

September 2020

# Health Equity Issue Brief

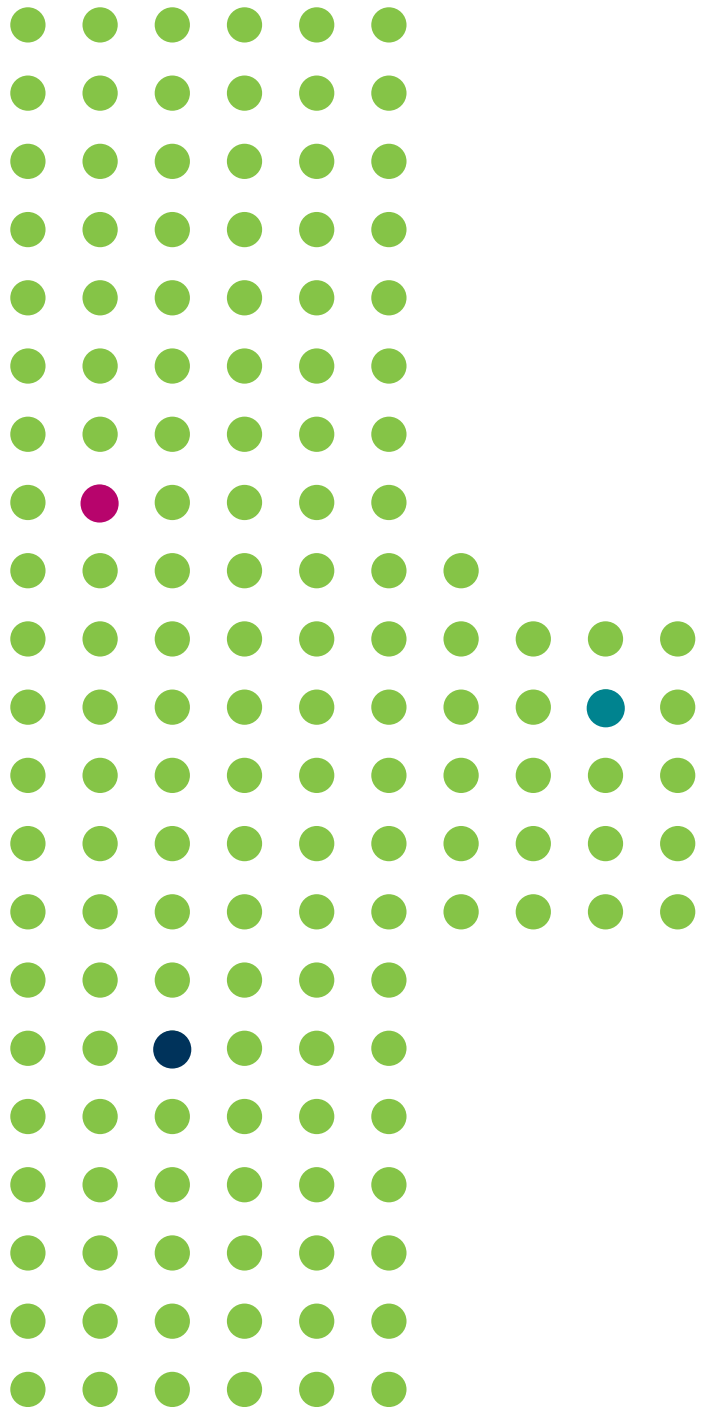
BOLD GOAL,  
POPULATION HEALTH STRATEGY  
OFFICE OF HEALTH AFFAIRS AND ADVOCACY

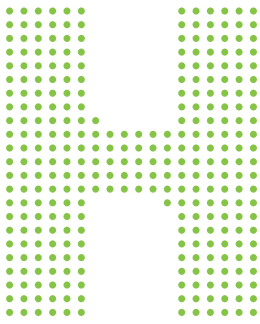
The intent of this policy brief is to inform and update stakeholders on health equity, including current research and public policy. It's meant to spark conversations over opportunities to affect change. Humana's Bold Goal is dedicated to improving the health of the communities we serve 20% by 2020 and beyond by addressing the health of the whole person.

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## The impact of health equity

With each news cycle comes additional evidence that the coronavirus pandemic is having different consequences for Black, Indigenous, and People of Color (BIPOC) versus White people living in the U.S. Tragically, the disproportionate impact of the COVID-19 pandemic on BIPOC only underscores existing health inequities, which result in shorter lifespans and more chronic illness for BIPOC. These inequities span from cradle to grave and are a burden not only on individuals but also on our economy through lost productivity and higher healthcare costs.<sup>1</sup>

The following brief discusses some of the root causes and effects of racial and ethnic health inequity, as well as opportunities for the healthcare sector to advance equity. While it focuses on one type of inequity, we acknowledge there are other minority groups experiencing inequities such as sexual and gender minorities and people with disabilities. In this brief, we are using the acronym BIPOC, which stands for “Black, Indigenous, and People of Color,” a term that originated around 2013 to be more inclusive of historically marginalized groups, when speaking collectively about non-White people in the U.S. who may identify as Black, African American, Hispanic, Latinx, Indigenous, Native, multi-racial, or other ethnic origins.<sup>2</sup> When citing research on inequities facing individual groups, we will use more specific terminology.

