

# Connecting Neighbors for Better Health

Wider Circle creates trusted community circles that have been shown to improve quality, drive access to care, and reduce unplanned utilization.

## Presented By:

Claude Pinnock MD, MPH, *Chief Medical Officer* – **Wider Circle**

Bill Friedman, *VP of Payer and Provider Engagement* - **Wider Circle**





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# Who we are

We are a healthcare company addressing SDoH with a novel community care model. Wider Circle employs analytics, social engineering and the psychology of influence to form lasting neighborhood groups – or circles – of health plan members.

## Neighbors helping neighbors.

Wider Circle members inform, support, and motivate their neighbors to achieve better health in a culturally competent manner. When your circle is bigger, life is better: **Engaged members are happier, healthier, more active, and overcome isolation.**

**Driving lower costs and higher engagement and retention.**

# How we do it

- Data science team combines eligibility and claims metrics to group population into separate cohorts
- Group individuals by **shared life experience** and current health challenges
- Member cohorts engage in more **health-focused gatherings** to address issues such as cardiovascular disease, chronic kidney disease, COPD, dementia, exercise, diet, screenings, and other topics
- Community Engagement Liaisons from the communities they will serve are introduced to groups to build trust and facilitate in-person and virtual events
- Identify potential ambassadors from cohort groups to take on a larger role and use their influence to **change health behaviors**
- Leverage technology to help members **stay connected** and facilitate the most effective outcomes

# SBDoH and isolation

- Payers and regulators are beginning to acknowledge the impact that social and behavioral determinants of health (SBDoH) can have on improving a person's well-being and lowering healthcare costs.
- SBDoH disproportionately affects seniors and lower-income communities in the U.S. and globally.
- The complexities of the current healthcare system do not support a widespread model for payers and providers to address these factors where they exist, upstream in the community.
- Current communications pipelines are not effective; payers are often unable to reach members via most used channels.
- SBDOH are increasingly seen as an underlying driver of up to 30-80% of variation in health outcomes





# SBDoH solution

- Establishing trust between members. This basis of trust helps with populations that are historically underserved and have storied histories of inequity and distrust of the healthcare system.
- Leverage proprietary technology to group individuals together, to create a neighborhood network of members linked by similar challenges who influence and support one another.
- Eliminate the absence of community void to tackle issues and influence behavior change upstream of traditional healthcare settings.

***We create communities that support one another, help build connections, tackle SBDoH and other important health topics that need to be addressed.***



# Our footprint

- Wider Circle is active in 12 states
- Today we serve sponsors and members locally in thousands of communities and in seven different languages
- Additional states can be stood up within 60 days





# How it works: Connect for Life®



## Human Connection

Local meet-ups revive **latent connections**

Relationships drive **engagement**



Purposeful peers support **lasting behavior change**

### Local Community Staff

- Trained and coached by Wider Circle
- Immersed in the local culture
- Facilitate introductions and nurture group formation

### Build Trusted Connections

- Breed familiarity and trust through 4–6 weekly sessions
- Nurture similar experiences and diversity
- Weave in behavioral narratives for physical and mental health

### Ambassador Driven Chapters

- We identify and empower influential, purpose-driven community leaders
- They then go on to use their peer influence to support others with behavior change.

# How it works: Connect for Life®

**Algorithms** identify affinity and need-based groups



Technology assists our local team in **building communities**



Members **stay in touch** with us and each other



**Powered by Technology**

- Identify high opportunity individuals
- Group similar individuals based on their lived experiences
- Evaluate outcomes to help sharpen the program focus

- Seamless connection via multiple channels
- Member context that we can build upon
- A collaborative hub for events and resources
- A knowledge center with action planning guide

- RSVP to events and see who is coming
- Keep the conversation going after the events
- Check-in and connect with the facilitator and ambassadors

# Connect for Life<sup>®</sup> journey

Extending care management reach by building trust in the last mile

1

## Onboard.

We engage and enroll target patients into 6-week onboarding programs that surface barriers to optimal care.



*As trust builds, members surface hesitations and questions about their care*

2

## Social connections drive health improvement.

Members join larger community groups that meet regularly and offer ongoing support.



