WVCONNECT

Evaluation of a Pilot Project to Expand Coverage and Access to Care for Working Uninsured West Virginia Residents

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Evaluation conducted by the Health Research Center at the West Virginia University School of Public Health

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Executive Summary

Program Description

In 2009, thirteen states received funding from the Health Resources and Services Administration (HRSA) through the State Health Access Program (SHAP) to expand access to affordable health care coverage to uninsured individuals. In West Virginia, where nearly half of working adults <200% Federal Poverty Level are uninsured, the Department of Health and Human Resources (DHHR) utilized a portion of the funding to subsidize access to primary care for 10,240 working uninsured residents on a per-member, per-month basis at patient-centered medical homes around the state.

Program Evaluation

The Health Research Center at the West Virginia University School of Public Health evaluated this pilot program, called WV Connect, by conducting key stakeholder interviews and surveys of health care center providers and administrators, and program enrollees from the seven participating health care centers to answer five questions:

1. How does WV Connect impact working uninsured individuals' access to, and the ability of centers to provide access to, primary and preventive care services?
2. What barriers do centers and enrollees encounter with the WV Connect program?
3. What is the impact of the WV Connect program on health-care related decision-making and chronic disease self-management behaviors?
4. What additional health care services are needed by WV Connect enrollees?
5. How does WV Connect impact the health care utilization and health status of enrollees?

Evaluation Findings

The vast majority of the feedback about WV Connect was positive, though findings are tempered by a low response rate to the enrollee surveys (3.8%; n=390). Over 90% of respondents to the enrollee survey rated the range of services offered as good or excellent; felt they were being cared for by a team of people; indicated it was easy or very easy to get the care, tests, and treatment they needed; and rated their overall experience with WV Connect as good or excellent. All 31 respondents to the administrator (n=12) and provider (n=19) surveys had a positive or somewhat positive overall impression of WV Connect. Findings are presented below for each evaluation question (EQ).

EQ1: WV Connect improved access to primary care and was a sustainable, economically viable model of care for the participating health care centers

- Administrators unanimously agreed that WV Connect was sustainable and all but one agreed that the per-member/per-month cost structure was adequate to cover expenses incurred
- Providers were mixed in their belief in capitation as an effective practice for delivering care
- Enrollment demand outstripped allotted spaces, but centers were able to meet program demands with existing staff during existing (already extended) hours
- Among enrollee survey respondents, 35% reported being new patients at the health care center and 30% reported not visiting a health care provider for routine care or when sick or injured

EQ2: Enrollees experienced few barriers but still faced financial struggles and centers expressed desire for more training and help developing community awareness

- WV Connect enrollees experienced few logistical barriers to enrollment and accessing care, but the majority were still worried that they would have to pay more for care than they could afford
- Administrators' and providers' survey responses highlighted needs for training of staff about eligibility criteria and reporting processes, marketing to improve community awareness, a desire for more enrollees, and concerns about future funding and care for enrollees

EQ3: WV Connect impacted health-care related decision-making and chronic disease self-management behaviors, but financial concerns persisted for enrollees

- According to self-report, the percentage of enrollees visiting hospital emergency departments for health care was reduced to 27% during the program from 43% pre-WV Connect, with enrollees indicating the majority of pre-program ED visits were for care covered by WV Connect
- Health-care related decisions of enrollees were still adversely impacted by financial concerns, as the majority (63%) of survey respondents indicated that they still frequently delayed addressing health needs for financial reasons
- Chronic conditions were highly prevalent, a common reason for provider visits, and better managed because of WV Connect coverage

EQ4: Enrollees and administrators were mostly satisfied with the services covered, but providers highlighted additional health care service needs

- Many centers were able to provide or find free or reduced care for many additional services for enrollees such as medications, labwork, and mammograms
- Services varied among the centers, but the vast majority of enrollees were satisfied by the level of service covered, most often citing dental care as an additional coverage desired
- Many centers also supplemented WV Connect with other programs or resources, but most often cited labwork, specialist care, behavioral/mental health, and dental as additional service needs

EQ5: Enrollees' health care utilization was appropriate according to their relatively poor health status

- Providers indicated the vast majority of their WV Connect patients "appropriately utilized" care according to their medical needs and that the healthcare status of their WV Connect Program patients was improving
- However, the general health of WV Connect enrollees that responded to the survey was still relatively poor and about half of the enrollees reported their overall health was better than it was prior to enrolling in WV Connect

Lessons Learned

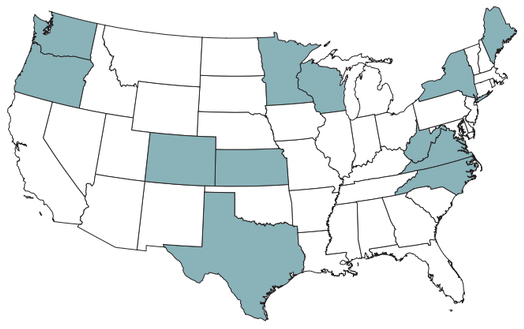
Some key lessons learned that may advise forthcoming Medicaid expansion include the following:

1. Provide plenty of clear, direct, ongoing training of - and communication with - health care center staff and providers about eligibility criteria, technology, and reporting
2. Assist centers in creating community-tailored marketing materials and campaigns to compliment statewide efforts to reach newly eligible residents not yet a part of the health centers
3. Provide comprehensive coverage for a full range of services to provide care and treat chronic disease

West Virginia Connect Program Overview

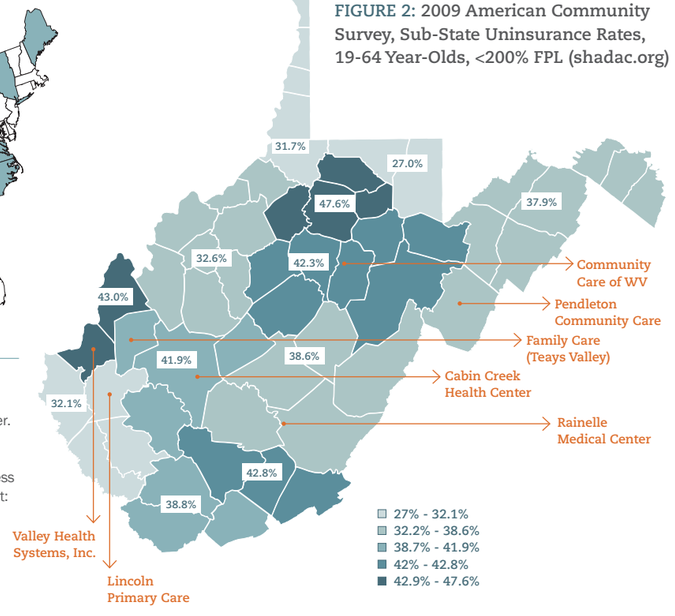
In 2009, thirteen states received funding from the Health Resources and Services Administration (HRSA) through the State Health Access Program (SHAP). SHAP grants were designed to help states expand access to affordable health care coverage to uninsured individuals [SEE FIGURE 1]. While states varied in their approach to meeting the goals of SHAP, the West Virginia Department of Health and Human Resources (DHHR) utilized the funding to do the following: 1) develop a health insurance exchange; 2) link working uninsured residents with patient-centered medical homes through an expansion of pre-paid health care center pilots; and 3) use Health Information Technology to create a centralized portal for the pilot health care centers.[1, 2] Item #2, above, the Medical Homes, Prepaid Clinic Model, and Premium Assistance pilot project ("WV Connect") is the focus of this evaluation report.

