Provider Newsletter

October 2022

Renewal
Redetermination

Data Measures
CAHPS®

Connected In Care
& so much more

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In this Issue

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INFORMATION TO HELP YOU PREPARE FOR UPCOMING REDETERMINATION/RENEWALS:

Will you know which of your patients are at risk for losing their Medicaid coverage?
SilverSummit Healthplan is actively working to get member lists to providers, so they can help communicate with their patients who are at risk of losing their Medicaid coverage.

What if my patient didn't take action, lost their coverage, but is still eligible for Medicaid?
We are reviewing this process and getting clarification from Nevada Medicaid. We will be sharing this information with providers soon.

What if a patient is no longer eligible for Medicaid?
Ambetter by SilverSummit is available on Nevada Health Link. If a prior recipient loses their coverage, please refer them to https://www.nevadahealthlink.com/ and have them navigate to Ambetter by SilverSummit.

Most of our popular Value-Added Benefits are available on Ambetter. Our Ambetter provider network is large and comprehensive. Prior SilverSummit Healthplan members who choose Ambetter, will have a seamless transition for providers and services.

Our Provider Relations Team is always available to help with any questions.
Email us at NVSS_ProviderRelations@SilverSummitHealthPlan.com This is information as of July 28, 2022. SilverSummit will continue to update our Medicaid providers as new information becomes available. If you have specific questions about this notice, please contact your provider advocate.

What tools are available for you to communicate with your patients?
SilverSummit Healthplan has developed flyers, posters, handouts, and other materials to help our providers communicate this information. If you'd like to use these materials, reach out to your provider relations contact, or email us at NVSS_ProviderRelations@SilverSummitHealthPlan.com.

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2022 Provider Newsletter

Resources for Closing Gaps in Care

Welcome back to Connected in Care from SilverSummit Healthplan, our newsletter developed specifically for providers with a focus on helping get the right care, in the right place, at the right time. Even as the prevalence of COVID-19 diminishes, we can still feel the effects of the pandemic on the healthcare system and on our world around us. Although we are slowly returning to a state of normalcy, there is still work to be done in assisting others to gain access to care.

In this issue, we will discuss the ways in which SilverSummit Healthplan, providers, care managers, and other healthcare professionals are working to close the care gaps in our system and provide better outcomes for everyone. We will also be looking at the importance of health equity in relation to HEDIS and the essential support that the Start Smart for Your Baby® program offers new and existing parents.

Without your continued dedication, many would struggle to get the support they need. And for that, we thank you. We hope these resources help to continue closing the gaps in healthcare, and to better serve you in the fantastic work being done for our members.

Together, we are all connected in care.

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Start Smart for Your Baby® Offers Crucial Support, Results in Better Outcomes

A healthy pregnancy that results in a healthy, full-term baby is the gold standard for OB-GYNs. Start Smart for Your Baby® provides a wide array of benefits to members, with additional interventions available to high-risk patients. Services range from assistance with basic needs like transportation, lodging, and food, to a rewards program that encourages preventive care visits and information about pregnancy and newborn care. There's also a robust focus on mental health both before and after delivery.

The process of connecting a patient with these services begins with their OB-GYN sending a Notification of Pregnancy (NOP) to SilverSummit Healthplan. All NOPs are carefully evaluated for risk factors, and members are referred to the Start Smart for Your Baby program. From there, a care manager reaches out to begin the process of supporting the pregnancy. Jessica Imming, Senior Manager, Program Management says, "We focus on empowering new and expectant parents to take care of their own health and connecting them with the support they need to do that."

Within the program, one-on-one interventions fall into four main areas of focus:

1. **Care Management**
   Clinical guidance for the member throughout their pregnancy
2. **Care Coordination**
   Management of substance use and Social Determinants of Health (SDOH)
3. **Member Connections®**
   Non-clinical guidance and outreach for the member throughout their pregnancy
4. **Connections Plus Phone**
   Phone services for high-risk members without reliable access

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Start Smart for Your Baby® Offers Crucial Support, Results in Better Outcomes

Additional interventions include incentive programs such as the My Health Pays® rewards program, baby showers, birthday parties, a neonatal admissions program, and perinatal depression screening, all of which are aimed at encouraging preventive care that supports a healthy, full-term pregnancy. Care managers can connect members with community resources they may not be aware of. Imming says, "We're able to bridge gaps for things like assistance with utility bills and daycare."

