Diabetes and Obesity Action Report for the Healthy Louisiana Program

Report Prepared in Response to Act 210

Prepared by:

Louisiana Department of Health

Medicaid Quality Section

Quality Improvement

Medical Vendor Administration

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Contents

Executive Summary

Obesity and diabetes are two critical and interlinked public health concerns in Louisiana. These two chronic conditions increase the risk of other costly health conditions, such as high blood pressure, heart disease and stroke. Obesity and diabetes can also decrease the quality and duration of life and result in avoidable health care costs.

This report is submitted pursuant to Act 210 of the 2013 Legislative Session. Per Louisiana Revised Statute (RS) 46:2616 and RS 46:2617, the Louisiana Department of Health (LDH) is required to submit an annual diabetes and obesity action plan to the Senate and House Committees on Health and Welfare after consulting with, and receiving comments from, the medical directors of each of its contracted Medicaid partners. Data presented on prevalence, utilization and costs of obesity and diabetes are based on 2016 data submitted by each of the five Healthy Louisiana Managed Care Organizations (MCOs) and cover the managed care population only.

Below are some highlights from this year's report:

- *The State of Obesity* is a collaborative project of the Trust for America's Health and the Robert Wood Johnson Foundation that produces annual reports on national obesity trends. According to *The State of Obesity's* 2017 report, Louisiana dropped from first (36.2 percent) in 2015 to fifth (35.5 percent) in 2016 among all states for adult obesity.[1] The following obesity summary was based on 2016 Healthy Louisiana MCO claims data:
    - In 2016, 86,562 members or 6.60 percent of the Healthy Louisiana population had a claim for obesity; 36.77 percent (31,830 individuals) of those diagnosed with obesity were 21 years of age or younger. The Gulf region had the most members (24,065) with an obesity diagnosis. (See appendix B for regional breakdown for obesity).
    - The Healthy Louisiana Plans paid $153.7 million for obesity-related services.
- According to the *State of Obesity 201*7 report, Louisiana dropped from fifth (12.7 percent) in 2015 to eighth (12.1 percent) in 2016 among all states for adult diabetes. The following diabetes summary was based on 2016 Healthy Louisiana MCO claims data:
    - In 2016, 45,520 adult members, or 9.54 percent, of the adult Healthy Louisiana population had a claim for diabetes. Of those diagnosed with diabetes, 70.31 percent (33,368 individuals) were male, and 95.92 percent (45,520 individuals) were over the age of 21. The highest percentage of people with diabetes, regardless of age, resided in the Gulf region (33.5 percent). *(See appendix C for regional breakdown for diabetes)*
    - The average cost of treating a pregnancy complicated by diabetes ($2,087) was slightly more than 50 percent higher than a pregnancy not complicated by diabetes ($1,372).
    - There were 4,664 inpatient hospital discharges that noted diabetes as the main diagnosis for admission. The total financial cost associated with these inpatient diabetes-related hospital discharges was $10.3 million**.**

[1] *The State of Obesity in Louisiana*. (August 2017). Retrieved November 17, 2017, from http://www.stateofobesity.org/states/la

- Diabetic ketoacidosis was the most common diabetic complication on hospital inpatient claims for those 21 years of age or younger, accounting for nearly 70 percent of all inpatient hospital discharges for this age group.
- There were 29,240 Emergency Department (ED) visits for Healthy Louisiana members for which diabetes was the primary diagnosis. The majority of ED visits occurred among members older than 21 years of age.
- The medical condition related to diabetes that resulted in the most expensive average cost per member was coronary heart disease at $6,737.43 per member.

LDH strives to protect and promote health statewide and to ensure access to medical, preventive and rehabilitative services for all residents. Below are some recommendations from LDH and the MCOs on ways to empower the community, promote self-management training and monitor health outcomes.

LDH and MCO Recommendations:

- Appropriately fund outpatient nutritional services provided by registered dietitians for all patients and all diagnoses, not just those diagnosed with diabetes and obesity. Currently, primary care physicians that take care of people with, or who are at risk for, obesity or diabetes are unable to adequately counsel and educate children, their caregivers, and adults about nutrition during routine visits. To properly educate them regarding nutrition, recurring appointments with a registered dietitian are necessary. Some of these appointments can occur in a group setting. However, if there is no ability for the registered dietitian to recover the cost of providing the service, they (or their employer) are unable to provide the service.

- Implement educational reforms aimed at improving diabetes and obesity outcomes in Louisiana. These could include:
  - Enforce the Louisiana law (RS 17:17.1) that requires physical activity in schools, currently applicable to kindergarten through eighth grade classes.
  - Expand Louisiana's physical activity law to the high school system.
  - Adequately fund school systems to teach basic nutrition in the classroom at all schools and for all ages.
  - Provide continuing education units (CEUs) to educators through subject matter experts (e.g. kinesiologists or exercise science experts) in order to increase their understanding about the methodology of correctly providing physical activity and nutritional education in the school setting.

Healthy Louisiana Response to ACT 210

1. Introduction

This report will give an overview of obesity and diabetes within the Healthy Louisiana Plans. This report will also describe the scope of the obesity and diabetes epidemics in Louisiana, and in the Healthy Louisiana Plans, by examining costs, complications and how LDH, along with its contracted Medicaid partners, will address obesity and diabetes in the populations they serve. In addition, the report discusses recommendations on how to improve the health of Louisiana residents with, or at risk for developing, obesity and diabetes. Data presented on prevalence, utilization and costs of obesity and diabetes are based on data submitted by each of the five Healthy Louisiana MCOs and cover the managed care population only.

LDH is required to provide an annual submission of the report in keeping with Act 210 of the 2013 Legislative Session. (See Appendix A for a copy of the legislation.)

1.1 Report Methodology

Each MCO was required to complete a template, which included requests for prevalence and other clinical data that summarize diabetes and obesity among their members. Additionally, each plan submitted details of their diabetes and obesity action plans. In response to Act 210, Louisiana Medicaid aggregated the data and information submitted by each of the plans to create the *Diabetes and Obesity Action Report for the Healthy Louisiana Program*.

1.2 Overview of Obesity Impact

Although national, state and local governments, and many private employers and payers have increased their efforts to address obesity since 1998,[2] more than one-third (36 percent) of U.S. adults, and 17 percent of U.S. children and adolescents, were considered obese between 2011 and 2014[3]

1.3 What is Obesity?

Obesity is a diagnosis when an individual has accumulated enough body fat to have a negative effect on their health. If a person's bodyweight is at least 20 percent higher than it should be, he or she is considered to be obese. Obesity is calculated using a statistical measurement known as the Body Mass Index.[4]

1.4 What is Body Mass Index?

The Body Mass Index (BMI) is derived from an individual's height and weight. If the BMI is between 25 and 29.9, a person is considered overweight. If the BMI is 30 or greater, the individual is classified as obese.[4] A child's weight status is determined using an age- and sex-specific percentile for BMI rather than the BMI categories used for adults because children's body composition varies by age and sex. In children

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[2] *Annual Medical Spending Attributable To Obesity: Payer-And Service-Specific Estimates. (n.d.). Retrieved February 17, 2017, from http://content.healthaffairs.org/content/28/5/w822.full.pdf html*

[3] *Ogden, C. L., Fryer, M. D., & Flegal, K. M. (2015). Prevalence of Obesity Among Adults and Youth: United States, 2011-2014. NCHS Data Brief,219, 1-8. Retrieved February 17, 2017.*

[4] *BMI and Obesity. (2012, December 01). Retrieved February 17, 2017, from http://www.ahrq.gov/news/newsroom/audio-video/bmieng.html*

and adolescents age two to 19 years, obesity is defined as a BMI at or above the 95th percentile of the sex-specific Centers for Disease Control and Prevention's (CDC) BMI-for-age growth charts.[5]

According to the American Diabetes Association, children who are overweight, obese, or unfit are at increased risk of developing high blood pressure, abnormal lipid levels, inflammation in their blood vessels and higher than normal blood sugar levels. Obesity is a precursor of diabetes and adult-onset cardiovascular disease. Despite the growing efforts of government and public health officials, the number of overweight and obese youth continues to remain stable.[6]

1.5 Overview of Diabetes Impact

Diabetes is a common disease: the CDC reports that more than 29 million Americans are living with diabetes, and another 86 million are living with prediabetes. About 90 percent to 95 percent of diagnosed cases are type 2, and about 5 percent are type 1. In the United States, diabetes was the seventh leading cause of death in 2013. The CDC also reports that more than 20 percent of health care spending is for people with diabetes.[7]

1.6 What is Diabetes?

Food we eat is usually turned into glucose, a type of sugar, and our pancreas makes a hormone called insulin to help the glucose get into the cells of our bodies so it can be used for energy. Diabetes is a disease in which the body either doesn't make enough insulin, or can't use its own insulin as well as it should, causing sugar to build up in the blood. When the amount of sugar circulating in the blood is too high, it causes damage to many parts of the body including the eyes, heart, blood vessels, kidneys and nerves. This damage makes diabetes the leading cause of adult blindness, end-stage kidney disease and amputations of the foot and/or leg. People with diabetes are also at a greater risk for heart disease and stroke.[8, 9]

1.7 Types of Diabetes

Type 1 diabetes (previously called "juvenile diabetes" or "insulin-dependent diabetes") develops when the body produces little to no insulin due to destruction of the pancreas cells that make insulin. To survive, people with type 1 diabetes must have insulin delivered by injection or through an insulin pump. This form of diabetes usually occurs in children and young adults, although disease onset can occur at any age. In adults, type 1 diabetes accounts for approximately 5 percent of all diagnosed cases of diabetes. There is no known way to prevent type 1 diabetes.[5]

Type 2 diabetes (previously called "non-insulin-dependent diabetes" or "adult-onset diabetes") develops with "insulin resistance," a condition in which cells (e.g., liver, muscles) of the body do not use insulin properly. As the body resists its own insulin, the pancreas begins to lose the ability to make enough of it. In adults, type 2 diabetes accounts for about 90 percent to 95 percent of all diagnosed cases of diabetes. The risk factors for developing this type of diabetes include: older age, obesity, family history of diabetes, personal history of gestational diabetes, physical inactivity and race/ethnicity. African Americans,

[5] *Childhood Obesity Facts. (2016, December 22). Retrieved February 17, 2017, from http://www.cdc.gov/obesity/data/childhood.html*

[6] Ogden, C. L., Fryer, M. D., & Flegal, K. M. (2015). Prevalence of Obesity Among Adults and Youth: United States, 2011-2014. *NCHS Data Brief,219*, 1-8. Retrieved February 17, 2017.

[7] Diabetes. (2016, July 25). Retrieved February 17, 2017, from https://www.cdc.gov/chronicdisease/resources/publications/aag/diabetes.htm

[8] *National Diabetes Statistics Report, 2014* (pp. 1-12, Rep.). (2014). Atlanta, GA: Centers for Disease Control and Prevention.

