

BAYOU HEALTH DIABETES AND OBESITY REPORT

REPORT PREPARED IN RESPONSE TO ACT
210 OF THE 2013 REGULAR SESSION

JANUARY 2014

Contact:

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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.

The Department of Health and Hospitals' (DHH) goals are to provide quality services, protect and promote health, develop and stimulate services by others, and deploy available resources in the most effective manner. On February 1, 2012, DHH launched the single-largest transformation of the delivery of health care services in Louisiana Medicaid history when it transitioned nearly 900,000 Medicaid and LaCHIP enrollees from the state's 45-year old legacy, fee-for-service program to a managed health care delivery system for acute care services, known as Bayou Health. Bayou Health aims to transform patient care and dramatically improve health outcomes for Louisiana's Medicaid population. Bayou Health Plans manage the health care needs for the majority of children and pregnant women enrolled in Medicaid. However, most individuals who have partial Medicaid coverage or those with both Medicare and full Medicaid are excluded from Bayou Health enrollment, and are not captured in this report.

Louisiana Medicaid's acute care delivery system was reorganized by expanding and realigning state capacity to monitor health plan operations, system performance and member health outcomes. Improving the health of Louisiana Medicaid recipients is a key aspect of this system revamp. Achieving this goal requires a reduction in the incidence of chronic disease and adverse outcomes resulting from the prevalence of these conditions.

DHH is committed to improving the health of Louisiana's residents through partnerships and collaboration, by empowering community-based programs, promoting self-management training, and monitoring health outcomes. Some Bayou Health Plans are collectively working with other community-based programs, such as the Boys and Girls Club, to educate enrollees on how to achieve a healthier weight. Other Health Plans are encouraging enrollees to engage in counseling and coaching sessions.

This report is in response to a directive from Act 210 of the 2013 Louisiana Legislative Session relative to the development of diabetes and obesity improvement action plans. The Act calls for DHH to collaborate with each of the five contracted Bayou Health Plans for the annual submission of action plans. These action plans are essential to reducing adverse health outcomes and the economic burden on those affected with these disease conditions as well as to Louisiana taxpayers. Research suggests that preparing action plans related to improving health is a vital part in yielding positive impacts on health outcomes.

BAYOU HEALTH ACT 210 RESPONSE

SECTION ONE: FINANCIAL IMPACT AND REACH OF OBESITY IN THE BAYOU HEALTH POPULATION

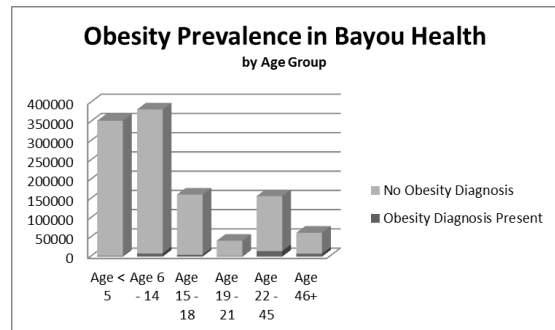
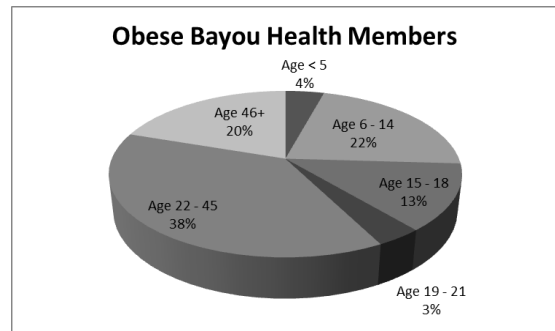
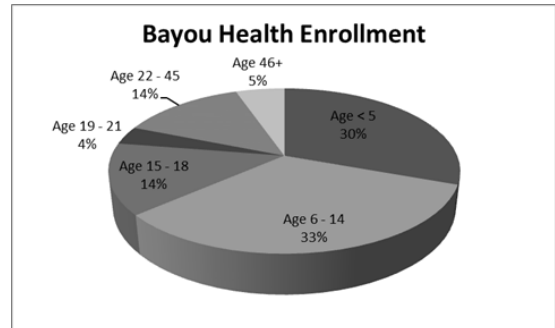
An analysis of Louisiana Medicaid claims for state fiscal year 2013 was conducted by DHH. Claims data were used as an indicator of obesity prevalence in the Bayou Health population. Considering the overall prevalence of obesity in Louisiana is 34.7 percent, the results of the Medicaid analysis clearly underrepresent the burden of obesity within this population. A more thorough analysis using body mass index data obtained from medical records reviews would yield a more reliable result. The analysis below is the most comprehensive possible based on currently available data.

Based on an analysis of Louisiana Medicaid SFY 13 claims data, obesity affected approximately 37,559 of Bayou Health recipients. This represents roughly 3.2% of the 1,156,058 individuals who were enrolled in a Bayou Health Plan at some point during SFY 13. Of the recipients with obesity, 16,091 (42% of Medicaid managed care recipients who are obese) were 21 years of age or younger. While those 21 years of age or older make up more than 81% of Medicaid managed care recipients with a diagnosis of obesity. The value of obesity-related services paid for by Health Plans totaled \$39,036,864 (including complications related to obesity). Approximately 43% of these payments were made on behalf of recipients between the ages of 46 and 64 years. The top three most costly complications of obesity were type 2 diabetes (\$9,475,359), gastroesophageal reflux disease (\$2,564,954), and esophageal cancer (\$2,016,488), respectively.

According to UpToDate, the premier evidence-based clinical decision support resource authored by physicians to help health care practitioners make the best decisions at the point of care, obesity has been linked to esophageal cancer and stomach cancer.

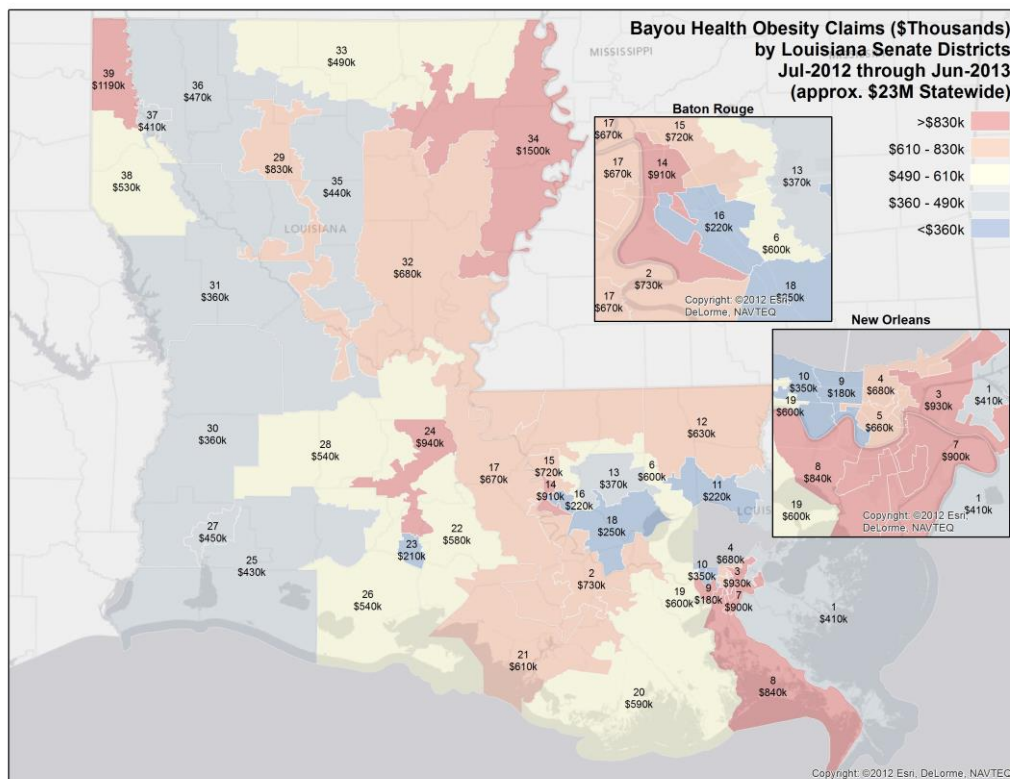
Below is a table representing a total number of obesity-related healthcare costs by Health Plan (specific health condition related services were found using diagnostic codes).