*Community builds trusted relationships where vendors can't*

3

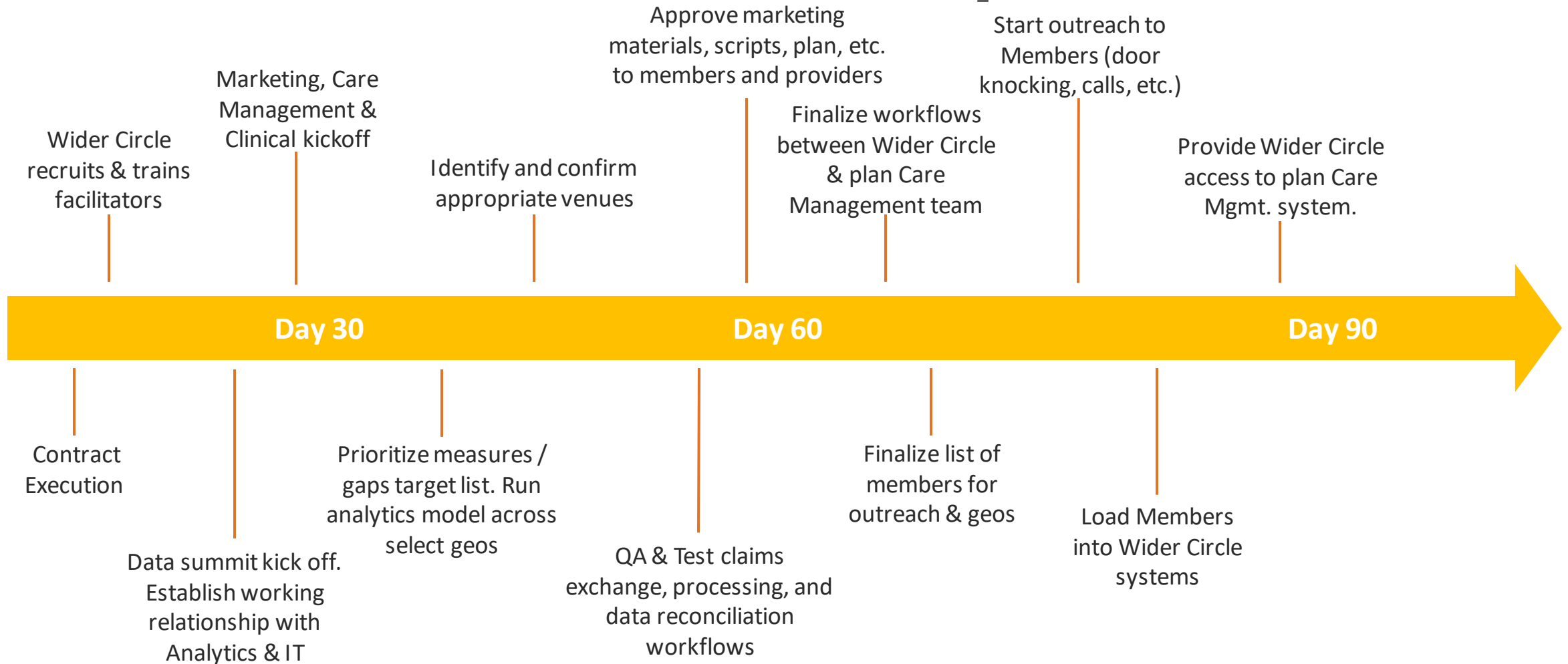
## Expand the impact.

Our volunteer ambassadors continue our mission of community engagement for health.