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**Health equity means that everyone has a fair and just opportunity to be as healthy as possible.** This requires removing obstacles to health, such as poverty, discrimination, powerlessness, and their consequences, including lack of access to good jobs with fair pay, safe environments, and quality education, housing, and health care.

”

- Robert Wood Johnson Foundation, What Can the Health Care Sector Do to Advance Health Equity? (2019)



## By the numbers

**16.08**  
average

**Unhealthy Days** reported by Black Humana Medicare Advantage (MA) Members in the 2019 Annual Healthy Days Survey, compared to 12.62 Unhealthy Days reported by White members.

**6x**  
higher

**COVID-19 mortality rate** in predominantly Black U.S. counties than in predominantly White counties.<sup>3</sup>

**40%**  
greater

Likelihood a Black adult is to have **high blood pressure** than a non-Hispanic White adult, putting them at greater risk for heart disease and stroke. For women, this increases to 60 percent.<sup>4</sup>

## Causes of health inequity

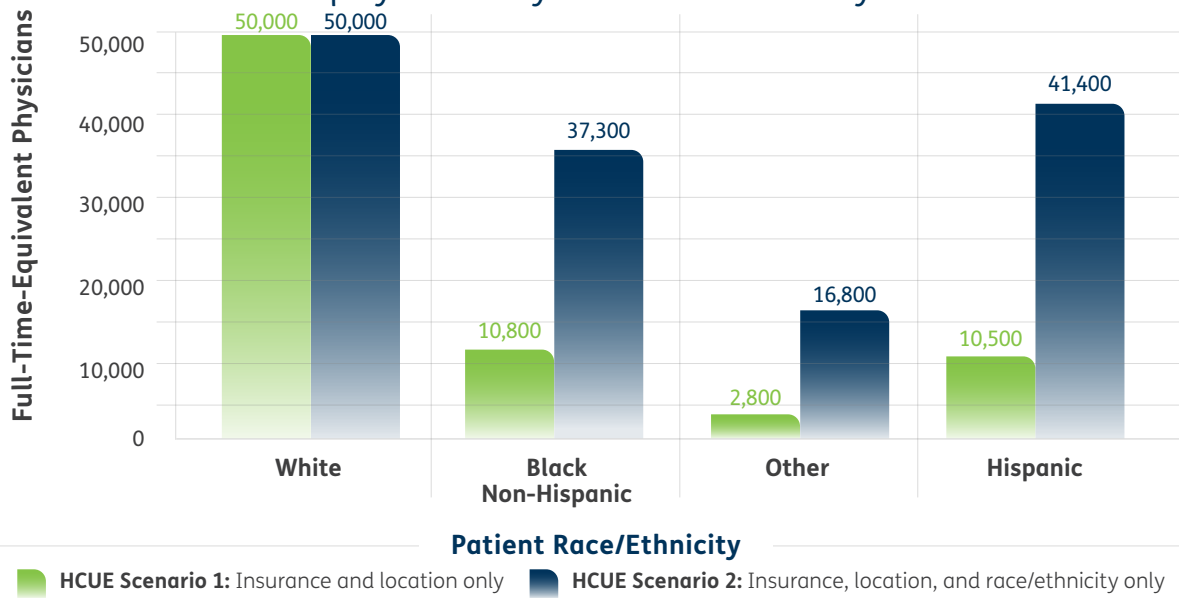
Racial and ethnic health inequities are the result of individual and institutional, or systemic, biases and discrimination in the healthcare system and the U.S. more broadly. What we often perceive as health differences by race and ethnicity are, in actuality, differences in how people are able to experience and benefit from the environmental, economic, or social factors that influence health outcomes. The social determinants of health (SDOH) – including access to healthcare, healthy food, safety, social support, and economic opportunity – and structural determinants of health – such as systemic racism in public policies, labor/employment policies, and cultural values – dictate the choices available to individuals, which, in turn, influence their behavior and their health.

### **Bias, disparate treatment and trust**

On the individual level, most healthcare providers appear to have implicit bias in terms of positive attitudes toward Whites and negative attitudes toward BIPOC. This influences care recommendations in a variety of settings, including acute care and advanced illness.<sup>5</sup> This may be partially explained by the fact that BIPOC are underrepresented among physicians relative to both U.S. and patient demographics. In 2019, 2.6 percent of physicians were Black or African American, 3.8 percent were Hispanic, Latino, or of Spanish origin, 23.3 percent were Asian, and 68.2 percent were of White origin. While the demand for physicians is projected to grow proportionately faster for minority populations in the coming years, the medical school pipeline is not adequate to meet this growing demand for BIPOC physicians.<sup>6</sup> As a result, **Black patients have a much lower chance than White or Asian-American patients of finding a racially concordant physician. Black patients are more likely to trust, and heed the advice of, Black physicians.**<sup>7</sup> This lack of trust in non-racially concordant physicians impairs access to and compliance with quality care and, therefore, health outcomes.