Most care managers are OB-trained and can answer any and all questions a parent may have. That emotional support can be invaluable during a stressful, high-risk pregnancy. "Outside of quick OB visits, this gives the member someone they can talk to, anytime, about any questions or concerns they have," says Imming.

After delivery, SilverSummit Healthplan members are provided with 60 days of benefits, and the program ends once Medicaid coverage ends.

Care managers work with members to either reapply for Medicaid or secure other coverage if their coverage is ending.

The Start Smart for Your Baby program provides crucial interventions that can make a huge difference in pregnancy outcomes. Imming says, "We have proven that this kind of engagement reduces preterm deliveries, low birth weights, and neonatal admissions, and helps avoid the financial and emotional stress of caring for a preterm baby." The best way for providers to help expectant parents is to include all risk factors and accurate contact information when filling out an NOP.

Reach out to your SilverSummit Healthplan contact to find out what services are available to your patients.

Jessica Imming

Senior Manager, Program Management

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Health Equity, SDOH, and How They Relate to HEDIS

Health Equity and Social Determinants of Health (SDOH) are key strategies used by healthcare providers

Health Equity is the cumulative process of addressing macro and micro injustices that impact or impede the ability of any individual to reach their best health outcome. This includes social, economic, health and other policies that impact individual autonomy. Health equity recognizes and addresses historical trauma caused by racism, sexism, bias and other injustices. Equitable healthcare works to negate the impact of structural and institutional discrimination in all its forms and to define and facilitate equitable outcomes for all persons.

SDOH are underlying, community-wide social, environmental, and economic conditions in which people are born, grow, live, work, and age. They impact individual needs; one example is food deserts.

Health inequities affect individual patient outcomes by creating access barriers and driving poor outcomes to healthcare. While these conditions have existed in the U.S. for a very long time, the pandemic brought renewed attention to the impact of inequity. Death rates for minoritized and marginalized communities from COVID-19 were between 3-6 times the rates of the majority population. There are some clear steps providers can take to identify and address equitable quality health outcomes within their patient population:

1. Training – In addition to reaching out to SilverSummit Healthplan for specific needs, the Centene Institute offers free continuing education courses such as "Cultural Humility and Unconscious Bias in Healthcare." There are numerous national and provider association trainings on health equity, bias, cultural competency, structural racism and social determinants of health. We encourage our network providers and their staff to become health equity literate through these widely available resources.

2. Partnering with the SilverSummit Healthplan provider engagement team to identify resources and community organizations that may be able to address the social needs of your patients. As a health plan, we want to help you to close the social gaps for your patients while you meet their medical needs.

3. Working to overcome unconscious bias in order to provide more culturally appropriate services. Look at your institutions and practices to identify opportunities to create a more inclusive environment. What does equity look like for you, your staff, your patients, and your community?

4. Using "teach back" methods, such as reflective listening and empathy, to understand what patients and staff need. Empathy is a learned model of reflective listening and true partnership. In what ways do your care models demonstrate empathy?

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Health Equity, SDOH, and How They Relate to HEDIS

Additionally, SilverSummit Healthplan can often help providers address health inequities through a variety of resources. Dr. Gloria Wilder MD MPH, VP, Innovation and Health Transformation Business Development, says, "There's an opportunity for change through partnerships with providers, community organizations, and the health plan. Each group brings a different piece of the puzzle to address social needs and improve health equity. We recognize the needs of providers and their staff. You can't pour from an empty cup. Empathy is demonstrated by efforts to reduce provider burnout while improving access to care." Below are some examples of how partnerships have helped to advance health equity.

- Boosting patient annual wellness visits and partnerships with trusted community organizations in marginalized and minority communities by eliminating barriers to care through provision of transportation and technology solutions.
- To improve cancer screening rates, SilverSummit Healthplan can sometimes partner with community leaders to help bridge care gaps related to cultural sensitivity issues.
- To raise immunization rates among populations that don't have the flexibility to attend clinics during business hours due to work obligations, SilverSummit Healthplan can help bring appointments to members via mobile immunization vans and/or helping the primary care providers expand hours.

When it comes to promoting health equity and improving health outcomes, Dr. Wilder says, "Our goal is to support local, social, and health leaders to build alliances that drive quality outcomes for all. Our health plans have strong teams in place locally and nationally, working diligently on building equitable infrastructures to support local change. We believe strong partnerships provide a tremendous opportunity for shared impact."