[9] Statistics About Diabetes. (n.d.). Retrieved February 17, 2017, from http://www.diabetes.org/diabetes-basics/statistics/

Hispanic/Latino Americans, American Indians, some Asian Americans and Native Hawaiians or other Pacific Islanders are at a higher risk for development of type 2 diabetes and its complications. Type 2 diabetes may be preventable through modest lifestyle changes. [10]

Gestational Diabetes is a type of diabetes that is first seen in a pregnant woman who did not have diabetes before she was pregnant. The risk factors for gestational diabetes are similar to those for type 2 diabetes. Gestational diabetes requires treatment to lessen the risk of complications such as preterm births, larger babies requiring cesarean sections, preeclampsia, birth defects, and increased risk of type 2 diabetes for both the mother and the child once she/he reaches adulthood. Often, gestational diabetes can be controlled through eating healthy foods and regular exercise. Sometimes a woman with gestational diabetes must also take insulin.[11]

2. The Scope of Obesity in Louisiana

Based on 2016 claims data, the prevalence of obesity among Healthy Louisiana members was 6.6 percent, representing 86,562 enrollees. However, the Trust for America's Health and the Robert Wood Johnson Foundation's *State of Obesity 2017* report stated that Louisiana ranked fifth highest in adult obesity among all states, at 35.5 percent.[12] This is down from being ranked first with a rate of 36.2 percent in the *State of Obesity 2016* report. Women, Infants and Children (WIC) participants 2-4 years of age had an obesity rate of 13.8 percent, while 10-17 year olds had a 34.0 percent rate of being obese or overweight.[13] Given these reported high rates, it appears that obesity is under-coded as a diagnosis in Louisiana Medicaid claims data, leading to an underrepresentation of the burden of obesity in available claims data. Of the Healthy Louisiana members diagnosed with obesity, 36.8 percent (n=31,830) were 21 years of age or younger. The Healthy Louisiana obesity prevalence for the same group, 21 years and younger, was 3.81 percent. The geographic and age group breakdown of obesity among the four Louisiana regions are shown in Maps 2.1 and 2.2. For the 21 years or younger group, the South Central (28.95 percent) and Capital Area (27.50 percent) regions had the highest number of members with obesity. For Healthy Louisiana members older than 21, the Gulf (29.32 percent) and Capital Area (26.51 percent) regions had most members with obesity. The Northern region had the lowest percentage of individuals diagnosed with obesity in both age groups. For parish level information, please see Appendix C.

The 2016 financial burden of obesity is shown in Table 2.1, reflecting that the Healthy Louisiana Plans paid around $29.6 million for service-related claims for obesity. The amount paid for anyone identified with obesity and other related conditions totaled more than $153 million.

[10] *Childhood Obesity Facts. (2016, December 22). Retrieved February 17, 2017, from http://www.cdc.gov/obesity/data/childhood.html*

[11] Gestational Diabetes and Pregnancy. (2015, September 16). Retrieved February 17, 2017, from http://www.cdc.gov/pregnancy/diabetes-gestational.html

[12] *The State of Obesity in Louisiana*. (August 2017). Retrieved November 17, 2017, from http://www.stateofobesity.org/states/la

[13] *The State of Obesity in Louisiana*. (August 2017). Retrieved November 17, 2017, from http://www.stateofobesity.org/states/la

Table 2.1: Financial Burden of Obesity in 2016 Among Healthy Louisiana Plan Members		
Age Group	**Service-Related Payments for Obesity***	**Total Obesity-Related Payments****
≤ 21 years	$4,719,464.54	$21,240,015.58
> 21 years	$24,967,591.94	$132,469,657.89
Total	$29,687,056.48	$153,709,673.47

*Service-related payments are defined as claims with obesity as one of the diagnoses

**Total payments are defined as all claims related to members identified as obese but may not have been in diagnosis

Map 2.1: Geographical Distribution of Healthy Louisiana Members with Obesity, Age ≤ 21 Years, 2016 (n = 31,830)

Region	
	Capital Area (8,754; 27.50%)
	Gulf (8,016; 25.18%)
	Northern (5,845; 18.36%)
	South Central (9,215; 28.95%)

Map 2.2: Geographical Distribution of Healthy Louisiana Members with Obesity, Age > 21 Years, 2016 (n = 54,732)

Region	
	Capital Area (14,507; 26.51%)
	Gulf (16,049; 29.32%)
	Northern (11,575; 21.15%)
	South Central (12,601; 23.02%)

3. The Scope of Diabetes in Louisiana

This section of the report provides data on the scope of diabetes among children and adults in the state, and within the five Healthy Louisiana Plans. Data from the Behavioral Risk Factor Surveillance System (BRFSS) compares how Louisiana residents with diabetes fare nationally in meeting clinical and self-care measures.

Based on Louisiana's results of the annual BRFSS survey, Figure 3.1 shows the 15-year trend of diagnosed diabetes in Louisiana. With some fluctuation, the rate trended upward from a low of 7.15 percent in 2002 to a high of 12.7 percent in 2015. Most recently, the 2016 prevalence rate dropped to 12.1 percent. Louisiana's trend mirrors the long-term trends published by the CDC, which reported the U.S. population diagnosed with diabetes rose from 0.93 percent in 1958 to 7.40 percent in 2015.[14]

[14] *Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Division of Population Health. BRFSS Prevalence & Trends Data [online]. 2015*

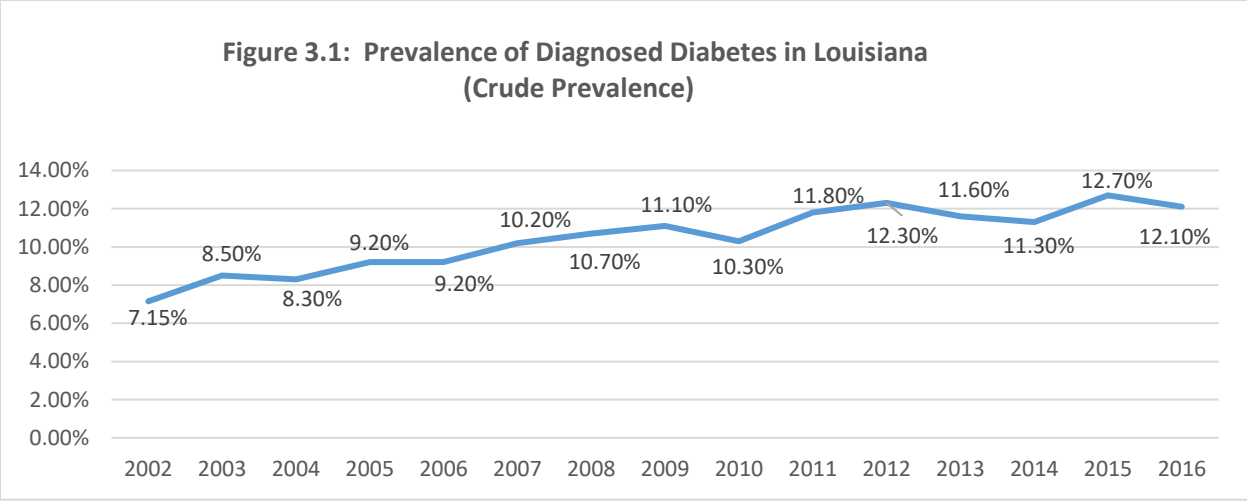
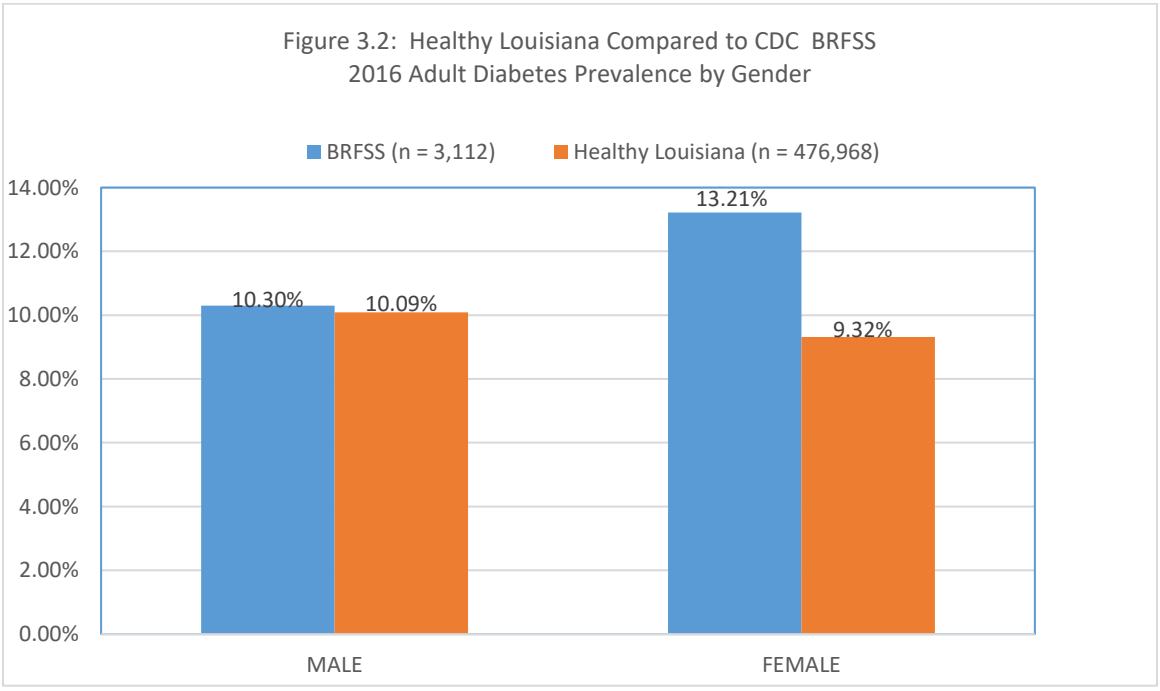


Figure 3.2 shows adult diabetes prevalence by gender in the overall Louisiana population and in the Healthy Louisiana population. The Healthy Louisiana populations show a slightly lower prevalence in females (9.32 percent) than in males (10.09 percent). However, according to the Centers for Disease Control, the overall Louisiana prevalence was higher among adult females (13.21 percent) than adult males (10.3 percent) and the overall adult diabetes prevalence for Louisiana in 2016 was 12.1 percent.[15]



[15] *Centers for Disease Control, 2015*

Figure 3.3 displays how diabetes prevalence for Healthy Louisiana members is distributed across age groups and gender. Healthy Louisiana 2016 diabetes prevalence is highest in adult males (10.09 percent; 14,090) and is followed closely by adult females (9.32 percent; 31,430).