### Additional Physicians Required to Achieve Health Care Utilization Equity in 2018 by Patient Race/Ethnicity<sup>8</sup>



The lack of trust that BIPOC have in White medical professionals and the healthcare systems itself is due not just to individual instances of bias, but also to generations of discrimination and outright medical exploitation. Among the most well-known examples is the Tuskegee Study, an experiment launched in 1932 by the U.S. Public Health Service to study the effect of untreated syphilis on Black men in rural Alabama. In the 1940s, penicillin became the recommended treatment syphilis, but researchers and local physicians recruited to participate in the study withheld treatment without informed consent, causing these men and their loved ones to experience unnecessary suffering and death.<sup>9</sup>

After 40 years, a whistle-blower finally helped bring an end to the experiment in 1972. In subsequent years, Congress established the Tuskegee Health Benefit Program to provide lifetime medical benefits to all living study subjects and the widows and offspring of deceased study participants and enacted the National Research Act to institute basic principles of research conduct. However, **it was not until 25 years after the end of the Tuskegee Study that the men, their families, and the Black community received a formal apology from the President of the United States.** Of the 600 original study subjects, eight survived to hear President Bill Clinton’s apology on May 16, 1997.<sup>10</sup>

Although the Tuskegee Study is emblematic of the inequity in healthcare and medical research (see also numerous examples of experimentation on enslaved African men and women and Native Americans, Alaskans, and Hawaiians, as well as prisoners, people in psychiatric institutions, and orphans), there is also evidence that the public revelation of the study itself led to deepening of medical mistrust and changes in medical behavior among Black males.

**Researchers estimate that life expectancy for Black men fell by up to 1.4 years by 1980 due to lower healthcare utilization in direct response to the 1972 disclosure.<sup>11</sup>**



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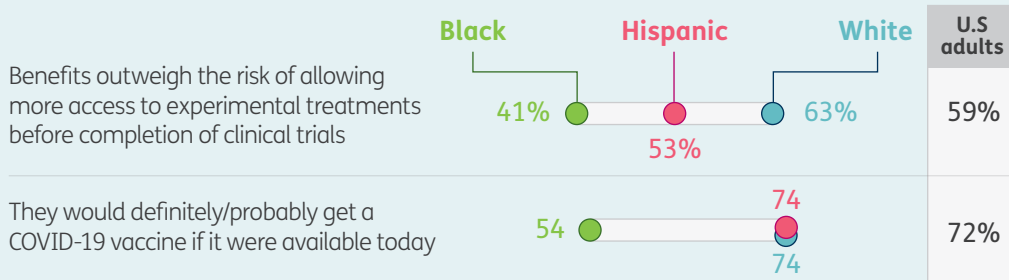
**Without building rapport and trust in these communities, there is no guarantee that the highest risk populations will get the vaccine or that they will even want the vaccine.**

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Mercedes Carnethon, PhD, Professor Of Epidemiology And Vice Chair Of The Department Of Preventive Medicine, Northwestern University Opening statement, The COVID-19 Pandemic and Seniors: A Look at Racial Health Disparities, July 21, 2020

This **real and immediate impact** underscores the crucial role of trust in improving health outcomes – and how ingrained medical mistrust may be for BIPOC. This barrier is particularly acute as the world races to develop a coronavirus vaccine. **In order to ensure the efficacy and safety of a potential vaccine**, a diversity of individuals, including BIPOC, older adults, and people with underlying medical conditions, will need to participate in clinical trials, and then all these individuals must be willing to get the vaccine when one is available to be protected.

In a Pew Research Center survey conducted in April and May 2020, Black Americans were far less likely to say they would definitely or probably get a coronavirus vaccine if one were available than White or Hispanic Americans.<sup>12</sup>