Dr. Gloria Wilder
MD MPH, VP, Innovation and Health Transformation Business Development

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Closing Gaps In Chronic Disease Management Through Teladoc® and Babylon

At the beginning of the COVID-19 pandemic, on top of dealing with a global health crisis, doctors faced a serious problem: helping patients with chronic conditions. These people who relied on preventive care, ongoing visits, lab tests, and other means to manage their diseases were now finding it impossible to gain access to nonemergency care.

In the early stages of the pandemic, it was widely agreed-upon that patients should only go to their provider's office if absolutely necessary. But soon, that idea turned into a question for healthcare providers. Is there a way to provide some of the assistance a patient could get from urgent care in their own home?

Much of society pushed toward a more virtual world during the lock-downs – and healthcare was no different. Within months of the first lock-down, Centene met the problem head-on and made a successful leap into providing more help through virtual care than ever before.

"We really doubled down on telehealth so our existing provider networks could be available to deliver care to their members during the pandemic." said Gale Patterson, Staff Vice President of Provider Engagement. "We already had a broader relationship with Teladoc; Babylon was just in a couple of markets, but we went through the process of expanding our networks through those services."

Dr. Vincent Nelson, Corporate Senior Vice President and Deputy Chief Medical Officer, knows that, prior to the pandemic, many providers had not used virtual care. But once it was needed, telehealth was quickly adopted. Dr. Nelson said,

"If there's a bright spot that occurred during the pandemic, it's the significant increase in adoption of, and even preference of, many providers utilizing telehealth to care for their patients."

Dr. Vincent Nelson
Corporate Senior Vice President and Deputy Chief Medical Officer

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Closing Gaps In Chronic Disease Management Through Teladoc and Babylon

These platforms gave providers training on technology best practices and how to effectively deliver care in a virtual setting. Patterson said, "There's a lot about virtual care that's different in terms of understanding how to get patients to describe more specifically what they need help with when doctors can't physically examine them in person, and how to handle things like bedside manner issues online."

Thanks to Centene expanding telehealth services, the loss of chronic care maintenance and preventive care for those individuals wanting to stay out of care facilities has been mitigated. And now there is a full spectrum of specialists that are available virtually, not just primary care providers. If a patient needs to find a face-to-face visit, that flexibility is available as well. SilverSummit Healthplan has care managers ready to help patients, along with scheduling in-person visits to help further provide care.› But Dr. Nelson warns that not all the care gaps have been covered just yet.

"Colonoscopies declined by 88 percent during the peak of COVID-19 and are still 33 percent lower than normal at the most recent review of the data," said Dr. Nelson. "Mammograms and Pap smears, which fell 77 and 80 percent respectively, are still down 23 and 25 percent."

Although these cancers are common, they can also be treatable if caught early in their development. And that, Dr. Nelson believes, is why it is crucial that healthcare providers coordinate efforts to get all age-appropriate patients screened for these cancers by their providers on schedule.

Dr. Nelson said, "Many of us are still apprehensive about visiting hospitals and clinics due to COVID-19 risks, so providers should be utilizing telehealth when appropriate as a means to engage more of their patients on the importance of getting screenings and checkups during virtual care visits."

Providers can take full advantage of these services and learn more by getting in touch with SilverSummit Healthplan

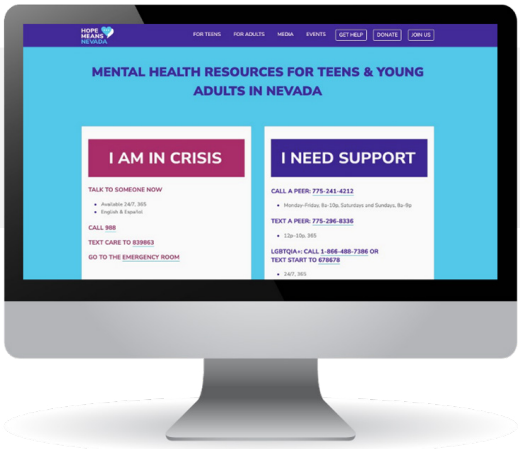
Gale Patterson
Staff Vice President of Provider Engagement

TEEN SUICIDE PREVENTION PUBLIC HEALTH CAMPAIGN

Hope Means Nevada (HMN), the community-based non-profit focused on eliminating youth suicide in the state, has partnered with SilverSummit Healthplan, which has sponsored a $1.5 million statewide youth suicide prevention campaign. The campaign is designed to connect Nevada youth and their families to free resources to improve mental health in an effort to reduce suicide in the state. The campaign, made possible through the one-time donation from SilverSummit Healthplan, represents a large-scale effort to place reminders of mental health resources and tools in both Washoe and Clark counties.