The greatest prevalence of obesity and burden of cost resides with Bayou Health recipients ages 21 and older. However, those members (n = 21,468) are responsible for a disproportionate share of obesity related costs and comprise approximately 2% of all Medicaid managed care recipients. The majority of managed care recipients are children and pregnant women. This is important to note given costs associated with preterm birth are five times more than the known direct costs associated with obesity in Bayou Health.



Obesity (Direct Cost only)			
Health Plans	Service-related Payments	Complications-related Payments	Total Obesity-related Payments
UnitedHealthcare Community Plan of Louisiana, Inc.	\$5,749,730.41	\$4,720,177.76	\$10,469,908.17
Community Health Solutions of Louisiana	\$3,519,066.44	\$2,133,074.30	\$5,652,140.74
Amerigroup Louisiana Inc.	\$4,349,716.17	\$2,719,035.60	\$7,068,751.77
Louisiana Healthcare Connections	\$4,551,529.29	\$2,670,500.86	\$7,222,030.15
AmeriHealth Caritas Louisiana	\$4,953,469.15	\$3,670,568.94	\$8,624,038.09
Total	\$23,123,511.46	\$15,913,357.46	\$39,036,868.92
Source: Management and Administrative Reporting Subsystem (MARS) Data Warehouse.			

The map below represents obesity- related claims within Louisiana’s Bayou Health population, based on the value of claims paid from July 2012 to June 2013. The amount of obesity-related claims reflects direct cost only and does not include complication-related claims. Senate districts were used to adjust for variation in population density. Based on this geographic analysis, a disproportionate share of obesity



related claims is concentrated in seven districts comprising more than \$7,000,000 (31%) of total direct costs. Those include the 3rd, 7th, 8th, 14th, 24th and 39th districts.

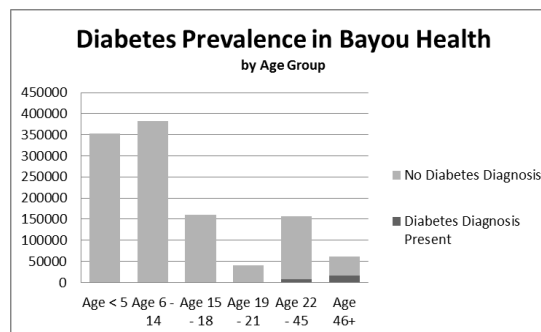
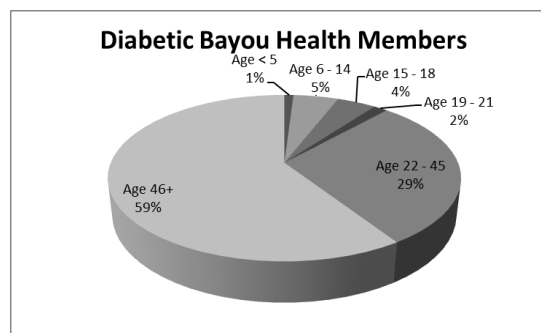
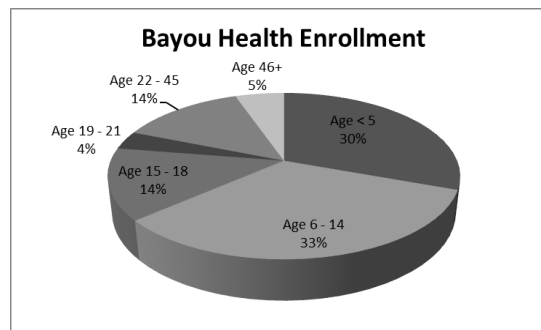
Source: Management and Administrative Reporting Subsystem (MARS) Data Warehouse, geospatial analysis performed by the Office of Public Health.

SECTION TWO: FINANCIAL IMPACT AND REACH OF DIABETES IN THE BAYOU HEALTH POPULATION

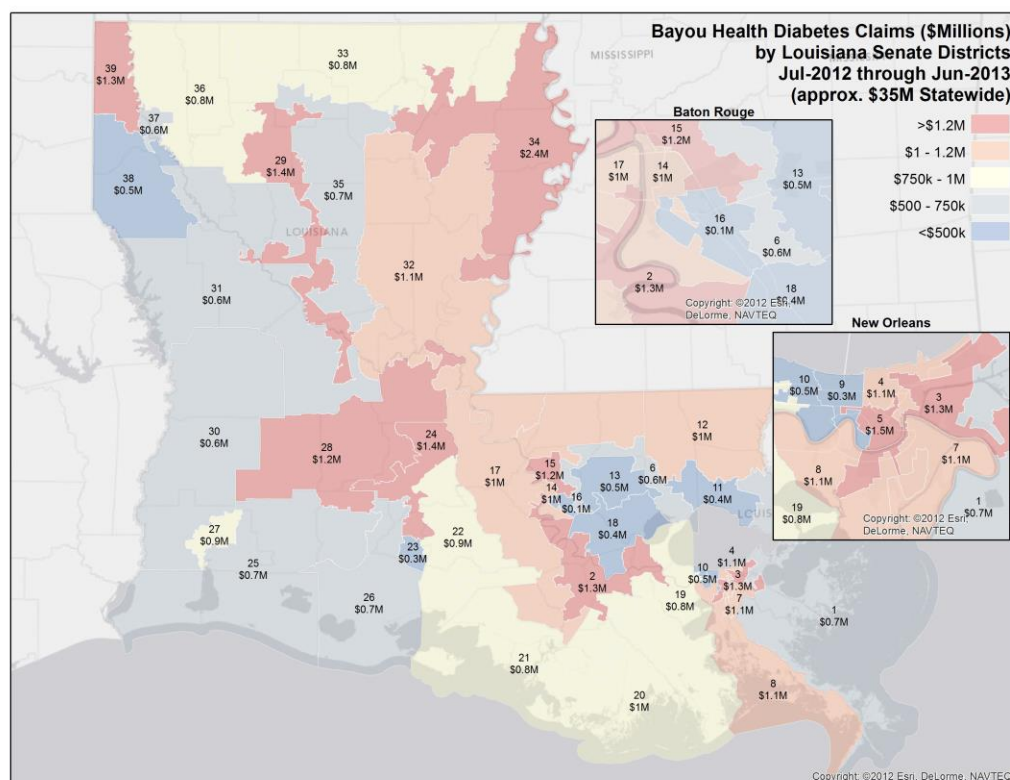
Diabetes affects a higher proportion of Louisiana residents than the national average according to the 2012 America's Health Rankings report. Louisiana is ranked 48th in the nation with 11.8 percent of its residents diagnosed with diabetes as compared to the national average of 9.5 percent. Diabetes-related health care costs place a disproportionate cost burden on the state's health care budget. However, Louisiana Medicaid recipients - and particularly those enrolled in the Bayou Health plans - tend to not suffer from diabetes at the same rate as Louisiana residents as a whole. This is not surprising given the disproportionate enrollment of women and children in Louisiana Medicaid compared to their overall proportion of the total population. Enrollment data shows that more than 85 percent of all Medicaid recipients enrolled in a managed care plan belong to the Families and Children category of assistance. This category is comprised of women and children who are at a low risk for developing diabetes. In fact, 60.1 percent of those diagnosed with diabetes are 46 years or older. Approximately 61 percent of diabetes related costs can be attributed to individuals in this age group while these individuals only make up 5 percent of all managed care enrollees.