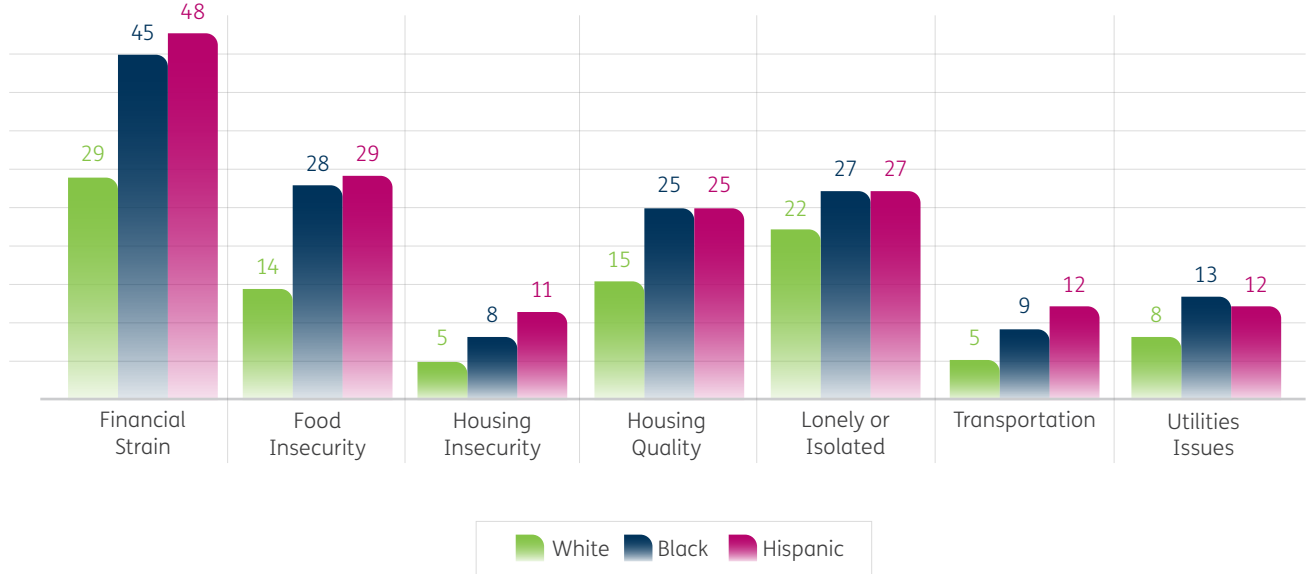




## Health related social needs and policy associations

We must also look to institutions other than healthcare to understand health inequity, as studies that define the drivers of health outcomes consistently indicate social context and healthy behaviors have a much greater impact on health than the delivery of healthcare services. Humana recently conducted a survey to assess the health-related social needs of our MA members (November 2019-February 2020). We learned that Black and Hispanic members have a higher prevalence of all social needs measured. These disparities persist even when looking at only those members who do not qualify for the Part D low-income subsidy (LIS), presumably controlling for the greater number of low-income Black and Hispanic beneficiaries.

### Health Related Social Needs by Race Non-LIS Members (%)



**BIPOC experience a greater burden of social needs because of systemic racial exclusion and discrimination** embedded within our housing, banking, employment, education, and criminal justice policies and institutions that create inequities in both health and economic opportunity. There is considerable research into each of these areas. We will look at housing policy and how it has contributed to the wealth gap between Black and White people living in the U.S. and racial segregation that relegates BIPOC to neighborhoods with poorer opportunities for health and prosperity.



## A Deeper Look Housing policy

In the 1930s, the Home Owners' Loan Corporation was created to stabilize struggling cities and prevent foreclosures during the Great Depression. However, its most enduring legacy is codifying the practice of [denying access to credit and homeownership to Black Americans](#). Government surveyors created color-coded “residential security” maps to rate the desirability of certain neighborhoods for mortgage lending, with the least-desirable neighborhoods colored red. This practice became known as “redlining,” and it disproportionately affected communities of color, withholding capital investment for decades. (The term, “redlining,” is now more generally applied to the discriminatory practice of withholding access to services or investment based on community demographics.)

While redlining in mortgage lending was officially prohibited by the Fair Housing Act of 1968, in three decades the practice had already made a lasting impact both on the built environment of American cities and on the wealth-building and economic stability of generations of Black families.

• **Formerly redlined neighborhoods are still largely racially segregated and lag behind in access to mortgage credit, homeownership rate, and housing value.<sup>13</sup>**

Due to this lack of investment (including from public sources, which, on a local level, rely heavily on property taxes for revenue<sup>14</sup>), BIPOC are more likely to live in neighborhoods that limit their ability to choose healthy behaviors, such as those without sidewalks, bicycling infrastructure, and other opportunities for physical activity.<sup>15,16</sup> They are also more likely to live in “food deserts,” which have limited access to affordable and nutritious food, and “food swamps,” where there is an over-abundance of fast food, junk food outlets, convenience stores, and liquor stores.<sup>17</sup> These neighborhoods are also likely to have [high levels of air pollution and poor tree canopy coverage, which can help mitigate air pollution](#).<sup>18</sup> As a result, residents are at a higher risk for a number of respiratory and cardiovascular conditions and cancers.<sup>19</sup>

Today, city zoning laws perpetuate the legacy of redlining by restricting where affordable, multi-family housing can be built, confining it to under-resourced neighborhoods and frequently near industrial zones.<sup>20</sup> For families unable to buy homes, build capital, and pass accumulated wealth on to their children, the lasting impact of redlining can be seen in limited mobility, as homes in better resourced and less polluted communities are out of reach. Families also have [limited opportunity to invest in healthy behaviors](#), such as better nutrition and physical activity, as well as in health-related factors such as education. These conditions perpetuate ongoing differences in health outcomes between BIPOC and White people living in the U.S.



## Disproportionate impact of health conditions and adverse outcomes on BIPOC (non-exhaustive list)

### Cardiovascular disease (CVD)

- African Americans are nearly twice as likely to die from a stroke.<sup>21</sup>
- CVD age-adjusted death rates are over 30 percent higher for African Americans than for the overall U.S. population<sup>22</sup> and studies have shown they receive less lifesaving treatment (e.g., 30 percent less coronary revascularization) than Whites.<sup>23</sup>

### Cancer

- African Americans have the highest mortality rate and shortest survival of any racial or ethnic group for most cancers.<sup>24</sup>
- African American men have the highest incidence of prostate cancer and have higher mortality than White men have.<sup>25</sup>
- Ethnic minorities are substantially more likely to be diagnosed with cancer at a later stage of the disease, which often leads to less successful treatment.<sup>26</sup>
- Hispanics and African-Americans have lower colon cancer screening rates and higher mortality rates than Whites.<sup>27 28</sup>
- African Americans with colorectal cancer received less aggressive treatment than Whites, even after adjusting for comorbidities, hospital type, and insurance coverage status.<sup>29</sup>

### Diabetes

- Whites have the lowest rates of diabetes, with 7.6 percent of adults aged 20 years or older diagnosed with diabetes. Comparatively, 9.0 percent of Asian American, 12.9 percent of Hispanic, 13.2 percent of African American, and 15.9 percent of American Indian and Alaska Native adults have been diagnosed with diabetes.<sup>30</sup>
- Non-Hispanic Blacks are 2.3 times more likely to be hospitalized for lower limb amputations as compared to non-Hispanic Whites.<sup>31</sup>