A variety of mass media channels to promote the campaign include TV, Radio, Digital Media, Bus Shelters, and Outdoor Boards.

The campaign drives to this website below, Mentalhealthresouresnv.org



Examples of the statewide campaign messaging (English/Spanish):

Project Neighborhood Health

Project Neighborhood Health provides access to current or potential patients/ members of SilverSummit Health Plan, who will receive on-site screenings or care.

Provider Benefits:

-Hosted twice a month directly within a neighborhood (apartment/mobile home) complex's clubhouse

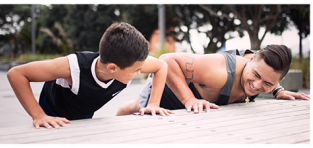
-Direct marketing campaigns to residents to inform them we will be on location

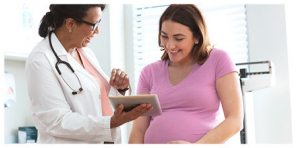
-We bring together a small number of providers to provide on-site screening and to make office appointments. Screenings offered include vision, dental, and medical

Providers, if you are interested in participating or would like to suggest an area to host an event, please contact:

Ritchie Duplechien - ritchie.duplechien@silversummithealthplan.com
Carlisha Hartzog - carlisha@hartzogconsulting.com

Consumer Assessment of Healthcare Providers and Systems (CAHPS)



Consumer Assessment of Healthcare Providers and Systems (CAHPS)

What is CAHPS?

It is a standard survey of patients developed by the National Committee for Quality Assurance (NCQA) to determine their satisfaction with their healthcare. This provides the patients' perspective of the healthcare they have received. It includes the accessibility to medical services, physician and communication skills of the physician.

What does the CAHPS Survey ask patients about Physician Communication?

The CAHPS survey focuses on four questions that are listed below. In the last 6 months:

- How often did your personal doctor explain things in a way that is easy to understand?
- How often did your personal doctor listen carefully to you?
- How often did your personal doctor show respect for what you had to stay?
- How often did your personal doctor spend enough time with you?

What are the benefits to effective physician communication to our members?

- Physician satisfaction
- Patient/member satisfaction
- Adherence to medical advice
- Diagnostic accuracy
- Improved health outcomes
- Malpractice reduction

What can a physician do to improve communication to our members?

ALERT is a model that is intended to help physicians to improve CAHPS questions and scores:

- Always
- Listen to member/patient carefully
- Explain in an understandable way
- Respect what the member/patient says
- Time management perception

Consumer Assessment of Healthcare Providers & Systems (CAHPS®

CAHPS® Overview

CAHPS® is the Consumer Assessment of Healthcare Providers and Systems

- Annual survey that captures a patient's experience will all aspects of healthcare
- CAHPS surveys ask our members – your patients – topics like provider communication skills, ease of accessing healthcare, and their Health Plan performance

CAHPS Measures Patient Experience with the Healthcare System

- Care from Health Plan
- Quality of Care
- Encounters with Providers (Physician Practices, Hospitals, and Healthcare Facilities)
- Experience with the Health Plan

CAHPS Data Measures

- Patient ease of obtaining information from the Health Plan
- Timeliness of service
- Speed and accuracy of claim processing

CAHPS Weights / Results Year over Year

STAR Category	CY19/RY21	CY20/RY22	CY21/RY23
Admin/Ops	22%	18%	25%
CAHPS	21%	22%	31%
HEDIS	18%	18%	15%
HOS	11%	12%	9%
Improvement	12%	13%	10%
Pharmacy	16%	17%	10%

CAHPS Star Measure Weight Changes

Composite & Rating Measures	Data Source	CY20/RY22	CY21/RY23
Annual Flu Vaccine	CAHPS	1	1
Getting Needed Care	CAHPS	2	4
Getting Appointment and Care Quickly	CAHPS	2	4
Customer Service	CAHPS	2	4
Rating of Health Care Quality	CAHPS	2	4
Rating of Health Plan	CAHPS	2	4
Care Coordination	CAHPS	2	4
Rating of Drug Plan	CAHPS	2	4
Getting Needed Prescription Drugs	CAHPS	2	4

CAHPS: Survey Questions Crosswalk

CAHPS Composite	Question Number	Questions
Getting Appointments & Care Quickly	4	In the last 6 months, when you needed care right away, how often did you get care as soon as you needed?
	6	In the last 6 months, how often did you get an appointment for a check-up or routine care as soon as you needed?
	8	Wait time includes time spent in the waiting room and exam room. In the last 6 months, how often did you see the person you came to see within 15 minutes of your appointment time?