Based on an analysis of Louisiana Medicaid SFY13 data, diabetes of all types affected approximately 32,541 managed care recipients, roughly 4% of Medicaid's managed care population. Of the recipients with diabetes, 4,231 (13% of the managed care diabetics) were 21 years of age or younger.

The value of diabetes-related services paid for by Health Plans totaled \$73,193,644 (including pharmacy services and complications related to diabetes). Approximately 61% of these payments were on behalf of recipients between the ages of 46 and 64 years. Pharmacy payments consume approximately 34% of the total value of diabetes-related services paid by Bayou Health Plans. The most costly complications for type 1 and type 2 diabetes were neurologic (\$220,400) and renal (\$4,009,997), respectively. However, endocrine metabolic complications (\$2,220,646) were most common among both types of diabetics. Below is a table representing the total number of diabetics and diabetes-related healthcare costs by Health Plan (specific health condition related services were found using diagnostic codes).



Diabetes				
Health Plans	Service-related Payments	Pharmacy-related Payments	Complications-related Payments	Total Diabetes-related Payments
UnitedHealthcare Community Plan of Louisiana, Inc.	\$8,001,177.15	\$7,086,197.24	\$3,212,875.22	\$18,300,249.61
Community Health Solutions of Louisiana	\$4,670,950.40	\$3,525,780.73	\$1,479,877.96	\$9,676,609.09
Amerigroup of Louisiana, Inc.	\$6,901,037.50	\$4,082,776.49	\$2,674,662.53	\$13,658,476.52
Louisiana Healthcare Connections	\$7,375,782.55	\$5,196,728.36	\$2,533,365.89	\$15,105,876.80
AmeriHealth Caritas Louisiana	\$8,205,251.23	\$5,329,848.26	\$2,917,332.75	\$16,452,432.24
Total	\$35,154,198.83	\$25,221,331.08	\$12,818,114.35	\$73,193,644.26
Source: Management and Administrative Reporting Subsystem (MARS) Data Warehouse.				



The financial impact of diabetes can also be interpreted geographically. Concentrating on areas where disease prevalence and costs are considerably higher allows DHH and its contracted partners to be efficient in its use of resources.

This map represents diabetes-related claims within Louisiana's managed care population, based on the value of claims paid from July 2012 to June 2013. Louisiana Senate districts were used to compensate for population density variances.

Source: Management and Administrative Reporting Subsystem (MARS) Data Warehouse, geospatial analysis performed by the Office of Public Health.

The amount of diabetes-related claims reflects direct cost only and does not include pharmacy claims or complication-related claims.

**SECTION THREE: THE DISTRIBUTION AND ECONOMIC IMPACT OF
DIABETES AND OBESITY IN COMPARISON TO OTHER CHRONIC DISEASES**

Chronic Diseases (Recipients)				
Health Plans	Diabetes	Obesity	Cardiovascular Disease	Stroke
UnitedHealthcare Community Plan of Louisiana, Inc.	7,622	9,329	1,563	1,343
Community Health Solutions of Louisiana	4,143	5,709	767	696
Amerigroup Louisiana, Inc.	5,849	6,735	1,182	1,054
Louisiana Healthcare Connections	7,127	7,404	1,438	1,152
AmeriHealth Caritas Louisiana	7,800	8,382	1,536	1,390
Total	32,541	37,559	6,486	5,635
Source: Management and Administrative Reporting Subsystem (MARS) Data Warehouse.				

Chronic Diseases (Payments)				
Health Plans	Diabetes	Obesity	Cardiovascular Disease(CVD)	Stroke
UnitedHealthcare Community Plan of Louisiana, Inc.	\$18,300,249	\$10,469,907	\$2,693,003	\$2,611,082
Community Health Solutions of Louisiana	\$9,676,610	\$5,652,140	\$1,240,463	\$1,520,702
Amerigroup Louisiana, Inc.	\$13,658,476	\$7,068,750	\$2,102,832	\$2,053,089
Louisiana Healthcare Connections	\$15,105,880	\$7,222,030	\$2,362,762	\$2,200,099
AmeriHealth Caritas Louisiana	\$16,452,434	\$8,624,037	\$2,635,908	\$2,771,805
Total	\$73,193,649	\$39,036,864	\$11,034,968	\$11,156,777
Source: Management and Administrative Reporting Subsystem (MARS) Data Warehouse				

SECTION FOUR: OFFICE OF PUBLIC HEALTH AND MEDICAID COLLABORATION ON OBESITY AND DIABETES REDUCTION

Over the last several years, the Office of Public Health (OPH) chronic disease unit piloted successful strategies for diabetes and obesity control and reduction. The Louisiana Diabetes Excellence Initiative (LaDEI) reached approximately 200 individuals through an evidence based clinical quality improvement program. Results included improved blood pressure and cholesterol control as well as a decrease in body mass index. In addition, the unit invested in an expansion of diabetes self-management educators in the parishes surrounding Baton Rouge. Diabetes self-management is an evidence based community intervention proven to have long term impact on self-care behavior related to metabolic and cardiovascular health.¹ These programs while effective are small in scale. In order to appropriately invest in interventions or health system change that will impact the state's obesity and diabetes burden, OPH leadership chose to elevate and restructure the chronic disease team.

In November 2013, OPH redesigned existing programs to create the DHH's first-ever Health Promotion team within the Office of the Assistant Secretary. The activities of this team are entirely funded through CDC grants from the National Center for Chronic Disease Prevention and Health Promotion. Starting in March 2013, CDC merged funding streams across several chronic disease categories into one large grant, the State Public Health Actions grant (commonly referred to as 1305). Currently, this grant is OPH's key funding stream for clinical, environmental, and community-based change related to obesity and diabetes. With the first year of 1305 funding, the Health Promotion team is investing in school health and wellness, creating a clinical rapid response team to design a statewide hypertension reduction program, expanding diabetes self-management programs, and implementing comprehensive worksite wellness efforts in large companies across the state.

Based on Louisiana Medicaid's eligibility criteria, an opportunity for reversing the state's obesity trend is to identify areas of alignment and collaboration between public health 1305 and Bayou Health strategies so they mutually reinforce health promotion in children, adolescents and pregnant women enrolled in Louisiana Medicaid. This will include leading integration of evidence based health promotion activities across all OPH programs with direct impact on children, adolescents and pregnant women. Although women and children comprise a large proportion of Medicaid enrollees, it is paramount to include men's health in future deliberations regarding statewide obesity prevention and diabetes control efforts. Especially in regard to modeling healthy behaviors for Louisiana's children, both fathers and mothers must be included in that effort.

¹ http://www.cdc.gov/pcd/issues/2012/11_0313.htm

**SECTION FIVE: DIABETES AND OBESITY ACTION PLAN BY BAYOU HEALTH
PLAN**

AMERIGROUP LOUISIANA, INC. (AMG)
2014 Diabetes & Obesity Response



January 10, 2014

Mr. Joshua Hardy
Section Chief
Medicaid Quality Management, Statistics and Reporting
Louisiana Department of Health and Hospitals
628 N. 4th Street
Baton Rouge, Louisiana 70802

Dear Mr. Hardy:

Amerigroup is pleased to submit this proposed plan to combat obesity and diabetes in the state of Louisiana. I attest that these plans are submitted with my knowledge and consent.

Sincerely,

A handwritten signature in black ink, appearing to read "Marcus J. Wallace".