### Kidney Disease

- Non-Hispanic Blacks are 3.5 times more likely to be diagnosed with end stage renal disease as compared to non-Hispanic Whites.<sup>32</sup>
- American Indians and Alaska Natives are less likely to receive kidney transplants.<sup>33</sup>

### Infant/Maternal Health

- African American women are twice as likely to give birth prematurely.<sup>34</sup>
- Maternal mortality rates are 2-3 times higher in Black and Native American mothers.<sup>35</sup>
- A Black infant born in the U.S. is more than twice as likely to die before his or her first birthday than a White infant does.<sup>36</sup>

### Behavioral Health

- Minority children were less likely than white children to be diagnosed with attention-deficit/hyperactivity disorder (ADHD), and among those who were diagnosed, racial and ethnic minorities were less likely than Whites to be prescribed medication for the disorder were.<sup>37</sup>





## Political and regulatory landscape

### COVID-19: An inflection point for health equity?

According to the Centers for Disease Control and Prevention (CDC), racial and ethnic minority groups are at a higher risk of COVID-19 for a number of reasons, all related to economic and health inequities that predate the current crisis. The living and working conditions of BIPOC are more likely to put them in close contact with many people and contribute to health circumstances that make it less likely they will seek and receive appropriate care and experience positive outcomes.<sup>38</sup> BIPOC are also more likely to have underlying medical conditions that put them at higher risk for severe complications from COVID-19 infection.<sup>39</sup>

While awareness of health inequity is not new to the healthcare community, since early in the COVID-19 public health crisis, advocates have pressured the CDC and others to collect and report data stratified by patient race and ethnicity to help more clearly measure disparities.

**Centers for Medicare and Medicaid Services (CMS) claims data show gaping racial disparities in the burden of coronavirus.**

**Black individuals who are Medicare beneficiaries have been hospitalized four times (465 per 100k) more than White beneficiaries (123 per 100k) and have contracted the virus nearly three times as often. Hispanic and Asian beneficiaries were also more likely to become infected and hospitalized than White people.<sup>40</sup>**

The stark differences in coronavirus infection rate and outcomes between BIPOC and White people have ignited calls for immediate action to address inequities. In Washington, DC, several congressional committees have held hearings, including the House Education and Labor Committee,<sup>41</sup> House Committee on the Budget,<sup>42</sup> and Senate Special Committee on Aging.<sup>43</sup> Advocates, including prominent professional associations, have called on Congress and the Trump Administration to do more for BIPOC during this crisis. In July, the American Hospital Association, American Medical Association, and American Nurses Association called on Senate leaders to tackle health inequities in a future COVID-19 relief package and recommended specific actions to address the health and social needs of BIPOC and marginalized communities.<sup>44</sup>



## Patient Protection and Affordable Care Act

The Affordable Care Act (ACA), enacted in 2010, made the most significant changes to the American healthcare system – and most targeted action toward health equity – since the creation of Medicare and Medicaid in 1965. While not all ACA provisions have been fully implemented due to court challenges, relevant ACA provisions include:

- **Increasing health insurance coverage** via the individual and employer mandates, Medicaid eligibility expansion, and increasing the age of dependent coverage
- Prohibiting annual and lifetime benefit limits
- Providing specific preventative health services **without cost-sharing**
- Encouraging the shift toward value- or outcomes-based contracting through delivery system reforms and demonstrations, including providing MA plans bonus payments based on quality ratings (Star Ratings).<sup>45 46</sup>

The ACA also elevated the issue of health equity within the U.S. Department of Health and Human Services (HHS) by reauthorizing and funding the HHS Office of Minority Health (OMH), establishing individual offices of minority health within the Agency for Healthcare Research and Quality (AHRQ), CDC, CMS, Food and Drug Administration (FDA), Health Resources and Services Administration (HRSA), and Substance Abuse and Mental Health Services Administration (SAMHSA), and by elevating the National Center on Minority Health and Health Disparities to an institute within the National Institutes of Health (NIH). Collectively, these offices have goals to:

- ↓ **Reduce disparities** in population health
- ↑ **Increase the availability** of data to track and monitor progress in reducing disparities
- ↓ **Reduce disparities** in health insurance coverage and access to care
- ↓ **Reduce disparities** in the quality of healthcare
- ↑ **Increase healthcare workforce diversity** and cultural competency.<sup>47</sup>

OMH funds a number of grants and initiatives each year to further these goals. In 2020, these include a specific focus on disparities related to COVID-19. It launched the National Infrastructure for Mitigating the Impact of COVID-19 (NIMIC) Initiative, which is a three-year cooperative agreement between the OMH and the Morehouse School of Medicine in Atlanta, Georgia, to develop and disseminate culturally and linguistically diverse information on COVID-19.<sup>48</sup>



## Promoting equity through quality measurement and accountability

A number of thought leaders, including the Institute of Medicine in its landmark 2003 assessment of health inequity, *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*, have recommended the promotion of and alignment of incentives to evidence-based guidelines to advance equity.<sup>49</sup>

Some progress has been made to this end, particularly in the process of healthcare delivery for which there are quality measures and clear disease-specific best practices. Research suggests there is minimal difference in the chronic condition management recommended by clinicians for Black, Hispanic, and White patients,<sup>50</sup> and a recent systematic review conducted by researchers at CMS and William H. Shrank, M.D., M.S.H.S., Humana's Chief Medical and Corporate Affairs Officer, have affirmed these conclusions.<sup>51</sup>

