

# Anthem<sup>®</sup>



## **Initiatives to Tackle Social Determinants of Health and Improve Care**

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

# Mission:

Improving Lives and Communities. Simplifying Healthcare. Expecting More.



## Access to Quality Care



95%  
of physicians

96%  
of hospitals

Member access through BCBSA's national BlueCard® PPO program

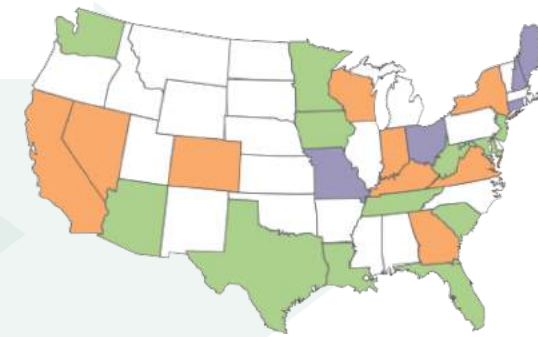
1 in 8  
Americans or  
more than  
**40 million**

total medical members in  
affiliated health plans

more than  
**77 million**

total lives served

Q2 2019 data



BC or BCBS licensed plans (5)

BC or BCBS licensed plans + Medicaid presence (9)

Medicaid presence (13)

14  
states\*  
BC or BCBS plan

23  
states  
and DC  
Medicaid presence

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

## Corporate Social Responsibility



\$59.2  
million

in open community  
activity across the country

76,000

employee volunteer hours  
through Anthem's Dollars for  
Doers Program in 2018

\$7.1  
million

raised in 2018 through  
our Employee Giving  
Program

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

# 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



## Apprenticeship Program

Offering apprenticeship opportunities for those transitioning from Foster Care



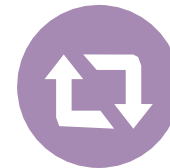
## Education Initiatives

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

### Employment, Education, Housing

### Transportation & Access to Care

*\*Examples, not exhaustive list*

# Blue Triangle: Indianapolis, Indiana



# Homelessness in Indiana: Why we developed a housing program?



# Blue Triangle Program Overview

Blue Triangle Program  
**Structure**

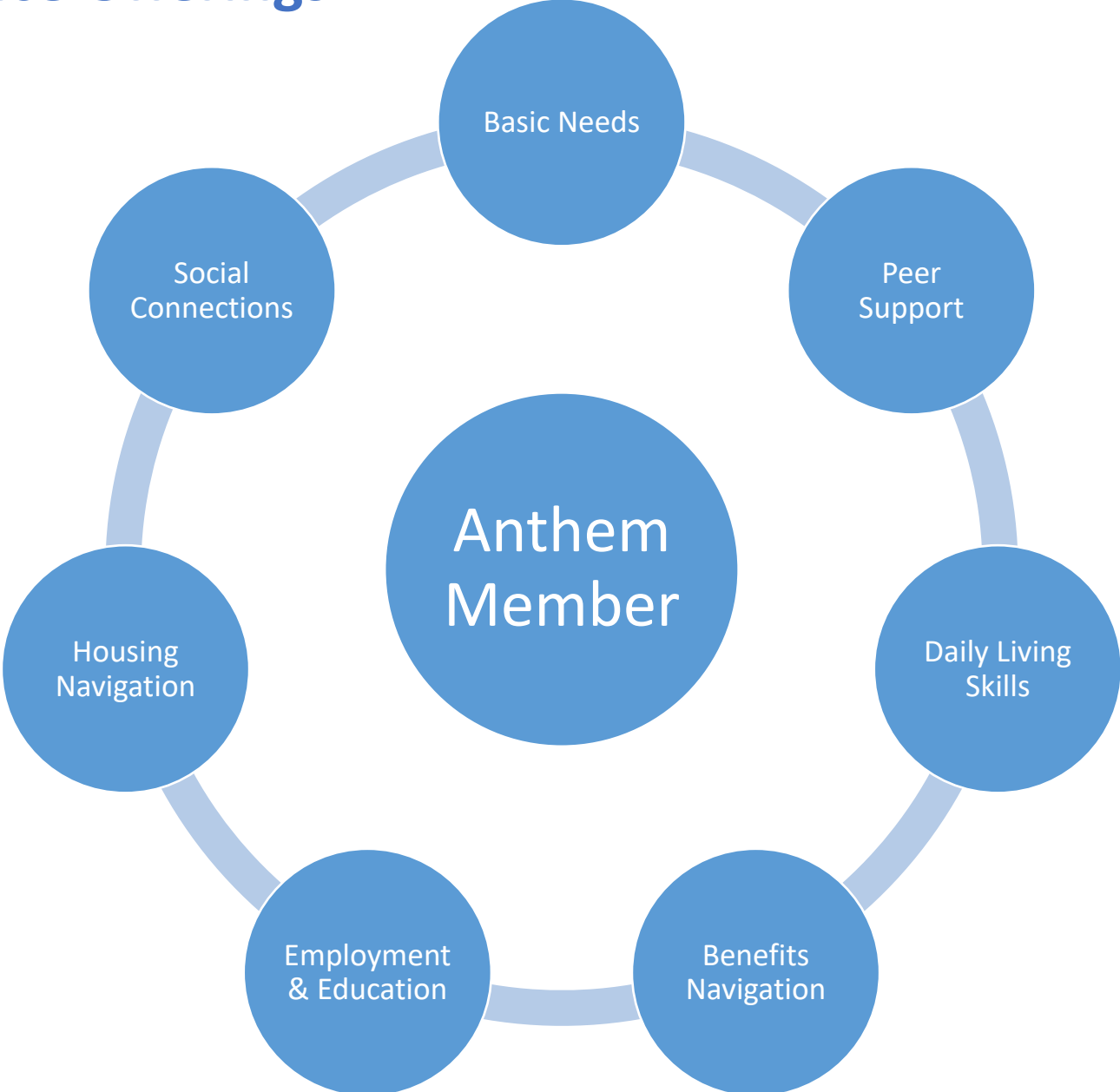
- 53 Efficiency Units (Studio Apartments)
- 2 dedicated PSH units and 2 ADA compliant units
- On-site Support Services Staff
- Laundry & Computers
- Overnight Security
- Only Anthem Medicaid Members

