18 - Health Education and Wellness/Population Health

18.1 Nevada Health Education Program Offerings

Health Education and Wellness (HEW) provides programs that empower patients with the support, information, and tools to prevent illness, manage existing health concerns, and overcome obstacles that allow them to live healthier lives.

Wellness Programs:

- Diabetes – 1 hour virtual or in-person class in English and Spanish
- Healthy Nutrition / Weight Management for children, ages 1-17 (Consultation)
- Lactation (Consultation)
- Medical Nutrition (Consultation)
- Tobacco Cessation Program (TCP) for adults and teens 14-17 years. Includes vaping cessation consultations for adults and teens 14-17 years
- Weight Management – Adult 4 part virtual class
- Weight Management Adult (Consultation with follow-up)
- Prediabetes Program
- Pregnancy – 1 hour virtual class in English and Spanish

The Health Education and Wellness Department is comprised of a dedicated team of Registered Dietitians (RD), a Certified Diabetes Care and Education Specialist (CDCES), a Licensed Alcohol and Drug Counselors (LADC), a Certified Lactation Counselor (CLC), and a Certified Personal Trainer (CPT).

Telephonic, video and in person-Registered Dietitian consultations are currently available in both English and Spanish.

There are three ways to refer patients to Health Education and Wellness:

1. Call 702-877-5356
2. Fax to 702-838-1404
3. Visit provider.healthplanofnevada.com and sign in to the Online Provider Center

Wellness Programs Overview

Diabetes –Self-Management Education
1-hour virtual or in-person class
This program helps patients learn how to self-manage their diabetes and keep symptoms at bay. This program includes:

- Understanding the different types of diabetes, including signs and symptoms
- Complications of diabetes
- Taking medications
- Healthy eating for diabetes control
- Staying active

Healthy Nutrition / Weight Management for Children – Consultations Ages 1 - 17
A registered dietitian can help parents with a step-by-step approach to good nutrition, food choices, portion sizes, healthy activity levels and behavior modification for their child. Consultation with monthly follow-ups recommended.

Lactation / Breastfeeding Solutions
Certified Lactation Counselors (CLC) can provide patients with breastfeeding information through a one-on-one consultation. Lactation counselors can assist with the following:

- Positioning and latching-on
- Techniques to relieve soreness/pain
- Milk production
- Reducing fullness discomfort
- Safe handling of expressed milk
- Guidelines for storing and transporting milk
- Returning to work/school

Medical Nutrition - Consultations
Registered dietitians are available to help patients with medical nutrition topics, such as cancer nutrition, adult malnutrition, renal support, food allergies, gout, and other gastrointestinal conditions.

Tobacco Cessation Program (TCP)
This program provides guidance and support for patients who want to quit using nicotine delivery systems, including vaping.
Program Overview:

- One-hour program orientation
- One-on-one assessment and treatment plan developed for each patient
- Education, support, and possible medication therapy is included
- A medication component may include either Varenicline or Zyban or Nicotine Replacement Therapies (NRT) such as the patch, gum, lozenges and inhaler
- Zyban and Varenicline prescriptions are authorized only for participants in concert with their provider
- Participants are encouraged to attend at least 10 of 12 educational sessions, but they may attend as many sessions as needed.
- Dedicated TCP scheduling phone line: **702-243-8424**

Weight Management – Adult
Our team of Registered Dietitians provides a multitude of options to assist members in their weight loss journey, including virtual classes and consultations with monthly follow-ups. Let our HEW Advocate team assist your patients in determining the best option to meet their needs.
Nourished is a weight management program focused on making lifestyle changes that result in losing weight and keeping it off.

Topics discussed in this 4 part virtual class include:

- Nutrition
- Physical activity
- Stress reduction
- Goal setting and action planning
- Developing a wellness attitude

Pre-diabetes – Adult

Empowered is a pre-diabetes program, focused on making lifestyle changes that prevent or slow down the progression to diabetes. The program consists of:

- 1 hour virtual class led live by a Registered Dietitian covering the following topics:
  - Understanding prediabetes and the potential complications of diabetes
  - The importance of weight loss for those with prediabetes
  - Physical activity and weight loss
  - Healthy nutrition
  - Developing a wellness attitude
- 1:1 Consultation with a registered dietitian
- Ongoing support & education provided by a registered nurse within our Disease Management program. The RN will monitor lab values and perform periodic check-in calls to motivate the member to live a healthy lifestyle and control their prediabetes.
- 1:1 consultation with a certified personal trainer to help member meet their fitness goals.

18.2 Population Health Program

HPN works to improve the health status of members with chronic conditions through its Population Health Management (PHM) Program. The PHM Program includes member and practitioner education and targeted interventions for members who are at higher risk for complications or future health care utilization.

The goal of the PHM Program is to partner with providers to help members better self-manage their health. Below is an overview of some of the components in the current Population Health Management Program.