Marcus J. Wallace, M.D., M.B.A.
Senior Medical Director
Amerigroup Corporation

AMG Disease Management & Louisiana Healthy Families Program

AMG Disease Management – Diabetes and Obesity

- Amerigroup's Disease Management (DM) Programs address the needs of members with conditions including diabetes and obesity. Members may receive clinical or non-clinical interventions based on their level of need and willingness to participate in the program.
- Non-clinical interventions include automated, interactive telephone messaging and mailings, which both include educational and condition-specific content. Clinical interventions include comprehensive health risk assessment, care planning, education and health coaching through a DM Care Manager.
 - Note: Specifically, this includes the general portion of the initial and follow-up assessments along with the specific diabetes and obesity questions contained in the initial and follow-up assessments. The Disease Management Health Risk Assessment (DM HRA) is a comprehensive set of questions that identifies needs across the continuum of care. It captures information regarding both physical and behavioral conditions and condition maintenance, special needs, health history, lifestyle behaviors, risk factors and activities of daily living. Results of the HRA are used to develop a tailored plan of care and drive both the intensity and frequency of follow-up outreach.
- Care Managers monitor and follow-up with members and collaborate with the health care team to adjust the care plan as appropriate and are tailored to the unique needs of the individual member.
- Members that engage with a DM Care Manager complete a brief satisfaction survey upon completion of the program to provide feedback on various components of DM. **During 2013 (through November), 4,827 Louisiana members participated in these DM Programs.**
 - Note: The DM satisfaction survey is administered to members as they are completing the program. The survey is administered telephonically by non-clinical support staff after the DM nurse and member have had their final follow-up dialogue. While DM attempts to administer the survey on the total population completing the program, participation in the survey is voluntary.
- Among the Louisiana members who completed the program and were surveyed during 2013:
 - 100% report being satisfied with the responsiveness and courtesy of DM Care Managers
 - 99.0% report overall satisfaction with the DM Programs
 - 87.5% feel the DM Programs facilitates better communication with their providers
 - 85.0% perceive an overall improvement in their health since enrolling in the DM Programs
 - Note: This is member reported data and reflects the members' perception of overall health since enrolling in their respective program. Enrolled members showed an average BMI decrease of 6.7%.

AMG Healthy Families – Weight Management

- Amerigroup's Healthy Families Program is designed to promote healthy lifestyles in an attempt to impact the growing obesity epidemic. The program focuses on members age 7-13 that could benefit from healthy lifestyle education and are interested in goal setting and working toward that end. Amerigroup recognizes that the need for this program extends into the teenage population in Louisiana. As a result, Amerigroup launched a teen pilot targeting members age 14-17 in late 2013 with plans to evaluate and potentially expand that program in 2014. Note: Members are identified by their age and outreach is conducted to determine appropriateness and interest in the program. The program is not limited to members with certain PCPs; it is open to any member in the age range regardless of their PCP.

- Eligibility for the program is based on both age qualification and clinical assessment of height, weight, BMI, co-morbid conditions and family history in addition to readiness level and interest in the program. Built on evidence-based clinical guidelines, Healthy Families connects the member with a nurse coach who works with the family and the health care provider to engage the member in a six month program, which includes collaborative goal setting and action planning.
 - Note: Amerigroup assesses any co-morbid conditions common with obesity (HTN, diabetes) and conditions that might increase the risk of obesity (medications for behavioral health conditions). Family history considered under this program includes diabetes, heart disease, high blood pressure and obesity. Amerigroup uses its Clinical Practice Guidelines for childhood and adolescent obesity as evidence-based clinical guides. In relation to collaborative goal setting and action planning, they focus on small, doable steps and meet the member/parent where they are in setting goals. For example, one member/parent may have a goal of increasing fruit/vegetable intake while another may want to focus on increasing activity or reducing screen time. Amerigroup has care plan guidelines that are used by their nurses (included in submission) for obesity as well as general guidelines for improving/maintaining health. The nurse will frequently use these and supplement for a member-centric plan. Amerigroup's nurses are specially trained in motivational interviewing and the goal is for them to assist members in developing a self-care plan, overcoming barriers and accessing resources rather than prescribing a specific type of nutrition or exercise plan. The nurses are also knowledgeable regarding the barriers and needs of the Medicaid population where finances are a barrier to standard weight loss techniques.
- Healthy Families combines Care Management, education, coaching and community-based resources to support a healthy lifestyle not only for the member but the entire family. Members that participate in the program set goals related to increasing physical activity, incorporating healthy dietary habits and reaching a healthier weight. Amerigroup plans to introduce new written materials in 2014 to appeal to our target population to include graphic novel style materials with widely recognized characters.
 - Note: Examples of community-based resources include the YMCA sponsors, parks and recreation programs and school programs. Nurses work to develop regional lists of available programs and activities. Nurses also collaborate with the Health Plan for information about community events. Since parents make the decisions about what to buy at the grocery and what to prepare for dinner, any healthy behaviors naturally spill over to the rest of the family. Amerigroup's information about family engagement is anecdotal and is demonstrated in their Real Stories (included with submission).
- Members that engage with a Healthy Families Case Manager complete a brief Satisfaction Survey upon completion of the program to provide feedback on various components of the program.
- **59 Louisiana families** participated in the Healthy Families program in 2013; **two Louisiana families** participated in the teen pilot since the 4th quarter launch.
 - Note: On average enrolled members have demonstrated the following:
 - 12.8% decrease in consumption of sugary beverages
 - 0.7% decrease in BMI percentile
 - 13.4% increase in fruit/vegetable servings
 - 11.1% increase in 8 ounce servings of water
 - 6.6% decrease in screen time
 - 3.2% increase in 30 minute activity sessions

AMERIHEALTH CARITAS LOUISIANA (ACLA)
2014 Diabetes & Obesity Response



P.O. Box 83580
Baton Rouge, LA 70884

January 17, 2014

Mr. Joshua Hardy
Section Chief
Medicaid Quality Management, Statistics and Reporting
Louisiana Department of Health and Hospitals
628 N. 4th Street
Baton Rouge, Louisiana 70802

Dear Mr. Hardy:

AmeriHealth Caritas Louisiana is committed to helping our members with diabetes and obesity. We screen and stratify members for these conditions. Resources are utilized to educate and manage the care of the member. We are able to incorporate various departments – Integrated Care Management, Rapid Response, Community Education and Quality. In addition to educating the members, we educate our providers caring for our members.

AmeriHealth Caritas Louisiana acknowledges that obesity is a major issue in Louisiana. We have built two playgrounds to promote physical activity for children. In 2014, we will implement an obesity program with our regional partners to promote healthy eating and increase physical activity.

AmeriHealth Caritas Louisiana also acknowledges that diabetes is a major issue in Louisiana. We had a diabetes boot camp in GSA B last year which included a focus on diabetes education, healthy cooking demonstration and physical activity. In 2014, we hope to promote in other regions.

The attached diabetes and obesity plans are reviewed and approved by our Quality of Clinical Care Committee which consists of medical directors and clinical participation for which I am the chairperson. They are also submitted to the Quality Assessment and Performance Improvement Committee. We remain committed to addressing these health concerns in hopes to improving the health of Louisianans.

