Population Health Management Strategy

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Medicaid 2024

Presentation Overview

- **2023 Population Health Program Summary with Achieved Goals**
- **Overview of SilverSummit HealthPlan 2024 Strategy**
- **Summary of Programs to Achieve Objectives and Goals**

Summary:
2023 Population Health Program

Population Health Management

2023 Program Summary

Clinical and Quality

- **Increased in Member outreach calls for both Quality and Population Health**
- **Member rewards program - *My Health Pays* –**
  - **Increased utilization year over year**
  - **Increased dollar reward amounts**
- **Increased incentive pay to Providers for CPT II coding usage**
- **Successful 2023 Chart Chase and increased medical record review**
- **Obtained 2023 NCQA Distinguished Health Equity accreditation**
- **Developed HEDIS specific dashboards to increase visibility into member detail**
- **Developed and executed internal work groups to drive strategy and performance**

Case Management and Community Outreach

- **Successfully opened SSHP Healing Home in Northern Nevada**
- **Expanded Justice-involved program in Northern Nevada**
- **Launched multiple programs to drive and improved clinical outcomes (Project Accelerate and Project Guardian)**
- **Key HEDIS measures improvement**
- **Development and execution of Chronic Kidney Disease Center of Excellence in Case Management**

2023 Maternal Child Health Program

In 2022, Black women accounted for 47% of SSHP's *Very Low Birth Weight* babies.

2023 Goal - **reduce rates of pregnancy complications, premature deliveries, low birth weight babies, and infant diseases to ensure maternal and infant health.**

- **Start Smart for Your Baby®**
- **Count the Kicks**
- **Pacify – Doula and Lactation Services**
- **Strategic Provider partners**

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High Acuity and Transitions

2023 Goal – **improve appropriate emergency room utilization by** 10%

- **Reduction of non-emergent emergency utilization**
- **Case Management and Care Coordination**
- **Digital Care Management**
- **Strategic provider partners**
- **Readmission reduction program**

2024 Population Health Management Strategy

DHCFP Quality Strategy for 2024

Preventative Services

Follow-up and access to Behavioral Health services

Managing Chronic Conditions

Reduction of opioid use – improve behavioral health outcomes

Improving Maternal Child Health

Outcomes

Dental Services

Reduction in healthcare disparities

2024 Goals and Objectives

- **Increase access to care for all Members,** improve preventative screenings and services
- **Improve Management of** Chronic Conditions
- **Improve** Maternal Child Health **outcomes and reduce disparities**
- **Increase access to** Behavioral Health Services **and improve** outcomes
- **Reduce** readmission rates **and improve** transitions of care
- **Decrease and eliminate** healthcare disparities **and decrease** social drivers **of health**
- **Improve the** Member **and** Provider **experience**

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Preventative Services

- **My Health Pays– Program**
  - **Dental**
  - **Mental health**
  - **Developmental and specialty services**
- **Immunizations**
- **Fluvention Program**
- **Recommended Health Screenings**

Managing Chronic Conditions

Case Management

Target High Acuity Members for Engagement

Leverage Programs

- **Project Guardian**
- **Project Expedite**
- **On-Demand Diabetes program**

Leverage Network Provider Relationships

- **Network contracting Pay for Performance, Federally Qualified Health Centers**

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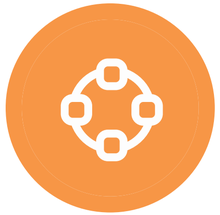
Maternal Child Health

Improve outcomes for specific high risk OB populations

- **Gestational Diabetes**
- **Hypertension & Preeclampsia**



OB and Substance Use program

- **Bunorpephine clinic**
- **CHA OB program**

Start Smart for Your Baby®

- **Decrease in Preterm delivery and NICU utilization**

47% of all preterm, preeclampsia births are from black mothers as opposed to 11% from white mothers

Increase **in adherence to prenatal/postpartum visits**

Doula Program**, OB community health worker**

Syphillis **&** LARC **initiative**

SDOH Gap Closure

Transportation, housing, food insecurity

Increasing Access and Improving Behavioral Health Outcomes

- **Increase access to Behavioral Health services**
  - **Increase our members' awareness and knowledge of existing programs and services**
- **Expand resources to improve social drivers of health for Behavioral Health Members**
  - **Expand housing options for Members experiencing homelessness**
- **Increase network of mental health care providers**
  - **Collaborate with strategic Emergency Room partners**
- **Improve integration of Mental Health and Substance Use services**
- **Targeted efforts on Quality measures for Substance Use Disorder**

Pivoting Northern NV Healing Home

Justice Involved Community Reentry

SDOH Transportation, Housing

- **Among the FUA follow-ups within 7 and 30 days, Hispanic members show the most disparity.**
- **Among the follow-ups after 7 and 30 days, Asian members show the most variation in FUM, followed closely by Hispanic membership.**

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High Acuity and Transitions

> *“Right Person, Right Place, Right Time”*

Readmission reduction program

- **Transition of Care Team**
  - **Readmission reduction**
  - **Ensure appropriate services at right level of care**
  - **Improve Member and Provider satisfaction**
- **Strategic Provider partner for post discharge follow-up**
  - **Improve FUH, PCR**

Appropriate ED utilization

- **Reduction in non-emergent ED utilization**
- **Behavioral Health high utilization initiative**

Case Management

- **Expand digital Case Management**
- **Develop Centers of Excellence for chronic condition management – CKD/ESRD**

Questions and Thank You