Despite the reduction in racial disparities in process measures, **stark inequities persist in health outcomes**. Quality research and accreditation organizations have already provided considerable guidance on how to measure and reduce disparities, and medical societies, such as the American Medical Association (AMA), which created the AMA Center for Health Equity in 2019 and published a health disparities toolkit for physicians, are helping their members implement these standards and best practices.<sup>52</sup> The American Hospital Association also established the Institute for Diversity and Health Equity to advance equity and expand leadership opportunities for BIPOC in health management.<sup>53</sup>

**The National Quality Forum (NQF)** has endorsed a number of disparity-sensitive measures and a framework for measuring cultural competency. NQF has also been exploring social risk adjustment of performance measures and has been commissioned by CMS to develop new methods for social risk adjustment in accountable care organizations and in MA. <sup>54</sup> **The National Committee for Quality Assurance (NCQA)** was contracted by the CMS Office of Minority Health to develop a toolkit to help healthcare providers reduce inequities among BIPOC, people with limited English proficiency, sexual and gender minorities, and people with disabilities by providing culturally and linguistically appropriate services (CLAS).<sup>55</sup> NCQA also offers a Distinction in Multicultural Health Care.<sup>56</sup> In addition, CMS has contracted with NCQA and RAND to develop a new Health Equity Summary Score to characterize the quality-of-care delivered by MA plans to people with social risk factors.<sup>57</sup> At this time, CMS intends this to be a quality-improvement tool rather than a public report.

The **Institute of Medicine** also highlighted value-based contracting as an opportunity to promote equity. It recommended structuring healthcare payment systems to ensure adequate access for minority patients, limit provider incentives to promote disparities, and link payment to favorable clinical outcomes. This includes incentives not only to adhere to evidence-based protocols but also for high scores on patient satisfaction measures.<sup>58</sup> Many states, due to the vulnerable population served, have already incorporated equity and SDOH into their Medicaid managed care contracts and demonstration projects. **In recent years, CMS has increasingly emphasized patient experience in payment models**. On May 22, 2020, CMS issued a final rule for the MA and Part D programs for 2021 and 2022 that increased the weight of patient experience and access measures, as measured through Consumer Assessment of Healthcare Providers and Systems (CAHPS®) and related surveys, in the Star Ratings methodology.<sup>59</sup> CMS uses CAHPS patient experience surveys in other areas as well, including some value-based purchasing programs such as hospitals, home health, and the Merit-based Incentive Payment System (MIPS).<sup>60</sup>



## What Humana is doing

### Addressing the upstream causes of poor health through Medicare Advantage

Key to Humana’s efforts to reduce inequity in our members’ health is a focus on upstream determinants of health. For our MA members, we are addressing these factors by treating health-related social needs – specific needs of individual patients such as food insecurity, transportation access, housing instability, and loneliness – as true “gaps in care.” We have instituted broad screening of our members for social needs. In 2019, we completed over 2.6 million social need screenings with referral to appropriate Humana benefits or programs or community resources.<sup>61</sup>

We are also working closely with physicians, community partners, and national leaders in this space – such as Feeding America and Meals on Wheels – to test and scale interventions to “treat” social needs. Many of these involve deep community collaborations, such as establishing the process to screen patients for food insecurity in their doctor’s office and immediately connect them to the local food bank for benefit enrollment and emergency food provision. Others are interventions that we are incorporating into the health plan benefits we provide to members. We are leveraging new flexibility from CMS to offer non-medical benefits to MA beneficiaries to address social needs, including:

**Value Based Insurance Design (VBID):** An example of this is the Healthy Food Grocery Card. In 2020, we began offering a Healthy Food Grocery Card providing a monthly grocery stipend to low socioeconomic status (SES) members on certain plans under VBID, a CMS Innovation Center demonstration project. With this benefit, we are testing, for the first time, the ability to lower cost and improve quality by targeting benefits based on SES/income. We hope this benefit will alleviate some of the economic impacts of COVID-19 for our members.

**Special Supplemental Benefit for the Chronically Ill (SSBCI):** SSBCI, which is also new in 2020, allows health plans to better tailor benefits to a member’s individual needs, including clinical and social health needs. We are offering benefits to address the financial strain on members and to provide them with services and supports to help them remain safely in their homes. In 2021, Humana – and others – will be expanding these offerings, with a focus on addressing financial strain, loneliness and social isolation, and food insecurity.



## Advancing equity for Medicaid beneficiaries

For our Medicaid beneficiaries, many of whom are BIPOC, issues of health equity are particularly resonant, so we have intentionally built our health plan benefits and programs with this in mind. Steps taken include:

**Incorporation of the National CLAS** standards into our overall Medicaid Population Health Strategy

**Assessing social needs and integrating social factors** into our core clinical model through Health Risk Assessments, Social Needs Assessments, comprehensive assessments, all of which feed into risk stratification for enrollment in case management

**Employing specialized staff** dedicated to addressing unmet social needs and members at high risk for being adversely impacted by SDOH (e.g. community health workers, social determinants of health coordinators, housing specialists, peer support specialists)

**Utilizing plan level** community engagement teams to solidify community partnerships and relationships with community-based organizations (CBOs) that are addressing unmet health related social needs

**Exploring innovative payment models** (value-based care, outcomes-based financing) to better align incentives of the plan, CBOs, physicians and clinicians, and others to better address unmet social needs and the determinants of health in our membership

