Initiatives to Tackle Social Determinants of Health and Improve Care

Alan Gilbert, Vice President New Business Initiatives & Drivers of Health Strategy

Access to Quality Care

- **95%** of physicians
- **96%** of hospitals

1 in **8 Americans or**
more than **40 million**
total medical members in affiliated health plans

- more than **77 million**
total lives served

Q2 2019 data

Member access through BCBSA’s national BlueCard® PPO program

Corporate Social Responsibility

- **$59.2 million**
in open community activity across the country

- **$7.1 million**
raised in 2018 through our Employee Giving Program

- **76,000**
employee volunteer hours through Anthem’s Dollars for Doers Program in 2018

- **10 million**
Americans trained in Hands-Only CPR, on track to double cardiac arrest survival rates

- **16 million**
kids engaged in healthy, active lifestyle programming while increasing fruit and vegetable consumption

Vision: To be the most Innovative, Valuable and Inclusive Partner

- **65,000** Associates

- **73%** of Anthem’s workforce are women
- **42%** of Anthem’s workforce are minorities

*Note: Service area includes all or portions of affiliated plans’ state, effective 1/1/19.

**14 states**
BC or BCBS licensed plans (5)

**23 states and DC**
BC or BCBS licensed plans + Medicaid presence (9)

Medicaid presence (13)
Anthem’s Drivers of Health Intervention Portfolio

**Enhanced Case Management**
Community health workers helping high risk members connect to local resources.

**Local Resource Connection**
Helping to connect members with curated local resources.

**Togetherness Program**
Addressing social isolation with outreach from non clinical teams.

**Food as Medicine**
Working with essential hospitals in food deserts so people are educated and provided with healthier food options.

**Mobile Groceries & Food Pantries**
Partnering to bring fresh foods to food deserts and increases local capacity.

**Medically Tailored Meals**
Conditions like Diabetes are sensitive to diet choices. Medically tailored meals may lower A1C.

**Enhance Care Delivery**

- **Healthy Food**

- **Employment, Education, Housing**
  - **Apprenticeship Program**
    - Offering apprenticeship opportunities for those transitioning from Foster Care.
  - **Education Initiatives**
    - Helping to support health and well-being in schools and after school programs.
  - **Transitional Housing**
    - Helps homeless members discharged from hospital with no where to go with housing for 30 – 60 days.
  - **NEMT**
    - Expanding benefits for NEMT in transit deserts to help those who experience transit as a barrier to care.
  - **On Demand Transportation**
    - Making getting to and from appointments easier & more cost effective.
  - **Paramedicine & Home Visits**
    - Enabling care on the spot when appropriate and not requiring the person to go to the ER.

**Transportation & Access to Care**

*Examples, not exhaustive list*
Blue Triangle: Indianapolis, Indiana
Homelessness in Indiana: Why we developed a housing program?

30,000
People
Experiencing Homelessness in Indiana

12,000
Individuals
Experiencing Homelessness in Indianapolis who utilized homeless services during 2017

2,700
Anthem Members
Experiencing Homelessness in Indianapolis
Blue Triangle Program Overview

**Structure**
- 53 Efficiency Units (Studio Apartments)
- 2 dedicated PSH units and 2 ADA compliant units
- On-site Support Services Staff
- Laundry & Computers
- Overnight Security
- Only Anthem Medicaid Members

**Philosophy**
- Low Barrier
- Transitional/Safe Haven
- Harm Reduction Approach
- Social Determinant of Health Focus
- Service Connection
- Meet People Where They Are

**Blue Triangle follows housing first philosophy; first provide housing, then surround members with support services**
Blue Triangle is a collaboration among public, private, not-for profit entities.
# Blue Triangle Program Outcomes Measures

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<thead>
<tr>
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<th>IP Mental Health</th>
<th>IP Physical Health</th>
<th>Nursing Facility</th>
<th>OP ER</th>
<th>OP Other</th>
<th>OP Surgical</th>
<th>Primary Care</th>
<th>RX</th>
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</thead>
<tbody>
<tr>
<td>Change Utilization</td>
<td>-61%</td>
<td>-55%</td>
<td>-82%</td>
<td>-49%</td>
<td>-3%</td>
<td>90%</td>
<td>37%</td>
<td>22%</td>
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*We also saw a substantial decrease in crisis utilization*

*Based on admits /1000 member months for inpatient and visits/1000 member months for outpatient services.*
It’s All About... FOOD
CareMore Programs & Services

- Post-Discharge Meals
- Prescribed Meals
- Prescribed Nutrition
- Nutritional Consultations
- Healthy Foods Disease Management Program
- H.O.P.E. Food Pantry
- Eating IPAD Healthy
- Food Raffle
- Volunteering
- CBO Referrals
• **Purpose:** Designed to address existing chronic conditions

• **Target:** For select CA & AZ patients with BMI $\geq 25$ and HbA1c $\geq 9.0$ or Congestive Heart Failure (CHF)

• **Benefit:** 180 home-delivered meals (2 meals per day for 90 days) + nutritional consultations with Registered Dietician / $0$ copay

• **Delivery:** Coordinated through CareMore & Anthem. Delivered by plan approved meals provider

• **Results*: 
  - **YTD Oct 2019** - 48,662 meals delivered to 437 unique members

*Based on 2019 benefit (3 meals per day for 6 weeks/42 days)
New in 2020

• **Purpose:** Designed to address existing chronic conditions

• **Target:** For select Arizona Medicare patients after they’ve exhausted their Prescribed Meals benefit

• **Benefit:** Monthly home-delivery of non-perishable pantry staples and up to 8 telephonic nutritional consultations with Registered Dietician / $0 copay

• **Delivery:** Coordinated through CareMore & Anthem. Pantry items delivered by plan approved food provider and CareMore RDs
• **Purpose:** To provide food insecure patients with access to healthy foods and tools to continue the healthy lifestyle

• **Target:** Memphis, TN diabetic patients with A1C > 7.5 and BMI > 25

• **Benefit:** 3 meals per day for 90 days & consistent nutritional consultations / $0 copay

• **Delivery:** Coordinated through CareMore & Amerigroup. Delivered by plan approved meals provider & CareMore RDs.

• **Results:**
  - 70,000 meals delivered to 50 patients
  - A1c Reduction: 0.6 reduction (10.1 to 9.5)
  - BMI Reduction: 2.3 reduction (39.9 to 37.6)
H.O.P.E. Food Pantry
( Helping Our Patients Eat )

• **Purpose:** To help those with an immediate need for food and connect them to community resources

• **Target:** Texas Medicaid patients who identify as being food insecure during their appointment/SDOH screening

• **Benefit:** One food kit per appointment, unlimited visits / $0 copay

• **Delivery:** Coordinated through TX CareMore Care Center & Tarrant Area Food Bank