Evidence-Based Clinical Practice Guidelines

HPN uses evidence-based clinical practice guidelines as the basis for its PHM Program. You may access these guidelines on the provider section of the HPN website at: www.healthplanofnevada.com/provider/clinical-guidelines. For a hardcopy of a guideline, call (702) 562-4666.

Identification for the Disease Management Registry

Members are identified for one of the population health programs by using criteria developed under the guidance of primary and specialty care practitioners. HPN uses one or more of the following data sources to identify members with specific chronic conditions such as asthma (pediatric and adult) and diabetes (adult only) for clinical interventions. These sources include laboratory, pharmacy and claims/encounter (including in-patient and out-patient utilization) data. Once identified, members are stratified according to levels of risk for future health care utilization and potential complications.

How HPN Works with Members in the Population Health Program

Members identified for the Disease Management portion of our Population Health Program are contacted by phone. Additionally, members are informed of the service via articles in the “Health Matters” newsletter. Language in the article includes information on how to opt in or opt out of the programs. Individuals who participate in the PHM Program automatically receive certain benefits

directly from the health plan and may access other benefits directly or through their primary physicians.

Benefits provided to members directly by the health plan:

- Member-friendly guidelines to help them better manage their conditions.
- Reminders for important services, such as diabetes eye exams.
- General condition specific education is provided verbally as well as in written format to member once enrolled. Written information can be e-mailed or mailed upon member request.
- Telephone calls from R.N. health coaches are provided to members interested in learning more about disease self-management skills as well as members identified as at high and moderate risk for future health care utilization. Members may also work with the registered nurse via a secure video platform.

Benefits available to members through primary physicians:

- Referral to the health plan's specialty clinics.
- Referral to the health plan's Tobacco Cessation Program (members may also self-refer to the program).
- Referral to the health plan's outpatient case management or provider's case management for high-risk members (members may also self-refer to the health plan program).

Benefits that may be directly accessed by members:

- Participation in the health plan's Health Education and Wellness classes and one-on-one consultations on a variety of subjects including the management of chronic conditions, preventive health and additional topics (members may also be referred to the program by their provider).
- 24/7 Advice Nurse (phone number is located on the back of the member's ID card).
- Urgent care after hours.
- Dispatch Health (mobile urgent care) services.

How Practitioners Can Use PHM Services

HPN issues member-specific "Gaps in Care" reports to primary physicians on a monthly basis. Members in the HPN PHM programs who are empaneled to each primary physician will appear on these reports. These profiles highlight whether individual members have received important condition-specific tests and preventive services. These reports allow providers to follow-up with individuals to schedule necessary appointments.

The gaps in care reports supply a variety of information, such as relevant medical test dates and results, flu shot status, preventive services (e.g., diabetes eye exams) and/or medication usage and compliance in the previous 12 months. This information focuses on each individual's specific chronic condition.

A Few Components of HPN's Population Health Management Program

Diabetes

- Clinical guidelines for providers are available to assist in the management of diabetes. These guidelines are located in the provider section of the HPN Web site.
- RN health coaches are available for people with diabetes at high and moderate risk of future health care utilization as well as any member interested in learning more about

diabetes self-management skills. Follow-up phone call contact frequency is determined by member needs.

- Diabetes retinal exam reminders help members take advantage of this important screening exam for early identification of eye problems. If the member desires, the RN coaches are able to assist the member with scheduling a retinal eye exam through one of the internal health plan teams.
- Complex Case Management services are provided for members who are at high risk of hospitalization or emergency care. The health plan's case managers coordinate services and promote communication among the different providers and facilities. Case managers help members adhere to treatment plans and facilitate needed services.

Pediatric and Adult Asthma

- Clinical guidelines for providers are available to assist in the management of pediatric and adult asthma. These guidelines are located in the provider section of the HPN Web site.
- Telephone calls from RN health coaches are available for parents of children with asthma and adults who are interested in learning more about asthma self-management skills. Use of a secure video platform allows the RN health coach to observe medication technique with inhalers to educate on proper medication administration. Follow-up calls are scheduled according to the member's or child's needs. Asthma educational materials are mailed or emailed to member.
- Complex Case Management services are provided for children and their parents and adults who are at high-risk of hospitalization or emergency care. RN case managers coordinate services and promote communication among the different providers and facilities. Case managers help adults and families adhere to treatment plans and facilitate services.

Chronic Kidney Disease (Stage 3)

- Telephone calls from RN health coaches are available to any adult with Stage 3 CKD who is interested in learning more about CKD self-management skills. Program emphasis is on those members who have CKD in addition to diabetes and/or hypertension. Referrals to HEW Registered Dietitians or Tobacco Cessation program made by RN health coach as appropriate. Kidney health educational materials emailed or mailed to member. Lab data for those members with a case opened for CKD Stage 3 monitored on a periodic basis with calls placed to members as needed to encourage diabetes and/or hypertension management skills.

If you have an individual who would benefit from participation in HPN's Population Health Management Program, please contact the plan at (702) 242-7346 or (877) 692-2059.