Sincerely,


Yolonda Spooner, MD
Medical Director
AmeriHealth Caritas Louisiana

ACLA Diabetes Management Blueprint

Disease State	Diabetes
Importance to	
<p>Diabetes Mellitus</p> <p>People with diagnosed diabetes, on average, have medical expenditures that are approximately 2.3 times higher than those without diabetes. Diagnosed diabetes patients account for 8.3 % of the total U.S. population^[1]. Many factors contribute to this rise, including a higher prevalence of an overweight and obese population, decreasing mortality, a growing elderly population, and growth in minority populations in whom the prevalence and incidence of diabetes are increasing. Complications of diabetes include hypertension, heart disease, stroke, blindness, kidney failure, amputations, and tooth decay. Diabetes is more prevalent in African American (1.8 times relative risk) and Hispanic (1.7 times relative risk) populations^[2]. The disease is also increasing in children. AmeriHealth Caritas has a special mission to assist all of these underserved populations in maintaining and improving their health. Diabetes and associated conditions are a significant threat to these people's health.</p> <p>According to the CDC in 2010, 25.8 million Americans had diabetes, with nearly a third undiagnosed. Another 79 million have pre-diabetes and are likely to develop the disease if they do not alter their living habits. This increase in patients diagnosed with diabetes represents a 20% increase from the 20.8 million in 2005.^[3]</p> <p>LA: In 2011, 11.8% of the Louisianan adult population aged 18 years and older were told by a doctor that they have diabetes.² Another 1.3% were diagnosed with pregnancy-related diabetes, and 1.5% were diagnosed with borderline diabetes or pre-diabetes. Medicaid currently assists an estimated 59,100 Louisianans with diabetes in getting the care they need to manage their diabetes and associated complications, 2,800 of whom are children and 22,640 of whom are seniors.³ In 2010, only 71.1% and 68.5% of Louisianan adults diagnosed with diabetes had a foot examination and dilated eye examination, respectively, once in the past year; only 56.8% had ever attended a class in diabetes self-management; only 66.6% perform daily self-monitoring of blood glucose; and only 71.3% had at least two HgbA1c tests in the past year.⁴</p>	

^[1] Diabetes Clinical Practice Guideline - American Diabetes Association Clinical Practice Recommendations 2012. http://care.diabetesjournals.org/content/35/Supplement_1/S4.extract accessed on 6/4/13.

^[2] Ibid.

^[3] <http://www.cdc.gov/nchs/fastats/diabetes.htm> accessed on 6/4/13.

² The Henry Kaiser Family Foundation, 2013 <http://kff.org/statedata/>, accessed on 6/4/13; Behavioral Risk Factor Surveillance System, 2011.

³ ACSAN/ADA/ALA/Families USA, Medicaid's Impact in Louisiana: Helping People with Serious Health Care Needs, September 2011. <http://www.diabetes.org/assets/pdfs/advocacy/states/louisiana-medicaid-report.pdf>. accessed on 6/4/13.

⁴ *Age-adjusted*; Centers for Disease Control and Prevention: National Diabetes Surveillance System. <http://www.cdc.gov/diabetes/statistics>. accessed on 6/4/13.

In 2006, the total cost of diabetes to Louisiana was approximately \$2.431 billion, which includes \$1.625 billion in direct medical costs and \$806.2 billion in lost productivity.⁵ In 2010, the total cost of hospital discharges for people with diabetes in Louisiana was approximately \$231 million.⁶ The total annual economic cost of diabetes in the United States in 2007 was estimated to be \$174.4 billion.⁷ This is an increase of \$42 billion since 2002. This 32% increase equals over \$8 billion more each year and is unsustainable in an era of increasingly rapid escalation of health care costs. The 2007 per capita annual costs of health care for people with diabetes is \$11,744 a year, of which 57% is directly attributable to diabetes.⁸ People with diagnosed diabetes, on average, have medical expenditures that are approximately 2.3 times higher than those without diabetes.

Supporting Clinical Guidelines

Diabetes Clinical Practice Guideline - American Diabetes Association Clinical Practice Recommendations 2012
http://care.diabetesjournals.org/content/35/Supplement_1/S4.extract

Date last reviewed/adapted by Diabetes Workgroup: 7/2013

Is this guideline available to Providers via website ☒ Yes ☐ No

Advisory Group

Diabetes Workgroup: All plans will maintain Workgroup meeting minutes which will list Workgroup meeting attendees. The minutes will be available upon request

Physician Consultant: Richard Plotzker, MD

Program Goals

- Decrease Emergency Room and Hospital use in members with diabetes
- Decrease HgbA1c levels in the diabetic population
- Improve management of Members identified with diabetes with respect to HEDIS metrics
- Enhance both the knowledge base and customer/member's decision making abilities within the plan of care through targeted education and collaboration with healthcare providers
- Improve and increase self-management through a sick-day plan and understanding of when to call the PCP/Specialist
- Improve and increase self-management of monitoring and recording of blood sugar in log and understanding of when to call the PCP/Specialist

⁵ ADA 2008. Referenced in 2010 Louisiana Health Report Card. LA Department of Health and Hospitals. 2012. <http://dhh.louisiana.gov/assets/oph/Center-RS/healthstats/HlthRprtCrd2010.pdf>, accessed on 6/4/13.

⁶ Louisiana Hospital Inpatient Discharge Data (LaHIDD), 2010.

⁷ American Diabetes Association. Economic costs of diabetes in the U.S. in 2007. Diabetes Care. 2008;31 (3):576–615.

⁸ American Diabetes Association, 2008 <http://www.diabetes.org/diabetes-basics/diabetes-statistics>, accessed on 6/4/13.

<ul style="list-style-type: none">Identify and close care gaps based on best practice and clinical guidelinesDecrease smoking rates among members with diabetesImprove medication adherence		
Outcome Measurements	<i>Applicable HEDIS® measures</i> <i>At least 2 measures must relate to clinical guideline and 1 measure should relate to a population-based disparity (UM measures do not count as clinical guideline measures)</i>	
<ul style="list-style-type: none">HgbA1c screening (HEDIS) (total and by available race/ethnicity breakdown)HgbA1c control (HEDIS)Dilated Retinal Exam (HEDIS)Serum LDL screening (HEDIS) (total and by available race/ethnicity breakdown)Serum LDL < 100 mg/dl (HEDIS)Inpatient admissions/1,000 membersEmergency room visits/1,000 membersPercentage of members showing improvement in SF-12 score after 6 months of engagement		
Stratification & Interventions	<i>Criteria used to assign member to low- or high-risk group</i> <i>Program components for low- and high-risk groups</i> Member stratification is updated on a quarterly basis and as needed based upon identified needs as outlined below. Members can move from one level to another as individual needs change.	
	Low Risk	High Risk
Stratification	Eligible member and one of the following: <ul style="list-style-type: none">Claim Diagnosis of Diabetes (250.xx) on two occasionsEligibility self-disclosureHRA/New Member assessment disclosureProspective risk Score is determined by each LOB in order to stratify the members accordingly. The score is available at each LOB.	In addition to low risk any of the following: <ul style="list-style-type: none">HgbA1C > 8.5%No HgbA1C screening in the prior yearIP/ER admission in last 3 monthsNew diagnosis of diabetesNew diagnosis of diabetic complicationUnstable medical, behavioral health or support situation.Prospective Risk score is determined by each LOB in order to stratify the members accordingly. The score is available at each LOB.
Relative Risk Score	The average relative risk score is provided annually for each LOB. <u>AmeriHealth Caritas Louisiana (LOB 2100): 0.616</u>	The average relative risk score is provided annually for each LOB. <u>AmeriHealth Caritas Louisiana (LOB 2100): 0.616</u>
Interventions	<ul style="list-style-type: none">Welcome letter/educational material mailed to newly identified membersFocused educational MailingsMonitoring for medication	In addition to low risk interventions, Complex Care Management services, including: <ul style="list-style-type: none">Comprehensive AssessmentIndividualized Care Plan focusing on Priority Interventions (detailed below)

	<p>adherence</p> <ul style="list-style-type: none"> • Monitoring for LDL and HgbA1C screening and results • Access to Rapid Response Unit • Access to 24/7 Nurse Line • Smoking Cessation Program • Complex Care Management Assessment available upon request 	<ul style="list-style-type: none"> • Frequent outreach based according to level of intensity • Focused education, based on assessment including preventive measures, worsening of symptoms and supportive measures • Monitoring of pharmaceutical medication • Utilization of Diabetes tools to monitor member outcomes • Provider contact and care plan collaboration • Provide high level supportive services and equipment • Outreach to members with HbA1C > 8.5% • Outreach to members with no HbA1C on file • Identification, communication and intervention to resolve Gaps in Care • Smoking cessation program • Connection to appropriate community resources and services
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Participation	<input type="checkbox"/> opt-in <input checked="" type="checkbox"/> opt-out
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Priority Intervention(s)	<i>Top priorities – no more than 5 Should reflect clinical guideline measures</i>
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HgbA1c control

Member should have HgbA1c test every six months

If result is > 7.0, there should be an appropriate change in treatment regimen under their provider's guidance and a retest in 3 months.

