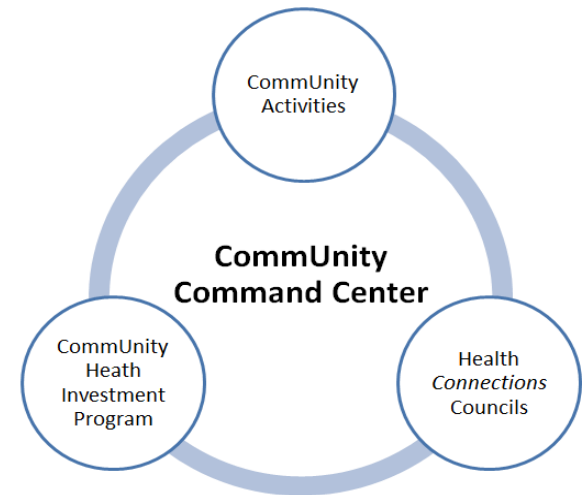


Health *Connections* Model



WellCare strives to address community health needs and eliminate social barriers to accessing healthcare while quantifying the impact of the social safety net on health outcomes.

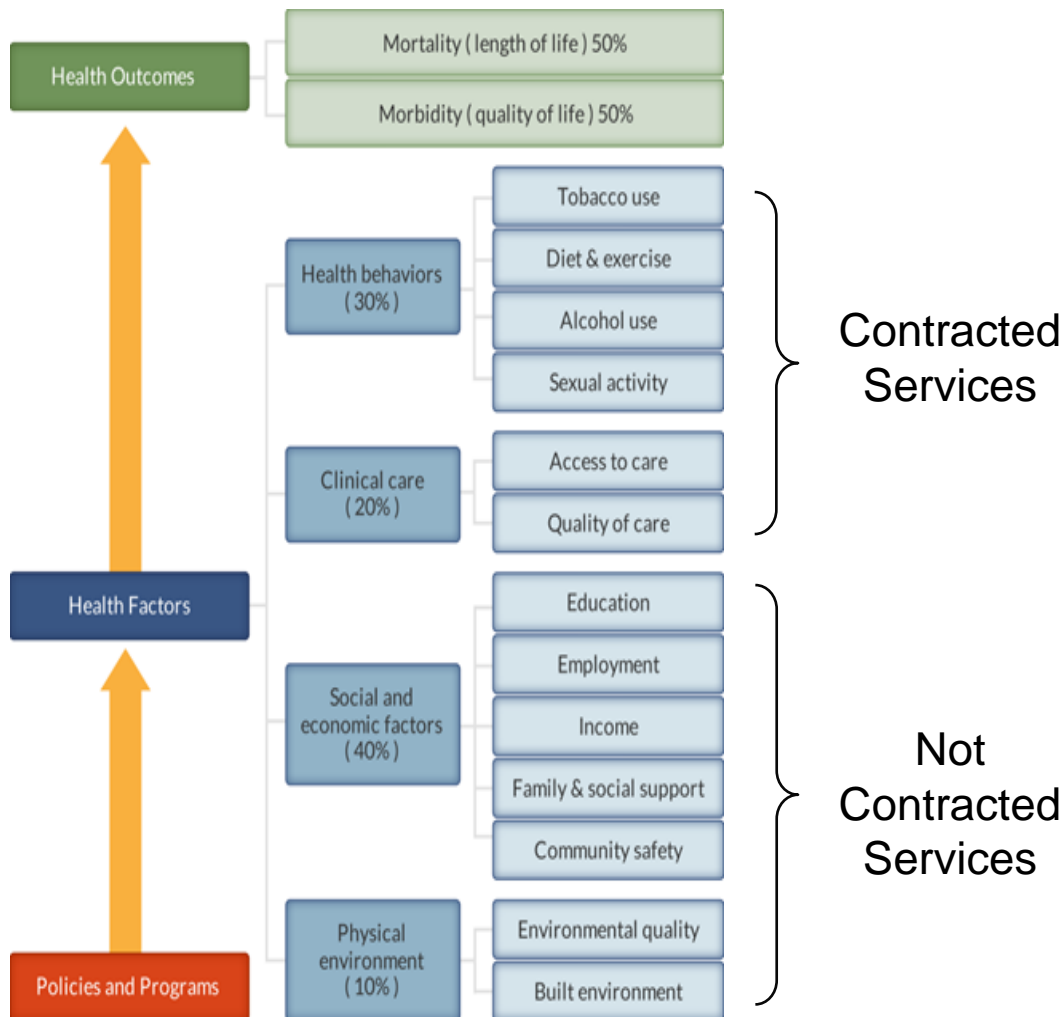
In essence, we're creating a safety net for the social safety net.

The HealthConnections Model has four complementary elements:

- **CommUnity Activities**: Community-based health and wellness events.
- **HealthConnections Councils**: Community planning councils focused on sustaining the social safety net.
- **CommUnity Health Investment Program**: Grants for program innovation.
- **Social Service Utilization Support**: Facilitating member connections to social services and bridging gaps in service availability.



WellCare Addresses All Health Factors Leading to Positive Health Outcomes



Community Advocacy

Social and economic factors create barriers to positive health outcomes.

To address member needs and strengthen the communities we serve, Community Advocacy identifies gaps in the social safety net and works with local communities to fill the gaps.