FIGURE 1: States receiving State Health Access Program (SHAP) Grant Funding, 2009 (shadac.org)



According to 2009 American Community Survey data compiled by the State Health Access Data Assistance Center (SHADAC)[3], 21.1% of West Virginians aged 19-64 years were uninsured, with the rates increasing to 37.9% for residents at <200% Federal Poverty Level (FPL). Further, the rates of uninsurance among 19-64 year-olds, <200% FPL were 47.6% and 43.2% for those working part-time and full-time, respectively, compared to 29.8% of non-working 19-64 year olds. The WV Connect program linked 10,240 uninsured residents with patient-centered medical homes, with the intent of improving access to primary and preventive care. See FIGURE 2 for Census Sub-State area uninsurance rates for 19-64 year-old residents <200% FPL and WV Connect pilot locations. Seven health care centers were chosen from around the state to participate in WV Connect. For context, please see FIGURE 2 for locations and the APPENDIX ON PAGE 16 for center-by-center enrollment numbers and Community Health Status Indicators of the counties in which the centers operate. Participating health centers were paid a per-month, per-member fee according to income level of enrollees, and were able to tailor care based on their resources and the needs of their patients.

FIGURE 2: 2009 American Community Survey, Sub-State Uninsurance Rates, 19-64 Year-Olds, <200% FPL (shadac.org)



1. Teresa A. Coughlin and Brigette Courtot (2012). SHAP Enrollment and Eligibility Activities: Implications for Process and System Modernization under National Health Reform. State Health Access Data Assistance Center. Issue Brief #29. Minneapolis, MN: University of Minnesota.

2. State Health Access Data Assistance Center (SHADAC). State Health Access Program (SHAP) Grant Summary: WEST VIRGINIA. July 21, 2010. Available at: http://www.shadac.org/files/shadac/SHAP_GrantSummary_WV.pdf.

3. State Health Access Data Assistance Center (SHADAC). West Virginia SHAP Grantee Chartbook: Health Insurance Coverage Estimates from the 2009 American Community Survey (ACS). May 13, 2011. Available at: http://www.shadac.org/files/SHAPChartbook_WV_May2011.pdf

Access to the health center was fully subsidized for working uninsured residents with income less than 200% of the FPL. Working uninsured between 200% and 400% FPL paid a $30 annual fee to their center.

TABLE 1: WV Connect Enrollee Income Eligibility

Family Size (household)	Annual 200% of FPL
1	$21,660
2	$29,140
3	$36,620
4	$44,100
5	$51,580
6	$59,060
7	$66,540
8	$74,020
For each additional family member add	$7,480

Evaluation Plan

An evaluation of the WV Connect program was undertaken by the Health Research Center (HRC) in the West Virginia University School of Public Health to help gauge the implementation and impact of the per-member-per-month strategy for providing primary and preventive health care to uninsured working adults. Objectives of the evaluation of WV Connect conducted by the HRC were: (1) assess the effectiveness of the WV Connect program in recruiting patients and providing quality primary health care and preventive services to the working uninsured; and (2) identify factors effecting recruitment and health care delivery, as well as lessons learned, that have relevance to the design and implementation of 2014 heath care reform in WV. [SEE FIGURE 3 ON NEXT PAGE]

More specifically, activities were conducted to answer the following evaluation questions (EQs):

1. How does WV Connect impact working uninsured individuals' access to, and the ability of centers to provide access to, primary and preventive care services?
2. What barriers do centers and enrollees encounter with the WV Connect program?
3. What is the impact of the WV Connect program on health-care related decision-making and chronic disease self-management behaviors?
4. What additional health care services are needed by WV Connect enrollees?
5. How does WV Connect impact the health care utilization and health status of enrollees?

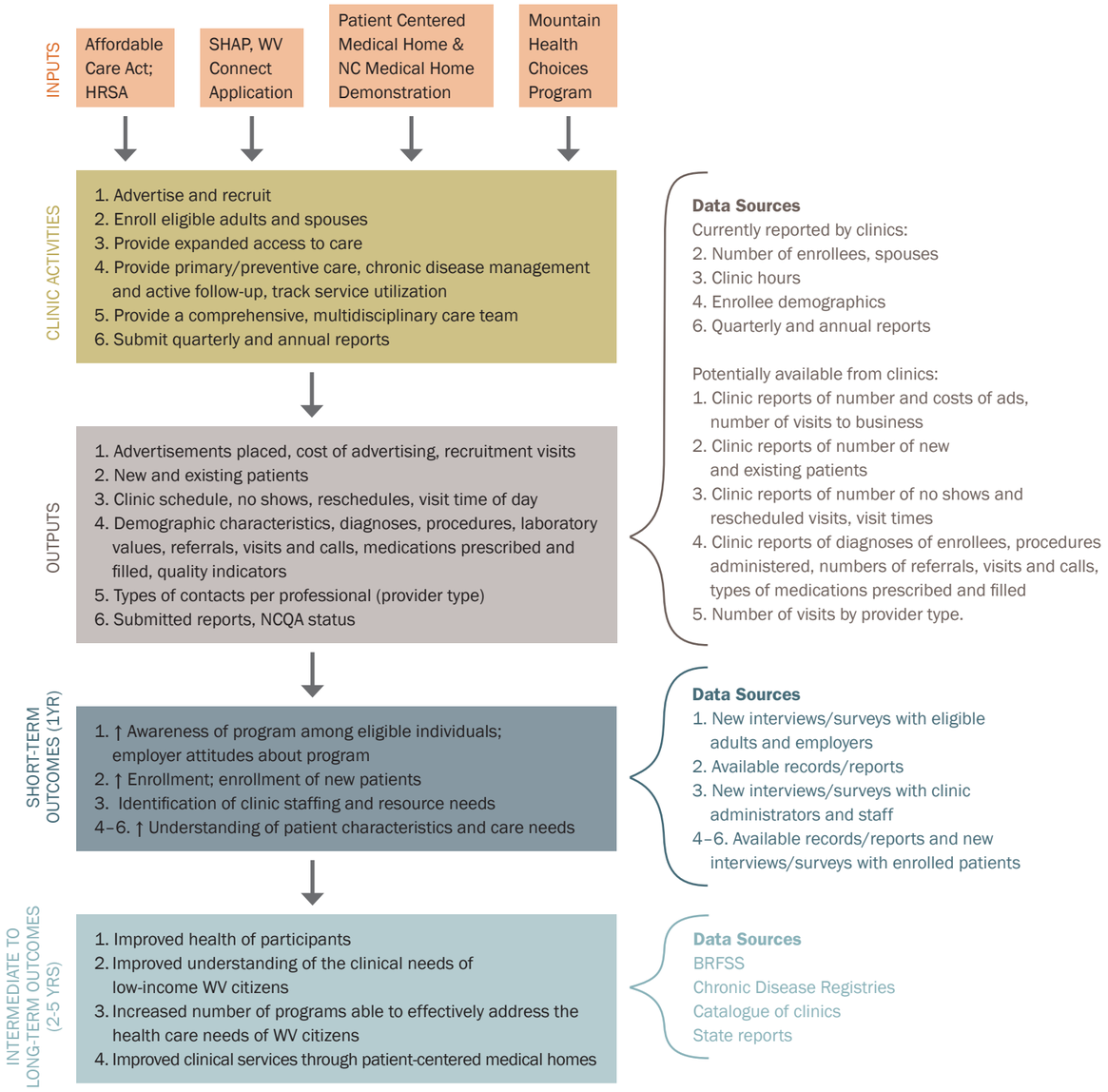
The following activities were completed by the HRC to answer these questions:

1. Key informant interviews with health care center administrators
2. Key informant interviews with health care center providers
3. Key informant interviews with information technology specialists involved with WV Connect
4. Interviews with WV Connect enrollees
5. Surveys of health care center administrators
6. Surveys of health care center providers
7. Surveys of WV Connect enrollees
8. Analysis of clinical data from four FQHCs via data provided by the WV Community Health Network and WV Health Information Network*

Results from the provider, administrator, and enrollee surveys will be provided below according to the EQ addressed, with a discussion of potential implications of the findings to follow.

*Please note, analysis of enrollee clinical data, which will be used to augment the answer to EQ5, is ongoing and will be presented in a supplement to this report in the coming months.