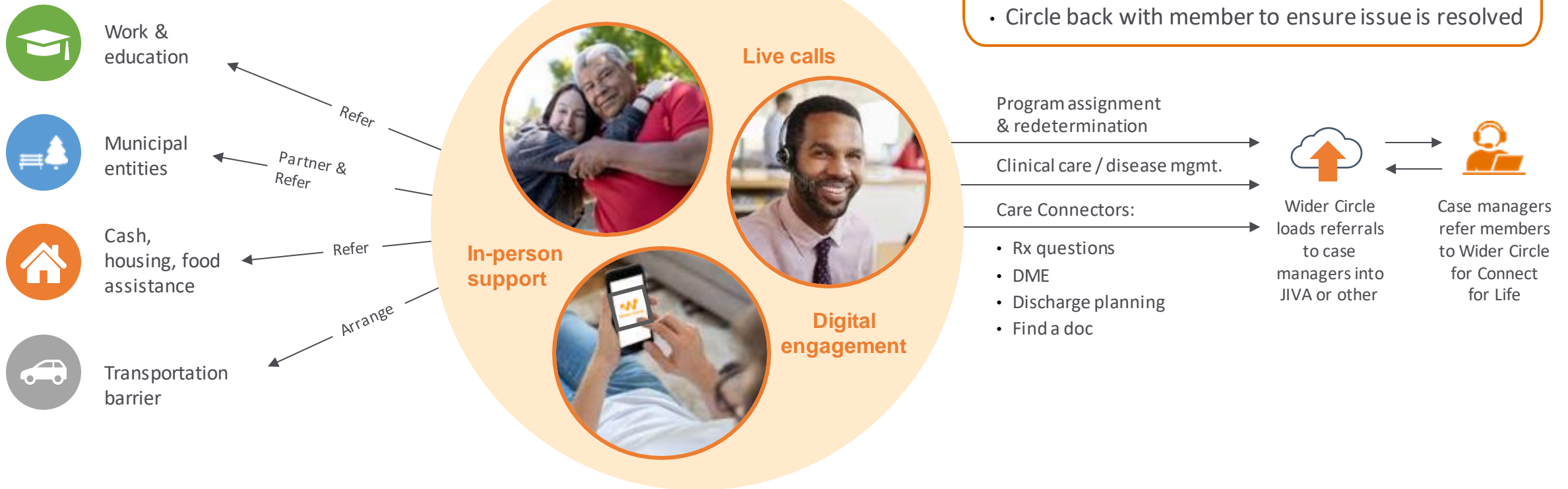
*Ambassadors help members navigate care and act*

# Connect for Life<sup>®</sup> rollout process



# Wider Circle activates SDoH support ecosystem, coordinates members needs with the sponsor

## Circle of Trust





# Eye-opening results



**\$138**

**PMPM overall savings**



**50%**

**lower disenrollment rate**



**14 fewer**

**emergency department visits<sup>1</sup>**

<sup>1</sup>Per 1,000 Wider Circle members versus general population



- 22.5% improvement in annual wellness visits
- Members are 3.8x less likely to consider themselves lonely
- 64.5 overall Net Promoter Score (NPS)
- Attrition rate 20.2% in control vs. 11.9% in CFL group

