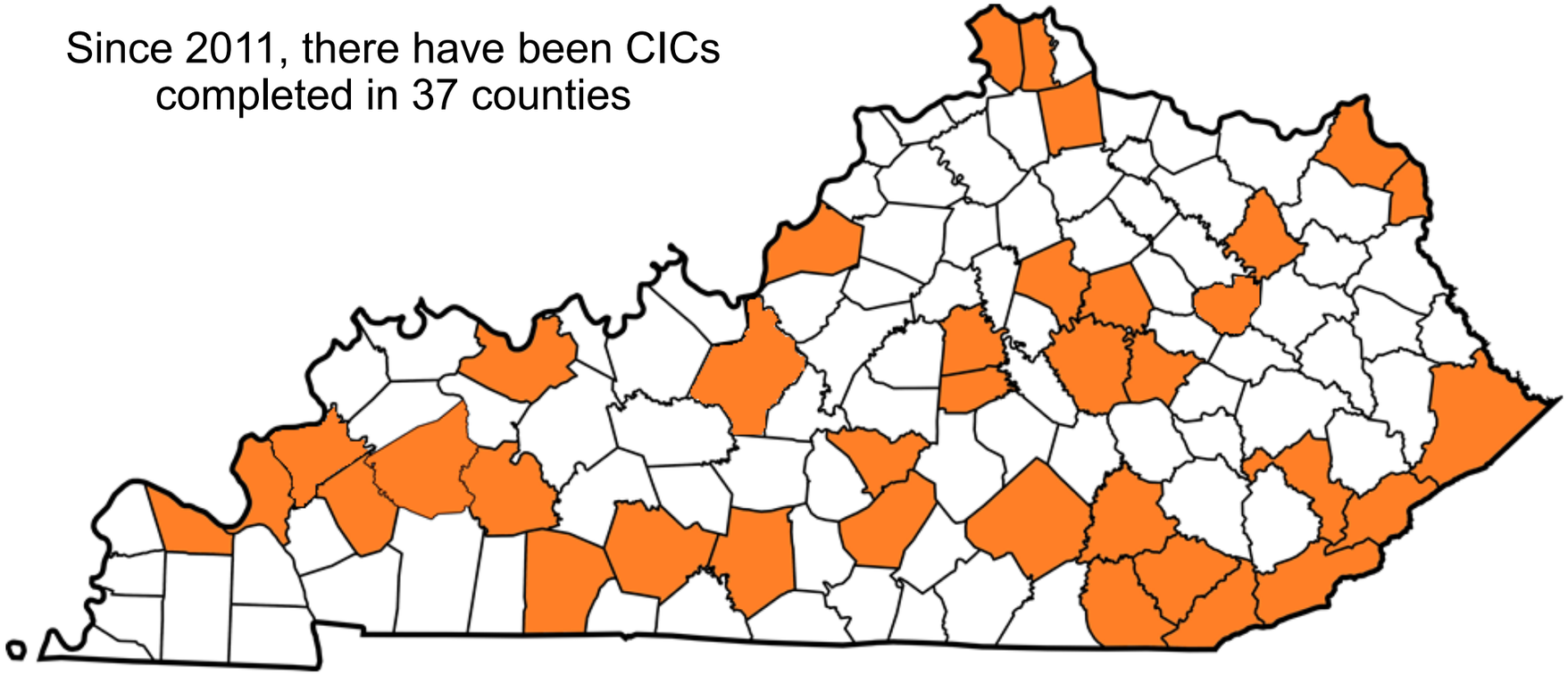
Since 2011, there have been CICs completed in 37 counties



Adair, Barren, Bell, Boone, Boyd, Boyle, Caldwell, Clark, Crittenden, Daviess, Estill, Fayette, Greenup, Hardin, Harlan, Hopkins, Jefferson, Kenton, Knox, Laurel, Letcher, Livingston, Logan, Madison, McCracken, Menifee, Mercer, Muhlenberg, Nelson, Pendleton, Perry, Pike, Pulaski, Rowan, Taylor, Warren, and Whitley Counties.