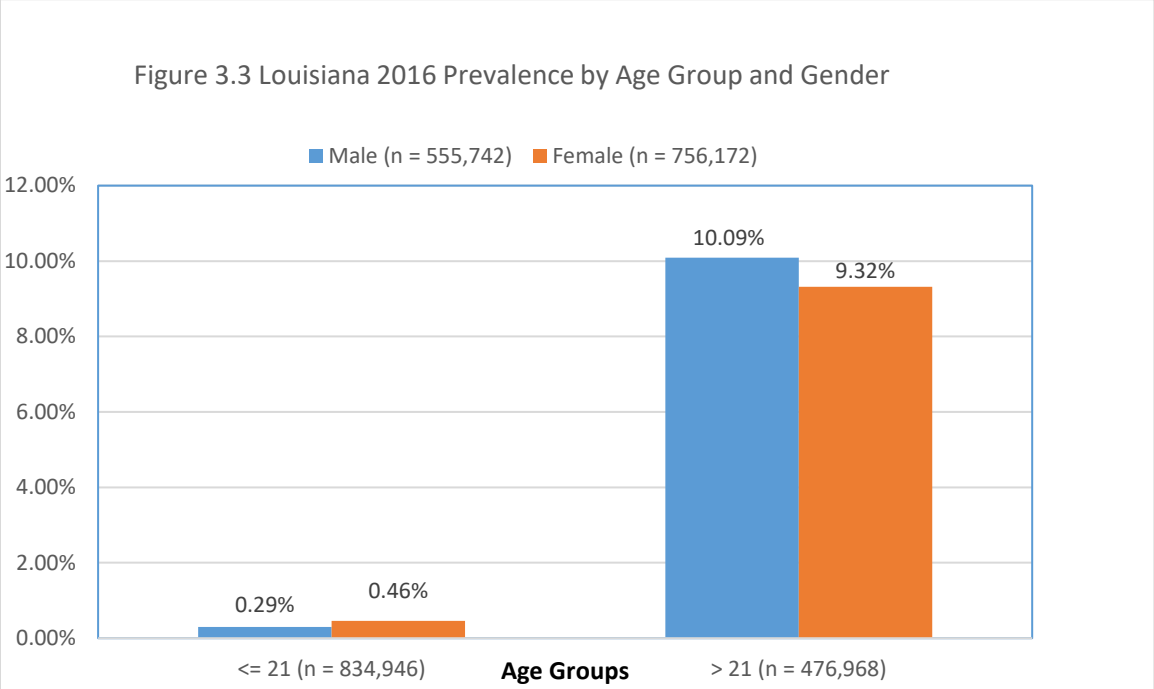


Table 3.1 details how members in Healthy Louisiana compared with state and national levels for preventive practices recommended for patients with diabetes. Louisiana's BRFSS percentages were close to the 2012 national numbers for most of the listed preventive care practices. Although the Healthy Louisiana Plans have a smaller percentage of those with diabetes in the state, the majority of their preventive care practices increased. However, the MCOs had lower preventive care practices for a member ever receiving a pneumonia shot or for self-management. A possible reason for these low findings among the Healthy Louisiana members is their ability to receive some vaccines at little to no cost in a setting that does not generate a typical insurance claim. For this reason, administrative claims data is likely to produce artificially low flu and pneumonia vaccination rates.

Table 3.1: Reported Rates of Diabetic Care Practices Among Adults with Diabetes: Healthy Louisiana Plans, Louisiana and the United States			
Preventive Care Practice	**Healthy Louisiana (2016)†**	**BRFSS Louisiana (2013)**	**U.S. (2012)††**
Annual dilated eye exam	63.67%	66.6%	64.9%
Received one or more HbA1c in current (2016) year	86.69%	88.1%	72.8%
Received a flu shot in current (2016) year	4.73%	60.2%	***
Ever received a pneumonia shot[3]	6.44%	53.1%	***
Daily self-blood glucose monitoring[4]	39.40%	61.9%	63.5%
Ever had self-management education[4]	0.14%	54.1%	57.6%

†Because Healthy Louisiana members may receive immunizations from organizations outside of the normal healthcare delivery settings and who may offer the vaccines free or nearly free, the claims data will produce artificially low rates for flu and pneumonia vaccines.

††2012 represents the most recent year of data available from the CDC *Diabetes Report Card*. Available at: https://www.cdc.gov/diabetes/pdfs/library/diabetesreportcard2014.pdf

***Rates not included in *CDC's Diabetes Report Card 2014.*

The geographic and age group breakdown of diabetes among the four regions are shown in Maps 3.1 and 3.2. The Gulf region had the largest number of enrollees with diabetes, for both age groups. The region with the fewest number of Healthy Louisiana enrollees with diabetes age 21 and under was the Capital Area region, although both the Northern and the South Central regions had only slightly larger percentages. For enrollees over the age of 21, the Northern region had the lowest number of enrollees with diabetes. For parish-level data, please see Appendix D.

Map 3.1: Geographical Distribution of Healthy Louisiana Members with Diabetes, Age ≤ 21 Years, 2016 (n = 3,083)

Region	
	Capital Area (525; 17.03%)
	Gulf (1,393; 45.18%)
	Northern (593; 19.23%)
	South Central (572; 18.55%)

Map 3.2: Geographical Distribution of Healthy Louisiana Members with Diabetes, Age > 21 Years, 2016 (n = 45,424)

Region	
	Capital Area (9,740; 21.44%)
	Gulf (14,877; 32.75%)
	Northern (9,446; 20.80%)
	South Central (11,361; 25.01%)

4. Diabetes and Pregnancy

Table 4.1 shows the 2016 percentage of pregnancies complicated with diabetes and the financial burden on Healthy Louisiana. Nearly 9 percent of pregnancies involved diabetes. The average paid, per member, for a pregnancy with diabetes was one and one-half times that paid for pregnancies without diabetes ($2,087 vs. $1,372).

Table 4.1: Burden of Diabetes* on Pregnancies in 2016 Among Healthy Louisiana Members

Pregnancy Type	Number of Members	Total Amount Paid	Average Amount Paid per Member
Pregnancies with diabetes	5,427 (8.82%)	$ 11,325,008.42	$ 2,086.79
Pregnancies without diabetes	56,112 (91.18%)	$ 76,957,807.42	$1,371.50

*Diabetes is defined as pre-existing in pregnancy and gestational diabetes

5. The Financial Impact of Diabetes and its Complications

5.1 Estimated Costs of Diabetes

The American Diabetes Association estimates that the largest component of medical expenses attributed to diabetes is for hospital inpatient care, at 43 percent of total medical costs.[16] Given that inpatient hospital care is such a large component of diabetes costs, examining Louisiana's data on diabetes hospitalization costs is important to understanding its impact on individuals, families, and the state. These data also serve as a reflection of how well diabetes is, or is not, managed by the health care system.

5.2 Hospitalization Costs Due to Diabetes

An inpatient hospital discharge record includes all information from admission to discharge. An Emergency Department (ED) record includes visits to an ED that do not result in an inpatient admission. ED records also include data of patients who are held for an observational stay but who are not admitted as inpatients to the hospital. This section of the report includes hospital discharge and ED visit data for 2016.

Table 5.2.1 shows, by age group, the number and percentage of inpatient hospital discharges, the percentage of overall hospital admissions, and Healthy Louisiana plan payments for admissions in which diabetes was coded on the discharge paperwork as the primary (principal) diagnosis for admission. In 2016, there were 4,664 inpatient hospital discharges for which the principal diagnosis was diabetes; this was 4.19 percent of the overall inpatient discharges for Healthy Louisiana members in 2016. Most (86.7 percent) of these inpatient discharges for diabetes occurred among Healthy Louisiana members older than 21 years of age. The total paid by Healthy Louisiana Plans for diabetes-related inpatient admissions amounted to $10,326,112.69.

It is important to note that the costs reported in this table do not include costs that may be related to diabetes, and thus, were not coded in the claim as having been related to diabetes. For example, conditions like hypertension, heart disease, kidney disease, influenza, and others are made worse by diabetes, and may, in turn, make diabetes more difficult (and more expensive) to manage and control.

Table 5.2.1: Inpatient Hospital Discharges and Total Paid for Hospitalizations with Diabetes as the Primary Diagnosis* Among Healthy Louisiana Plan Members in 2016 by Age Group

Age Group	Number of Diabetes Discharges	Percent of Overall Discharges Due to Diabetes	Total Paid for Diabetes Hospitalizations
≤ 21 years	619	1.62%	$1,334,018.94
> 21 years	4,045	5.54%	$8,992,093.75
Total	4,664	4.19%	$10,326,112.69

* Primary diagnosis is defined as diabetes noted in the first three discharge diagnosis listings.

5.3 Specific Diabetes Complications as Principal Diagnosis for Inpatient Hospital Discharges

Hospitalizations for diabetes may occur due to complications of the disease. The complications discussed in this section of the report were identified from the principal diagnosis code assigned by the physician

[16] Diabetes. (2016, July 25). Retrieved February 17, 2017, from https://www.cdc.gov/chronicdisease/resources/publications/aag/diabetes.htm

during the hospital stay. Again, the principal diagnosis is defined as the condition responsible for admission of the patient to the hospital. Table 5.3.1 shows, by age group, inpatient discharges in 2016 where a complication of diabetes was the primary diagnosis. This table also provides the total percent of inpatient discharges due to a diabetes complication and the total amount paid by the Healthy Louisiana Plans for these complications.

For members 21 years or younger, the most frequent diabetes complication associated with an inpatient hospital discharge was diabetic ketoacidosis (DKA). DKA is a life-threatening complication in which ketones (fatty acids) build up in the blood due to a lack of insulin. DKA accounted for more than 87 percent of all inpatient hospital discharges due to a diabetic complication for this age group and cost a total of $1,328,665.39. For members older than 21 years of age, "diabetes with other specified manifestations" was the most frequent diabetic complication (more than 25 percent), closely followed by DKA (almost 23 percent). The total cost for these two complications were $2,464,632.52 and $2,317,838.46, respectively.

Table 5.3.1: Inpatient Hospital Discharges in 2016 by Age Group Where a Diabetes Complication Was the Primary Diagnosis *

Diabetes Complications	Number of Discharges	Percent of Diabetes-Related Discharges Due to Complication**	Total Amount Paid for Diabetes Complication	Number of Discharges	Percent of Diabetes-Related Discharges Due to Complication**	Total amount paid for diabetes complications
	≤21 years			>21 years		
Ketoacidosis	539	87.08%	$1,328,665.39	930	22.99%	$2,317,838.46
Hyperosmolarity	2	0.32%	$1,983.22	126	3.11%	$345,720.86
With Other Coma	6	0.97%	$38,587.70	17	0.42%	$36,719.80
With Renal Manifestations	1	0.16%	$1,447.55	293	7.24%	$731,819.92
With Ophthalmic Manifestations	0	0.00%	$0.00	6	0.15%	$15,581.55
With Neurological Manifestations	4	0.65%	$10,043.92	629	15.55%	$1,733,574.27
With Peripheral Circulatory Disorders	0	0.00%	$0.00	155	3.83%	$1,233,980.08
With Other Specified Manifestations	142	22.94%	$247,831.29	1,028	25.41%	$2,464,632.52
With Unspecified Complications	25	4.04%	$1,097.01	170	4.20%	$9,934.77

*Primary diagnosis is defined as diabetes noted in the first three discharge diagnosis listings.

**Total diabetes-related inpatient hospital discharges for ≤21 years of age are 619. Total diabetes-related inpatient hospital discharges for >21 years of age are 4,045. (See Table 5.2.1.)

