

## 16 - Health Education and Wellness/Population Health

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### 16.1 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 as well as cannabis cessation consultations.
- 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
- Heart Health Program

The Health Education and Wellness Department is comprised of a dedicated team of, Registered Dietitians (RD), a Certified Diabetes Care and Education Specialist (CDCES), Licensed Alcohol and Drug Counselor (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 multiple 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](https://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-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**
- Consultations are available for those wishing to quit vaping or cannabis use.

## **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. 1:1 consultation with a certified personal trainer offered to help members meet fitness goals.

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 members to live a healthy lifestyle and control their prediabetes.
- 1:1 consultation with a certified personal trainer to help meet fitness goals.

### **Heart Health – Adult**

This comprehensive program empowers patients to proactively manage their cardiovascular health. Focusing on members with hypertension or high cholesterol, participants receive tailored guidance to help reduce risk factors and adopt sustainable, heart healthy habits. The program consists of:

- Virtual heart health overview led by a registered dietitian
- Individual nutrition consultations with a registered dietitian
- Medication and lab review with a registered nurse
- Customized exercise and lifestyle planning with a health coach

## **16.2 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 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: [Clinical Guidelines - Doctor / Provider - Health Plan of Nevada](#). For a hard copy 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 (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 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 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 members 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 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.
- Doctoroo (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.
- 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.
- 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.
- 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 members.
- 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 the Tobacco Cessation Program are made by RN health coaches as appropriate. Kidney health educational materials are emailed or mailed to members. Lab data for those members with a case opened for CKD Stage 3 are monitored on a periodic basis with calls placed to members as needed to encourage diabetes and/or hypertension management skills.

If you have a patient who would benefit from participation in SHL's Population Health Management Program, please contact the program at (702) 242-7346 or (877) 692-2059.