# 2024 Population Health Strategy

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April 17, 2024

United Healthcare

# Our focus

Building a more equitable, accountable, and community-integrated delivery system to improve health, reduce costs and eliminate health disparities. Our cornerstone focuses on delivering the highest quality of care and focusing on what matters most.

# Our Aims

Our Population Health strategy is largely based on the state quality strategy.

We use this strategy to inform our:

- quality assurance performance improvement objectives (QAPI),
- pediatric strategy,
- value-based contracting, and
- care management programs.

# 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

# Assessing our population

We utilize a multitude of proprietary and industry tools along with learned and best practices to understand and best serve the needs of our membership.

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

# 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
- Claims and encounter data
- Homeless management system
- Provider reporting (gaps in care)
- Unite Us
- Predictive modeling
- Internal and external documentation systems

# Stratification

We use a diverse set of resources to inform our dynamic and unique stratification approach. This allows us to identify the appropriate services to offer. Getting it right the first time and continuing to improve.

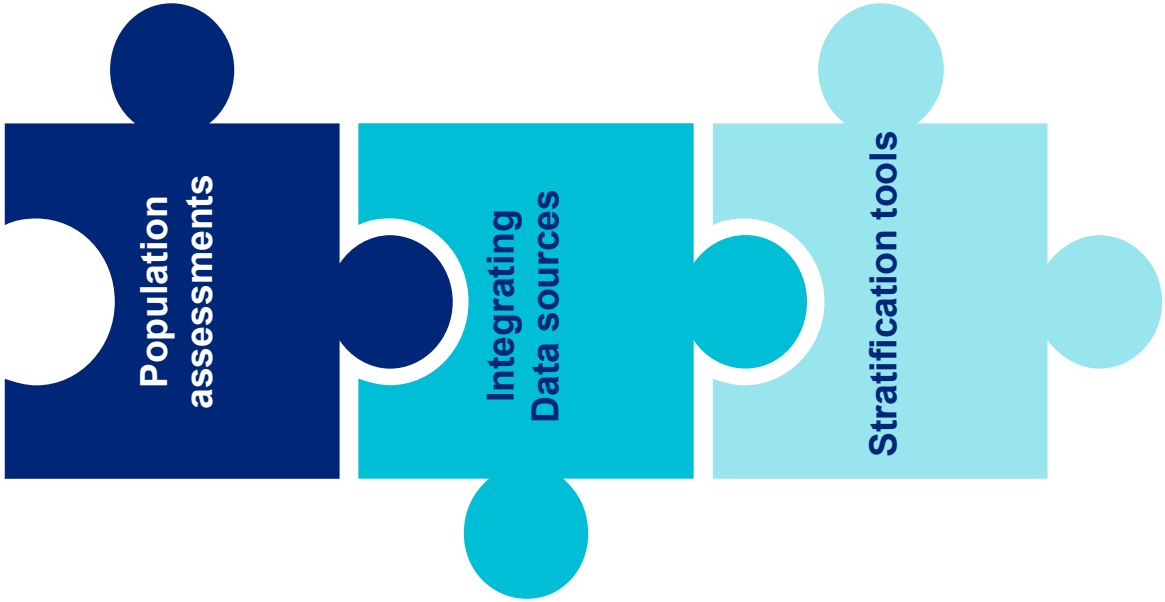
I-Pro

Member profile report

ICM

Hotspotting tool

# Putting the pieces together




The ability to layer the knowledge gained from these three areas allows UHC HPN to target specific populations, create custom interventions and creatively and proactively address unique populations who need assistance.

Our local, hands-on approach to patient outreach and care, guides our strategy and allows us to set well thought-out, meaningful goals to align with and achieve our mission.

