
WellCare®
Health Plans
HERITAGE
HEALTH

2017 Minority Health Conference

Social Economics & Environment Matters

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This data summary reviews key findings from an online survey of 1,000 American physicians in the American Medical Association Masterfile who agreed to be invited to participate in the survey, of which 690 were primary care physicians and 310 were pediatricians. The survey was conducted by Harris Interactive between September 16 and October 13, 2011, on behalf of the Robert Wood Johnson Foundation, and there findings provided in the document ‘Health Care’s Blind Side.’

Summary of Findings

- Currently many physicians do not have the time or sufficient staff support to address patients' social needs — such as access to nutritious food, transportation assistance and adequate housing — even though these needs are as important to address as medical conditions.

- Physicians feel so strongly about the connection between social needs and good health that 3 in 4 physicians surveyed (76%) wish the private/public health plans would pay for costs associated with connecting patients to services that address their social needs.

Summary of Findings

- A national survey reveals that physicians believe unmet social needs are directly leading to worse health for Americans — and that patients' social needs are as important to address as their medical conditions.
- Medical care alone cannot help people achieve and maintain good health if they do not have enough to eat, live in a dilapidated apartment without heat or are unemployed.
- Physicians report that their patients frequently express health concerns caused by unmet social needs beyond their control.

4 in 5 physicians surveyed (85%) say unmet social needs are directly leading to worse health.

In addition, 4 in 5 physicians (87%) say the problems created by unmet social needs are problems for everyone, not only for those in low-income communities.

4 in 5 physicians surveyed (85%) say patients' social needs are as important to address as their medical conditions. This is especially true for physicians (more than 9 in 10, or 95%) serving patients in low-income, urban communities.

Specifically, 3 in 4 physicians surveyed (76%) wish the health care system would cover the costs associated with connecting patients to services that meet their social needs if a physician deems it important for their overall health.

Physicians wish they could write prescriptions to help patients with social needs.

Physicians in this survey reported that if they had the power to write prescriptions to address social needs, such prescriptions would represent approximately 1 out of every 7 prescriptions they write would be on social needs or an average of 26 additional prescriptions per week.

Some of the top social needs they would write prescriptions for include:

-Fitness program 75%
-Nutritional food 64%
-Transportation assistance 47%

Additionally, physicians whose patients are mostly urban and low-income wish they could write prescriptions for:

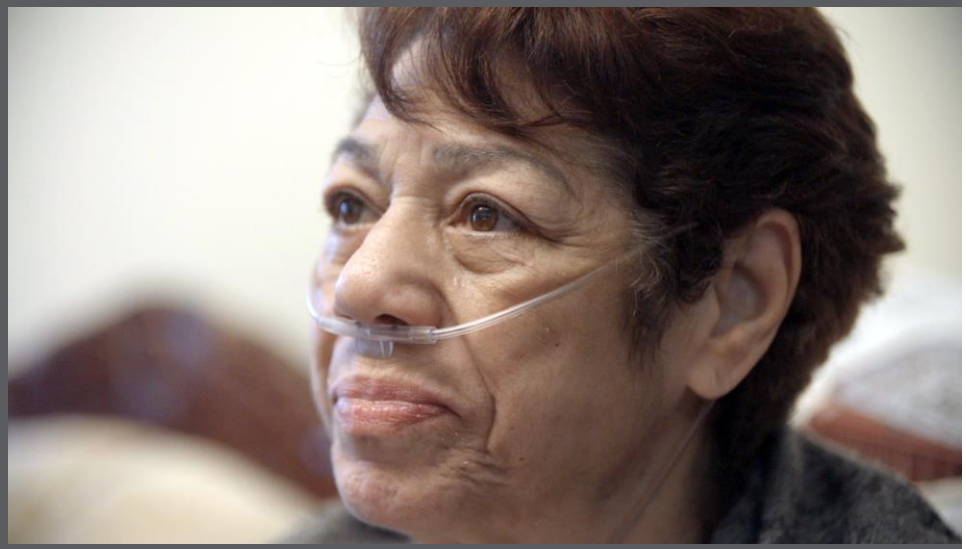
- Employment assistance 52%
- Adult education 49%
- Housing assistance 43%

Let’s talk about real situations. These people are real and their situations had a great impact on their health.
If you would like to hear in their story in their own words, you can find them at the site below.

www.youtube.com/user/WellCareHealthPlan

Case Study #1: Maria

- Female in mid to late 60s
- Diabetic
- Coronary Artery Disease
- Stage 5, chronic kidney disease
- Refused dialysis
- Breathing difficulties
- Swelling
- Lived in an apartment with stairs
- Wheelchair bound
- Family called 911 due to Maria being unresponsive



Case Study #1 Solution

- Transitioned from hospital to home
- WellCare assigned a bilingual Case Manager
- Arranged medical transport to home
- Oxygen provided
- Bilingual WellCare RN assigned
- Good Support System at home
- Started dialysis

Case Study #2: Gloria

- 72 years old
- Type 2 Diabetic
- Sore on toe that led to gangrene
- Left leg amputee
- Anxiety when traveling even 15 miles away from home
- Severe depression
- No support system

Case Study #2 Solution

- Prosthetic was received
- Assigned WellCare Case Manager
- Assigned WellCare RN
- She had PT, OT and HHA
- Learn to walk with prosthetic
- Medication management
- Diabetic education
- Case Manager would ride the bus with the client to appointments
- Due to anxiety, services were brought into her home
- She stated at age 72, she learned to love herself

Case Study #3 Moise

- 24 years old
- Motorcycle accident
- Triple amputee
- Clinical depression
- Refused to leave his room
- His mother did not know how to help him
- Weighed only 76 pounds within 6 months of accident

Case Study #3 Solution

- Assigned WellCare Case Manager
- Received prosthetics for his legs
- Amputee support group
- Dexter, the service dog
- Outpatient rehab
- Started using a stationary bike
- Now bikes 100 miles per week
- Full-time, college student
- Start training 2016 Para-Olympic as a cyclist

Case Study #4 Brandi & Dillon

- Single mother who is deaf
- Anxiety because she can't hear Dillon when he's not in her sight
- Lives in an area where the unemployment rate is high
- Dillon was learning to speak like his deaf mother
- Dillon, was not enrolled in preschool
- Dillon needed speech, physical & occupational therapy
- Lack of transportation
- Brandi had stomach issues for 9 years, she was unable to get anyone to listen to her regarding her stomach

Case Study #4 Solution

- Assigned WellCare Case Manager
- Connected to a specialist for her stomach issues
- Received help to register Dillon for school
- Brandi received help opening a checking account
- Dillon received PT, OT and speech therapy
- Assistance with transportation to appointments

WellCare works with communities to remove barriers to healthcare and achieve positive health outcomes in both individual members and their communities.

HealthConnections 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.

Unless someone like
you cares a whole
awful lot,
nothing is
going to get
better.
It's not.

Thank You!