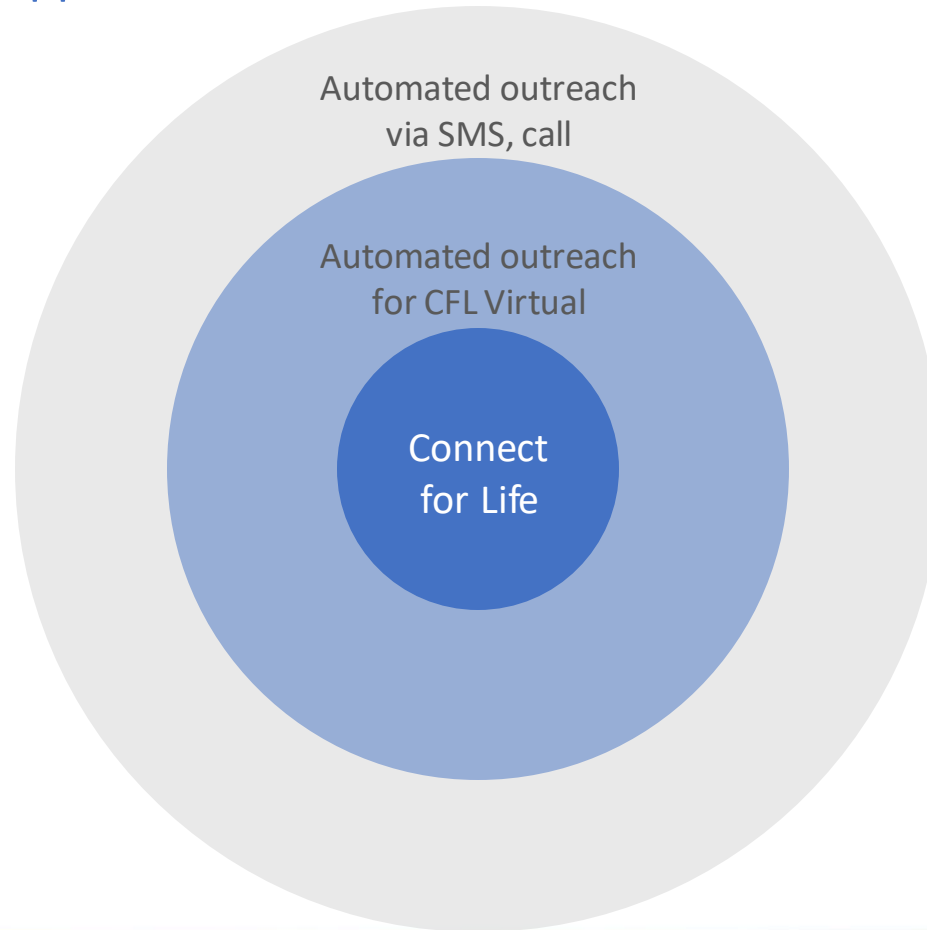


**RISE**

# Driving population health outcomes using an orchestrated multi-channel engagement strategy

Engagement approach based on member risk and value of intervention

Outreach to  
**100%**  
of population  
in program  
year



## Engagement Priorities

**CAHPS: Member experience and education**

**Objective:** Member retention and satisfaction

**Gap closure, chronic condition maintenance**

**Objective:** PCP attribution and AWVs

**Preventative care and screenings**

**Objective:** AWVs, gap closure, chronic condition mgmt. to reduce acute utilization

## Unplanned Utilization Risk



**Multi-channel demand gen campaigns engage hard-to-reach members:**

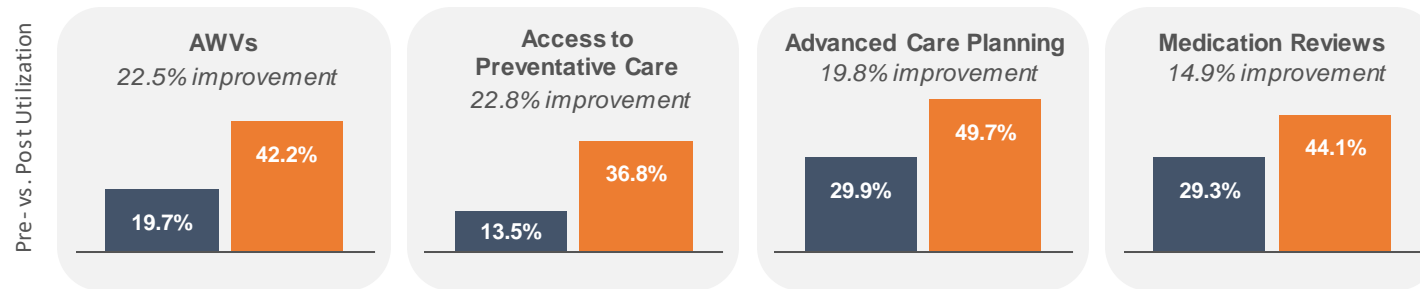
- Automated calls
- Live calls
- SMS
- Digital campaigns
- Neighborhood canvas
- Ambassador network

# Success story 1



## Quality Outcomes

The analysis below shows that CFL members closed quality gaps at a higher rate than controls. All differences statistically significant.



# 45%

of CFL member spend originated in a preventative care setting, compared to 33% for controls