FIGURE 3: WV Connect Evaluation Logic Model



Survey Methods and Responses

Provider and Administrator Surveys

Using data from key informant interviews, the HRC developed original surveys and recruited providers and administrators from the seven health care centers to complete an online survey in December, 2012 and January, 2013. Recruitment methods and surveys were approved by the WVU Institutional Review Board. Nineteen respondents completed the provider survey, including eight MDs, six PAs, three NPs, two DOs, and one RN. The average age of the respondents was 39.4 years, with fourteen female respondents. Roughly half had five or fewer years of practice, though five had over 15 years of practice.

Twelve respondents completed the administrator survey, including CEO, COO, CFO, billing managers, site coordinators, care supervisors, and some clinicians. All had a college degree or higher, six had over 10 years of experience, eight were female, and the average age was 43.1 years.

Enrollee Survey

A 43-item, telephone-administered WV Connect Enrollee Survey was developed using items from existing measures (e.g., Medical Expenditure Panel Survey) and findings from key informant interviews. Prior to administration, the survey was reviewed and revised by state partners at the West Virginia DHHR. WV Connect enrollees were recruited from June through September of 2012 to complete the enrollee survey through a mailing sent by the seven health care centers. The evaluation team prepared recruitment packets that centers sent to all patients enrolled in the WV Connect program. Centers also posted recruitment flyers in waiting rooms. Those patients interested in participating were given a toll free number to call that connected to Perceptive Market Research, a call center in Gainesville, FL that administered the survey. Centers received an economic incentive of $10 in gift cards for every 100 mailings and respondents were entered into a drawing for one of three, $100 gift cards, or one of 12, $25 gift cards. The recruitment methods and survey were approved by the Institutional Review Board at WVU.

As indicated in the table below, 390 surveys were completed for a response rate of 3.8% that varied from 2.8% to 6.7% across centers. This response rate is very low, suggesting caution in interpreting the results and drawing conclusions based on the data. However, in presenting these results to health care center administrators, they believe the results accurately depict their experience with WV Connect and feedback from enrollees.

TABLE 2: Enrollee Survey Recruitment and Completion

Site	Enrollees Recruited	Completed Surveys	Response Rate
Rainelle Medical Center	140	5	3.6%
Pendleton Community Care	400	11	2.8%
Lincoln Primary Care	800	35	4.4%
Family Care	900	60	6.7%
Valley Health Systems, Inc.	1,500	49	3.3%
Cabin Creek Health Center	2,000	70	3.5%
Community Care of WV	4,500	160	3.6%
Total	**10,240**	**390**	**3.8%**

The average age of respondents to the WV Connect Enrollee Survey was 48, and respondents were predominantly female (81.8%) and white (93.6%). Just over half were married, 28.2% were not employed, and 38.2% had completed at least some college education. Please see TABLE 3 on the following page for a full demographic profile of enrollee survey respondents.

TABLE 3: WV Connect Enrollee Survey Demographic Profile

Gender	%
Female	81.8%
Male	18.2%
Marital Status	
Married	56.9%
Separated or Divorced	22.6%
Widowed	3.6%
Single	16.9%
Spouse also enrolled in WV Connect	32.2%
Race	
Hispanic or Latino	4.6%
Non-hispanic White	93.6%
African American/Black	0.8%
Asian/Pacific Islander	0
American Indian/Alaskan Native	0.3%
Mixed	0.8%
Education	
Less than high school	10.8%
High school graduate	50.0%
Some college	25.6%
College degree or more	12.6%
Number of Children Under 18 years old in the Home	
Zero	67.4%
One	18.5%
Two or more	13.8%
Number of Jobs Worked	
None	28.2%
One	59.7%
Two or more	11.0%

Overall impression of WV Connect

The vast majority of the feedback about WV Connect was positive. Enrollee survey respondents were very satisfied with WV Connect.

> Nearly all (95%) rated the range of services offered as good (27%) or excellent (68%); 96% felt they were being cared for by a "team of people;" 93% indicated it was easy (48%) or very easy (45%) to get the care, tests, and treatment they needed; and 97% rated their overall experience with WV Connect as good (17%) or excellent (80%).

All 31 respondents to the administrator and provider surveys had a positive (67%) or somewhat positive (33%) "overall impression of the WV Connect Program." A positive result cited by providers was the ability of WV Connect to reach a population that was unable to afford any care prior, even if just for basic care, specifically: "I have had many patients come for their first visit as a new patient to our health center saying they haven't seen a doctor in several years, since they lost insurance, and now they can again because of Connect." Some were optimistic that long-term benefits of WV Connect and Medicaid expansion would be seen in reduced emergency and urgent care visits because of better prevention and management of chronic diseases.

> WV Connect did, according to the majority of administrators, have a very positive (50%) or positive (33%) economic impact on their center. The majority (75%) also indicated that prior to WV Connect their center was "losing money due to the inability of patients to pay co-pays or sliding scale fees."

Seven administrators also agreed or strongly agreed with the statement, "the current per member/per month cost structure is adequate to cover expenses incurred by the WV Connect Program." The few concerns of administrators and providers generally focused on: (1) misunderstanding by enrollees of the services that would be covered, (2) reporting and training needs among staff, and (3) the need for additional follow-up and specialist services that were not covered by WV Connect. In addition, survey responses highlighted some details that may be leveraged to inform forthcoming coverage expansion through Medicaid and the Affordable Care Act.

EQ1: How does WV Connect impact working uninsured individuals' access to, and the ability of centers to provide access to, primary and preventive care services?

> All respondents to the administrator survey indicated they agreed or strongly agreed that the program was sustainable for their center and all but one agreed with the statement that a per-member/per-month cost structure was adequate to cover expenses incurred by the WV Connect Program.

In response to a similar item, seven providers agreed that capitation was "an effective practice for delivering care," with 10 indicating they were "not sure," and two indicating that capitation was not effective. Ten providers (53%) indicated WV Connect was similar in its ability to provide primary care services relative to sliding scale, whereas eight providers (42%) indicated WV Connect was better. When asked for details, providers wrote,

> "[I] Feel patients are more willing to see physician and complete follow up on WV Connect than on sliding fee so better comprehensive care."

> "The Connect Program helps more people than our sliding scale program but those that make a little too much money do not qualify for any outside testing."

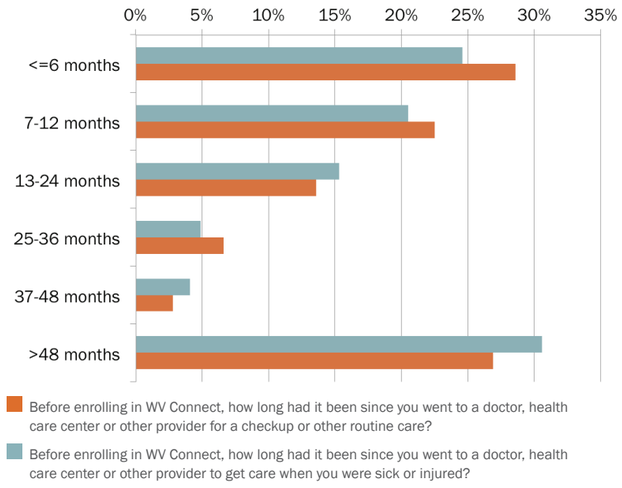
> "The percentage of fee covered under the program is higher and my patients have better access to care."

While the vast majority of administrators reported having more patient interest than allotted slots (92%) and having patients on a waiting list (75%), the vast majority (83%) also reported having the needed staffing to meet the demands of the program. Roughly half of administrators indicated the enrollment and data reporting processes did require additional staff time or staffing. All 12 administrators responding to the survey indicated their center already offered extended hours to their patients before the WV Connect Program started. If demand were to increase by 20% (an arbitrary amount), the greatest need, according to administrators, would be staffing with some indications that funding and space may also be needed.