Community Impact Councils

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Where: Kenton County

When: 2019

Who: Welcome House, Women's Crisis Center, Public Library, Public Schools, UK Targeted Assessment Program, etc.

Gap: Homelessness/Housing

Why: Discussion with Welcome House highlighted the needs around homelessness in the area; County Health Ranking Data

Project: Group created an infographic flyer to increase education around the average housing price vs. income within the county

Community Impact Councils

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Where: Montgomery County

When: 2019

Who: Mayor(s), Chamber of Commerce, Gateway Community Action Agency, Sterling Health; St. Joseph, Food Pantry, etc.

Gap: Transportation

Why: Strong relationships in this area; Gap requests for this county

Project: Partnership with Community Action, funding from the city, and grant application to begin public transportation pilot for the county

Community Impact Councils

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Where: Boyd/Laurel/McCracken Counties

When: 2019

Who: DCBS, UK Targeted Assessment Program, Community Action Agency, Foster Parents, CASA, etc.

Gap: Foster Care

Why: Targeted CICs organized as a result of partnership with Orphan Care Alliance (OCA) due to need of resources and supports for foster parents/families

Project: OCA was able to expand connections in each territory with community partners and kick-off events were held to provide education around foster care

Community Impact Councils

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Where: Crittenden County

When: 2018

Who: Pennyrile District Health Department, UK Extension, Pennyroyal Center, Pennyrile Allied Community Services, FRYSC, Crittenden County Counseling

Gap: Family Supports – Grandparents raising Grandchildren

Why: Group identified primary need in the area was supports and education for Grandparents raising Grandchildren

Project: Series of school-based community education sessions designed to increase knowledge/training sets for Grandparents

Community Impact Councils

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Where: Mercer County

When: 2018

Who: Bluegrass Community Action, Mayor, UK Extension Agent, United Way, Salvation Army, FRYSC, etc.

Gap: Transportation

Why: Group identified primary need as transportation; Gap requests for this county

Project: Partnership with Community Action that supported Bluegrass Ultra-Transit Service to provide transportation to WIC appointments, local colleges, IEP/ARC meetings at schools, Adult Education, extension office programs; Following year this partnership expanded to the full nine county service area

Community Partnerships

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Pennyrile Allied Community Services

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Between 7/1/2017 and 3/31/2019, **1,614** WellCare Members received **36,969** total services.

Among the participants included in pre-post analysis, the average age was **50.2** years old and **62.4%** were female.

On average, members who accessed Pennyrile Allied Community Services, Inc. (PACS) have:

3.5 chronic diseases, including:

- **66.2%** diagnosed with hypertension
- **34.1%** diagnosed with asthma
- **35.9%** diagnosed with diabetes
- **31.4%** diagnosed with obesity

1.5 behavioral health issues, including:

- **42.8%** diagnosed with depression
- **53.4%** diagnosed with some other mental illness
- **18.0%** diagnosed with severe mental illness
- **12.4%** diagnosed with bipolar disorder
- **16.2%** had substance abuse issues

The following **reduction** in healthcare **utilization** and **improvement** in some health **outcomes** were observed in the one-year post interaction in members who had diabetes *

- **12.6%** reduction in emergency room visits.
- **41.4%** reduction in non-emergent emergency visits.
- **38.9%** reduction in inpatient admissions and **36.3%** reduction hospital stay days.

In members with asthma, the following was observed:

- **43.2%** reduction in inpatient admissions.
- **63.%** reduction in hospital days.
- **72%** reduction in visits related to asthma exacerbations.

Among other members, the following was observed:

- **19%** reduction in visits related to COPD exacerbations.
- **42%** reduction in visits related to acute lower respiratory infections.

*One year pre and post interaction analysis was performed on members with an initial interaction date between 07/01/2017 and 01/31/2018.