**Building off of Bold Goal** national relationships and doubling down with local pilots such as medical respite and eviction diversion (medical legal partnership) in our newest markets



**To advance Humana's whole person care strategy, in July 2020, Humana CEO Bruce Broussard announced the creation of a new role, a Chief Equity Officer. This leader will provide strategic direction in developing clinical programs, education, and communications that address underlying drivers of disparities in healthcare, with the express goal of fostering more equitable care and health outcomes.**



## Leading healthcare transformation

We are also working to transform healthcare so that physical, mental, and social health are treated as equal dimensions of health. This includes paying physicians to screen, document, and treat or refer for social needs through our Social Determinants of Health Value Based Care Program.<sup>62</sup> A feature of value-based care is enhanced patient-provider communication and trust by rewarding for time spent engaging patients and their families, which may help to overcome barriers of culture, communication, and empathy.<sup>63</sup> This will only be strengthened by incorporating SDOH.

Further, Humana's Chief Medical and Corporate Affairs Officer William H. Shrank, M.D., M.S.H.S. and NQF President and CEO Shantanu K. Agrawal, M.D., MPhil co-authored a paper in the ***New England Journal of Medicine*** calling for exploring the impact of incorporating social risk factors, along with physical and mental health, into payment models. They argue that social risk adjustment in population-based payment models would provide incentives for addressing health-related social needs to improve health outcomes, rather than lowering the standards for their care.<sup>64</sup>

Humana is leading efforts to standardize benchmark measurements and expectations to help physicians address food insecurity by working with NQF to define quality measures around food insecurity.

As part of this work, in February 2020, we released an implementations guide for healthcare organizations to effectively intervene and assist individuals who may experience negative health outcomes from unstable access to food.<sup>65</sup>

Planning for the next generation of clinicians, in 2018, [Humana invested \\$15 million into a new medical school at the University of Houston](#) that is focused on integrating interdisciplinary training, focused population health, into medical education. The Humana Integrated Health System Sciences Institute aims to be a leader in health systems science that produces high impact research to inform policy, innovative inter-professional educational programs that prepare the next generation of healthcare providers and practitioners, and novel programs that support population health and community transformation, with emphasis on Houston's Third Ward and East End. Collaborative programs have tested a community health worker (CHW) intervention and a partnership with the Patient Care Intervention Center to understand and analyze our members' use of community resources, enabling us to expand and target partnerships with community-based organizations (CBOs).



## Advancing health equity in the community

As we reflect on the progress our country and we have made toward health equity, we know that we need to go further upstream than just the social needs of individuals to improving the systemic and social conditions in communities. That is why the Humana Foundation announced in 2018 a commitment to address SDOH, with the key aim of promoting health equity. With this new focus came a recognition that long-term, larger investments would be needed to support strategies addressing upstream determinants of health. The Foundation also recognized the need to co-create processes with communities to understand how to provide essential holistic supports. The Foundation focuses on data in the local context of the community, recognizing that is specific culturally and historically driven and designed and that it is more than healthcare.

The Humana Foundation's Strategic Community Investment Program (SCIP) addresses SDOH by funding initiatives that are working to close systemic gaps in eight communities that also parallel with some of the Bold Goal communities. Currently, 12 programs receive a Humana Foundation investment, with a specific focus on organizations that address food security, postsecondary attainment, financial asset security, and social connectedness with an intentional focus on historically marginalized populations.

Some of the SCIP initiatives that are sustainably impacting communities while also influencing individual changes include:



**Growing Local Food Collaborative (New Orleans, Louisiana)** | Advocates to make shifts in local policy that prohibits people, especially Black people and other communities of color, from engaging in farming because of land access and other barriers.



**Healthy BR (Baton Rouge, Louisiana)** | Intentionally focuses on North Baton Rouge, an area that is predominantly Black, and ensures that the dollars are going to organizations led by people who live in that community and serve that community.



**University of Florida (Jacksonville, Florida)** | With an emphasis on cultural sensitivity and partnerships with trusted organizations such as African Methodist Episcopal (AME) churches, focuses on Health Zone 1, a geography that is predominantly Black and experiencing concentrated poverty.<sup>66</sup>

The Humana Foundation's Community Partners Program addresses SDOH by funding initiatives that provide critical safety net services that make Louisville a more appealing place to live for all. Through August 2020, the program provided \$2.2 million to community organizations, with a specific focus on addressing root causes of health inequities in historically marginalized populations. One example is the Parent Advocates High Road Program led by 2not1 Fatherhood & Families. This initiative promotes family stability through parental leadership development to create effective co-parenting relationships, improve interaction with children, and build community.<sup>67</sup>

