Health Equity at the Core of our Whole Health Strategy

Dr. Darrell Gray | Chief Health Equity Officer
Anthem’s Integrated Approach to Advancing Whole Health

**Focuses on improving health equity**, where individuals have fair and just opportunities to be healthy

**Creates a strong health leadership platform**, where we are vocal about our purpose and impact and lead by example on a national stage

**Emphasizes whole health** beyond healthcare, considering individuals’ physical, social, pharmacy, and behavioral health needs

**Optimizes associate and consumer health** and connects individual health to community health
“Health equity means that everyone has a fair and just opportunity to be as healthy as possible.”

— Robert Wood Johnson Foundation (RWJF)
There Is a Difference Between Equality and Equity
Anthem’s health equity objective supports the mission and goals of the enterprise

**Our Objective**

Anthem will **advance health equity** locally and nationally to **improve** lives and communities and be a **lifetime, trusted health partner**

**Guiding Principles**

- **Accountability**: Health equity is a **strategic priority for all** levels of the enterprise. It is a key component of how we **optimize quality, performance, and growth** of our business.

- **Authenticity and Empathy**: We believe **human connection is essential** in driving the necessary conversations and actions to eliminate health inequities; this starts with **acknowledging and tackling the challenges** within ourselves, the Anthem enterprise, and the broader healthcare landscape.

- **Data Driven**: We will leverage an **evidence-based approach** to identify and track health inequities and implement **person-centered, affordable solutions with cultural humility**.

- **Inclusion and Reciprocity**: We honor the **knowledge, experiences, dignity, and diverse backgrounds of individuals and communities**, and we develop **mutually beneficial products, programs, and partnerships** with health equity at the core.
Anthem’s approach to advancing health equity is data-driven, inclusive, and nimble

**What it IS**

1. A plan for ensuring individuals have a fair and just opportunity to be as healthy as possible
2. A focus on health and health care – this includes addressing health-related social needs (HRSN) in order to advance health equity
3. An inclusive approach that addresses whole health among members, providers, associates, and communities
4. A collaborative approach across all lines of business
5. A set of clear priorities and tactics based on data that will identify and eliminate health inequities and improve health care access, quality, and outcomes

**What it is NOT**

1. A judgement of individual personal opinions
2. A siloed or single solution. A more equitable health care system will be the result of coordinated and ongoing efforts by all parts of Anthem
3. Limited to health-related social needs (HRSN)
4. An exhaustive inventory of Anthem’s health equity efforts – we acknowledge there may be initiatives addressing health equity that have not been captured here
5. A static and/or inflexible approach – It is intentionally nimble to local and national needs and expected to evolve over time
Identifying and addressing social needs is a key lever in advancing health equity and whole health.

**Social and Institutional Inequalities**
Poverty, racism, discrimination, classism, ableism, sexism

**Living Conditions**
Housing, transportation, violence, access to good jobs and education, exposure to toxins, income inequality, digital divide, food insecurity

**Health Outcomes, Symptoms**
Poor nutrition, chronic disease, toxic stress, communicable disease, infant mortality, poor mental health, life expectancy, COVID-19 deaths

Health disparities are **costly to consumers** (morbidity, mortality, out-of-pocket costs) and to Anthem.

Health-related social needs contribute to **70-80% of clinical outcomes** (clinical care 20%).

Addressing social needs leads to **significant cost savings**.

Disparities can exist even in high Star plans.

Improving laws and policies that shape community conditions.

Addressing individuals’ social needs.

Addressing health outcomes.
Anthem is uniquely positioned to provide an innovative and end-to-end solution

The industry is making headway with focused initiatives, but no payer has comprehensively embedded an effective way to address health-related social needs into an enterprise strategy; Our clients are asking for social innovation.

Major payers dedicated ~$14M-$270M each to health-related social needs in the past year, and many have branded initiatives, creating urgency for Anthem to differentiate.

**United Healthcare** partners with national and local community-based organizations and is focused on food, transportation and social isolation, including $80 million to fight the pandemic and support vulnerable minority populations disproportionately impacted by COVID-19.

**CVS Health** has members partnered with Unite Us to confront gaps in awareness of community social services.

**Humana** is partnering with NowPow to improve the health of communities across Chicago by identifying and addressing root causes of poor health. *Unite Us now owns NowPow.*

**Kaiser Permanente** has a large-scale initiative called Thrive Local, that will link community organizations with healthcare providers, to create a seamless platform (partnership with Unite Us) for supporting connections between organizations.

**AmeriHealth Caritas** just created Social Determinants of Life subsidiary and invested $30M in Wider Circle (a CA-based tech company).

Nearly 90% of physicians say some of their patients have a social condition that impedes their health; providers are beginning to show ROI from interventions and creating opportunities to partner, especially in value-based arrangements.

Innovators/tech disruptors on drivers of health have earned more than $1B in funding to date, and could enable payers to scale their efforts.

**Providers**

**Innovators**

**SOURCE:** Company websites; press search; Physicians Foundation; Advisory Board

1 The biennial survey from the Physicians Foundation shows 88% of physicians have at least “some” patients impacted by social determinants of health. At the same time, 70% or more physicians in a survey conducted by Advisory Board indicated that they do not believe physicians or insurers are responsible for addressing these needs (e.g., income, transportation).
Anthem’s Whole Health Index: Grounding Our Strategy in Data

We developed a Whole Health Index (WHI) to measure consumer health holistically with a single score that takes community, social and clinical drivers into account. This provides the data infrastructure to support Anthem’s commitment to improve the health of humanity, helps us see the whole picture, and better informs our efforts to improve outcomes for consumers and associates.

A powerful tool
- Track health systematically over time
- Compare statistics for Anthem population segments
- Calculated for both existing and new consumers
- Reports age, sex, racial/ethnic population, rural/urban status and more

A higher WHI score generally means better health

Key Measures and Weighting

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<thead>
<tr>
<th>Percentage</th>
<th>Area</th>
<th>Measures</th>
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<tbody>
<tr>
<td>30%</td>
<td>Global Health</td>
<td>Multiple chronic conditions</td>
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<tr>
<td>50%</td>
<td>Social Drivers</td>
<td>Socioeconomic status, affordability, access to food, transportation</td>
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<tr>
<td>20%</td>
<td>Clinical Quality</td>
<td>Appropriateness of care, preventive care</td>
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## Our Community Connected Care Solution

Anthem has integrated and synchronized social support coordination with healthcare delivery. Current healthcare evaluation limits success to cost of care and quality improvements. **Our approach establishes the evaluation / actuarial foundation for cost predictability.**

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<th>Step</th>
<th>Description</th>
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<td>1</td>
<td><strong>Social Need Identification and Stratification (ID/Strat)</strong> Using insights from the <strong>PRAPARE tool</strong> and other sources to identify the most prevalent social needs and stratifying the population based on those needs.</td>
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| 2    | **Social Care Coordination** Designated pathways to connect members (employees and their families) to related social support based the degree of need either directly or through a support team.  
  
  - **Light Touch ("Social EAP")**: Anthem helps members find local resources to address a presenting social need through a telephonic team of local experts or through digital tools.  
  - **High Touch ("Social Case Management")**: Anthem meets with the member and their family, identifies a comprehensive social resource action plan and works collaborates with a comprehensive network of partners who will work together to resolve the presenting social needs. |
| 3    | **Social Innovation** After identifying trends in social data, *Anthem proactively creates social interventions anchored to targeted health topics or conditions to achieve specific health outcomes.* |
Improving the health of humanity requires that we address drivers of health. Anthem is doing just that.

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