

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 – 2-part class or 1 hour WebEx
- Exercise – 1-part class or WebEx
- Healthy Nutrition / Weight Management for children, ages 1-17 (*Consultation*)
- Lactation (*Consultation*)
- Medical Nutrition (*Consultation*)
- Tobacco Cessation Program (TCP), includes vaping cessation consultations for adults and teens 14-17 years
- Weight Management - Adult 1 part class or Webex
- Weight Management telephonic support program – Adult
- Prediabetes Program

The Health Education and Wellness Department is comprised of a dedicated team of, Registered Dietitians (RD), a Certified Diabetes Educator (CDE), Licensed Alcohol and Drug Counselors (LADC), a Certified Lactation Counselor (CLC), Certified Sports Nutritionists (CISSN), a Certified Specialist in Obesity and Weight Management (CSOWN), a Certified Personal Trainer (CPT) and a specialist in Exercise Physiology, and Health Promotion.

Telephonic and telemedicine consultations are available. In-person consultations will resume when safe from the pandemic. One-on-one nutrition consultations are available as noted. Consultations are recommended for patients who are at high risk or may be having special health issues.

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

- 1.) Call 702-877-5356
- 2.) Fax to 702-838-1404

Some wellness classes are available at select Southwest Medical Associates clinics. For information about class offerings in your clinic location, please contact HEW at the numbers listed above. In-person classes currently not available due to pandemic but will be resuming at some point in the future.

Wellness Programs Overview:

Diabetes –Self-Management Education

Diabetes 2-part program (Two – 2-hour sessions) or a 1-hour Webex

This 2-part 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

Exercise

HEW offers an exercise program for adults looking to incorporate physical activity safely and effectively into their daily lives. All fitness levels are encouraged to attend.

This program includes:

- Relationship between exercise and nutrition
- 30-45 minute workout
- How to engage and strengthen core muscles properly
- How to improve flexibility, mobility and balance
- How to exercise safely and effectively without relying on specialized equipment

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.

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, tube feeding and other gastrointestinal conditions.

Tobacco Cessation Program (TCP)

This program provides guidance and support for patients who want to quit smoking or vaping and maintain a tobacco-free lifestyle.

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 Chantix or Zyban or Nicotine Replacement Therapies (NRT) such as the patch, gum, lozenges and inhaler
- Zyban and Chantix prescriptions are authorized only for participants in conjunction with the patient's 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

Nourished is a weight management program focused on making lifestyle changes that result in losing weight and keeping it off.

Topics discussed in this one-part class or Webex include:

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

Telephonic Weight Management - Adult

In this program, member receives weekly phone calls from a Registered Dietitian providing the education, motivation and support members need to assist them in their weight loss journey.

Program consists of 12 weeks of individualized phone calls.

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 Webex led by a Registered Dietitian. Topics in this Webex include:
 - 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 or Telephonic Weight Management Program
- Ongoing support & education provided by Registered Nurse within our Disease Management program. RN will monitor lab values and perform periodic check-in calls to motivate member to live a healthy lifestyle and control their prediabetes.

18.2 Population Health Program

SHL 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

SHL uses evidence-based clinical practice guidelines as the basis for its PHM Program. You may access these guidelines on the provider section of the SHL website at: www.sierrahealthandlife.com/provider, “I need help with”, select “**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. SHL uses one or more of the following data sources to identify members with specific chronic conditions such as asthma (pediatric and adult) and diabetes 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 SHL 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 service via an advertisement in the Health Matters newsletter as well as the Medicaid newsletter. Language in the advertisement includes the information on how to opt in or opt out.

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.
- Annual flu shot reminders.
- 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 skill as well as members identified as at high and moderate risk for future health care utilization.

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).
- Case management for high-risk members.

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-hour Telephone 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.

A Few Components of SHL'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 SHL Web site.
- Annual flu vaccination reminders help members remember to take advantage of this important preventive health service.
- R.N. 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 on 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 SHL Web site.
- Annual flu shot reminders help members take advantage of this important preventive health service.
- 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. RN Health Coach has the ability to send Dispatch Health to member home if determined that an environmental assessment could prove valuable in asthma management or if a check on inhaler technique is needed. Follow-up calls are scheduled according to the member's or child's needs.
- Complex Case Management services are provided for children and their parents and adults who are at high-risk of hospitalization or emergency care. R.N. 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. Emphasis on program placed 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 the SHL's Population Health Management Program, please contact the plan at (702) 242-7346 or (877) 692-2059.