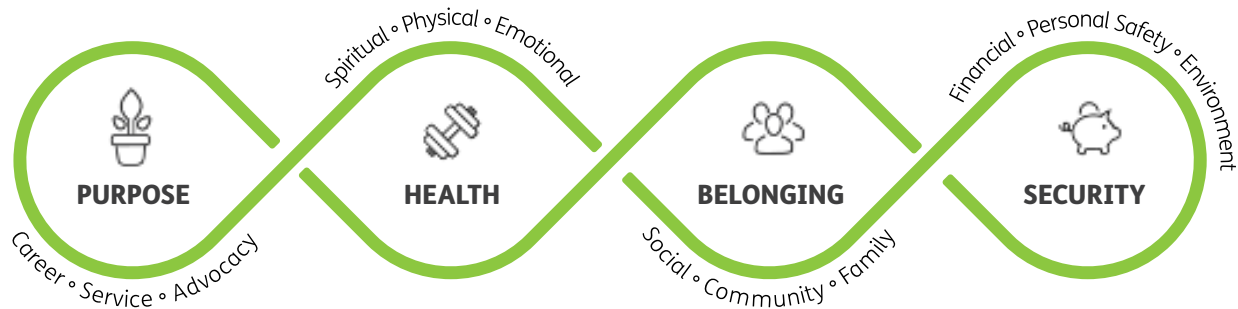




## Supporting whole person health of Humana associates

Humana applies a holistic view and commitment to employee well-being that encompasses multiple dimensions, including SDOH, and focuses on addressing the varying and very personal barriers employees face in achieving their best health. Humana’s goal is to systematically embrace the diverse cultural backgrounds of associates so that the workplace can become a venue for solutions that improve health outcomes by fostering well-being both while at work and when at home. Associate well-being is measured and reported in four domains (purpose, health, belonging, and security) applying approximately 70 metrics, with results and insights delivered to drive action plans for improvement at the team, unit, and enterprise levels. While this serves well-being advancement for the associate population at large, this analysis also forms the basis for uncovering unmet needs impacting sub-communities vulnerable to health inequity.

### ..... The Humana Well-being Model .....



Through this well-being measurement, social isolation was identified as a barrier to engagement and health-related quality of life for BIPOC associates. Among the efforts to improve social connectedness, was the development of [Network Resource Groups](#), nine experience-based forums for exchanging ideas, building community, and bringing a diverse lens to business decisions. Measured levels of belonging have increased for these groups, as well as Humana overall, in the last five years. Network Resource Groups are also advancing inclusion in the workplace by facilitating open discussion and education about equity issues. For example, the Pride LGBTQ (lesbian, gay, bisexual, transgender, and queer) Associates & Allies Network Resource Group developed an Ally Playbook that provides education, tools, and resources on how to foster ally growth and inclusive behaviors around the LGBTQ community.<sup>68</sup>

To realize our customer-centric strategy, Humana is transforming the way we work as well as accelerating the focus on the associate experience. Underpinning these efforts is building an inclusive culture and diverse workforce that drives collaboration and represents the communities we serve. The Office of Inclusion and Diversity (I&D) supports enterprise initiatives such as the creation of a robust Inclusion Toolbox of training and workshops available to all associates and leaders and Local I&D Councils that foster a sense of belonging through cultural awareness, a celebration of diversity, and community partnerships. [In addition, to accelerate progress, in 2020, leaders will also be held accountable for I&D goals around hiring, promotion, and retention, as well as mentoring talent and other measures.](#) In recognition of this work, Humana was honored on the 2020 DiversityInc list of Top 50 Companies for Diversity, making the list for the third year in a row and jumping 17 spots to number 25 on the list.<sup>69</sup>





# Humana priorities to pursue

## Humana's Values

Achieving health equity requires intentionality, specifically targeting the sources of inequity, setting outcome-driven goals, and using data to track progress and course-correct when needed. Sometimes this will necessitate approaching what we do with equity – giving people what they need to achieve their best health – rather than equality – giving everyone the same thing – in mind.





## Inspire health

- Scale or implement evidence-based interventions to improve access to care. The County Health Rankings and Roadmaps, a program of the Robert Wood Johnson Foundation, has identified a number of strategies that are likely to decrease disparities, including the medical home model of care,<sup>70</sup> telemedicine,<sup>71</sup> community health workers,<sup>72</sup> and health literacy interventions.<sup>73</sup>
- Include incentives for reducing health disparities in value-based payment models to promote better data collection and measurement, as well as an intentional focus on equity.
- As we shift more healthcare into the home, safeguard the health of frontline workers during and after the COVID-19 pandemic, who are more likely to be female, BIPOC, and low-wage hourly employees. Research on the early months of the COVID-19 crisis in New York City found that home health workers were at heightened risk for contracting and transmitting COVID-19 due to these vulnerabilities.<sup>74</sup>

## Cultivate uniqueness

- Embrace whole person health by considering medical, social, and mental health needs in all our member interactions, programs, and benefits.

## Rethink routine

- Disaggregate data by race, ethnicity, and other key sub-populations such as disability status and language preference when tracking and reporting clinical, utilization, and quality metrics to make disparities evident and measure progress.
- Seek out diverse, underrepresented companies through the procurement process who may be able to deliver as well or better than existing vendors may. Similarly, when forming national or community partnerships, ensure they are representative of the population and diverse voices are included.

## Pioneer simplicity

- Build equity into quality assurance processes so it becomes part of the way we do business. This may include building additional reviews into workflow for new analytic models, clinical products, and marketing materials to ensure diverse perspectives are considered.
- Make it easy for members to self-report their race, ethnicity, written and verbal language preferences, sexual orientation, and gender identity upon enrollment.

## Thrive together

- Participate in local public health conversations and planning to foster shared funding, services, governance, and collective action. This perspective may provide insight into how business decisions – such as capital investments and advocacy – may affect public health, as well as how policy decisions may promote equity. There are a number of resources for identifying evidence-based policy, such as County Health Rankings and Roadmaps<sup>75</sup> and CityHealth.<sup>76</sup>



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