Among enrollee survey respondents (N=390), before enrolling in WV Connect the average length of time since a visit to a doctor, health care center or other provider for a checkup or other routine care was 53.7 months (SD = 86.5), and 50.5 months (SD = 90.0) since the last visit when sick or injured. Roughly ½ of respondents reported a visit for either purpose to a provider within the 12 months prior to enrolling in WV Connect, though 30% reported it having been at least four years since a visit for either reason.

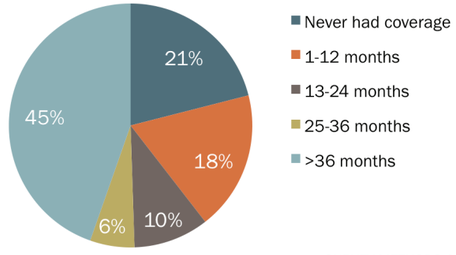
> "I have had many patients come for their first visit as a new patient to our health center saying they haven't seen a doctor in several years, since they lost insurance, and now they can again because of Connect."

FIGURE 4: Pre-WV Connect Health Care Utilization



The majority of enrollee survey respondents (65%, n=253) reported being a patient at the health center prior to being enrolled in WV Connect and, of these, 89% had been receiving care on a sliding scale program or fee. Excluding participation in sliding scale programs, 21% reported never having health coverage and 45% of responses were 36 months or more. When asked about reasons for not having coverage prior to enrolling in WV Connect, the vast majority reported being unable to afford private insurance (77%).

FIGURE 5: Not including sliding scale programs, how long had it been since you had some form of health care coverage before enrolling in WV Connect?



EQ2: What barriers did centers and enrollees encounter with the WV Connect program?

Enrollees responding to the survey were generally very satisfied with the program and reported very little impact of many potential barriers. Center administrators were asked two open-ended items to list the top three barriers encountered during the initiation of the program and the top three barriers remaining at the time of the survey.

The top three initial barriers (with number of respondents) included:

1. Lack of clarity/understanding of the program at the center (4)
2. Advertising/marketing/community awareness (3)
3. Lack of clarity about reporting (3)

Barrier #1: Six providers indicated they had specific needs that may have improved the program if they had been addressed at startup, with five wanting a clearer understanding of the details of the program and what was covered by it. Roughly half of the respondents to the administrator survey indicated they had a "fair" or "poor" level of communication with state partners about enrollment criteria and reporting requirements for WV Connect.

FIGURE 6: How would you rate the level of communication between your health care center and state partners regarding enrollment criteria for WV Connect?

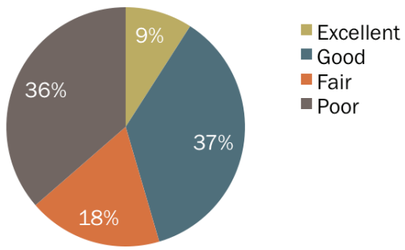
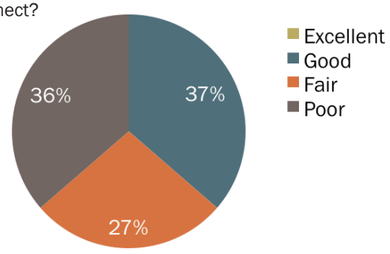
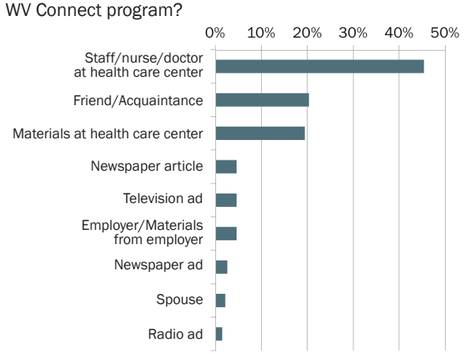


FIGURE 7: How would you rate the level of communication between your health care center and state partners regarding the reporting requirements for WV Connect?



Barrier #2: One solution to barrier 2 is to improve public awareness via statewide marketing. However, when asked, only 50% of responding administrators believed such a marketing program would be beneficial. Providers were more optimistic, as 94% believed such a marketing campaign would be beneficial. According to enrollees, health care center staff and providers were key to marketing the program, providing the main gateway to WV Connect. Enrollees reported the most common mechanisms for learning about the WV Connect program was through center staff, nurses or doctors (45%). Enrollees that were already members at the health center prior to WV Connect (n=253) cited center personnel and materials at the center more often than non-members of the center (n=137), and non-members cited friend/acquaintence more often than enrollees that were center members pre-WV Connect.

FIGURE 8: How did you first learn about the WV Connect program?



Barrier #3: One administrator commented that information about reporting, "needs to filter all the way down to the front desk employees, and there was nothing to share at that level," and half of the administrators used the data from the quarterly reports to gauge the impact of WV Connect.

The top three remaining barriers (with number of respondents) included:

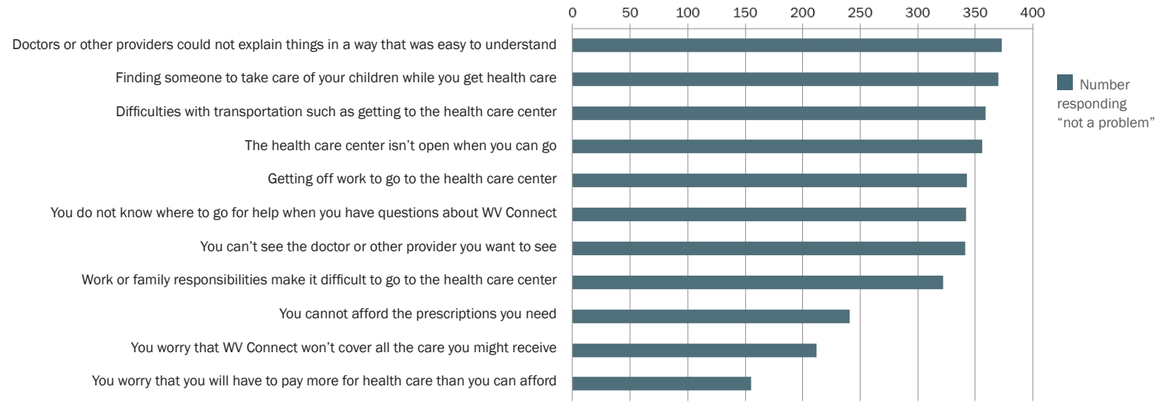
1. Reporting (4)
2. Limited space for more enrollees (4)
3. Funding/uncertainty about program's future (2)

Promisingly, very few enrollee survey respondents endorsed potential logistical barriers as effecting access to the health care center. Specifically, 86-97% of respondents reported that it was easy to travel to the enrollment site, get enrollment forms, fill out the WV Connect application, and have the application processed quickly. In addition, 87% of enrollee survey respondents were very satisfied with the hours that their WV Connect health care center was open and 82% indicated they believed it was easy to get assistance from their center by phone for health-related questions.

Respondents were also asked whether 11 potential barriers had been "a big problem, a small problem, or not a problem" for them in getting the health care needed since being enrolled in WV Connect.

The only barrier statements that more than 20% of respondents endorsed as a small or big problem were "you worry that you will have to pay more for health care than you can afford," (60.3%) "you worry that WV Connect won't cover all the care you might receive," (45.6%) and "you cannot afford the prescriptions you need" (38.2%). However, 71% of respondents that they were able to fill prescriptions at a lower cost since enrolling in WV Connect.

FIGURE 9: Since being enrolled in WV Connect, please tell me if the following items have been a big problem, a small problem, or not a problem for you in getting the health care you need:



EQ3: What is the impact of the WV Connect program on health-care related decision-making and chronic disease self-management behaviors?