CAHPS: Survey Questions Crosswalk

CAHPS Composite	Question Number	Questions
Care Coordination	18	In the last 6 months, when you visited your personal doctor for a scheduled appointment, how often did he or she have your medical records or other information about your care?
	20	In the last 6 months, when your personal doctor ordered a blood test, x-ray or other test for you, how often did someone from your personal doctor's office follow up to give you those results?
	21	In the last 6 months, when your personal doctor ordered a blood test, x-ray or other test for you, how often did you get those results as soon as you needed them?
Care Coordination	23	In the last 6 months, how often did you and your personal doctor talk about all the prescription medicines you were taking?
	26	In the last 6 months, did you get the help you needed from your personal doctor's office to manage your care among these different providers and services?
	32	In the last 6 months, how often did your personal doctor seem informed and up-to-date about the care you got from specialists?

Current WellCare CAHPS Programs

Annual Mock Survey

All Medicare patients are sent a survey to help gauge patient perception

Provider Scorecards

Based on the mock survey results

Provider Plaque Program

Recognizes primary care providers and their office staff for receiving 90%- plus member satisfaction rate

CAHPS Provider Materials

Flyers, posters, toolkits and postcards provided by Corporate Quality which QPA and PR teams deliver to our provider partners

Improving Coordination of Care

A QUALITY INITIATIVE

The Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys patients on their experiences with healthcare.

PATIENTS ARE ASKED TO EVALUATE:

- Access to, and ease of obtaining, the care they need
- Experiences with their health plans
- Experiences with their healthcare providers
- How well their healthcare providers communicate with them
- How well their healthcare providers coordinate their care

Care coordination refers to activities that reassure patients that their care needs and preferences are being met and their information is being shared with their other providers. (AHRQ)

EXAMPLES OF CARE COORDINATION ACTIVITIES:

- Communicating & sharing information
- Helping with transitions of care
- Establishing accountability & agreeing on responsibility
- Assessing patient needs & goals
- Creating proactive care plans
- Monitoring & follow-up
- Supporting patients' self-management goals
- Linking to community resources
- Working to align resources with patient & population needs
- Ask patients if they are being treated by other providers
- Ask about the diagnoses and treatment plans the patient has with other providers
- Tell patients that you will follow up with their other providers
- This reassures patients that you are coordinating their care

TIPS FOR PROVIDERS

- Invite patients to connect with you via patient portals.
- Encourage patients to ask questions about their care.
- Follow up with patients after ER visits and hospital discharge.
- Share resources that support self- management.

Improving Coordination of Care

Ways to improve scores on listening carefully to the member/patient and also to improve the perception of time spent by the physician with them:

- Maintain eye contact when member/patient is talking
- Sit down, lean in, keep open and receptive body language
- Use reflective statements, paraphrases/summaries –
  ("what I hear you say is . . ." or "let me make sure I understand . . .")
- Avoid interrupting the member/patient, multitasking, and unnecessary interruptions if possible

Ways to improve the member/patient perception about their care being thorough and appropriate:

- Explain why tests, treatments or referrals are necessary
- Use simple, easy to understand wording
- Speak in a slow and clear manner and at a volume level that member/patient can understand
- Do not use medical jargon or abbreviations
- Share goals for treatment and tell what to expect in their recovery
- Explore specific barriers to their compliance with treatment, medications and follow up
- Provide them with resources like hand-outs, brochures, diagrams, and other material to help them understand -Check to see if they understand and are in agreement
- Ask if they have additional questions or if they need any clarification

Ways to demonstrate respect for the member/patient and what he/she has to say:

- Ask for his/her input about illness or care
- Ask about how the issue or illness is impacting daily life
- Allow them to work in collaboration with you to find a resolution or treatment plan that is agreeable to both the member/patient and the provider