May 2019

Team Ultra

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Between 9/1/2016 and 1/6/2019, **136** students received **2,441** total services.

The top services received were school based supports, free and reduced cost dental care, county or community health department offered services, endocrine-specific support service and supplemental nutrition assistance program.

Among these participants, the average age was **11.5** years old and **46.8%** were female.

On average, WellCare members who participated in Team Ultra have:

0.72 chronic conditions, including:

10.1% diagnosed with asthma

5.0% diagnosed with obesity

0.6 behavioral health issues, including:

10.1% diagnosed with depression

19% diagnosed with some other mental illness

30.4% diagnosed with severe emotional disorder

2.53% diagnosed with bipolar disorder

The following **reduction** in healthcare **utilization and costs** and **improvement** in some health **outcomes** were observed in one-year post interaction.*

35.9% reduction in emergency visits.

32.5% reduction in non-emergent emergency visits.

98.3% increase in routine child health exams.

81% reduction in visits related to acute lower respiratory infections.

*One year pre and post interaction analysis was performed on members with an initial interaction date between 9/1/2016 and 01/30/2018.

May 2019

HOTEL INC.

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Between 8/1/2016 and 1/31/2019, **859** WellCare Members received **14,743** total services, or **17** services per person.

The top services received were homeless service, food pantry, free or reduced cost health care, housing, education and employment assistance and transportation assistance.

Among these participants, the average age was **43.7** years old and **68%** were female.

On average, members who accessed Hotel Inc. have:

3.1 chronic diseases, including:

- **46%** diagnosed with hypertension
- **35.4%** diagnosed with asthma
- **22.5%** diagnosed with diabetes
- **61.9%** diagnosed with obesity

1.6 behavioral health issues, including:

- **43.4%** diagnosed with depression
- **55.3%** diagnosed with some other mental illness
- **7.6%** diagnosed with severe mental illness
- **17.9%** diagnosed with bipolar disorder
- **31.1%** had substance abuse issues

A **reduction** in healthcare **utilization** was observed in one-year post interaction.*

- **10.5%** reduction in emergency room visits.
- **18.4%** reduction in flu related visits.

** One year pre and post interaction analysis was performed on members with an initial interaction date between 02/2017 and 01/30/2018.*

May 2019

Kentucky Homeplace

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During this partnership, **1,903** WellCare Members received **9,066** total services.

The top services received were health literacy, free or reduced cost health care, food pantry and utility assistance.

Among these participants, the average age was **59.4** years old and **68.4%** were female.

On average, members 45 years and older have:

4.1 chronic diseases, including:

- **81.4%** diagnosed with hypertension
- **44.1%** diagnosed with asthma
- **49.4%** diagnosed with diabetes
- **57.4%** diagnosed with obesity

1.4 behavioral health issues, including:

- **42%** diagnosed with depression
- **62.3%** diagnosed with some other mental illness
- **15.7%** diagnosed with severe mental illness
- **30%** had substance abuse issues

A sizable **reduction** in healthcare **utilization** was observed in one-year post interaction.*

- **10.3%** reduction in emergency room visits and **12.9%** reduction in non-emergent ER visits.
- **23.3%** reduction in inpatient admissions and **27.6%** reduction in inpatient days.

The reductions are greater among groups with a variety of chonic conditions.

In members who had diabetes, there was a **16.4%** reduction in ER visits, a **28.9%** reduction in inpatient admissions, and a **31.5%** reduction in inpatient days.

In members who had asthma, there was a **10.7%** reduction in ER visits, a **15.5%** reduction in non-emergent ER visits, a **19.3%** reduction in inpatient admissions, and a **19.3%** reduction in inpatient days.

In members who had asthma and diabetes, there was a **22.7%** reduction in non-emergent emergency visits.

In members who had COPD, there was a **32%** reduction in visits related to acute lower respiratory infections.

In members who had asthma, there was a **15.2%** reduction in visits related to asthma exacerbations.