Sick day plan

Member should have a plan for diabetic medications when sick

Medication

Member should be refilling prescriptions timely/report taking accurately

If HgbA1c > 7.0, there should be a discussion of a change in medications with the provider.

PCP visit schedule/screening measures recommendations

Member with type II diabetes should see physician at least every 4 months (TIY); Evaluate need for HgbA1c screen

Member with type I diabetes should see physician at least every 3 months (QIY); Evaluate need for HgbA1c screen

Every physician visit should include a peripheral neuropathy exam, foot exam and a blood pressure screening

Every six months, lipid test (if LDL-c result is > 100 mg/dl, member should be receiving treatment)

Annual dilated retinal exam (DRE), urine test for microalbumin

HbA1c measurement should be in the physician chart at least every six months (BIY)

Behavioral Risk Management

Consistent message surrounding impact of:

- Diet- Member should have nutritionist visit for diet plan within last 6 months

<ul style="list-style-type: none">• Exercise- Member should exercise minimum of 30 minutes walking (or equivalent) 5 days/week• Cigarette smoking• ETOH use• Illicit Drug (e.g. cocaine) use							
Educational Topics and Corresponding Resources		<i>List the topic and the source material:</i> (NOTE: Education resources subject to ACHA approval)					
Educational Material from Krames for the “Plan” <ul style="list-style-type: none">• Understanding Type I Diabetes• Understanding Type II Diabetes• Hyperglycemia• Hypoglycemia• A1C and eAG• Diabetes: Exams/Tests• Sick Day Plan• Diabetes: Ways to Take Your Medications• Diabetes & Your Child: High Blood Sugar• Diabetes & Your Child: Sick Day Plan• Diabetes & Your Child: the A1c• Healthy Meals for Diabetics• Diabetes: Shopping & Preparing meals• Diabetes: Learning about Serving & Portions• Diabetes: Understanding Carbohydrates• Eating Out When you have Diabetes <p>Based upon individual plan requirements additional diabetic educational material may be provided to the member.</p> <p>http://www.ndep.nih.gov/ (Tips Diabetes; Tips Teen Dealing; Tips Active; Tips Weight; Tips Eat)</p>							
Innovations		<i>Synergistic initiatives supporting program goals and desired outcomes</i>					
Provider Connection		<i>Provider-centric interventions</i>					
Ongoing collaboration between member and primary care provider/specialist via case management. Relationship with Diabetic clinical expert.							
Internal Education		<i>Date of case rounds</i> <i>Date and topic of targeted in-service</i>					
All “plans” will maintain a log on internal and external education topics. The log is available upon request. The person maintaining the log for each plan will be the Integrated Care Manager lead for the diabetic workgroup.							
External Education		<i>Date and topic of member and provider communication materials</i>					
<table><tr><td><u>Date</u></td><td><u>Audience</u></td><td><u>Topic</u></td><td><u>Type</u></td></tr></table>				<u>Date</u>	<u>Audience</u>	<u>Topic</u>	<u>Type</u>
<u>Date</u>	<u>Audience</u>	<u>Topic</u>	<u>Type</u>				

All “plans” will maintain a log on internal and external education topics. The log is available upon request. The person maintaining the log for each plan will be the Integrated Care Manager lead for the diabetic workgroup.	
Reporting	<i>Once a year Blueprint is presented to and approved by the Diabetes Workgroup. Annual effectiveness report (Integrated Care Management Program Evaluation) is presented to and approved by Quality Assessment Performance Improvement Committee</i>
<div> <div>Diabetes Workgroup Blueprint</div> <div> <div>November 29, 2012</div> <div></div> </div> </div> <div> <div>Annual Effectiveness Report(Integrated Care Management Program Evaluation)</div> <div></div> </div>	

ACLA Obesity Management Blueprint – Adult

Disease State	Obesity
Importance to Louisiana	<p>Over one-third of U.S. adults (33.8%) are obese. Obesity prevalence varies across states and regions. Many factors continue to contribute to the increasing prevalence of obesity and overweight, including behavior, environment, and genetic factors. Individuals identified as obese or overweight are at risk for coronary artery disease; type 2 diabetes; certain cancers (endometrial, breast and colon); hypertension; dyslipidemia—including high cholesterol and high triglyceride levels; stroke, liver and gallbladder disease; sleep apnea; respiratory problems; osteoarthritis; and gynecological problems, such as abnormal menses and infertility.⁹</p> <p>Overweight is defined as a body mass index (BMI) of 25 or higher; obesity is defined as a BMI of 30 or higher. An adult who has a BMI between 25 and 29.9 is considered overweight. An adult who has a BMI of 30 or higher is considered obese.</p> <p>Twelve states have an obesity prevalence of 30% or more. No states have met the Healthy People 2020 goal of reducing obesity by 10 %</p> <p>Medical costs associated with obesity are estimated at \$147 billion; the medical costs paid by third-party payors for people who are obese were \$1,429 higher than those of normal weight. Medicaid pays \$1,021 more than it pays for normal-weight beneficiaries. Medicare pays \$1,723 more than it pays for normal-weight beneficiaries.¹⁰</p> <p><i>LA:</i> In 2012, Louisiana had the highest rate of adult obesity in the nation at 34.7%. When the overweight population is included, the rate jumps to 69.6%. The rate of physical inactivity of adults in Louisiana was 29.9%, ranked 4th in the nation.¹¹</p> <p>If obesity rates continue on their current trajectories, the obesity rate in Louisiana could reach 62.1% by 2030.¹² If average BMIs were lowered by 5 %, Louisiana could save 7.3% in health care costs, which would equate to savings of \$9,839,000,000 by 2030. The number of Louisiana residents who could be spared from developing new cases of major obesity-related diseases by 2030 includes:</p> <ul style="list-style-type: none"> • 127,455 from type 2 diabetes; • 99,640 from coronary heart disease and stroke; • 91,451 from hypertension; • 55,676 from arthritis; and • 7,640 from obesity-related cancer.

⁹ Centers for Disease Control, www.CDC.gov, 2011

¹⁰ Weight-control Information Network (WIN); www.nih.gov

¹¹ Behavior Risk Factor Surveillance System (BRFSS)/CDC; Levi J, Segal LM, Thomas K, St. Laurent R, Lang A, Rayburn J. *F as in Fat: How Obesity Threatens America's Future* 2013 Report, 10th ed., Trust for America's Health/Robert Wood Johnson Foundation, 8/2013.

¹² Levi J, Segal LM, St. Laurent R, Lang A, Rayburn J. *F as in Fat: How Obesity Threatens America's Future* 2012 Report, 9th ed., Trust for America's Health/Robert Wood Johnson Foundation, 9/2012.