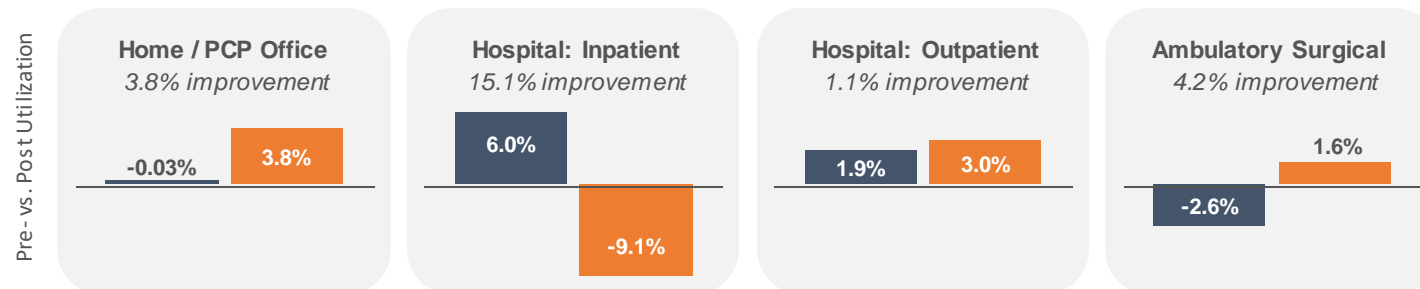
CFL members showed

# 50%

reduction in voluntary attrition and lower inpatient hospital costs

## Utilization Outcomes

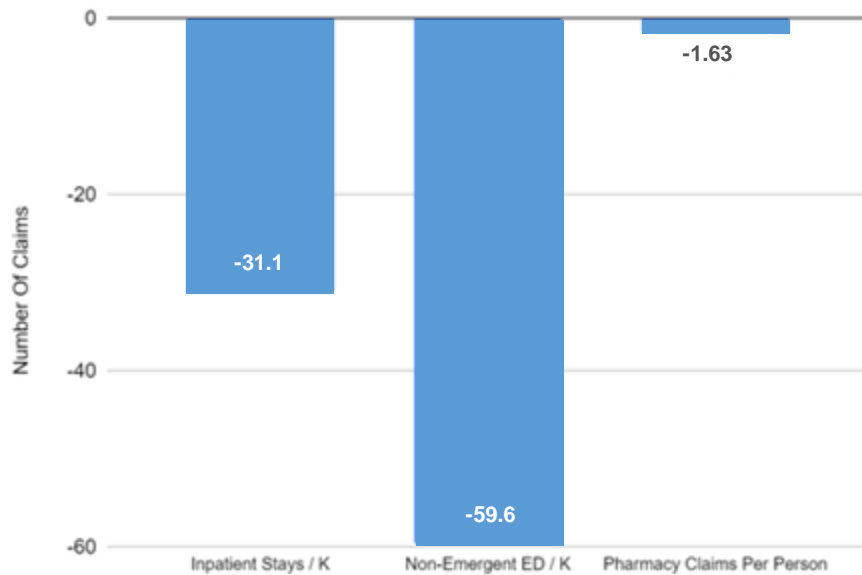
Outcomes demonstrate Connect for Life members shifting from acute care utilization in facility settings to primary preventative care.



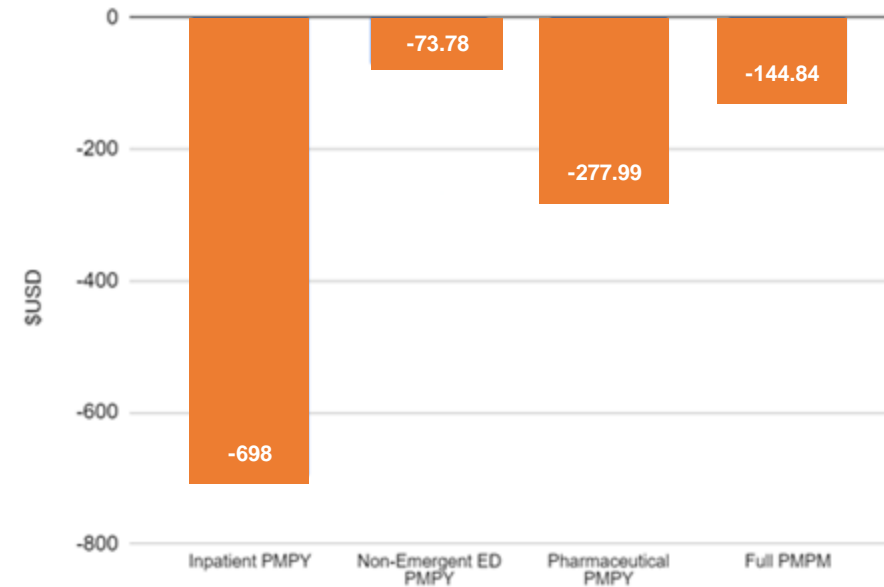
■ Control ■ Connect for Life

# Success story 2 - major BCBS plan

### Wider Circle Change Compared to Control in Utilization



### Wider Circle Cost Change Compared to Control



Wider Circle members had statistically significant lower PMPM:

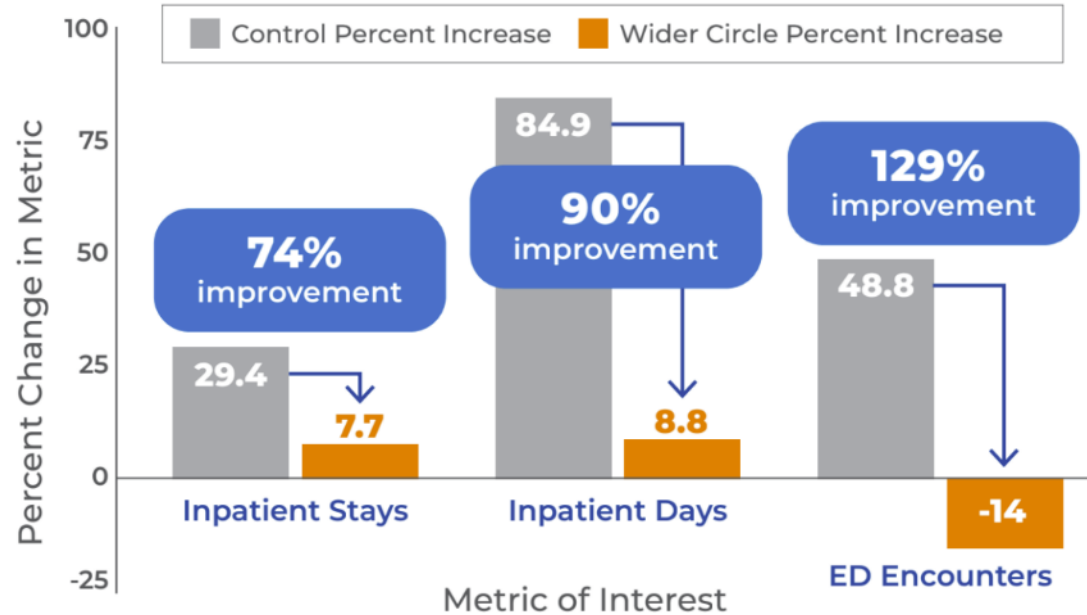
**\$114**

versus controls with equal or improved quality

# Success story 3

## Chronic Kidney Disease, End-Stage Renal Disease

### Change in Metrics Post-Intervention Period



- CKD can reduce quality of life and lead to depression and isolation
- To help combat and assist those with the disease, Wider Circle worked with a Medicare Advantage population ranging from stage 1 through end-stage disease

Bolstered by its  
**Connect for Life**  
Program, Wider Circle delivered:



Better health  
outcomes



Lower costs



Reduced  
emergency room  
department  
utilization for  
members



# Success story 4 – major national MA plan

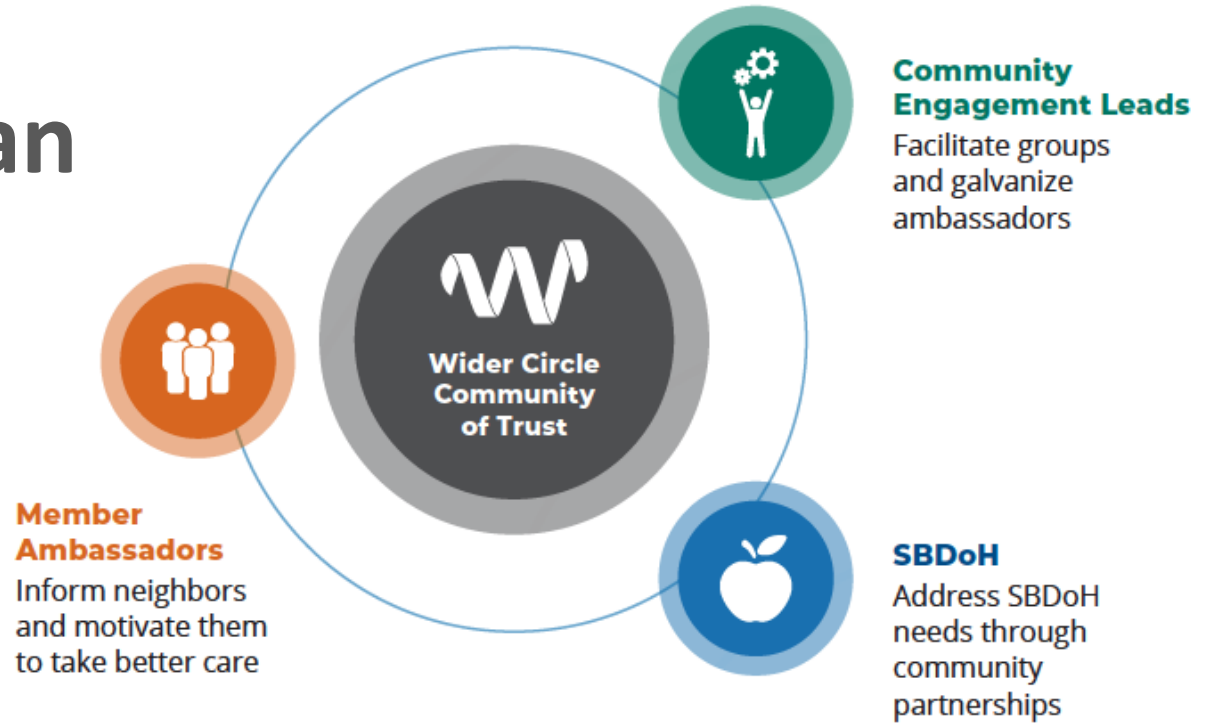
Wider Circle Members had a statistically significant better score of

**65%**

for loneliness using the validated UCLA 3-item scale

**3.8x**

more likely to go from being lonely to not lonely (p<0.0001)



	Wider Circle	Control
Percentage of days where health was not good:	<b>38%</b> improvement	<b>5%</b> worsening
Loneliness	<b>57%</b> improvement	<b>8.3%</b> worsening

# Maternal health program – Moms Connect for Life

Uplifts, Supports and Drives the best possible experience of pregnancy and motherhood

## Build community, address SDoH and disparities

- Identify distinct challenges low-income women face in obtaining reproductive health care in diverse communities.
- Group mothers together by their expected due date in Medicaid so they can share their experiences, challenges and how they overcame them.
- Provide peer-based support to reduce low birth weight, preterm birth, and other adverse outcomes throughout pregnancy.

## Tailored content and peer-to-peer community support

### Resources

- Classes
- Experts in the field
- Post-pregnancy information
- Network of friendships
- New skills, knowledge & more!



### Addressing barriers

- SDoH needs
- Gestational diabetes
- Pre-existing conditions
- Breastfeeding initiation and continuation
- Vaccination
- Maximizing the chances of having a full-term birth and a healthy infant

# Wider Circle outcomes

Wider Circle's maternity cohort Medicaid program **engagement rate = 3X higher**




- **88%** felt supported throughout their pregnancy
- **100%** felt they were given useful materials and resources in the program
- **100%** felt they understood the actions they needed to take to support their pregnancy.