5.4 Emergency Department Visits Due to Diabetes

Table 5.4.1 displays, by age group, the number of ED visits due to diabetes, the percent of overall ED visits due to diabetes, and the amount paid for ED visits by the MCOs in which diabetes was the primary diagnosis. In 2016, a total of 29,240 ED visits occurred in which diabetes was the primary diagnosis, amounting to 3.8 percent of all ED visits for Healthy Louisiana members. Similar to inpatient discharges, the majority of ED visits occurred among those older than 21 years. In total, Healthy Louisiana paid almost $6.5 million for diabetes-related ED visits in 2016.

Table 5.4.1: Total ED Visits by Age Group Where Diabetes was the Primary Diagnosis *

Age Group	Number of ED Visits Due to Diabetes	Percent of Overall ED Visits Due to Diabetes	Total Paid for Diabetes ED Visits
≤ 21 years	2,030	0.55%	$524,936.14
> 21 years	27,210	6.87%	$6,022,826.99
Total	29,240	3.84%	$6,547,763.13

* Primary Diagnosis is defined as diabetes notes in the first three discharge diagnosis listings

Table 5.4.2 shows ED visits in 2016, by age group, where a complication of diabetes was the primary diagnosis for the visit. Of the total diabetes-related ED visits across both age groups (n=29,240), 18.86 percent (5,514) were attributed to "diabetes with other specified manifestations." The second most common reason, for members over 21 years of age, for going to the ED was "diabetes with neurological manifestations" and for members 21 years old or younger, it was "diabetes with ketoacidosis."

Table 5.4.2: Emergency Department Visits in 2016 by Age Group Where Diabetes Complication Was the Diagnosis *

Diabetic Complications	Total Visits for Ages ≤ 21 years	Total Visits for Ages > 21 years
Ketoacidosis	250	330
Hyperosmolarity	0	62
With Other Coma	3	9
With Renal Manifestations	0	422
With Ophthalmic Manifestations	0	36
With Neurological Manifestations	13	1,247
With Peripheral Circulatory Disorders	0	42
With Other Specified Manifestations	284	5,230
With Unspecified Complications	28	470

*Primary diagnosis is defined as diabetes noted in the first three discharge diagnosis listings.

6. Diabetes and Common Chronic Conditions

The statute that defines the content of this report provides a comparison of the financial burden or impact of diabetes to that of other common chronic conditions. This section of the report looks at the relationship between diabetes and other common chronic conditions, by comparing its prevalence, cost per member, and total paid with other chronic diseases, as shown in Table 6.1.

Among the members of the Healthy Louisiana Plans with chronic conditions, hypertension was the most prevalent, affecting 140,466 members, followed by asthma, which affects 79,076 members. Diabetes was the third most common chronic condition, affecting 48,160 Healthy Louisiana members.

Table 6.1: Comparison of Prevalence and Cost Between Diabetes and Other Common Chronic Conditions

Chronic Condition	Number of Members	Per Member Cost	Total Paid
Hypertension	140,466	$3,251.71	$456,754,901.37
Asthma	79,076	$1,995.00	$157,756,855.52
Diabetes	48,160	$4,834.84	$232,846,041.92
Arthritis	25,792	$3,500.60	$90,287,522.83
COPD	22,516	$6,567.01	$147,862,887.74
Coronary Heart Disease	11,537	$8,258.88	$95,282,678.34
Congestive Heart Failure	10,988	$11,828.30	$129,969,389.01

It is always important to remember that diabetes does not exist in a vacuum – people with diabetes often have additional chronic illnesses that affect their ability to self-manage, therefore providing additional diabetes management challenges to their doctors. The chronic disease that resulted in the most expensive cost per member was congestive heart failure, with an average cost per member at $11,828.30. In terms of total cost, the most expensive chronic condition among Healthy Louisiana members for 2016 was hypertension, at $456,754,901.37.

Conclusion

Managing obesity and diabetes is a complicated endeavor, and the strategies described in this report serve as a foundation for healthier Louisiana residents. Changes must occur in multiple parts of the health care system, community settings and in personal behaviors in order to further impact the obesity and diabetes epidemic.

Appendix A – Act 210 Legislation

RS 46:2616

CHAPTER 46. HEALTH ACTION PLANS

§2616. Diabetes annual action plan; submission; content

A. The Department of Health shall submit an action plan, after consulting with and receiving comments from the medical director of each of its contracted Medicaid partners, to the Senate Committee on Health and Welfare and the House Committee on Health and Welfare no later than February 1 of each year on the following:

(1) The financial impact and reach diabetes of all types is having on the state of Louisiana and its residents. Items in this assessment shall include the number of lives with diabetes covered by Medicaid through the Department of Health and its contracted partners, the number of lives with diabetes impacted by the prevention and diabetes control programs implemented by the department and its contracted partners, the financial cost diabetes and its complications places on the department and its contracted partners, and the financial cost diabetes and its complications places on the department and its contracted partners in comparison to other chronic diseases and conditions.

(2) An assessment of the benefits of implemented programs and activities aimed at controlling diabetes and preventing the disease.

(3) A description of the level of coordination existing between the Department of Health and Hospitals, its contracted partners, and other stakeholders on activities, programmatic activities, and the level of communication on managing, treating, or preventing all forms of diabetes and its complications.

(4) The development of a detailed action plan for battling diabetes with a range of actionable items. The plan shall identify proposed action steps to reduce the impact of diabetes, prediabetes, and related diabetes complications. The plan shall identify expected outcomes of the action steps proposed while establishing benchmarks for controlling and preventing diabetes.

(5) The development of a detailed budget blueprint identifying needs, costs, and resources to implement the plan identified in Paragraph (4) of this Subsection.

B. The Department of Health shall include within the annual diabetes action plan the most current editions of the standards of medical care in diabetes by the American Diabetes Association and the American Association of Clinical Endocrinologists.

Acts 2013, No. 210, §1, eff. June 10, 2013; Acts 2014, No. 713, §1.

RS 46:2617

§2617. Obesity annual action plan; submission; content

The Department of Health shall submit an action plan, after consulting with and receiving comments from the medical director of each of its contracted Medicaid partners, to the Senate Committee on Health and Welfare and the House Committee on Health and Welfare no later than February 1 of each year on the following:

(1) The financial impact and reach obesity is having on the state of Louisiana and its residents. Items included in this assessment shall include the number of lives with obesity covered by Medicaid through the Department of Health and its contracted partners, the number of lives with obesity impacted by the prevention and control programs implemented by the Department of Health and its contracted partners, the financial cost obesity and its complications place on the Department of Health and its contracted partners, and the financial cost obesity and its complications places on the Department of Health and its contracted partners in comparison to other chronic diseases and conditions.

(2) An assessment of the benefits of implemented programs and activities aimed at controlling obesity and preventing the disease.

(3) A description of the level of coordination existing between the Department of Health, its contracted partners, and other stakeholders on activities, programmatic activities, and the level of communication on managing, treating, or preventing obesity and its complications.

(4) The development of a detailed action plan for battling obesity with a range of actionable items. The plan shall identify proposed action steps to reduce the impact of obesity and related obesity complications. The plan shall identify expected outcomes of the action steps proposed while establishing benchmarks for controlling and preventing obesity.

(5) The development of a detailed budget blueprint identifying needs, costs and resources to implement the plan identified in Paragraph (4) of this Section.

Acts 2013, No. 210, §1, eff. June 10, 2013.

Appendix B – Region and Parish Information for Members with Obesity

Total number of Healthy Louisiana Plan members with obesity diagnosis by region, parish and age group.

REGION	PARISH	≤21 YEARS	>21 YEARS
Out Of State	Out Of State	47	85
Capital Area	ASCENSION	799	1,598
Capital Area	EAST BATON ROUGE	3,257	5,928
Capital Area	EAST FELICIANA	184	329
Capital Area	IBERVILLE	214	625
Capital Area	LIVINGSTON	1,164	1,029
Capital Area	POINTE COUPEE	129	522
Capital Area	SAINT HELENA	57	172
Capital Area	SAINT TAMMANY	1,065	1,658
Capital Area	TANGIPAHOA	1,287	1,454
Capital Area	WASHINGTON	451	754
Capital Area	WEST BATON ROUGE	108	338
Capital Area	WEST FELICIANA	39	100
Capital Area	Total	8,754	14,507
Gulf	ASSUMPTION	206	408
Gulf	JEFFERSON	2,740	4,817
Gulf	LAFOURCHE	677	828
Gulf	ORLEANS	1,917	5,329
Gulf	PLAQUEMINES	100	235
Gulf	SAINT BERNARD	427	1,055
Gulf	SAINT CHARLES	436	620
Gulf	SAINT JAMES	194	357
Gulf	SAINT MARY	274	719
Gulf	ST JOHN THE BAPTIST	329	585
Gulf	TERREBONNE	716	1,096
Gulf	Total	8,016	16,049
Northern	BIENVILLE	90	248
Northern	BOSSIER	708	963
Northern	CADDO	1,659	2,968
Northern	CALDWELL	38	114
Northern	CLAIBORNE	90	171
Northern	DE SOTO	116	303
Northern	EAST CARROLL	71	152
Northern	FRANKLIN	110	405
Northern	JACKSON	172	237
Northern	LINCOLN	229	358
Northern	MADISON	41	145
Northern	MOREHOUSE	250	484

REGION	PARISH	≤21 YEARS	>21 YEARS
Northern	NATCHITOCHES	287	407
Northern	OUACHITA	872	2,479
Northern	RED RIVER	24	75
Northern	RICHLAND	276	419
Northern	SABINE	154	333
Northern	TENSAS	12	63
Northern	UNION	129	323
Northern	WEBSTER	435	765
Northern	WEST CARROLL	82	163
Northern	Total	5,845	11,575
South Central	ACADIA	603	810
South Central	ALLEN	88	168
South Central	AVOYELLES	444	352
South Central	BEAUREGARD	248	285
South Central	CALCASIEU	818	1,595
South Central	CAMERON	11	22
South Central	CATAHOULA	92	254
South Central	CONCORDIA	97	422
South Central	EVANGELINE	385	383
South Central	GRANT	170	128
South Central	IBERIA	1,121	1,412
South Central	JEFFERSON DAVIS	144	285
South Central	LA SALLE	51	234
South Central	LAFAYETTE	1,777	1,925
South Central	RAPIDES	935	914
South Central	SAINT LANDRY	840	1,408
South Central	SAINT MARTIN	500	654
South Central	VERMILION	427	798
South Central	VERNON	137	303
South Central	WINN	327	249
South Central	Total	9,215	12,601

Appendix C – Region and Parish Information for Members with Diabetes

Total number of Healthy Louisiana Plan members with diabetes diagnosis by region, parish and age group.