Supporting Clinical Guidelines	<p>Clinical Guideline on the Identification, Evaluation and Treatment of Overweight and Obesity in Adults- National Heart, lung and Blood Institute. NIH Publication Number 00-4084; October 2000. Available at www.nhlbi.nih.gov/guidelines/obesity</p> <p>Is this guideline available to Providers via website X Yes</p>
Advisory Group	<p>Obesity and Overweight Workgroup: TBD Physician Consultant: Kirt Caton MD</p>
Program Goals	<ul style="list-style-type: none"> • Identify target groups, risk factors and decrease the number of patients classified as overweight and obese • Implement a care plan to target and treat obesity and prevent progression from overweight to obese • Improve Self-management through education of member on education, diet and activity planning • Enhance the knowledge base and customer/member's decision making ability within the plan of care through targeted education and collaboration with healthcare providers • Risk factor identification • Intervention implementation for at risk • Dietary Consultation for at risk • Improvement of long-term physical health through permanent healthy lifestyle habits • Improvement of emotional health (good self-esteem and appropriate attitudes toward food and body) • Decrease gaps in care • Decrease ER visits and hospital use in adults with obesity and co morbidities
Outcome Measurements	<p>Applicable HEDIS® measures At least 2 measures must relate to clinical guideline and 1 measure should relate to a population-based disparity (UM measures do not count as clinical guideline measures)</p>
	<ul style="list-style-type: none"> • Modest, sustainable weight loss- Initial goal to lose 7- 10% of body weight • Member will self-report engaging in physical activity of moderate intensity for 150 minutes per week (30 minutes 5 times per week) • Member will report reduced consumption of calories from solid fats and added sugars • Member will report an increase in the variety and contribution of fruits and vegetables to the diet

Stratification & Interventions		
	Low Risk	High Risk
Stratification	<ul style="list-style-type: none"> • Eligible member with a BMI >25 < 30 kg/m² • Claim Diagnosis of Overweight (278.02) • Member self-report of diagnosis • Referred from Member services (new member orientation) • Prospective risk score • Provider Referral 	<p>In addition to low risk, any of the following:</p> <ul style="list-style-type: none"> • Eligible member with a BMI > 30 kg/m² • Co-morbidity diagnosis of diabetes, hypertension, depression, asthma, sleep disorders • Claim Diagnosis of Obesity and Morbid Obesity (278.00 and 278.01)
Interventions	<ul style="list-style-type: none"> • Welcome letter/describing obesity program and inviting member to call to talk to a CM for more information • Focused education mailings related to prevention of obesity, lifestyle changes, nutrition, and behavioral changes. • Complex Care Management Assessment available upon request • Access to Rapid Response Unit • Access to 24/7 Nurse Line 	<p>In addition to low risk interventions, Complex Care Management services, including:</p> <ul style="list-style-type: none"> • Access to a multidisciplinary team consisting of a primary care provider, behavioral health provider and care manager • Focused education on preventing obesity, medical and behavior health risks associated with obesity • Assessment of family dynamics, cultural values and beliefs • Assessment of family history of diabetes and obesity • Collaborative goal setting • Frequent outreach based according to level of intensity • Individualized Care Plan focusing on Priority Goals and Interventions • Monitoring of pharmaceutical medication • Identification, communication and intervention to resolve Gaps in Care, focusing on preventative care • Connection to appropriate community resources and services
Participation	<input type="checkbox"/> opt-in <input checked="" type="checkbox"/> opt-out	
Priority Intervention(s)	<i>Top priorities – no more than 5</i> Should reflect clinical guideline measures	

Weight Measurement

- Member should weight, height, and waist circumference measurement every 2 years or at each visit if at risk, with a history of BMI >24.9, or diagnosed overweight
- If BMI >25, or waist circumference >88cm (female) or 102 cm (male), assess risk factors

Weight loss, management and therapy Recommendations

- Dietary and Lifestyle education for Adult members with BMI 25-29.9
- Exercise therapy and program development
- Periodic progress monitoring
- Behavior therapy as needed
- Medication treatment as needed
- Reinforce Smoking cessation

CCM	<i>List the topic and the source material:</i> (NOTE: Education resources subject to DHH approval)		
Eating Healthier and Feeling Better Using the Nutrition Facts Label, http://www.fda.gov/Food/ResourcesForYou/Consumers/ucm266853.htm Choose Smart, Choose Healthy, http://www.fruitsandveggiesmatter.gov/downloads/AA_Womens_Brochure.pdf Double-check the portion sizes at your next meal, pocket guide, http://hp2010.nhlbihin.net/portion/servingcard7.pdf How to avoid portion size pitfalls to help manage your weight, http://wwwn.cdc.gov/pubs/dnpao.aspx How to use fruits and vegetables to help manage your weight, http://wwwn.cdc.gov/pubs/dnpao.aspx Rethink your drink, http://wwwn.cdc.gov/pubs/dnpao.aspx			
Innovations	Synergistic initiatives supporting program goals and desired outcomes		
Ongoing collaboration between member, provider and community-based health centers via case management for stepped weight management programs to support improved diet, increased physical activity, behavior modification and weight loss.			
Provider Connection	Provider-centric interventions		
Ongoing collaboration between member and primary care provider/specialist via case management. Relationship with Weight Loss clinical expert			
Internal Education	<i>Date of case rounds</i> Date and topic of targeted in-service Kirt Caton / Case Management Staff dated to be TBA /tentative for Aug/Sept 2013		
Development of Grand Rounds			
External Education	<i>Date and topic of member and provider communication materials</i>		
Date	Audience	Topic	Type
Reporting	<i>Once a year Blueprint is presented to and approved by the Obesity Workgroup. Annual effectiveness report (Integrated Care Management Program Evaluation) is presented to and approved by Quality Assessment Performance Improvement Committee</i>		
Obesity Workgroup Blueprint			

Annual Effectiveness Report(Integrated Care
Management Program Evaluation)

ACLA Obesity Management Blueprint – Pediatric

Disease State	Obesity and Overweight
Importance to Louisiana	<p>Currently, approximately 17% (or 12.5 million) of children and adolescents 2–19 years of age are obese. Since 1980, obesity prevalence among children and adolescents has almost tripled. One of three children is obese or overweight before their fifth (5th) birthday.¹³</p> <p>Body mass index (BMI) is a measure used to determine childhood overweight and obesity. It is calculated using a child's weight and height. BMI does not measure body fat directly, but it is a reasonable indicator of body fatness for most children and teens. Obesity is defined as a BMI at or above the 95th percentile for children of the same age and sex.¹⁴</p> <p>Obese children are more likely to have high blood pressure, high cholesterol, and type 2 diabetes, which are risk factors for cardiovascular disease. Additionally, the tracking of body mass index (BMI) that occurs from early childhood to adulthood show early adiposity rebound in young children is associated with increased risk of obesity in young adulthood.¹⁵</p> <p>Studies have shown that obese adolescents have a 70 % chance of becoming overweight or obese adults. If current trends continue, one out of three children born in 2000 will develop type 2 diabetes, primarily due to a poor diet and lack of physical activity¹⁶</p> <p><i>L4:</i> In 2011, the percentage of obese children, ages 10–17 in Louisiana was 21.1%, ranked 4th in the nation. The percentage of children ages 6–17 participating in vigorous daily physical activity was 31.1%.¹⁷</p> <p>In 2011, 35.6% of Louisiana high school students were overweight or obese. Additionally, only 24.2% of Louisiana high school students were physically active at least 60 minutes per day on all 7 days.¹⁸</p>
Supporting Clinical Guidelines	<p>American Academy of Pediatrics endorsed: AMA/CDC Recommendations for Treatment of Child and Adolescent Overweight and Obesity found at :</p>

¹³ Centers for Disease Control, www.CDC.gov, 2011

¹⁴ Centers for Disease Control, www.CDC.gov, 2011

¹⁵ Centers for Disease Control, www.CDC.gov, 2011

¹⁶ 2009 South Carolina Youth Risk Behavior Survey (YRBS), accessible at <http://apps.nccd.cdc.gov/youthonline/App/Results.aspx?LID=SC>

¹⁷ Maternal and Child Health Bureau (MCHB)/CDC, 2011 National Survey of Children's Health; CDC. Pediatric Nutrition Surveillance, 2011; Obesity Among Low-Income, Preschool-Aged Children–United States, 2008–2011. Vital Signs, 62 (Early Release): 1–6, 2013; Levi J, Segal LM, Thomas K, St. Laurent R, Lang A, Rayburn J. *F as in Fat: How Obesity Threatens America's Future* 2013 Report, 10th ed., Trust for America's Health/Robert Wood Johnson Foundation, 8/2013.