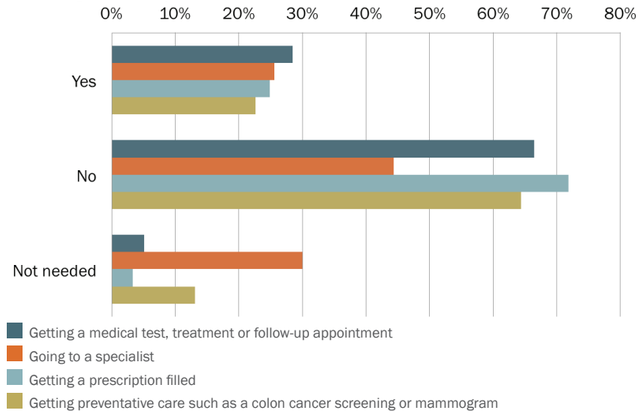
Decision Making

According to enrollee self-report, in the 12 months prior to enrollment in WV Connect, 43% visited a hospital emergency department for health care, reporting an average of 2.3 visits (SD = 1.9). When queried whether these visits "were for a condition that could have been treated at your WV Connect health care center," 42% indicated all of them were and 23% indicated some were, highlighting the benefit of WV Connect in reducing emergency department utilization. Since enrolling in WV Connect, 27% of respondents reported visiting a hospital emergency department for health care. Among these respondents (n=107), however, 51% indicated the number of visits was "more" than prior to enrollment in WV Connect.

Health-care related decisions of WV Connect enrollees were still impacted by financial concerns despite the subsidy. There was nearly universal agreement among enrollee survey respondents that the program improved their ability to afford health care (95%), improved the quality of care received (86%), made it easier to get care when sick or injured (93%), and made it easier to get routine care and check-ups (92%). However, the majority (63%) of respondents still indicated "yes" when asked if they "frequently delayed addressing health needs for financial

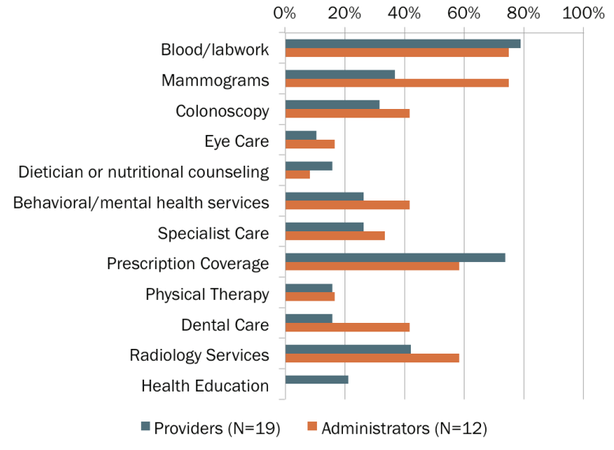
reasons." Enrollees still indicated financial reasons prevented them from seeking health care needs at 20-30% per item for specific items such as appointments, tests, specialists, prescriptions, or preventive screenings.

FIGURE 10: Since enrolling in WV Connect, have financial reasons prevented you from:



When asked about additional services expected by enrollees, the majority of providers and administrators indicated they believed the patients expected prescription drugs and labwork to be covered by WV Connect.

FIGURE 11: In your experience, have patients expected any of the following to be covered by WV Connect?

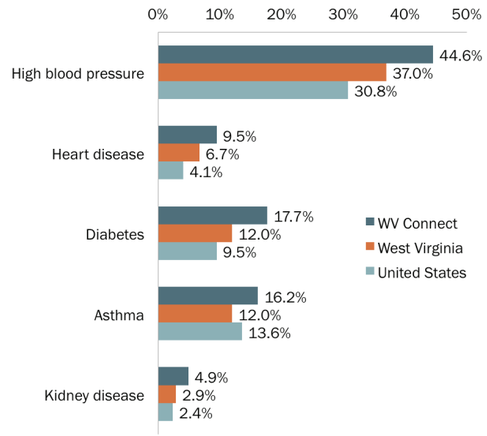


In addition to these, administrators believed that patients expected mammograms and radiology services to be covered by WV Connect.

Chronic Disease Self-Management

According to providers, patient visits were most often related to chronic disease management, specifically hypertension, diabetes, hypercholesterolemia, and mental health. Enrollee survey respondents, according to self-report, had a relatively high prevalence of high blood pressure, heart disease, diabetes, asthma/lung problems, and kidney disease compared to the general 2011 WV and US populations.[4]

FIGURE 12: Chronic Health Indicators among WV Connect Enrollee Survey Respondents



*Note: High blood pressure prevalence for WV & US is 2010, other indicators are 2011.

Mean number of chronic conditions reported (out of the five listed above) was 0.93 (SD = 0.97), with 41% reporting zero, 34% reporting one, and 18% reporting two conditions. Of the 231 respondents reporting having one or more chronic conditions, 88% reported that WV Connect helped them manage their condition(s) very well (54%) or well (34%). In addition, according to enrollee survey respondents, the majority of health care providers encouraged WV Connect enrollees to improve exercise and nutrition habits, with the majority heeding their providers' advice.

4. Centers for Disease Control and Prevention. Behavioral risk factor surveillance system: 2011 prevalence data. Retrieved July 30, 2013, from http://apps.nccd.cdc.gov/brfss/.

TABLE 4: Health Awareness and Behaviors of WV Connect Enrollee Survey Respondents

Since enrolling in WV Connecting has your doctor or health care provider…	% YES
Encouraged you to exercise more	71%
Encouraged you to eat a healthier diet	77%
Prescribed a new medication for you	56%
Told you that you have a medical condition or chronic disease you did not know you had before	30%
Since enrolling in WV Connect do you…	
Get more exercise	68%
Eat a healthier diet	74%
Take a new medication	61%
Pay more attention to your health	89%

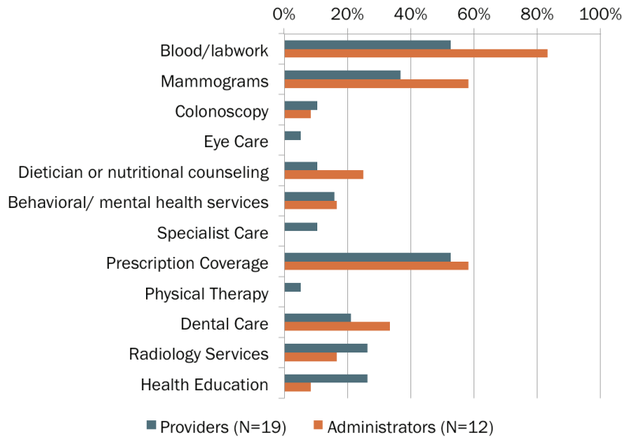
*Please note, these data are based on self-report and are subject to bias, and analysis of objective enrollee clinical data is ongoing and will be presented in a supplement to this report.

Management of chronic conditions could be further supported by a Registered Dietitian, mental health specialist, or health education programming. However, only three respondents to the administrator survey indicated they had access to an RD, psychologist, or social worker on staff. Further, seven of the 19 (36.8%) responding providers indicated their patients did not have access to disease management or chronic disease education programs at their center or in the community, suggesting additional needed community capacity to address chronic disease.

EQ4: What additional health care services are needed by WV Connect enrollees?

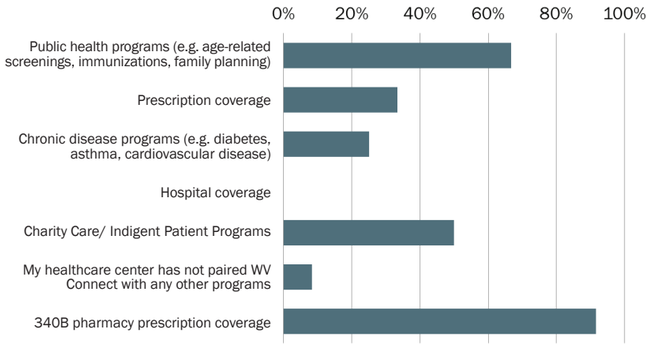
The intent of WV Connect was to provide primary care coverage. Not surprisingly, the 12 providers (63%) that had encountered barriers to treating WV Connect enrollees focused on the lack of coverage for specialists and testing (n=10) as primary barriers. Nonetheless, centers were creative in providing additional services that providers felt were needed. Ten of 19 providers were able to provide or obtain prescription drugs and labwork services at free or reduced cost. The majority of administrators reported also being able to provide or obtain these services, as well as mammograms, at free or reduced cost.