REGION	PARISH	≤21 YEARS	>21 YEARS
Out Of State	Out Of State	2	49
Capital Area	ASCENSION	43	693
Capital Area	EAST BATON ROUGE	187	3,414
Capital Area	EAST FELICIANA	8	249
Capital Area	IBERVILLE	29	411
Capital Area	LIVINGSTON	50	751
Capital Area	POINTE COUPEE	15	262
Capital Area	SAINT HELENA	3	114
Capital Area	SAINT TAMMANY	100	1,294
Capital Area	TANGIPAHOA	40	1,491
Capital Area	WASHINGTON	33	710
Capital Area	WEST BATON ROUGE	12	261
Capital Area	WEST FELICIANA	5	90
Capital Area	Total	525	9,740
Gulf	ASSUMPTION	18	272
Gulf	JEFFERSON	500	4,431
Gulf	LAFOURCHE	35	807
Gulf	ORLEANS	605	5,651
Gulf	PLAQUEMINES	11	188
Gulf	SAINT BERNARD	41	542
Gulf	SAINT CHARLES	25	375
Gulf	SAINT JAMES	19	241
Gulf	SAINT MARY	26	655
Gulf	ST JOHN THE BAPTIST	52	591
Gulf	TERREBONNE	61	1,124
Gulf	Total	1,393	14,877
Northern	BIENVILLE	13	221
Northern	BOSSIER	57	690
Northern	CADDO	145	2,554
Northern	CALDWELL	5	146
Northern	CLAIBORNE	17	149
Northern	DE SOTO	14	345
Northern	EAST CARROLL	4	173
Northern	FRANKLIN	19	303
Northern	JACKSON	19	211
Northern	LINCOLN	36	422
Northern	MADISON	6	150
Northern	MOREHOUSE	14	388

REGION	PARISH	≤21 YEARS	>21 YEARS
Northern	NATCHITOCHES	24	412
Northern	OUACHITA	134	1,652
Northern	RED RIVER	11	105
Northern	RICHLAND	19	277
Northern	SABINE	11	226
Northern	TENSAS	2	92
Northern	UNION	13	276
Northern	WEBSTER	27	485
Northern	WEST CARROLL	3	169
Northern	Total	593	9,446
South Central	ACADIA	36	686
South Central	ALLEN	10	240
South Central	AVOYELLES	21	507
South Central	BEAUREGARD	22	368
South Central	CALCASIEU	82	1,723
South Central	CAMERON	0	27
South Central	CATAHOULA	4	137
South Central	CONCORDIA	11	265
South Central	EVANGELINE	24	570
South Central	GRANT	15	195
South Central	IBERIA	46	815
South Central	JEFFERSON DAVIS	14	319
South Central	LA SALLE	10	161
South Central	LAFAYETTE	72	1,491
South Central	RAPIDES	69	1,234
South Central	SAINT LANDRY	58	1,161
South Central	SAINT MARTIN	28	410
South Central	VERMILION	30	549
South Central	VERNON	12	353
South Central	WINN	8	150
South Central	Total	572	11,361

Appendix D – MCO Action Plans

This section details the actionable items to address diabetes by Healthy Louisiana MCOs.

Appendix D1- Aetna Better Health of Louisiana

Aetna Better Health of Louisiana Diabetes and Obesity Care Management Plan

Aetna Better Health of Louisiana (ABHLA) works with our members to build a trusting relationship between providers, case managers, the member and the member's family/caregiver or guardian, to facilitate the identification of the member's goals, strengths, needs and challenges as they relate to diabetes or obesity.

Aetna Better Health of Louisiana's integrated care management is provided for any member identified with diabetes or obesity. The member receives person-centered outreach and follow-up. Our care management program is called Integrated Care Management (ICM), reflecting our belief that all care management must address the member's medical, behavioral and social needs in an integrated fashion and must address the continuum of acute, chronic, and long term care needs. Our case managers assist members in coordinating medical and/or behavioral health services.

The overarching goal of our ICM process is to engage members to address their critical physical, behavioral, environmental and social needs in order to enhance resiliency and enable optimal self-management. We collaborate with the member/member supports to create a Plan of Care based on clinical practice guidelines and preventive service guidelines that includes mutually agreed upon member-centered goals, actions for the member/member supports and the care manager, as well as services to be coordinated for the member. We team with our members, their families, community supports, community-based case managers and providers to enhance care outcomes. Every assessment and encounter includes attention to comorbidities and to reducing unhealthy behaviors. Members are identified who may benefit from care management, using predictive modeling, self-reported health risks (Health Risk Questionnaire, or HRQ, offered to every member) and referrals from a variety of sources (including state-identified and state-mandated populations).

Assessments are based on national clinical guidelines for care and self-management of specific chronic illnesses, which include diabetes and obesity. Assessments are used to provide chronic disease management education and to evaluate whether members are receiving recommended care for their chronic conditions.

Aetna Better Health of Louisiana has a secure portal for members and their designated caregivers which allows:

- Viewing and printing of their own Plan of Care and provide feedback to their case manager;
- Viewing their member profile, which includes demographic and utilization information during the past year;
- Sending a message to or receiving a message from the case manager; and
- Viewing upcoming appointments and updating personal information and self-reported medical information.

Remote Patient Monitoring Program Description

The purpose of the remote member monitoring is to provide members, with certain chronic conditions, a method to impact behavior change and improve their abilities to self-manage these conditions. Through the gathering and monitoring of key vital signs and biometric data, remote monitoring creates a

mechanism enabling care providers to interact with members in a timely manner and promptly intervene should adverse trends be detected. Our aim is to improve outcomes, avoid exacerbations and costly interventions.

Partnered with our vendor, our comprehensive member remote monitoring program is designed to:

- Provide a member-centered care model with flexible solutions that connect people to their care teams.
- Create early intervention protocols based on member biometric data to identify potential, preventable adverse health events leading to Emergency Room visits and/or inpatient admissions.
- Improve the quality and timeliness of care when a member needs them, at an appropriate site of service.
- Offer a safe, secure environment to transmit data and create a virtual environment that members can trust and rely upon.
- The overall strategy of Aetna Better Health is to leverage innovative programs, such as member remote monitoring, to enhance the member experience and improve health outcomes using evidence-based technology and approaches.

This program incorporates the principles of our Integrated Care Management program where appropriate including:

- Facilitation of timely access to a continuum of services based on the intensity and complexity of each member's need.
- Collaboration with the member, family, community supports, physical health and behavioral health providers to enhance care outcomes.
- The program allows transformation of medical health practices to incorporate the following actions typically in a sequential fashion:
    - Adopt member-centric care method delivery.
    - Improve quality of care on targeted metrics.
    - Improve member access to timely care.

Measurement

- Member access to and timeliness of care.
- Decrease of non-emergent, emergency room utilization.
- Decrease in inpatient stays.
- Quality score improvement.
- Increase in member satisfaction.
- The evaluation process will culminate in the production of a work plan that will be executed in the ensuing year so that the entire program is characterized by a continuous quality improvement mindset.

Reporting

- The member remote monitoring program will be reviewed by medical management and quality teams to examine progress of the metrics above, including but not limited to, trends and course corrections needed during the usage of the program.

- Medical Management will conduct an annual evaluation to determine the following:
    - If the goals of the plan, the program and Aetna Medicaid were achieved.
    - Measure and analyze overall program costs.
    - Quality/HEDIS scores.
    - Other identified key outcomes for each program.

Ted E. Bear Weight Management Program

Aetna provides a weight management program for children and adolescents age 5 through 20. Members screened by their PCP for participation, who meet the Centers for Disease Control and Prevention's BMI requirement for being overweight and obese and who are enrolled in the Integrated Care Management program will receive incentives for enrolling and participating in the program. Upon enrollment each member will receive a pedometer and exercise band. After enrollment, participants receive gift cards in graduated amounts as they meet the goals that they set when they enrolled.

To earn the incentives, the member must also have confirmed attendance at four weight management assessments and four nutritional consultations.

Ted E. Bear Program Process

- Assess interest in program participation and enroll member.
- Establish a care plan and specific, measurable, achievable, realistic, and time-sensitive (SMART)[17] goals.
- Introductory letter to member/parent or guardian and provider.
- Send member pedometer, exercise band or collapsible water bottle.
- Outreach performed monthly or adjusted as appropriate based on member's progress.
- Coordinate with nutritionist, counselor or any others involved in member-centered goals and care plan.
- Confirm successful completion of six-month program requirements.

Value Add Benefit Ted E. Bear Program Incentive

Incentive	Qualifying Activity
Pedometer, Exercise band or Collapsible Water Bottle (depending on age appropriate)	Enrollment in care management and development of care plan to include setting weight management goal.
$15.00 Gift Card	Complete first goal determined by member in collaboration with CM plus two weight management assessments and two nutritional consultations
$25.00 Gift Card	Complete second goal determined by member in collaboration with CM plus one weight management assessment and one nutritional consultation
$30.00 Gift Card	Complete third goal determined by member in collaboration with CM plus 1 weight management assessment and one nutritional consultation

[17] "Develop Smart Objectives." CDC.gov. Centers for Disease Control and Prevention, 31 Aug. 2017.

Value-Add Benefits

Aetna Better Health Louisiana uses mobile technology to inform and educate members and deliver personalized chronic care management programs. We have implemented Care4Life™, a diabetes coaching program with mobile and web-based interactive activities.

The Care4Life™ program works to increase compliance with HbA1c testing for members with diabetes. Care4Life™ is a diabetes-coaching program that uses text messaging to discretely remind members about their need for HbA1c testing and other services for managing their diabetes. Members receive educational messages and routine reminders regarding completion of recommended diabetes testing. A diabetes-related health tip is also texted every month. Care4Life™ integrates the text alert system with their system that documents when a member receives their test and generates a congratulatory message for test completion. The goal of the program is to increase the percentage of diabetics receiving at least one HbA1c testing in a six-month intervention period.

Members may engage in mobile and web-based activities that include:

- Diabetes education and support/personal care manager.
- Diabetes nutritional tips and recipes.
- Appointment and medication reminders.
- Exercise and weight goal setting and tracking.
- Blood glucose tracking.
- Personalized text messages related to diabetes care.

In addition, Aetna also offers annual wellness incentives for adults. Members receive gift cards after completing annual adult wellness visits for:

- Yearly diabetic dilated eye exam.
- Yearly diabetic blood testing (LDL).
- Yearly diabetic blood testing (A1c).

Process Measures

Aetna Better Health of Louisiana monitors progress of the Diabetes and Obesity action plan. The Plan tracks and trends our processes to inform decisions for improvement.

2016 Open Cases by Condition

Inclusion Criteria for this report is a diagnosis of diabetes or a diagnosis of obesity.*
Members under the age of 5 are excluded from this report.

