WellCare of Kentucky’s Quest for Quality
We have six offices throughout the Commonwealth staffed with Provider Relations Representatives and Case/Disease Managers that live in those communities to service the needs of members and providers.
Our approach to Quality is four-pronged. It is built on fostering partnership and working collaboratively with providers, members, the community and State to improve health outcomes.

**Providers**
- Manage members’ care
- Provide tools to assist providers
- Assist in coordinating members’ care

**Members**
- Educate members
- Assist in coordinating care and removing barriers to care

**Community**
- Bring community advocates together to serve members needs
- Identify member social resources

**State**
- Find solutions for State-wide issues and barriers to care

Improved Health Outcomes
Our Provider Focus

Provider Tools
• Identification of care gaps at eligibility checks

https://kentucky.wellcare.com
Provider Profile Report

WellCare of Connecticut, Inc.

**PROVIDER RATES BY PROVIDER ID**

8/27/2010

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<thead>
<tr>
<th>Provider Name</th>
<th>Provider ID</th>
<th>Address</th>
<th>Phone</th>
<th>Provider</th>
<th>Health Plan</th>
<th>Health Plan Goal</th>
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**Measures**

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<th>Provider Rate</th>
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Key - RED: < 10% from Goal  ORANGE: 5-10% from Goal  GREEN: > 5% from Goal or above Goal
Provider Care Gap Report

WellCare of Connecticut, Inc.

Noncompliant Member Report by Provider ID

8/27/2010

Provider Name: ROON, Inc, A058CT, H.A.
Provider ID: 107874
Address: 4099 MAIN ST, STE 100
BRIDGEPORT, CT 06604
Phone: (203) 311-2600, FAX (203) 311-454

<table>
<thead>
<tr>
<th>Member ID</th>
<th>Member Name</th>
<th>Phone</th>
<th>Sex</th>
<th>DOB</th>
<th>Colon Cancer Screen</th>
<th>Diabetes LDL-C Test</th>
<th>Diabetic Eye Exam</th>
<th>Diabetes HbA1c Test</th>
<th>Glaucoma Eye Screen</th>
<th>LDL-C Test</th>
<th>Mammogram</th>
<th>Preventive Visit</th>
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Closing care gaps improve health and provide revenue opportunities for providers.
Incentives to PCPs to close care gaps

• Specific preventive health measures are selected
• Members are identified as not previously receiving the preventive service and still needing it
• PCPs are rewarded for completing needed services if they meet a certain level of results
• Additional source of revenue for the providers and improves members health and quality of life
Case and Disease Management

Member-Centered Case and Disease Management

- Member and caregiver-centered model
- Service Coordination
  - Proactive and collaborative face-to-face outreach and assessment
  - Discharge Planning
  - Matching members needs with most appropriate provider and/or setting.
- Driving Interdisciplinary Care Teams
- Integrating care for members
- Holistic Management
  - Home & Community-Based
  - Behavioral Health
  - Pharmacy
  - Medicare and Medicaid
- Culturally Competent
  - Services in multiple languages
  - Understanding and sensitivity to subcultural norms and preferences
Emergency Department Diversion

• Identify members monthly who have had multiple visits to the ER for non-urgent conditions
  • Assigned a Case Manager for outreach
  • Assess the member for transportation issues, connectivity to a PCP, social barriers, etc.
• Identify members who have pulmonary disease, such as COPD and emphysema, and have been admitted to the hospital for these conditions
  • Assigned a Case Manager to outreach the member
  • Assess the member to identify their individual needs
    • Help scheduling follow-up appointments
    • Help getting the appropriate medications
    • Educating the member about their disease and appropriate treatment
• Identify members as obese through Health Risk Assessments and claims information
  • Assigned a Case Manager to outreach the member
  • Assess the member to identify their individual needs
  • Work with our Community Advocacy Program to find weight management resources and access to healthy food choices
• Educate members on healthy ways to improve nutrition and physical activity
• Identify members who have severe mental illness and 5 or more chronic medical conditions through claims information
  • Assigned a Case Manager and Social Worker work in collaboration to outreach the member
  • Assess their individual needs
  • Work with their providers to ensure needs of the mental illness and medical conditions are addressed
Our Community Focus

What are the physicians saying?

According to a study by the Robert Wood Johnson Foundation, 85% of surveyed physicians say unmet social needs are directly leading to worse health.

In addition, 4 in 5 physicians say the problems created by unmet social needs are problems for everyone, not only for those in low-income communities.

The County Health Rankings show that much of what affects health occurs outside of the doctor’s office.
How do we overcome these barriers?

- Educate members at community activities
  - Community Activity Tracker
- Bring the community, community advocates, members, providers, and the Health Plan together to serve members’ needs
  - Regional Health Connections Councils
- Identify a network of Social Safety Net organizations
  - My Family Navigator
- Connect members to Social Safety Net organizations that meet their specific needs
  - Health Connections Log
- Compile a library of community-specific data to identify potential areas of need
  - WellCare in the Neighborhood
- Support the needs of the communities our members live in
  - WellCare Innovation Institute
The community engagement model centers on the Social Safety Net while centralizing and automating the following through the Community Command Center:

- **Community Activity Tracker**: A tracking process for all community activities
- **My Family Navigator**: A database of the network of Social Safety Net organizations
- **HealthConnections Log**: A referral tracking log
- **WellCare in the Neighborhood**: A library of community data (health stats, census/demographics, etc.)
- **WellCare Innovation Institute**: WellCare’s fundraising and community investment arm.

The following are the social service-related outcomes of the pilot:

### HealthConnections Log
- From a pilot population of 5,600 members, 1,700 (30.4%) members were referred to 2,000 services.

### My Family Navigator
- WellCare identified and closed more than **85** gaps in the network of social support programs.
- The Navigator database grew to more than 8,000 entries across 40 different categories of services.
A family of six living in subsidized housing.
- Mom and Dad work full time without health benefits.
- 10-year-old son has special needs.
- 19-year-old daughter is pregnant.
- 73-year-old grandmother has dementia.

WellCare connected the family to the following:
- Health Care (along with condition-specific healthcare)
  - In-home services for grandmother
  - Prenatal care for the daughter
- Social Supports
  - WIC / SNAP support
  - Rental / Housing assistance
  - Adult day activity program for grandmother
  - CIL-based independence training for the son
  - Caregiver training through National Caregiver Assoc.

WellCare found and closed gaps in the following:
- Utility assistance
- Peer supports for the daughter
- Transportation assistance for mother / daughter

The Community Advocacy Response

What makes us different is that WellCare has created a function to ensure that information for referrals to social programs is readily available for the interdisciplinary team (My Family Navigator) and that the programs are still available.

The local community advocates:

- Identified faith-based LIHEAP-related programs that required funding because utility-based LIHEAP had closed.

- Created peer-support group at the local school with provider-partner to address teen pregnancy.

- Connected family to local United Way for their subsidized car loan program to ensure that the daughter could get prenatal care.
Summary

- WellCare employs a multi-pronged approach to improve quality
- Interventions to improve quality include:
  - Provider Incentives
  - Case and Disease Management Programs
  - Implementation of pilot programs to targeted groups and conditions
  - Targeted focus on inappropriate utilization of services
  - Connections with communities and available community resources

These efforts provide:
- An opportunity for increased revenue for providers
- More appropriate use of services
- Increased health and outcomes for the membership we serve
Questions?