**One year pre and post interaction analysis was performed on members 45 years and older with an initial interaction date between 12/30/2016 and 12/30/2017.*

April 2019

KY Team Coverage Area

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Community Engagement Partner Contact Information

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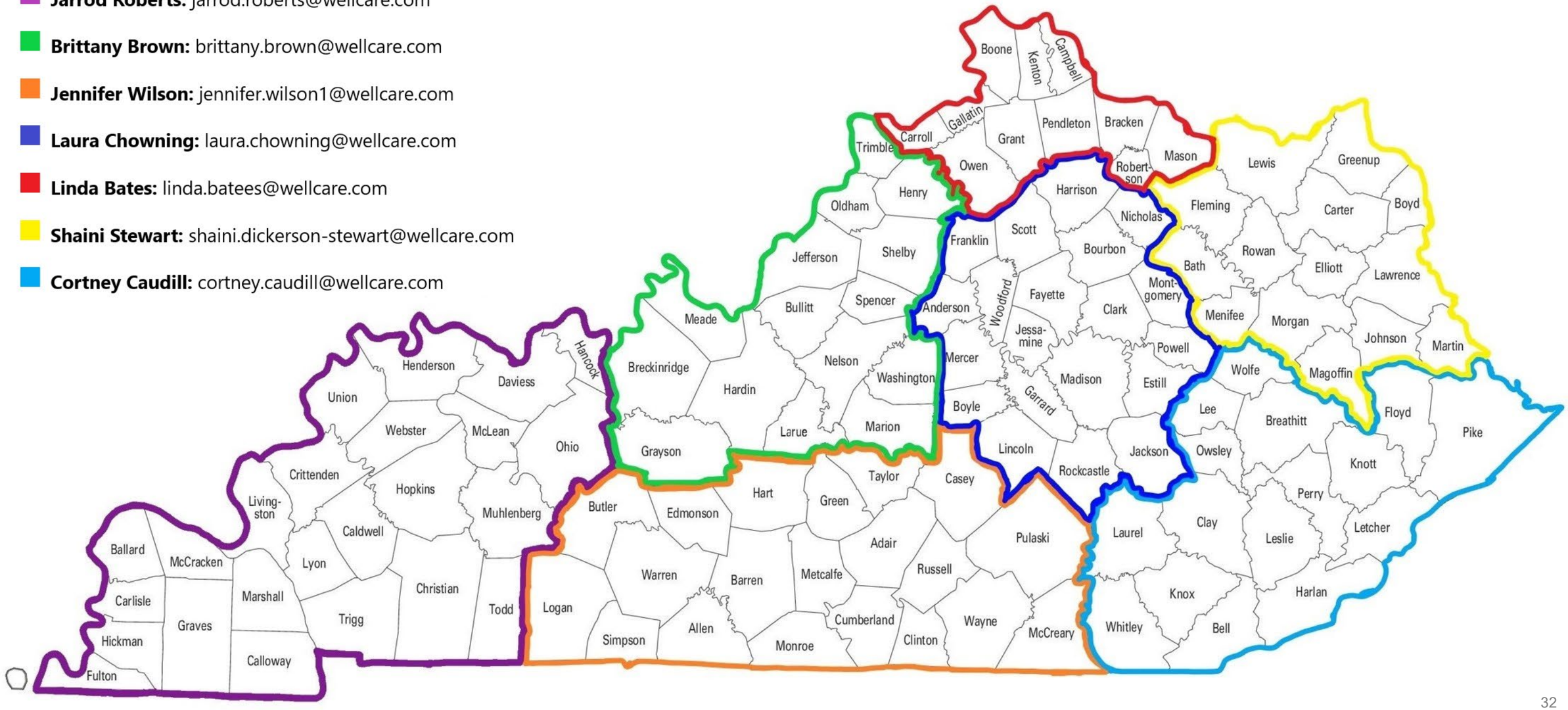

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Questions?

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