FIGURE 13: What services are you able to provide or obtain for the WV Connect patient for free or at a reduced cost?



When referring WV Connect patients for additional services, the majority of providers (n=9) made referrals to local health departments for vaccinations/immunizations, whereas specialist referrals were most common for cardiology, orthopedics, or mental health. Administrators also reported supplementing WV Connect with other existing programs or resources, including public health programs such as screenings, immunizations, and family planning; charity care programs; and 340B pharmacy prescription coverage.

FIGURE 14: Have you supplemented the WV Connect Program with any of the following programs or resources?



Despite the creativity in providing additional services at free or reduced cost, administrators noted dental care (n=6), specialist care (n=5), labwork (n=5), behavioral/mental health (n=4), and prescription coverage (n=4) most frequently in the top three services still needed by WV Connect enrollees [SEE TABLE 5 BELOW], with prescription coverage most often cited as the top need (n=3). Providers cited labwork most frequently (n=5) as the top service still needed by enrollees, citing specialist care (n=10), labwork (n=8), and behavioral/mental health services (n=7) most often in the top three services still needed by WV Connect enrollees. Conversely, when enrollees were asked to identify additional services needed, survey respondents most often cited "none" (n=159). Those that did identify some service most frequently cited dental (n=75), screenings (n=37), blood/labwork (n=33), or eye care (n=30).

TABLE 5: Administrator and provider rankings of top three services still needed by WV Connect Enrollees

	Administrators (N=12)				Providers (N=19)			
Service	**#1**	**#2**	**#3**	**Total**	**#1**	**#2**	**#3**	**Total**
Blood/Labwork	2	3	0	5	5	2	1	9
Mammograms	0	0	2	2	2	0	1	3
Colonoscopy	1	1	0	2	4	2	0	6
Eye Care	1	2	0	3	0	2	1	3
Dietary/nutrition counseling	0	0	0	0	1	1	0	2
Behavioral/mental health	2	1	1	4	1	3	3	7
Specialist care	1	0	4	5	1	3	6	10
Prescription drug coverage	3	0	1	4	2	0	1	3
Physical therapy	0	1	0	1	1	0	0	1
Dental care	2	1	3	6	0	3	2	5
Radiology	0	1	0	1	2	1	2	5
Health education	0	0	0	0	0	0	0	0
Vaccinations	0	2	1	3	1	2	2	5

Total column equals the total number of times a service was rated as the highest (#1), second highest (#2) or third highest (#3) service still needed.

EQ5: How does WV Connect impact the health care utilization and health status of enrollees?

Providers indicated the vast majority of their WV Connect patients "appropriately utilized" care according to their medical needs (n=16). The general health of WV Connect enrollees that responded to the enrollee survey was below average. Health status of enrollee survey respondents was based on self-report ascertained using items from the Behavioral Risk Factor Surveillance System. Respondents indicated "fair" (27%) or "poor" (8%) general health at a much higher rate than the 2012 national (16.9%) or state (25.2%) prevalence, though it may be equivalent to that of others of similar socioeconomic status.[5]

> The majority of providers (79%) believed that the healthcare status of their WV Connect Program patients was improving.

However, only 48% of enrollees reported their overall health was better than it was prior to enrolling in WV Connect.

*Please note, analysis of enrollee clinical data, which will help answer EQ5, is ongoing and will be presented in a supplement to this report in the coming months.

5. Centers for Disease Control and Prevention. Behavioral risk factor surveillance system: 2012 prevalence data. Retrieved July 30, 2013, from http://apps.nccd.cdc.gov/brfss/.

Lessons Learned

The WV Connect program successfully linked over 10,000 uninsured working adults with patient-centered medical homes, improving access to primary and preventive care. The per-month, per-member payment offered health care centers the flexibility to provide services based on their center's resources, their members' needs, and their community's resources. The vast majority of enrollees, health care center administrators, and health care providers were complimentary of the ability of WV Connect to provide an economically viable program for clinics to provide primary and preventive care to those in need.

Results of this evaluation should be interpreted with some caution because of the low response rate to the enrollee survey. However, when presented with these findings, many health care center administrators agreed that the survey data were in agreement with their experience and feedback received from enrollees. Lessons learned from this evaluation may be leveraged to inform forthcoming Medicaid coverage expansion and the Health Insurance Exchange in WV, which will expand coverage to an estimated 170,000 residents.

These lessons learned include the following:

1. Provide plenty of clear, direct, ongoing training of - and communication with - health care center staff and providers about eligibility criteria, technology, and reporting

2. Assist centers in creating community-tailored marketing materials and campaigns to compliment statewide efforts to reach newly eligible residents not yet a part of the health center

3. Provide comprehensive coverage for a full range of services to provide care and manage chronic disease

As West Virginia prepares for an increase in insured residents, it is important that the DHHR, Offices of the Insurance Commissioner, and health care centers work collaboratively to establish well-defined communication systems and identify administrator, staff, and provider training needs. It will be critical to clearly, succinctly express enrollment criteria and identify and eliminate information technology barriers to ensure any reporting system is easy to use - and beneficial to - all health care centers.

WV Connect expanded the pool of individuals from which to recruit the working uninsured but health centers may still need assistance and resources in marketing Medicaid expansion and the Insurance Exchanges to residents that have never been members of their center. The best marketing outlet for existing health care center members is likely at the centers themselves, whereas creative methods of recruiting non-members will be needed to enhance word-of-mouth recruiting of friends and family by the "early adopters." Social marketing campaigns that tailor marketing materials to community needs, such as Wheeling Walks and WV Walks (see www.wheelingwalks.org), have had an impact in WV. The community-based, participatory approach used in these programs to identify community partners, resources, challenges, and media campaign components could be considered. The efforts of "community assisters" and other community liaisons should be coordinated and expanded to ensure the dissemination of correct information and enrollment resources.

Lastly, the essential health benefits mandated by the Affordable Care Act should provide comprehensive coverage for prevention and treatment of chronic conditions that WV Connect did not cover. To compliment provider-based primary and secondary prevention options, partnerships should be forged among health centers and the DHHR to facilitate expansion of, and referrals to, evidence-based programming to treat chronic disease, such as the Chronic Disease Self-Management Program and the Diabetes Prevention Program, that utilize the skills of exercise, nutrition, and/or health education professionals already in the communities in which health centers operate.