Condition	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Grand Total
Diabetes	69	91	69	52	62	146	115	199	56	98	118	154	2,008
Obesity	64	77	57	64	62	154	114	157	63	79	107	135	1,961
Grand Total	**133**	**168**	**126**	**116**	**124**	**300**	**229**	**356**	**119**	**177**	**225**	**289**	**3,969**

**Open cases are counted for each condition and, therefore, members may be included in both condition counts.*

2016 Care4Life™ Report

Outreach Efforts and Program Enrollment

1. Program Mailers - Spring and Summer 2016
    - 2.989 members with a diagnosis of diabetes were outreached via a Care4Life™ enrollment letter

2. IVR Call Campaign - April 2016
    - 761 total calls made to members with a SafeLink Phone via IVR campaign
        - 78 percent Members successfully reached (596 households were reached)
            - 46 percent Call answered (349)
            - 32 percent Voicemail left (247)
            - 22 percent Not reached (166)
                - 41 members completed enrollment process

    *A call is considered "successful" if the call was answered or a voicemail was left

3. IVR Call Campaign - July 2016
    - 2,193 total calls made to members with a SafeLink Phone via IVR campaign
        - 64 percent Members successfully reached (1,393 households were reached)
            - 37 percent Call answered (820)
            - 26 percent Voicemail left (573)
            - 37 percent Not reached (800)
                - 41 members completed enrollment

    *A call is considered "successful" if the call was answered or a voicemail was left

2016 Care4Life™ Member Enrollment	
Quarter 2	61 members enrolled
Quarter 3	163 members enrolled
Quarter 4	171 members enrolled

2016 Diabetic Member Mailings	
Quarter 2	849 members were outreached for HEDIS diabetes screenings by a mailer
Quarter 3	780 members were outreached for diabetes care related services by a letter
Quarter 4	720 members were outreached for diabetes care related services by a letter

2016 Number of Sent Care4Life™ Member Messages and Reminders	
Quarter 2	1,134 messages and reminders related to diabetes care

Quarter 3	5,478 messages and reminders related to diabetes care
Quarter 4	5,425 messages and reminders related to diabetes care

2016 Diabetes Gift Card Incentive Totals		
Type of Screening	**Number of Gift Cards**	**Amount**
Dilated Eye Exam	37	$555.00
Diabetic Blood Testing LDL	116	$1740.00
Diabetic Blood Testing A1C	5639	$84,585.00

Outcome Measures

HEDIS Rates Year Over Year

Measurement Year 2015 - Effectiveness of Care: Diabetes	
Comprehensive Diabetes Care	**Final Reported Rate**
Hemoglobin A1c (HbA1c) Testing	79.47%
HbA1c Poor Control (>9.0%)	68.21%
HbA1c Control (<8.0%)	25.83%
HbA1c Control (<7.0%)	
Eye Exam (Retinal) Performed	39.07%
Medical Attention for Nephropathy	89.62%
Blood Pressure Control (<140/90 mm Hg)	41.50%

Measurement Year 2016 - Effectiveness of Care: Diabetes	
Comprehensive Diabetes Care	**Final Reported Rate**
Hemoglobin A1c (HbA1c) Testing	78.81%
HbA1c Poor Control (>9.0%)	77.48%
HbA1c Control (<8.0%)	18.76%
HbA1c Control (<7.0%)	
Eye Exam (Retinal) Performed	47.02%
Medical Attention for Nephropathy	91.39%
Blood Pressure Control (<140/90 mm Hg)	38.41%

You Don't Join Us, We Join You

A Member Story

Member's Summary/History

- New PCP and has not established a relationship.
- Unemployed, Retired.
- Member would like to work part-time until full retirement age.
- Member diagnosed overweight.
- Goal is to safely decrease blood pressure through diet and exercise.

Case Manager Interventions

- Initiation of a walking program to aid in decreasing blood pressure.
- CM and Member initiated a 1-2 mile walking track and completed it together.
- Education provided for low-salt diet and addition of more fruits and vegetables.
- Utilized motivational interviewing to keep member encouraged and to maintain participation in Care Management.

Outcome

- Member has maintained a walking regimen 3-4 times per week at a local park.
- Member has lost approximately 20+ pounds and has successfully decreased blood pressure readings.
- Member has started meditating daily to reduce stress, which increases blood pressure.
- Member has good follow-up and communication with PCP.
- Member is employed part-time.

Future Plans

Aetna continues to explore quality and process improvement strategies to affect the disease management of diabetes and obesity. Trained diabetic coordinators and diabetes community education remain the goal moving forward.

Appendix D2 – Amerigroup Louisiana, Inc.

Amerigroup Louisiana- Diabetes and Obesity Prevention Action Plan

Objective: To prevent diabetes and obesity prevalence by monitoring current performance measures and implementing key initiatives and interventions that engage our members and providers. Current performance measures being monitored include:

- Weight Assess and Counseling for Nutrition and Physical Activity Members aged 3-17
- Adult BMI Screening Members aged 18-64
- Comprehensive Diabetes Care HbA1c Testing
- Comprehensive Diabetes Care Eye Exams
- Comprehensive Diabetes Care Attention for Medical Nephropathy
- Comprehensive Diabetes Care Poor Control (>9.0 percent)
- Comprehensive Diabetes Care Good Control (<8.0 percent)
- Diabetes Short-term Complication
- Diabetes Monitoring for People with Diabetes and Schizophrenia
- Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications

Goal: Performance Measures are targeted to reach the 50th percentile NCQA Benchmark.

Methodology: The MCO uses a number of different methods to track and monitor performance measures. Methods included are:

- Monitoring of provider score cards.
- Monitoring of missed opportunities reporting.
- Monthly comprehensive data reporting and analysis of performance measures.
- Collaboration with other departments within the MCO to dissect data and develop key interventions to drive positive outcomes.

Strategy: As a result of analyzing performance measures, Amerigroup currently has the following interventions in place in order to provide education to providers, members and the community regarding the importance of prevention, management and follow-up care for obesity and diabetes.

Intervention	*Intervention Detail*
Provider Education	The MCO has identified providers with a high non-compliant population. Currently focusing on the top 124 providers to provide: • HEDIS Education • Documentation and coding • Education Development of Action plans with provider to improve performance outcomes
Provider Incentives	• Primary Care Quality Incentive Program – PQIP • Behavioral Health Quality Incentive Program-BHQIP
Member Incentive	• Member receives $10 for getting diabetes care. • Member can earn up to $25 for completing a well visit (Adult BMI and weight, nutritional counseling and physical activity).
Member Diabetes Classes	• Amerigroup provides diabetes classes throughout the state to members with a diagnosis of diabetes.
Quality Care Coordination	• Outreach calls to members who are non-compliant for preventive services such as eye exams, HbA1c testing and adult BMI Screenings.
Case Management Care Coordination	• Outreach to members who were discharged from an inpatient facility with a short-term diagnosis. The MCO goal is to get the member back to the PCP after discharge therefore reducing admissions.
Disease Management Program	• Educate and coach members with chronic conditions.
Diabetes Pharmacy MTM Program	• Pharmacists will receive an extra reimbursement for educating members about their diabetes drugs and open Comprehensive Diabetes Care HEDIS care gaps. The overall goal is to reduce adverse effects and complication in our diabetic population.
Community Events	• Hosting of community events to educate the population regarding the importance of prevention, management and follow-up care for obesity and diabetes.
Member Material	• Ameritips is an educational tool we send to our members to provide additional teachings regarding diabetes and obesity.

Appendix D3- AmeriHealth Caritas Louisiana

2016 ACLA Diabetes/Obesity Initiative Activities

Diabetes: AmeriHealth Caritas Louisiana's top priority is improved health outcomes and includes a multifaceted focus on quality programs and initiatives while promoting the development of partnerships with network providers and agencies that support the MCO's clinical and service activities.

Member Incentives-Encourages members to obtain recommended screenings

- Collaborate with our Community Health Education team in organizing events, such as "Caritas On the Move" for members with HbA1c, Nephropathy, and Vision care gaps, in which diabetes education and screenings are performed along with exercise/nutrition counseling, blood pressure checks, and BMI assessments. This opportunity is used to educate and screen our community. Members are offered incentives for participation.
- $10 gift card for receiving HbA1c, Nephropathy, and Vision screenings.

Member Education- Addresses the lack of knowledge regarding diabetes, self-management and treatment

- Mailings to all newly identified Diabetic members with follow up care information and relevant phone numbers for health or medication questions, appointment assistance, and transportation needs. Those identified as high risk are telephonically outreached as an attempt for engagement in case management.
- Incorporate information regarding gift card incentives for Comprehensive Diabetes Care measures during all member contact opportunities (mailings and verbal).
- Telephonic outreach to members engaged in case management regarding follow up care, transportation needs, appointment assistance, and health or medication questions.
- "I Am Healthy" educational member mailings and web content.
- Integrated Healthcare Management (IHCM), Member Services, and Rapid Response utilize all encounter opportunities to educate members of all care gaps.
- Year to Date mailing to members with diabetes care gaps. Opportunities to direct connect to our Rapid Response Outreach Team, is provided with our sound blasts, which can assist the member with transportation, appointment scheduling, and or obtaining prescriptions.
- Quarterly educational mailings by IHCM to all members diagnosed with diabetes.
- IHCM offers one on one teaching of self-management skills, for members who are engaged, which includes the importance of medication compliance, proper use of ED, importance of regular medical appointments, obtaining appropriate screenings such as HbA1c testing, nephropathy screenings, and eye examinations.
- Promote educational campaigns and messages that improve the awareness of diabetes prevention and control to our members and to the general public through the distribution of educational materials, newsletters, newspaper articles, and media interviews.
- Our "Make Every Calorie Count" program targets members with a diagnosis of obesity and other co-morbidities such as diabetes. Once engaged, they receive telephonic case

management addressing the disease and weight management from an RN. Members engaged in the "Make Every Calorie Count" program are eligible to receive nutritional counseling services. Members receive a "Make Every Calorie Count" Welcome Packet which includes: pedometer, tape measure, welcome booklet and calorie/activity journals. These tools are used as teaching tools, as the case managers educate/motivate and develop individualized plans of care.

- ACLA educational related member apps.
- ACLA's Community Care Management Team makes home visits to a targeted population in order to case manage our members.
- ED follow up and education through IHCM for members who were engaged in case management, at the time of admit and through Rapid Response Outreach Team (RROT) for members who were not engaged.

Provider Engagement- Addresses provider practice variation in adherence to recommended guidelines for appropriate diabetes management

- Quality Enhancement Program (QEP) which enhances primary care reimbursement through a performance incentive payment for PCPs with 50 or more linkages.
- Providers receive QEP report cards and HEDIS Performance Summaries throughout the year to remain aware of their HEDIS status and care gaps. Ongoing provider education regarding the use of the provider portal (NaviNet) for direct electronic access of assigned member care gaps.
- Provide Regional Provider Training- Discuss measure specification requirements and billing procedures for high priority measures which include LDH's incentive-based measures.
- Provide targeted provider visits, by clinical staff and account executives to address member care gaps.
- Distribute updated HEDIS coding and documentation guidelines to providers.
- Provide "I Am Healthy" education to providers through provider web content.
- Provide a $10 incentive for submitting CPT Category II code for Low Risk Retinopathy (no evidence of retinopathy in prior year) for eligible members and reminders to providers regarding this initiative.

Data collection on Comprehensive Diabetes Care Measures and others such as Adult BMI Assessment, and Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents outcome data, or other quality monitoring activities

- Enhanced efforts for reconciliation of returned member mailings and members who are unable to contact using listed phone numbers including utilization of our member services department to assist with obtaining correct addresses of members whose mail was returned.
- ACLA RN case managers embedded at one of the largest hospitals in which our members are admitted in order to facilitate all needed follow up opportunities.
- HEDIS Improvement Campaign in which providers are awarded a $15 incentive for each HbA1c gap closed and $10 extra for after hour visits to PCP.