## Areas of support include:

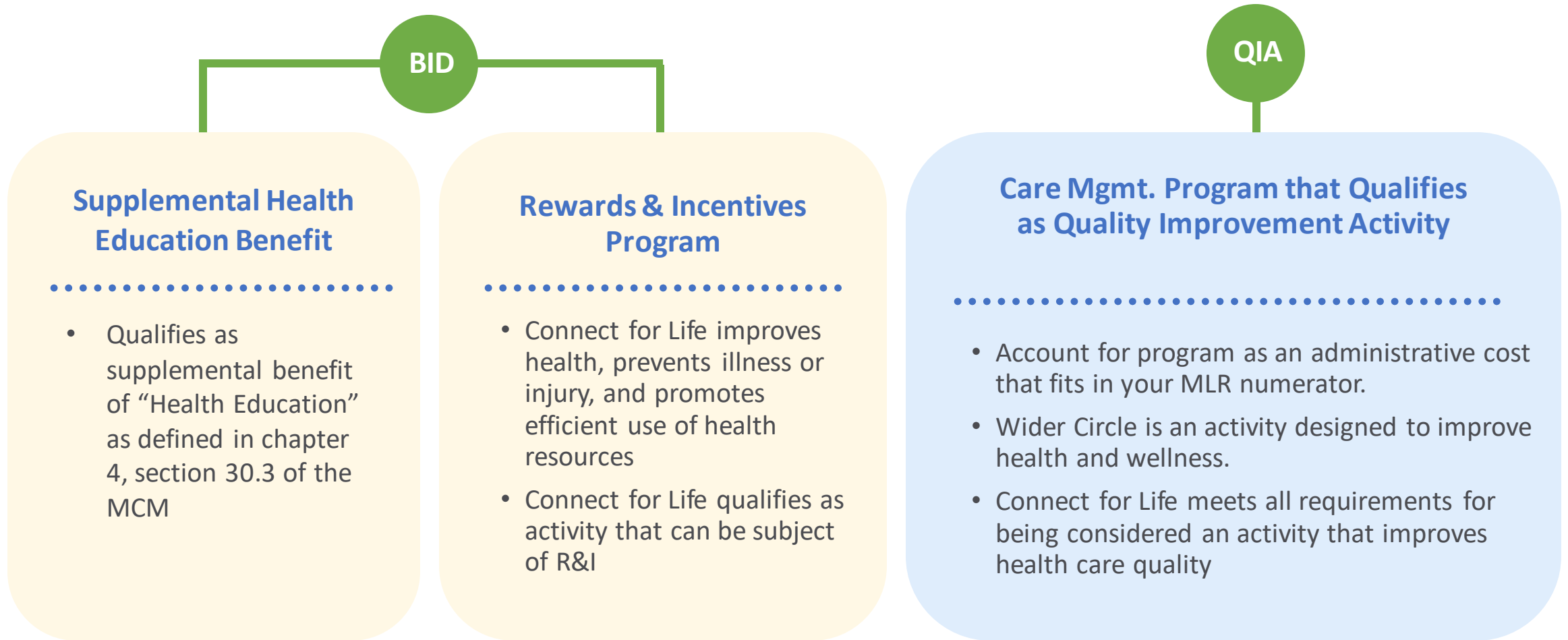
Dietary & healthy eating habits • Breastfeeding • Appropriate exercise • Harmful habits - alcohol consumption, smoking, drug use • Emotional well-being • Resource for housing, transportation & everyday necessities

# Sample performance incentive metrics

Wider Circle creates hyper-local peer support groups that motivate members to take better care of themselves and each other. While we routinely close HEDIS gaps, raise CAHPS and improve member satisfaction, the performance metrics below build a straightforward financial ROI for the program:

Performance Metric	Measure vs. Control	Value Per Unit Improvement	Performance Goal	Equivalent PMPM	Note
 <b>Annual Wellness Visit</b>	Incremental AWW's per K	\$2,400	20 Incremental AWW's per K	\$4.00	Average HCC capture leading to an incremental RAF improvement of 0.2 and average Medicare/DSNP member rate of \$12K PM
 <b>Member Retention</b>	Incremental members retained per K	\$1,800	27 Incremental members retained per K	\$4.05	15% MLR and average Medicare/DSNP member rate of \$12K PMPY
 <b>Hospital Days</b>	Decrement in hospital days per K	\$2,800	17 Fewer hospital days per K	\$3.97	\$2,800 per hospital day

# Wider Circle fits in your MLR as a QIA or in the bid





# How we work with you and your population

## Leverage claims data

and collaborate with you to identify your priorities, in which populations they exist, and to address outstanding issues and care gaps.

## Advancing care

for your Medicare and Medicaid members by going into their neighborhoods, building communities, and addressing SDoH challenges for your hard-to-reach members.

## Through scalability

with our supporting technology, we demonstrate a 3:1 ROI, leveraging our proprietary analytics engine, delivering monthly reporting and consistently high member NPS scores.

## Supercharge your existing community initiatives

and make your community health workers' lives easier by addressing gaps and guiding members towards the appropriate channels.



# We want to hear from you



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**Questions?**