Appendix

Select Community Health Status Indicators of counties in which seven WV Connect health centers operated

HEALTH CENTER: WV Connect Enrollees	Valley Health Systems, Inc. 1,500 Enrollees				Rainelle Medical Center 140 Enrollees	Cabin Creek Health Center 1,760 Enrollees					
COUNTY:	Cabell	Wayne	Putnam	Kanawha	Greenbrier	Kanawha	Jackson	Boone	Fayette	Roane	Clay
MEASURES:											
County data, population size	94,031	42,091	54,443	193,559	35,027	193,559	28,403	25,703	46,823	15,407	8,909
County data, population density (people per square mile)	334	83	157	214	34	214	61	51	71	32	30
County data, individuals living below poverty level, %	17.6	17.3	9.7	15.2	16.1	15.2	14.9	18.4	20.2	19.9	22.5
County data, White, %	93.7	98.7	97.6	90.3	95.4	90.3	98.7	98.8	93.4	98.9	98.8
County data, self-rated health status, % fair or poor	21.4	26.8	21.2	20.4	27.1	20.4	26.9	33.6	30.1	25.4	26.7
County data, no high school diploma (among adults age 25 and older)	12,721	8,663	6,078	27,639	6,669	27,639	4,477	6,540	10,240	3,597	2,574
County data, unemployed	1,994	914	1,157	4,465	902	4,465	681	430	1,028	401	270
County data, major depression	7,058	3,133	3,987	14,530	2,654	14,530	2,112	1,900	3,523	1,157	752
County data, recent drug users (within past month)	4,282	1,779	2,263	7,813	1,447	7,813	1,195	1,033	2,006	653	433
County data, no exercise, %*	22.5	32.6	25.9	26.9	33.1	26.9	28.9	37.3	32.2	35.4	n/a
County data, few fruits/vegetables, %*	80.9	83.4	83.5	77.4	78.6	77.4	79.2	84.2	79	80.6	90.4
County data, obesity, %*	25.9	31.1	23.7	27.5	28.6	27.5	27.8	32.2	30.4	24.3	28.2
County data, high blood pressure, %*	30.4	38.6	32.8	33.2	34.5	33.2	30.4	41.9	31.9	n/a	n/a
County data, smoker, %*	23.8	27.7	23.2	25.7	27	25.7	29.8	31.8	28.1	37	28.1
County data, diabetes, %*	9.8	9.1	9.5	10.3	11.4	10.3	8.4	13.4	10.5	14	9.2
County data, uninsured individuals	11,213	5,689	4,712	22,630	4,713	22,630	2,977	3,898	7,580	2,589	1,904
County data, primary care physicians per 100,000 pop.	198.9	557	80.8	146.2	62.8	146.2	21.1	19.5	66.2	38.9	19.3
County data, dentists per 100,000 pop.	58.5	19	25.7	66.6	48.5	66.6	35.2	31.1	32	19.5	9.7

HEALTH CENTER: WV Connect Enrollees	Lincoln Primary Care (Southern WV Health Systems) 800 Enrollees							Pendleton County Community Care 400 Enrollees			
COUNTY:	Lincoln	Logan	Mingo	Kanawha	Cabell	Boone	Putnam	Pendleton	Grant	Randolph	Hardy
MEASURES:											
County data, population size	22,374	36,237	27,210	193,559	94,031	25,703	54,443	7,844	11,673	28,571	13,287
County data, population density (people per square mile)	51	80	64	214	334	51	157	11	24	27	23
County data, individuals living below poverty level, %	21.4	21	24.7	15.2	17.6	18.4	9.7	12.5	14.4	17.4	12.9
County data, White, %	99.4	96.7	96.5	90.3	93.7	98.8	97.6	97	98.8	98	97.5
County data, self-rated health status, % fair or poor	31.5	36.6	37.2	20.4	21.4	33.6	21.2	26.1	22.2	23.4	20.6
County data, no high school diploma (among adults age 25 and older)	5,833	9,531	7,560	27,639	12,721	6,540	6,078	1,591	2,462	5,315	2,778
County data, unemployed	506	645	494	4,465	1,994	430	1,157	142	305	660	261
County data, major depression	1,659	2,722	1,998	14,530	7,058	1,900	3,987	592	877	2,152	986
County data, recent drug users (within past month)	932	1,483	1,139	7,813	4,282	1,033	2,263	310	462	1,232	548
County data, no exercise, %*	30.5	34.3	42.7	26.9	22.5	37.3	25.9	24.1	29.4	32.5	22.7
County data, few fruits/vegetables, %*	85.2	82.9	85.9	77.4	80.9	84.2	83.5	n/a	76.2	73.5	78.7
County data, obesity, %*	32.4	38.7	35.4	27.5	25.9	32.2	23.7	18.8	24.8	26.5	28.8
County data, high blood pressure, %*	28.6	41.7	41	33.2	30.4	41.9	32.8	n/a	n/a	36.4	n/a
County data, smoker, %*	38.9	31.9	35.3	25.7	23.8	31.8	23.2	12.7	20.9	28.4	28.5
County data, diabetes, %*	11	12.5	12.8	10.3	9.8	13.4	9.5	8.1	10.3	8.2	5.8
County data, uninsured individuals	3,756	6,190	4,885	22,630	11,213	3,898	4,712	939	1,429	3,980	1,427
County data, primary care physicians per 100,000 pop.	13.4	63.5	25.7	146.2	198.9	19.5	80.8	51	51.4	98	30.1
County data, dentists per 100,000 pop.	17.9	19.3	7.4	66.6	58.5	31.1	25.7	76.5	34.3	38.5	15.1

Community Health Status Indicators Project Working Group. Data Sources, Definitions, and Notes for CHSI2009. Department of Health and Human Services, Washington, DC: 2009. Available at http://communityhealth.hhs.gov.

* Taken from the Behavioral Risk Factor Surveillance System (BRFSS), a survey conducted jointly by states and the Centers for Disease Control and Prevention. County-level BRFSS survey data from 2000 to 2006 are presented.

Select Community Health Status Indicators of counties in which seven WV Connect health centers operated (continued)

HEALTH CENTER: WV Connect Enrollees	Family Care of Teays Valley 900 Enrollees			Community Care of West Virginia 4,500 Enrollees									
COUNTY:	Putnam	Boone	Kanawha	Upshur	Harrison	Braxton	Clay	Pocahontas	Randolph	Lewis	Webster	Nicholas	Barbour
MEASURES:													
County data, population size	54,443	25,703	193,559	23,712	68,369	14,851	8,909	8,851	28,571	17,199	9,804	26,464	12,238
County data, population density (people per square mile)	157	51	214	67	164	29	30	9	27	45	18	41	46
County data, individuals living below poverty level, %	9.7	18.4	15.2	18.8	16.7	19.9	22.5	15.7	17.4	16.9	24.1	19.2	19.4
County data, White, %	97.6	98.8	90.3	98.3	96.7	98.5	98.8	98.7	98	98.7	99.5	99	97.2
County data, self-rated health status, % fair or poor	21.2	33.6	20.4	24.1	18.8	30.2	26.7	24.6	23.4	28.6	40.7	30.7	29.6
County data, no high school diploma (among adults age 25 and older)	6,078	6,540	27,639	4,007	10,263	3,468	2,574	1,904	5,315	3,230	2,920	5,645	2,971
County data, unemployed	1,157	430	4,465	494	1,428	348	270	240	660	357	192	576	394
County data, major depression	3,987	1,900	14,530	1,756	5,075	1,124	752	681	2,152	1,295	743	1,996	1,176
County data, recent drug users (within past month)	2,263	1,033	7,813	1,096	2,872	624	433	358	1,232	709	416	1,111	689
County data, no exercise, %*	25.9	37.3	26.9	28	27	32.5	n/a	23.7	32.5	32.2	36.9	33.9	32.1
County data, few fruits/ vegetables, %*	83.5	84.2	77.4	82.7	80.6	n/a	90.4	n/a	73.5	78.5	n/a	79.6	79.7
County data, obesity, %*	23.7	32.2	27.5	26.2	26.6	24.4	28.2	31.7	26.5	24.3	42.6	26.7	30.6
County data, high blood pressure, %*	32.8	41.9	33.2	25.8	32.4	n/a	n/a	n/a	36.4	n/a	n/a	37.3	n/a
County data, smoker, %*	23.2	31.8	25.7	29.7	27	23.8	28.1	20.6	28.4	29	28	25.8	24.8
County data, diabetes, %*	9.5	13.4	10.3	10.7	9.5	11.1	9.2	12.1	8.2	10.1	15.4	9.9	12.2
County data, uninsured individuals	4,712	3,898	22,630	3,343	9,429	2,318	1,904	1,213	3,980	2,488	1,682	4,204	2,493
County data, primary care physicians per 100,000 pop.	80.8	19.5	146.2	59	95.1	20.2	19.3	22.6	98	52.3	30.6	68	31.9
County data, dentists per 100,000 pop.	25.7	31.1	66.6	29.5	54.1	26.9	9.7	67.8	38.5	17.4	20.4	18.9	25.5

Community Health Status Indicators Project Working Group. Data Sources, Definitions, and Notes for CHSI2009. Department of Health and Human Services, Washington, DC: 2009. Available at http://communityhealth.hhs.gov.