*2017 ACLA Diabetes/Obesity Initiative Activities

- Offering a one year membership to YMCA and YMCA-affiliated gyms for our members who enroll in our “Make Every Calorie Count” program.
- Collaboration with YMCA to offer swimming lessons to our members promoting safety and the potential for our members to become swimmers and incorporate this activity into their daily lives.
- Opening of ACLA’s Shreveport Community Wellness Center which will hold health related classes such as in nutrition and cooking.
- Implementation of a CPT II campaign targeting providers to submit applicable CPT II codes for DM screenings
- ACLA’s Value Based Contracting provider opportunities to promote compliance.
- Collaborate with our Community Health Education and Provider Network Management teams in organizing “Wellness Days” for members with HbA1c, Nephropathy, and Vision care gaps.

Appendix D4 - Louisiana Healthcare Connections

LOUISIANA HEALTHCARE CONNECTIONS (LHC) Diabetes and Weight Management Programs and Action Planning (2016)

Program Objective

The Program provides telephonic outreach, education and support services to optimize blood glucose, blood pressure and lipid control to minimize the development and/or progression of diabetic complications.

Eligibility Criteria

An individual will be considered to be medically eligible for the program if the following conditions are met:

- One or more primary or secondary diabetes or diabetes complications claims.
- A search of pharmacy claims finds one or more medications for the class glucose regulator.

Enrollment

Members are identified for enrollment based on medical and pharmacy claims data. Members may also be referred to the program by an MCO physician, case manager or self-referral.

An introductory mailing is sent to all targeted members and MCO physicians announcing the program and informing members they will receive a phone call. Several attempts to contact the member/guardian by telephone are made. Members who do not respond to telephonic outreach are sent a post card encouraging enrollment.

Once contact is made, the program is explained to members, eligibility is confirmed and a health assessment is initiated to identify clinical risk and education needs, and to assign the member to the appropriate health coach (a certified diabetes educator).

A member with more than one qualifying chronic condition will be offered enrollment into the appropriate chronic care program and/or complex case management based on hierarchy of disease processes present.

Ongoing Counseling

The health coach will complete an assessment and develop an individualized care plan based on the member's or caregiver's knowledge of the member's condition, lifestyle behaviors and readiness to change. Members are then assigned to the appropriate intervention level, which will determine the frequency of coaching calls and educational newsletters.

Internal clinical guidelines are developed from nationally recognized evidence-based guidelines published by The American Diabetes Association and the American Association of Clinical Endocrinologists. Components of the program include:

- Medication comprehension and compliance.
- Self blood glucose monitoring.
- Recognizing signs of low and high blood glucose levels.
- Nutrition counseling related to carbohydrate counting and weight management.
- Recommended annual screening for diabetic complications.
- Blood pressure and cholesterol management.

- Optimizing physical activity levels to meet recommended guidelines.
- Supporting tobacco cessation.
- Internal consults with specialty health coaches for participants at high risk for, or diagnosed with, another chronic condition (i.e. COPD, asthma, heart failure, heart disease, hypertension, hyperlipidemia). Specialty health coaches include Certified Diabetes Educators, Registered Nurses and Certified or Registered Respiratory Therapists.

Throughout the program, the health coach works with the member and/or caregiver to identify barriers to care plan compliance and to address questions regarding management of the condition.

Members who are not interested in telephonic coaching at enrollment, or who choose to opt out of counseling after enrollment is initiated, will receive quarterly newsletters and may call the MCO to speak with a health coach at any time to ask questions or to opt back in to telephonic counseling.

Pediatric Members

Pediatric-specific internal clinical guidelines are used for members under the age of 18. Health coaching services are provided to the parent or guardian of the member with participation of the member as appropriate.

Program Length

Members may participate in the program as long as they remain medically eligible, are receiving primary health care coverage with the MCO, and have not requested to be dis-enrolled from the program.

Referral Services

Members may be referred to other disease management programs offered by the MCO (either internal or external), health management or case management programs as appropriate. Members who are at high risk for non-adherence to medical care or are in need of social or behavioral services will be referred to case management. In addition, the health coach can support the member in accessing local resources. A referral system is also established to allow referrals directly from case management.

Dis-enrollment

Members may be dis-enrolled from the program under the following circumstances:

- Member dies.
- Member's health care coverage with the MCO terminates or the MCO no longer provides the member's primary coverage.
- Member's attending physician or the MCO requests disenrollment.
- Member is no longer capable of participation in the program, in the reasonable determination of the provider.
- Member has End Stage Renal Disease (ESRD).
- Member has enrolled in a Hospice Program.
- Member satisfies specified graduation criteria.

2016 Diabetes Program Outcome Highlights

- Total of 5,305 members were referred to the Diabetes Disease Management Program

- Approximately 22 percent of members referred were enrolled in telephonic coaching or agreed to receive educational mailings.
- Diabetes Management Coaching calls averaged 706 per month.
- Diabetes newsletters mailed averaged 687 per month.

Weight Management Program and Plan of Action

The weight management program provides telephonic outreach, education and support services to members of the MCO in order to improve nutrition and exercise patterns to manage weight and minimize health risk factors.

Eligibility Criteria

A member is considered medically eligible for the Program if any of the following conditions are met:

- Body Mass Index (BMI) > 30.
- History of BMI > 30 with need for weight maintenance support.
- Referral from provider for weight management.

A member who has a qualifying chronic condition such diabetes or heart disease will be offered enrollment into the appropriate chronic care program and/or complex case management based on hierarchy of disease processes present, and will be provided weight loss coaching as part of the program.

Enrollment

Members are identified for enrollment based on medical claims data. Members may be referred to the program by an MCO physician, case manager or self-referral.

Members will receive an introductory mailing announcing the program. Members are then contacted by phone to explain the program, confirm eligibility and conduct an Initial Health Assessment (IHA). The IHA evaluates current health status by collecting information on current weight, presence of co-morbidities and other risk factors.

If eligible for the program, member will be assigned to a health coach specializing in weight management (registered dietitian or nutritionist). The member will then receive an introductory mailing with education materials. Candidates who are unable to be reached by phone will be mailed a postcard encouraging enrollment.

A member who has a qualifying chronic condition such diabetes or heart disease will be offered enrollment into the appropriate chronic care program and/or complex case management based on hierarchy of disease processes present, and will be provided weight loss coaching as part of the program.

Ongoing Coaching

The health coach will complete an assessment and develop an individualized care plan based on the member's personal goals, knowledge of weight management strategies, lifestyle behaviors and readiness to change. Internal clinical guidelines are developed from nationally recognized evidence based guidelines published by National Institutes of Health and American Diabetic Association. Components of the program include:

- Nutritional counseling for appropriate rate of weight loss.
- Role of fats, carbohydrates and protein in proper nutrition.
- Optimizing physical activity levels to meet recommended guidelines.
- Behavior modification skills for long term weight control.
- Food preparation and portion control methods.
- Label reading skills.
- Strategies when eating out.
- Unlimited inbound calls.
- Education materials to enhance understanding and compliance.

Throughout the program, the coach works with the member to identify barriers to care plan compliance and will address questions regarding weight management. Members who are not interested in telephonic coaching at enrollment, or who choose to opt out of coaching after enrolling may call in to speak with a coach at any time, or opt back into telephonic coaching and receive remaining number outbound calls.

Program Length

Program is one year in length and includes the following:

- First call: 30 minutes; enrollment and initial assessment call.
- Ten coaching calls (over 12 months).
- Unscheduled check in calls.

Referral Services

Members may be referred to other Disease Management programs offered by the MCO (either internal or external) or Case Management programs as appropriate. Members who are at high risk for non-adherence to medical care or are in need of social or behavioral services will be referred to Case Management. In addition, the health coach can support the member in accessing local resources. A referral system is also established to allow referrals directly from case management.

Dis-enrollment

Members may be dis-enrolled from the Program under the following circumstances:

- Member dies.
- Member's health care coverage with the MCO terminates or the MCO no longer provides the member's primary coverage.
- Member's attending physician or the MCO requests disenrollment.
- Member is no longer capable of participation in the program.
- Member has End Stage Renal Disease (ESRD) or any complex medical condition.
- Member has enrolled in a Hospice Program.
- One (1) year has lapsed since Member's enrollment in this program.

2016 Weight Management Program Outcome Highlights

- Total of 219 members were referred to the Weight Management Program.
- Approximately 60 percent of members referred in 2016 were successfully enrolled.

- Weight Management Coaching calls averaged 118 per month.

Pilot - Pediatric Weight Management Program and Action Plan

Raising Well®, Louisiana Healthcare Connection's pediatric weight management program, helps overweight and obese children achieve long-term physical health improvement by targeting and working with parents to achieve permanent healthy lifestyle habits.

Eligibility Criteria

A member of the MCO is considered medically eligible for the program if his/her BMI is > 85th percentile for age. The program is designed for members two to 17 years of age.

Members with more than one chronic condition will be offered enrollment into the appropriate chronic care program and/or complex case management based on hierarchy of disease processes present, and will be provided weight loss coaching as part of the program.

Enrollment

Members are identified for enrollment based on medical and pharmacy claim data. Members may also be referred to the program by a MCO physician, case manager or self-referral.

An introductory mailing is sent to the parent/guardian of identified Members (candidates) announcing the program and informing Members they will receive a phone call. Several attempts to contact the member/guardian by telephone are made. Members who do not respond to telephone outreach are sent a post card encouraging enrollment.

Once contact is made, the program is explained to members, eligibility is confirmed and a health assessment is initiated to identify clinical risk and education needs, and to assign the member to the appropriate health coach (a Registered Dietitian Nutritionist or an Exercise Physiologist).

Ongoing Coaching

The health coach will complete the assessment and develop an individualized care plan based on the participant's knowledge of their condition, lifestyle behaviors, and readiness to change. Internal clinical guidelines are developed from nationally recognized evidence-based guidelines published by the American Academy of Pediatrics, the Academy of Nutrition and Dietetics, and the Department of Health and Human Services. Components of the program include:

- Promotion of physical activity.
- Parent training/modeling.
- Dietary coaching.
- Nutrition education.
- Exercise education.
- Behavioral coaching.
- Promoting and tracking regular physician visits.
- Unlimited inbound calls.
- Education materials to enhance understanding and compliance.
- Facebook private group for peer support.

Throughout the program, the health coach will work with the participant to identify barriers to care plan compliance and will address questions regarding condition management.

Candidates who are not interested in telephonic coaching at enrollment or who choose to opt out after enrollment may call to speak with a health coach at any time to ask questions or opt back into telephonic coaching.

Members may participate in the program as long as they remain medically eligible, are receiving primary health care coverage with the HMO and have not requested to be dis-enrolled from the program

Dis-enrollment

Members may be dis-enrolled from the program under the following circumstances:

- Member dies.
- Members with serious or life-threatening medical conditions including mental health will be referred to case management.
- Member's health care coverage with MCO terminates or MCO no longer provides the member's primary coverage.
- Member is no longer capable of participation in the program.

2016 Pilot - Pediatric Raising Well® Program Outcome Highlights

- Total of 1,002 members were referred to Raising Well®.
- Approximately 18 percent of pediatric members referred in 2016 were successfully enrolled.
- Weight Management Coaching calls averaged 112 per month.