# 2024 Priorities

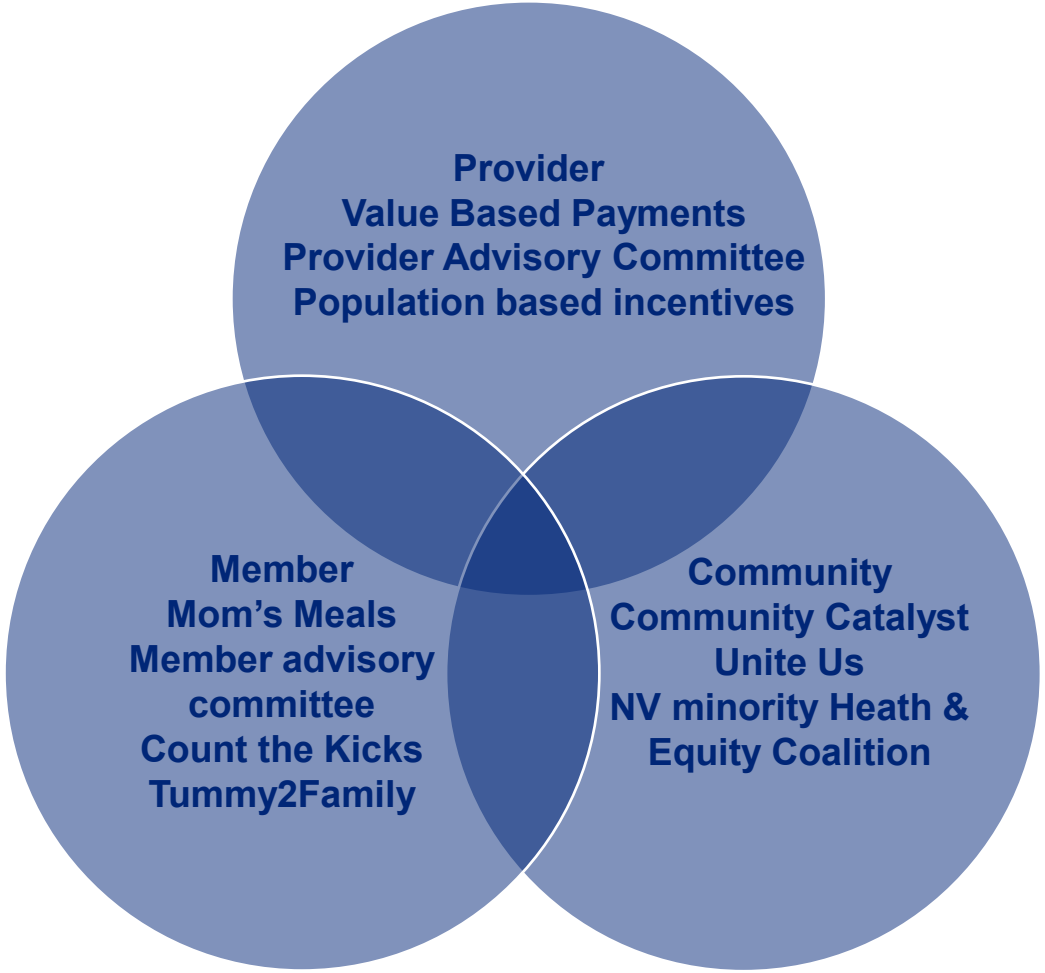
**To advance better health for all of Nevada**

1. **Impacting Maternal Health Outcomes**
   - Focused on the health and wellness of new mothers and infants
   - Mitigate disparities

2. **Promote Child and Adolescent Health and Well-Being**
   - Improved access and preventive care
   - Mitigate disparities
   - Chronic conditions

3. **Improve Whole Health Outcomes for Nevada Adults**
   - Improved access and preventive care
   - Chronic conditions
   - Mitigate disparities
   - Behavioral Health conditions

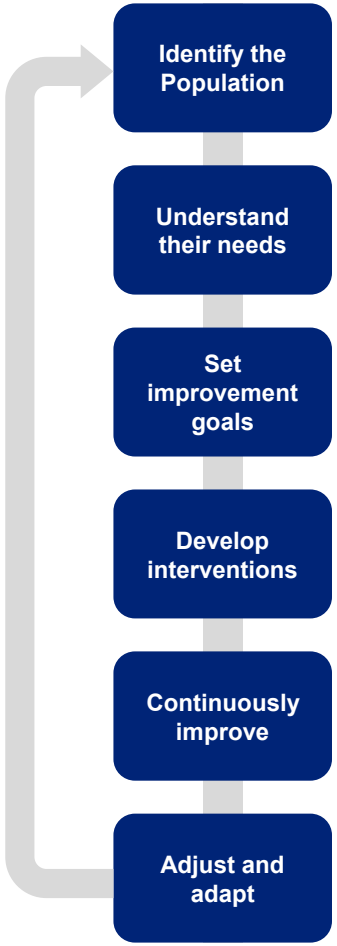
# Collaboration = Success




We take a local collaborative approach. Working 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 members we strive to advance a culture of compassion and innovation while mitigating health disparities.