* Taken from the Behavioral Risk Factor Surveillance System (BRFSS), a survey conducted jointly by states and the Centers for Disease Control and Prevention. County-level BRFSS survey data from 2000 to 2006 are presented.

Table Notes

POPULATION SIZE: This number is from "Annual estimates of the resident population by age, sex, race, and Hispanic origin for counties: April 1, 2000 to July 1, 2008," obtained from the Population Estimates Program, Population Division, U.S. Census Bureau. These data are mid-year estimates of the resident population for 2008, and can be obtained at http://www.census.gov/popest/counties/asrh/CC-EST2008-alldata.html.

POPULATION DENSITY: This number is calculated by using the following formula: mid-year 2008 Population Estimate divided by 2000 Land Area (square miles). Land area is from the Geographic Comparison Table GCT-PH1-R. Population, Housing Units, Area and Density: 2000, Census 2000 Summary File (SF1) 100-Percent Data, U.S. Census Bureau. "2000 Land Area by County" is a statistical abstract supplement published by the U.S. Bureau of the Census and obtained from the Area Resource File, Health Resources and Services Administration, 2008; http://www.arfsys.com/.

POVERTY LEVEL: The percentage of individuals living below the poverty level in 2008 is data obtained from the "Small Area Income Poverty Estimates (SAIPE)," U.S. Bureau of the Census and can be obtained at http://www.census.gov/did/www/saipe/data/statecounty/data/index.html.

POPULATION BY RACE/ETHNICITY: Race- and ethnicity-specific population sizes are from "Annual estimates of the resident population by age, sex, race, and Hispanic origin for counties: April 1, 2000 to July 1, 2008." These data are mid-year estimates of the resident population of 2008, and reflect standard race and ethnicity categories in use by the U.S. Bureau of the Census, and can be obtained at http://www.census.gov/popest/counties/asrh/CC-EST2008-alldata.html. Note, the percentages of white, black, Asian American/Pacific Islander, and American Indian do not total to 100% due to the multiple race category. The percent Hispanic is non-additive with the race categories. The reader is advised that populations cross-classified by race and ethnicity (e.g., non-Hispanic white; non-Hispanic black, etc.) are available at http://wonder.cdc.gov/Bridged-Race-v2008.HTML.

SELF-RATED HEALTH STATUS: The percentage of adults aged 18 years and older who report "fair" or "poor" overall health is provided by the Behavioral Risk Factor Surveillance System (BRFSS), 2000–2006, a survey conducted jointly by states and the Centers for Disease Control and Prevention. County-specific data are only reported for this indicator and average number of unhealthy days in the past month (below) if there are more than 50 respondents in the specific time period to the survey; BRFSS generated state weights are used in calculating the county prevalence.

NO HIGH SCHOOL DIPLOMA: The number of individuals aged 25 years and older who have not graduated from high school. Prevalence estimates of no high school diploma (from the 2000 Census of Population and Housing Demographic Profile: 2000, U.S. Census Bureau, STF3A, U.S. Bureau of the Census, and obtained from the Health Resources and Services Administration, 2008) were applied to the mid-year 2008 county population estimates (ages>=25).

UNEMPLOYED INDIVIDUALS: The number of persons who had no employment, were available for work, and had made specific efforts to find employment was obtained. The number of unemployed individuals for each county was obtained from Bureau of Labor Statistics' Labor Force Data by County, 2008 Annual Averages. This data is available at http://www.bls.gov/lau/.

MAJOR DEPRESSION: An estimate of the number of individuals aged 18 years and older experiencing a major depressive episode during the past year, was calculated by multiplying 2006–2007 Annual Averages Major depression prevalence by state for age 18 and older by 2008 mid-year county population estimates for people aged 18 years and older. The 2006–2007 annual average prevalence is from the U.S. Substance Abuse and Mental Health Services Administration (SAMHSA), Office of Applied Statistics State-age-specific percentage of adults 18 years and older experiencing a major depressive episode during the past year from website http://www.oas.samhsa.gov/2k7State/AppB.htm#TabB-24, Table B.24 Having at Least One Major Depressive Episode in Past Year, by Age Group and State: Percentages, Annual Averages Based on 2006 and 2007. Definition of a major depressive episode can be accessed electronically at http://www.oas.samhsa.gov/2k7State/Ch6.htm#6.2. Estimates are based on state prevalence information and adjusted to reflect local demographic characteristics; therefore these estimates may not be as accurate as when measured directly at the county level.

RECENT DRUG USE: An estimate of the number of individuals aged 12 years and older using illicit drugs within the past month was calculated. The figure was calculated by multiplying 2006–2007 Percentages Reporting Past Month Use of Any Illicit Drug by Age Group and State for age 12 and older by 2008 county population estimates for ages 12 and older. Illicit drug use includes use of one or more of the following: marijuana, cocaine (including crack), heroin, hallucinogens (including LSD and PCP), inhalants, or non-medical use of psychotherapeutics, Substance Abuse and Mental Health Services Administration (SAMHSA, Office of Applied Statistics, Table B.1 Illicit Drug Use in Past Month, by Age Group and State: Percentages, Annual Averages Based on 2006-2007 NSDUHs). This publication can be accessed electronically at http://www.oas.samhsa.gov/2k7state/AppB.htm#TabB-1. Estimates are based on state-level prevalence information and adjusted to reflect local demographic characteristics; therefore, these estimates may not be as accurate as when measured directly at the county level.

NO EXERCISE: The percentage of adults reporting of no participation in any leisure-time physical activities or exercises in the past month.

FEW FRUITS/VEGETABLES: The percentage of adults reporting an average fruit and vegetable consumption of less than 5 servings per day.

OBESITY: The calculated percentage of adults at risk for health problems related to being overweight, based on body mass index (BMI). A BMI of 30.0 or greater is considered obese. To calculate BMI, multiply weight in pounds by 703 and divide the result by height (in inches) squared.

HIGH BLOOD PRESSURE: The percentage of adults who responded yes to the question, "Have you ever been told by a doctor, nurse, or other health professional that you have high blood pressure?"

SMOKER: The percentage of adults who responded "yes" to the question, "Do you smoke cigarettes now?"

DIABETES: The percentage of adults who responded "yes" to the question, "Have you ever been told by a doctor that you have diabetes?"

UNINSURED INDIVIDUALS: The estimated number of uninsured individuals under age 65 in the county in 2006 is from the U.S. Census Bureau, Small Area Health Insurance Estimates Program (SAHIE). The SAHIE program models county-level health insurance coverage by combining survey data with population estimates and administrative records. Data and information on survey methodology and confidence intervals are found at http://www.census.gov/did/www/sahie/methods/index.html.

PRIMARY CARE PHYSICIANSAREA: This is the total number of active, non-federal physicians per 100,000 population in 2007. This figure includes those who practice in one of the four primary care specialties — general or family practice, general internal medicine, pediatrics, and obstetrics and gynecology. Source: American Medical Association Physician Master File, 2007, Resource File, Health Resources and Services Administration 2008; http://www.arfsys.com/.

DENTISTS AREA RESOURCE FILE: This is the total number of active dentists per 100,000 population, 2007. Source: American Dental Association, State and County Demographic Reports, 2007, Health Resources and Services Administration, 2008; http://www.arfsys.com/.

WVCONNECT

Evaluation of a Pilot Project to Expand Coverage and Access to Care for Working Uninsured West Virginia Residents

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An evaluation conducted by the
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