Appendix D5 – UnitedHealthcare of Louisiana

UHC 2016 Diabetes Action Plan

UHC Program Goal 1: Facilitate self-management of diabetes for members with a diagnosis of diabetes.

Description	Responsible Party	Timeframe
a. Perform Health Risk Assessment for New Members		
A telephonic health risk assessment (HRA) which includes monitoring for risk of diabetes. Members who are unable to be contacted by phone are sent a postcard with a request to contact UnitedHealthcare (UHC).	UHC Hospitality, Assessment and Retention Center (HARC)	Ongoing in 2017
Process Measures: # HRA's completed # members reached	***2015 (Jan-Sept)*** 23,783 (66%) 38,386 (78%)	***2016*** 58,433 (39.4%) 116,875 (78.7%)
b. Use Whole Person Care Modeling		
Software designed to predict health risks and assess utilization so that members can be placed appropriately into care management programs, such as diabetes, if warranted.	Utilization Management Team	Ongoing in 2017
Process Measures: # members identified and in care management	***2015*** 639	***2016*** 887
c. Educate Members Using "Taking Charge" Disease Management Materials		
Members identified with diabetes receive educational materials and newsletters with diabetes specific information, including recommended routine appointment frequency, necessary testing/ monitoring and self-care. Materials are designed to empower each member to take responsibility for their health and to equip themselves with the information necessary manage their diabetes as successfully as possible and live a healthy lifestyle.	Disease Management Team	Ongoing in 2017
Process Measures: # mailings to adults # mailings to children	***2015*** 2,014 165	***2016 (Jan-Dec)*** 6,909 140
d. Continue Collaboration with the YWCA to Educate Members about Diabetes in Lunch 'n Learn Venues		
Heart Smart Sisters is a program designed to empower women in ethnic communities to make positive changes to help reduce their risk of developing heart disease. The program includes a series of monthly classes to educate women about the causes of heart disease, the benefits of healthy diet and the importance of regular exercise. The program also includes education on diabetes risk.	UHC Marketing and Community Outreach	Ongoing in 2017
Process Measures: # women attending Lunch 'n Learn # Lunch 'n Learn events	***2015*** 735 15	***2016*** 500 11

Overall Health Outcome Measures	***2015***	***2016***	***2017***
HEDIS Comprehensive Diabetes Care Measures:	80.54	81.27	73.97
HbA1c Testing:	46.96	47.45	40.63
Eye Exam:	78.10	92.70	87.59
Attention for Nephropathy:			

Description	**Responsible Party**	**Timeframe**
e. *Pilot program* Clinic based interdisciplinary approach to the treatment of diabetes		
UHC Community Plan of Louisiana and DiAMC (Diabetes Assessment and Management Center), a diabetes management provider in NE Louisiana, will engage in a basic FFS agreement to monitor and treat 25 high risk adult diabetics in the Shreveport/Bossier area using their program of nutrition education, continuous glucose monitoring and frequent physician assessment. UHC will monitor the members and their inpatient/outpatient /medication utilization throughout the 12 month period and provide outcome data. DiAMC will provide quarterly follow up on members, including weight loss, HbA1c levels, medication changes and adherence to the program.	Disease Management Team	Pilot initiated in 2017

UHC Program Goal 2: Minimize poor birth outcomes due to complications of diabetes.

Description	**Responsible Party**	**Timeframe**
Educate and refer pregnant women with diabetes to maternal care management.		
Healthy First Steps (HFS) is a maternal management program designed to reduce the risk of infant mortality. The program begins with a risk assessment for various conditions that may complicate pregnancy including diabetes.	Healthy First Steps Team	Ongoing in 2017 April 2017 – HFS is plan driven with corporate support
Process Measures: # members identified # members qualified # members reached # members referred to case management	***2015 (Jan-Oct)*** 10,196 8,407 3,374 912	***2016*** 11,026 9,756 6,089 1,231

Overall Health Outcome Measures HEDIS Prenatal and Postpartum Care:	***2015***	***2016***	***2017***
Prenatal:	90.71	79.85	85.54
Postpartum:	55.01	58.72	64.84

UHC Program Goal 3: Engage with providers to ensure familiarity with current clinical practice guidelines and HEDIS® measurement.

Description	**Responsible Party**	**Timeframe**

Educate providers on current HEDIS standards.		
The Clinical Practice Consultant (CPC) Program includes six nurses for the state of Louisiana. CPCs engage in educating primary care providers about Healthcare Effectiveness and Data Information Set (HEDIS). To improve HEDIS rates, the plan has shared information about evidence-based guidelines tailored for the providers' needs, based on their requests for condensed information. For those providers who chose to participate in the value based care initiative, provider scorecards which indicate whether providers have met their targets for HEDIS measures were distributed by the CPCs, along with members of the leadership team in some cases. CPCs also distributed HEDIS guidelines, and HEDIS tip sheets to providers at individual offices as well as the Provider Expositions around the state. To help combat diabetes, the consultants will continue to educate providers on the importance of HbA1c testing, retinal eye exams, attention for nephropathy and blood pressure control. In the case of retinal exams, CPCs assure the providers are aware of the vision vendor March Vision.	Director, Quality Management & Performance	Revised for 2016
Process Measures:	***2016 (Jan-Oct)***	***2016 (Jan-Dec)***
# offices visited	351	403
# members potentially impacted based on panel assignments	236,247	286,854

HEDIS Overall Health Outcome Measures

HEDIS Comprehensive Diabetes Care Measures:	***2015***	***2016***	***2017***
HbA1c Testing:	80.54	81.27	73.97
Eye Exam:	46.96	47.45	40.63
Attention for Nephropathy:	78.10	92.70	87.59

Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents (WCC) Measures:	***2015***	***2016***	***2017***
BMI Percentage:	41.36	36.98	60.10
Counseling for Nutrition:	53.04	52.07	60.34
Counseling for Physical Activity:	41.61	31.14	43.80

Adult BMI Assessment (ABA) Measure:	***2015***	***2016***	***2017***
Adult BMI:	71.32	71.93	82.75

UHC Program Goal 4: Support local research on disparities in healthcare related to diabetes.

Description	Responsible Party	Timeframe
Refer members to Pennington for potential access to a physical fitness facility.		
Support local research on healthcare related issues as it relates to Diabetes. Pennington Wellness Day is to educate community of healthy lifestyles as it relates to obesity, diabetes, etc.	UHC Marketing and Community Outreach	Did not participate in 2015 Ongoing in 2017
Process Measures: # of events # of members attending	***2014*** 1 500	***2016*** 1 (Oct) 300

In addition to the above program goals, UnitedHealthcare recognizes that maintenance of a healthy body weight decreases the risk for developing diabetes. All initiatives outlined in the Obesity Action Plan are expected to impact diabetes prevention and chronic care as well.

UHC 2016 Obesity Action Plan

UHC Program Goal 1: Increase member awareness of healthy lifestyles.

Description	Responsible Party	Timeframe
a. Continue Eat4-H Partnership.		
Louisiana 4-H and UnitedHealthcare will continue their partnership, Eat4-Health, in 2014. Louisiana is one of 10 states participating in the campaign designed to empower youth to help fight the nation's obesity epidemic. Each state 4-H organization is receiving a grant funded by UnitedHealthcare to support healthy-living programs, events and other activities administered by 4-H that encourage young people and their families to eat more nutritious foods and exercise regularly. The partnership in Louisiana is being administered through the LSU Ag Center.	4-H and UHC Marketing and Community Outreach	Ongoing in 2017
Process Measures: # Louisiana youth reached # events	***2015*** 3225 15	***2016*** 3675 18
b. Continue 4-H Youth Voice: Food Smart Families (New)		
4-H's Youth Voice: Youth Choice provides grants to state-level 4-H programs and focuses on developing and enhancing healthy living at the community level through activities such as after-school programs, health fairs, camps, clubs, workshops and educational forums. Youth who participate in the programs are encouraged to take action for themselves and their families, and to promote healthy living in their communities.	4-H and UHC Marketing and Community Outreach	Ongoing in 2017

Description	Responsible Party	Timeframe
Process Measures: # Louisiana youth reached # events	***2015*** 3225 15	***2016*** 3675 18
c. Continue Partnership with the Boys & Girls Club and Playworks.		
UnitedHealthcare will continue its partnership with Playworks and the Boys & Girls Club to sponsor Family Play Nights.	UHC Marketing and Community Outreach	Ongoing in 2017
Process Measures: # Louisiana youth attending # events	***2015*** 1,385 7	***2016*** 500 1
d. Distribute Sesame Street Food for Thought toolkits/reading corners.		
Food for Thought is a bilingual (English-Spanish) multimedia outreach initiative that helps families who have children between the ages of two and eight cope with limited access to affordable and nutritious food (also known as food insecurity). The outreach is conducted in multiple venues including Head Start and Catholic Charities.	UHC Marketing and Community Outreach	Ongoing in 2017
Process Measures: # toolkits distributed	***2015*** 1,350 (5 reading corners)	***2016*** 325
e. Continue Dr. Health E. Hound visibility at community events.		
Dr. Health E. Hound is the friendly face of UnitedHealthcare Community Plan. As our mascot, he travels all across the country, making special appearances to engage with the public and help educate children, their families and the community about healthy living, including healthy eating habits.	UHC Marketing and Community Outreach	Ongoing in 2017
Process Measures: # events that Dr. Health E. Hound attended # of members	***2015*** 48 11,655	***2016*** 51 15,175
f. Participate in Louisiana Healthy Community Coalition /Parish Community Coalition activities/and Other Community activities		
The mission of the Louisiana Healthy Community Coalition is to improve the health and quality of life of Louisianans by mobilizing communities to enact policy, system and environmental changes to create healthy communities.	UHC Marketing and Community Outreach	Ongoing in 2017
Process Measures: # events # people attending	***2015*** 53 2,735	***2016*** 49 3,550

UHC Program Goal 2: Facilitate healthy lifestyles.

Description	Responsible Party	Timeframe
a. Continue partnership with faith and community based organizations to offer Heart Smart Sisters program.		
Heart Smart Sisters is a program designed to empower women in ethnic communities to make positive changes to help reduce their risk of developing heart disease. The program includes a series of monthly classes to educate women about the causes of heart disease, the benefits of healthy diet and the importance of regular exercise.	4-H and UHC Marketing and Community Outreach	Ongoing in 2017
Process Measures:	***2015***	***2016***
# members reached	735	1,895
# of events	22	16

Appendix E – Standards of Diabetes Care

American Diabetes Association
Standards of Care in Diabetes - 2017
http://care.diabetesjournals.org/content/diacare/suppl/2016/12/15/40.Supplement_1.DC1/DC_40_S1_final.pdf

American Association of Clinical Endocrinologists and American College of Endocrinology – Clinical Practice Guidelines for Developing A Diabetes Mellitus Comprehensive Care Plan – 2015
https://www.aace.com/files/dm-guidelines-ccp.pdf

Louisiana Department of Health
628 North Fourth Street, Baton Rouge, Louisiana 70802
(225) 342-9500
www.ldh.la.gov

www.facebook.com/LaHealthDept. www.twitter.com/LADeptHealth