CommUnity Command Center

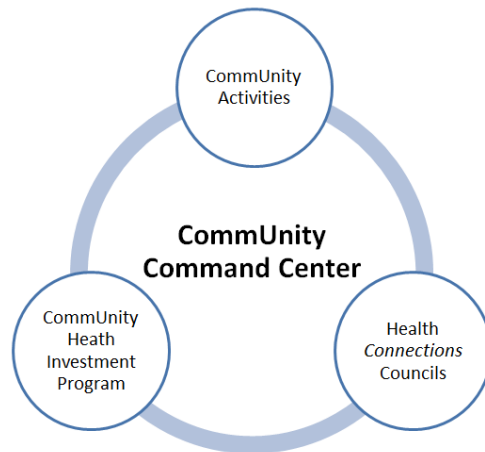
A collection of databases are used to refer members and their families to community-based programs and services, such as food banks, shelters, parenting classes.

It contains information on:

- Social Services
- Community activities
- Health/wellness programs
- Community Health Investments

Overview

- In 2011, WellCare launched HealthConnections in response to national social service funding cuts
- Two distinct elements
 - Technical platform with automated tools
 - Community-based, micro-level engagement

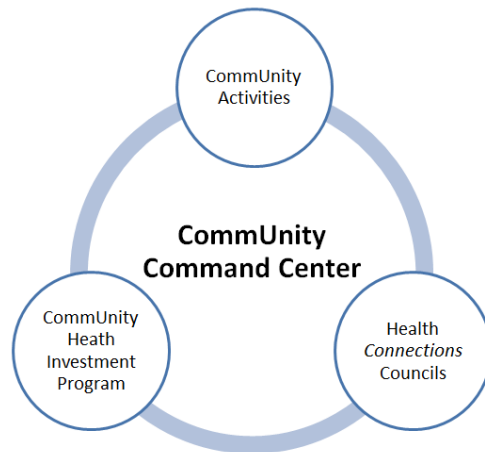


Here's How It Works:

- Social Service Referral Tracking: WellCare links members to social services and tracks each referral within a social service electronic health record
- Community Engagement: Using the referral data, WellCare:
 1. identifies and closes gaps in the social safety net;
 2. forms community planning councils to leverage innovative community-based programs or introduce new programs;
 3. creates CommUnity Health Investment Programs to pilot payment models with community partners.
- Evaluation: These activities generate the data on which we evaluate the impact of social services in two ways:
 1. Social delivery system effectiveness
 2. Health outcomes: cost and quality of care

Overview

- In 2011, WellCare launched HealthConnections in response to national social service funding cuts
- Two distinct elements
 - Technical platform with automated tools
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Key Data Points

- Social Services Catalogued: 177,000
- Social Service Referrals: 36,000 people : 114,000 services
 1. 13.5% - Food Pantry / Mission / Food Program
 2. 13.5% - Medication Assistance
 3. 11.3% - Transportation
 4. 10.8% - Utility Assistance
 5. 7.5% - Financial Assistance
- Total Social Service Accessed: 28%
- Network Gaps Filled: 3,500
 1. 16.0% - Transportation
 2. 11.0% - Utility Assistance
 3. 9.0% - Low Cost Dental Care
 4. 8.0% - Financial Assistance
 5. 7.0% - Housing

Homeless Healthcare Partnership Highlights

- Those experiencing homelessness are three to four times more likely to die prematurely than their housed counterparts; the average life expectancy is 50.
- In 2014, WellCare funded six months of the brand new Hotel, Inc. Street Medicine Program, allowing two staff to travel to Pittsburgh to shadow Dr. Jim Withers and learn from the man most widely credited with being the Father of Street Medicine in the United States.
- After a four year partnership with WellCare, Hotel, Inc. has gained enough experience that they are now being sought out to provide mentorship to other organizations.
- When social services are accessed, it creates a \$450 savings to the healthcare system as a whole.

Kentucky Street Medicine: An Overview

WellCare engaged with three organizations with a combined presence spanning Kentucky to connect homeless WellCare members with healthcare access and WellCare case managers.



- Over 2,200 homeless individuals were connected with.
- 281 WellCare members were connected with and 122 were referred to case managers.
- 76 individuals have been moved into housing. For many of individuals who have been housed, their overall health has improved.



- Teams conducted 561 health assessments, screenings and wellbeing checks.
- Individuals with copays were given co-pay vouchers for care: physician (32), pharmacy (21), dental (14), vision (2) and transportation (70).
- 32 individuals utilized KYnector to obtain health benefits.



- Studies have shown that the total service cost for homeless individuals drops by 50% after the first six months of being housed.¹
- Within 12 months of living in supportive housing situations, the rate of use of hospital medical services falls by more than half and residential mental health program use virtually disappears.²

1. Health Care and Public Service Use and Costs Before and After Provision of Housing, University of Washington
2. Supportive Housing and Its Impact on the Public Health Crisis of Homelessness, Corporation for Supportive Housing

CommUnity Liaison Program

Team of peer-support coordinators hired through workforce innovation programs to find and catalogue community-based programs and services.

- Annual cost: \$11,000 per Liaison
- Team represents many diverse cultures including individuals with disabilities, seniors, caregivers, students, veterans / military families and so on
- Less than \$500 a year per person for any special accommodations
- More than 75% of all CommUnity Liaisons transitioned to full time employment
- First-hand experience in navigating social services

CommUnity Assistance Line:

- Launched in September 2014
- Respond to 3,900+ calls per month
- Referred nearly 26,000 people to 85,000+ services
- Average 3 referrals per person with 29% access rate