# Measuring success




Alignment between teams allows a whole person care approach to meet members where they are and cater to their unique needs.

All interventions are reviewed on at least a quarterly basis.

PDSA is used to evaluate goals and need for different intervention strategies if targets are not being achieved.

UHC HPN meets with the National team to review trends and ensure proper resource deployment.

# 2023 Summary & Results

# Our 2023 successes

## Doula Pilot Outcomes

The program aimed to promote better birth outcomes in the African American population.

- 48 African American Women delivered
- 29% overall c-section rate
- 4.17% program NSTV (nulliparous, singleton infant, term and vertex position)

## Regulatory Outcomes

- Full auto-assignment (35%) achieved by ranking first in all rated measures
- Confidence and High Confidence ratings in the six performance improvement projects (PIPs)
- 100% validation score on all six PPs

## Population Health Outcomes

- 65% of our population health goals are on track to meet target by end of 2024.
- Through 2023, 44 Medicaid API members enrolled in the DM program with an average decrease in A1c of 3.41%.

# Diabetes Success Story

C.M., Member*

C.M., 38-year-old male, joined the Diabetes Fresh Start Program because of an outreach call from the Disease Management team.

On January 18, 2023, C.M.'s A1c was >14.

Maureen, DM RN started working with him in March 2023.

During their first call C.M. was frustrated that his blood sugars weren't improving, and he lost his CDL due to failing his physical examination.

Maureen Galka, RN

Over the course of 12 weekly phone calls Maureen worked through diabetes medication challenges and assisted in setting health goals with C.M.

Maureen provided diabetes nutritional advice, encouraged C.M. to get eye an exam and referred him to the Moms Meals program to educate on portion/carbohydrate control.

C.M. obtained eye exam, made dietary and lifestyle changes and lost 20 pounds.

By September 2023, his A1c was 7.6.

This was a decrease of 6.4 points.

*Not actual member

**Relationships = Success**

United Healthcare
Health Plan of Nevada
Medicaid

# Our 2024 activities

UHC HPN Medicaid continuously assesses and improves the quality of care and services our healthcare delivery system provides from both clinical and non-clinical perspectives from a person-centered approach. Focused activities play a role in achieving our strategic goals. Our focus is on mitigating disparities, meeting the members unique needs and creating an equitable health landscape for all.

# Our 2024 activities

## Childrens Health

**Children occupy the majority of our membership and have some of the poorest outcomes.**

- In depth-analysis on where gaps exist to fuel program expansions and revised strategies.
  - Nutrition
    - race & ethnicity focus
  - Focus on immunizations and well care
  - **New** Tummy2Family app

## Health Equity

**UHC-HPN Sexual Health Equity Program**

- Partnering with an FQHC to address sexual health disparities and improve outcomes in communities of color, LGBTQ+, and other at-risk populations.
  - Education and support
  - Increase access to needed testing and treatment.
    - Reduce the spread of STIs including congenital syphilis.

# Our 2024 activities

## Women's Health

**Improve the health and wellness of women and infants in NV by increasing access to preventive services and decreasing health disparities for our members.** Activate an educational campaign centered on family planning, birth spacing, and long-acting reversible contraception (LARC) for women of child-bearing age in Nevada

**2024 LARC and family planning strategy:**

- Increase health education on the value of family planning, healthy birth spacing, and best practice for LARCs after birth with providers, pregnant and postpartum women.
- Create culturally appropriate educational marketing materials to empower family planning choices and birth control options.
- Engage partners and stakeholders to increase culturally appropriate education and awareness about preconception and interconception health.

# Thank you