Blue Triangle Program  
**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 Service Offerings



# Blue Triangle Partner Roles & Responsibilities



Blue Triangle is a collaboration among public, private, not-for profit entities.

# Blue Triangle Program Outcomes Measures

	IP Mental Health	IP Physical Health	Nursing Facility	OP ER	OP Other	OP Surgical	Primary Care	RX
Change Utilization	-61%	-55%	-82%	-49%	-3%	90%	37%	22%

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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**  
HEALTH



## 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



# Prescribed Meals

- **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

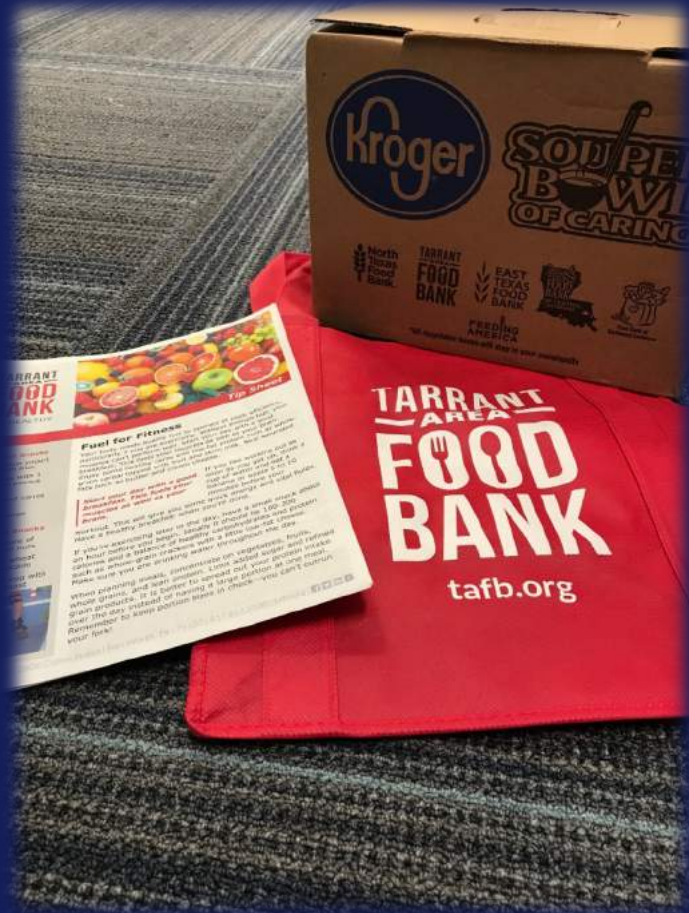


**Prescribed  
Nutrition**

- **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)



## Healthy Foods Disease Management Program (HFDMP)



## 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