Health Plan of Nevada
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Population Health Strategy

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Population Health Strategy

Our Key Principles:

- Focusing on the whole person across all their health care services and needs
- Providing wellness services
- Identifying target populations for PHM interventions
- Supporting practitioners and providers in their efforts to deliver better health outcomes

Population Assessment

The health plan utilizes a multitude of proprietary tools as well as industry tools and best practices to understand and address the membership at large.

- Race & Ethnicity data
- Hotspotting
- Health and social factors data
- Member focus groups
- Proprietary screening and assessment tools
- Medicaid enrollment file (834)
- State and county registries
- Pop health & equity mini assessment

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Data Integration

Our approach integrates diverse types and sources of data, predictive modeling and advanced analytics tools to stratify and segment our population, identify disparities, understand drivers and determine appropriate interventions.

- HEDIS & CAHPS data
- Health Needs Survey
- Coding
- Integrated internal & external documentation systems
- Homeless management info system
- Provider reporting (gaps in care)
- Unite Us
- Predictive modeling
- Internal wellness and disease management education

Population Stratification

- **Proprietary stratification tool - used to optimize member selection for care management programs**
  - With each data refresh, members are reassessed based on the most up-to-date claims data processed.

- **Member profile report**
  - An internal member specific dashboard that summarizes all member medical encounters (labs, pharmacy information, hospitalizations, and PCP appointments).

- **Internal case management system - used by all member-facing teams**
  - Supports member interaction documentation, and internal referrals.
  - SDoH screening tool
  - Provides valuable aggregate data on certain populations and their outcomes.

- **Hotspotting tool**
  - To focus on certain populations and drill down into geographic areas in which any anomalies exist

Targeted Interventions

We collaborate routinely with our internal teams: population health, quality improvement, outreach, internal behavioral health, and all care management teams to develop interventions, monitor, and evaluate their success.
By also working closely with our providers, community organizations, and other MCOs we strive to advance a culture of compassion and innovation while mitigating health disparities.

Provider

- Value based payments
- Alternative payment models
- Pop based payments
- PCPi/BHPi
- Collaboration via whole-person care model
- Cultural sensitivity training
- SDoH immediate-needs referrals
- Tools in place to reduce administrative burden

Member

- Doula
- Community Catalyst
- Mom's Meals
- In-home vaccinations
- Digital engagement
- Count the Kicks
- Member advisory committee

Community Collaboration

- Community Catalyst
- NV Minority Health & Equity coalition
- Doula scholarship
- Unite Us

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Birth Outcomes

State Goal 4

Doula Program - results to date

- 29 Members have successfully delivered with a doula present at delivery
- 82% of the women experienced a vaginal birth
- 18% delivered via a cesarean section
- Medical necessity attributed to the 3 cesarean section deliveries

Doulas may play a role in helping achieve better birth outcomes. It may prove beneficial to expand doula service across all populations and other lines of business.

Diabetes Outcomes

State Goal 2

Mom's Meals Partnership with Disease Management

Average Starting A1c	Average Ending A1c
10.86	8.96

Average HbA1c decrease in members participating in the program 1.9%

Mom's meals is a meal delivery program open to type 1 & 2 diabetics enrolled in the disease management program. Eligible members receive 2 nutritionally tailored meals per day for 8 weeks.

Measuring Quality Improvement

Measurement year 2021

Timeliness of prenatal care measure improvement:

Increase the rate of deliveries that received a prenatal care visit 66.41% → 77.52%

Diabetes A1c measure improvement:

Decrease in HbA1c greater than 9% 45.63%→34.78%

- 51% of the Nevada Quality Strategy objectives (performance measures) were met in 2021.
- HPN was the only MCE to receive “Confidence” and “High Confidence” ratings in the two performance improvement projects required in 2021.

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Thank you!