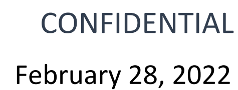


COMMUNITY REINVESTMENT PLAN

ANTHEM NEVADA MEDICAID

Community Reinvestment Plan
Anthem Nevada Medicaid

At Anthem, improving population and member health with person-centered solutions is at the heart of everything we do. Our goal is to provide whole person health to our members by identifying emerging health or safety risks and assisting with addressing their needs. Anthem recognizes that the factors impacting the health and wellness of individuals and communities are constantly changing. Our Population Health approach, *Elevate | Population Health*, focuses on improving the health of Nevadans while addressing health equity and building resilient communities.

Our *Elevate | Population Health* strategy prioritizes four areas of concern that align with DHCFP goals and priorities:

1. Elevate | Maternal and Child Health. Eliminating health disparities, ensuring healthy births, and improving the health of women and children across Nevada.
2. Elevate | Chronic Disease Management. Helping members reduce the risk of and manage chronic conditions. This includes reducing breast and colorectal cancer, cardiovascular diseases, incidence of diabetes and increases access to and continuity of care for all.
3. Elevate | Access to Behavioral Health. Improving member access to mental health and substance use disorder (SUD) services. Understanding and addressing the interrelation of serious mental illness and substance abuse and the stressors of unmet social determinant needs.
4. Elevate | Social Determinants of Health. Addressing SDOH needs, in the Center for Disease Control and Prevention's (CDC) five key areas: healthcare, education, social, economic stability, and neighborhood. Within these key areas we are addressing housing instability, food insecurity, transportation needs, employment needs, and the multifaceted needs of persons involved in the justice system.

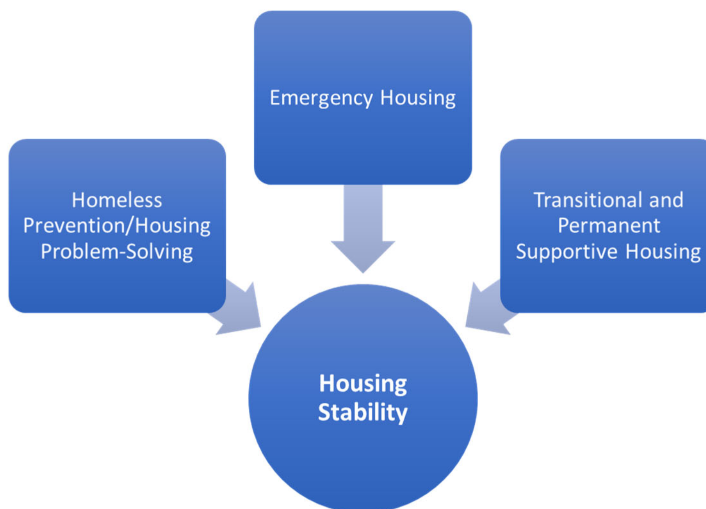
For every Member we serve, we aggregate enrollment data, claims and encounter data (including z-codes), risk scores, utilization data, as well as Social Determinant of Health (SDoH) assessment data from Members, Case Managers, and Providers.

Our Population Health Strategy, *Elevate | Social Determinants of Health* has identified housing, employment, and food insecurity as the key areas of focus that are most responsive to the needs of Nevadans and most critical to improving health outcomes, especially in light of the social impacts of COVID-19. Our Community Reinvestment commitment is focused on supporting our strategies to create pathways to stable housing for our members experiencing homelessness and housing insecurity.

Addressing Homelessness and Housing Insecurity

Understanding the importance of addressing housing instability to improve health outcomes for our members, we have developed a cross-system strategy to increase housing security for our members by

offering a full continuum of housing services, from homeless prevention to permanent supportive housing. Our dedicated Housing Program Manager, Emily Paulsen, LMSW has been hired to execute our robust housing strategy.



Overview of Nevada Community Reinvestment Programs:

Our investment into our SDoH strategies goes above and beyond our contract requirements for community reinvestment. For this report, we will limit the detailed description of our initiatives to those funded through our Community Reinvestment commitment.

Housing Problem-Solving Program provides short-term housing support and financial resources for eligible Anthem Nevada Medicaid Members experiencing housing instability or homelessness. These services include housing problem-solving counseling, housing referrals and placement, flexible financial assistance needed to acquire or to maintain housing, short-term follow up/support and connection to community resources. This program operates as a low-barrier, Housing-First program model.

Housing Support Services:

- Housing Search Assistance
- Liaison/mediation with rental properties
- Housing problem-solving and housing stabilization counseling
- Referral and linkage to legal, employment, and other community-based services

Financial Resources (provided on as-needed basis):

- Rental Assistance
- Utility Assistance
- Rental + Utility Arrears

- Move-In Fees/Deposits (Rent, Utility, Pet)
- Moving Costs (moving truck/storage fees)
- Household Goods
- Other financial needs deemed critical to stabilizing the housing of the member

Shared Housing Program for High Utilizers-

The Shared Housing program is designed to serve Anthem members who are homeless and high-utilizers of healthcare services with moderate to high acuity of housing insecurity. Shared Housing is an innovative program that can provide both short-term and long-term housing options for members to achieve stable housing. This program operates as a low-barrier, Housing-First program model.

The Shared Housing units include essential furnishings and household goods. Each member receives their own bedroom within a shared housing setting. Members share common areas such as living areas, kitchen, and bathroom(s).

The addition of Peer Support is key to program success. A Peer Support Specialist is a person with lived experience and sustained recovery from mental health, trauma, homelessness and/or substance abuse. Research shows that the addition of peer supports reduce crisis events, improve physical and emotional well-being, empower residents, increase social network, and increase housing stability and longevity.

Our housing vendor will master-lease units to provide shared housing placements, housing supports, financial assistance, and other community resources. Our housing vendor offers a low-barrier, problem-solving approach with the goal of moving members from the program into stable long-term housing. Additional resources include connection to education, employment, food and transportation

Goals

- Greater Member access to affordable housing options;

- Increased housing stability for members;
- Increased overall member health;
- Reduce the amount of ER and IP use;

Case Management:

All members experiencing homelessness and who are receiving services through these programs will receive care coordination through case management support provided through the health plan. Our Population Health strategy provides a stratified approach to case management that aligns with contract requirements and DHCFP priorities.

Health Equity and Cultural Competency:
Our Housing Interventions support our Population Health approach to improve health outcomes and increase health equity among our members. Our Health Equity Task Force, comprised of diverse health plan leaders across multiple functional teams will be performing continuous monitoring of our SDoH programs including our housing interventions with a critical look at existing, potential, and emerging disparities in race and ethnicity.

Additionally, our contracts with our community-based partners, require that the program staff hired to support our members in these programs be trained on Cultural Competency, Diversity, and Inclusion.

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