¹⁸ CDC, Youth Risk Behavior Survey (YRBS) 2011 Available at <<http://www.cdc.gov/HealthyYouth/yrbs/index.htm>>

<http://www2.aap.org/obesity/policystatements.html>

Is this guideline available to Providers via website

X Yes No__

Advisory Group

Obesity and Overweight Workgroup: TBD
Physician Consultant: Kirt Caton

Program Goals

- Improve and increase Self-Management skills related to nutrition and activity
- Enhance knowledge base for the parent/caregiver of the enrollee related to healthy lifestyle habits
- Improvement of long-term physical health through permanent healthy lifestyle habits
- Improvement of emotional health (good self-esteem and appropriate attitudes toward food and body)
- Improvement of Well Child Visits
- Decrease ER visits and hospital use in children with obesity
- Prevention of co morbidities in children with obesity

Outcome Measurements

Applicable HEDIS® measures
At least 2 measures must relate to clinical guideline and 1 measure should relate to a population-based disparity (UM measures do not count as clinical guideline measures)

- Increase BMI measurement in children and adolescents
- Early recognition and identification of overweight and obese children
- Improvement in Education of Diet and activity recommendations for children and adolescents
- Reduction in development of obesity related co morbidities in children and adolescents
- Improvement in overall health of member children and adolescents

Stratification & Interventions

	Low Risk	High Risk
Stratification	<ul style="list-style-type: none"> • Eligible member in the BMI category of 85th-94th percentile • Claim Diagnosis of Overweight (278.02) • New Member Assessment • Initial Health Risk Assessment • Prospective risk score 	<p>In addition to low risk, any of the following:</p> <ul style="list-style-type: none"> • Eligible member in the BMI category of $\geq 95^{\text{th}}$ percentile • Co-morbidity diagnosis of diabetes, hypertension, depression, asthma, sleep disorders • Claim Diagnosis of Obesity and Morbid Obesity (278.00, 278.01)
Interventions	<ul style="list-style-type: none"> • Welcome letter/educational material 	<p>In addition to low risk interventions, Complex Care Management services, including:</p>

	<ul style="list-style-type: none"> • Focused education mailings related to prevention of obesity, lifestyle changes, nutrition, behavioral changes • Complex Care Management Assessment available upon request • Access to Rapid Response Unit • Access to 24/7 Nurse Line 	<ul style="list-style-type: none"> • Access to a multidisciplinary team consisting of a dietician, primary care provider, behavioral health provider and care manager • Focused education on preventing obesity, medical and behavior health risks associated with obesity • Monitoring BMI • Assessment of family dynamics, cultural values and beliefs • Assessment of family history of diabetes and obesity • Collaborative goal setting • Frequent outreach based according to level of intensity • Individualized Care Plan focusing on Priority Goals and Interventions • Monitoring of pharmaceutical medication • Identification, communication and intervention to resolve Gaps in Care, focusing on Well Child Visits • Connection to appropriate community resources and services
Participation	<input type="checkbox"/> opt-in <input checked="" type="checkbox"/> opt-out	
Priority Intervention(s)	<i>Top priorities – no more than 5</i> <i>Should reflect clinical guideline measures</i>	
<p>Health Supervision</p> <ul style="list-style-type: none"> • Identify and track members at risk for overweight and obesity • Calculate BMI once yearly or more frequently as needed for children and adolescents to monitor accelerated weight gain • Promote healthy eating and physical activity level for member • Recommend limitation of sedentary activity <p>Patient Advocacy</p> <ul style="list-style-type: none"> • Help parents, teachers, coaches, and others who influence youth to discuss health habits, not body habitus, as part of their efforts to control overweight and obesity • Partner with provider/parent/caregiver to increase recognition of overweight and obesity • Encourage early intervention and risk assessment 		
Educational Topics and Corresponding Resources	<i>List the topic and the source material:</i> (NOTE: Education resources subject to DHH approval)	

<ul style="list-style-type: none">• Rethink your drink, http://www.cdc.gov/nccdphp/dnpa/nutrition/pdf/rethink_your_drink.pdf• Four Tips To Grow Healthy and Strong, www.healthychildren.org• Get Smart, Back to School, http://www.fruitsandveggiesmatter.gov/downloads/eat_more_fv.pdf• Let your kids pick one of these healthy snacks, http://www.nhlbi.nih.gov/health/public/heart/obesity/wecan/downloads/hundredcalories.pdf• Youth Physical Activity: The Role of the Family, http://www.cdc.gov/healthyyouth/physicalactivity/toolkit/factsheet_pa_guidelines_families.pdf• Eat Right When Money’s Tight, http://www.nal.usda.gov/snap/EatRightWhenMoneysTight.pdf• Charge Up! Healthy Meals and Snacks for TEENS, http://win.niddk.nih.gov/publications/PDFs/ChargeUp_tip.pdf			
Innovations	<i>Synergistic initiatives supporting program goals and desired outcomes</i>		
Ongoing collaboration between member, provider and community-based health centers via case management for stepped weight management programs to support improved diet, increased physical activity, behavior modification and weight loss.			
Provider Connection	<i>Provider-centric interventions</i>		
Ongoing collaboration between member and primary care provider/specialist via case management. Relationship with Weight Loss clinical expert			
Internal Education	<i>Date of case rounds</i> <i>Date and topic of targeted in-service</i>		
Development of Grand Rounds			
External Education	<i>Date and topic of member and provider communication materials</i>		
<u>Date</u>	<u>Audience</u>	<u>Topic</u>	<u>Type</u>
Reporting	<i>Once a year Blueprint is presented to and approved by the Obesity Workgroup. Annual effectiveness report (Integrated Care Management Program Evaluation) is presented to and approved by Quality Assessment Performance Improvement Committee</i>		
Obesity Workgroup Blueprint			
Annual Effectiveness Report(Integrated Care Management Program Evaluation)		_____	

COMMUNITY HEALTH SOLUTIONS (CHS)
2014 Diabetes & Obesity Response



Community Health Solutions
of Louisiana

a division of Community Health Solutions of America, Inc.

January 17, 2014

Mr. Joshua Hardy
Section Chief Medicaid Quality Management, Statistics and Reporting
Bureau of Health Services Financing
Louisiana Department of Health and Hospitals

Re: 2014 Diabetes & Obesity Action Plan

Dear Mr. Hardy:

Please find enclosed Community Health Solutions of Louisiana's (CHS-LA) submission of our 2014 Diabetes and Obesity Action Plan.

The CHS-LA team prepared this plan in response to your recent request as part of Act 210 of the 2013 legislative session. As Chief Medical Officer for CHS-LA, I have approved this plan.

We look forward to enacting our plan with the goal of improving the lives of many of our members impacted by Diabetes and Obesity. If you should have any questions, please do not hesitate contacting me.

Sincerely,

Stewart T. Gordon, MD, FAAP
Chief Medical Officer, CHS-LA

CHS 2014 Diabetes Management Action Plan:

Community Health Solutions of Louisiana (CHS-LA) identifies diabetic patients utilizing claims data, referrals, utilization management data, health risk assessment (HRA) data, and other reports such as ER utilization. Members identified are then referred to the member engagement unit (MEU) for telephonic outreach. The goals for outreach include reaching the member, introducing services, conducting an HRA, and enrolling the member into the program.

Members are identified through one of the mechanisms listed above. We use a predictive model scoring tool that assigns a level of risk to all identified diabetics. Based on that level of risk, the member is contacted by the MEU and offered the program most appropriate for their risk level.

Members are identified based on predictive model technology so the high risk members are referred to a case manager (on-site in LA) and the moderate risk members are referred to disease management. Case management is an intensive 1:1 process which involves assessment, development of the plan of care, implementation of the plan of care, monitoring and evaluation. This process is carried out in collaboration with the attending and consulting physicians, and the other members of the medical team. Coordination, collaboration and communication are hallmarks of case management.

Disease management is a process that includes identification of members with a specific disease, enrollment into the program, assessment, disease education, monitoring for treatment plan adherence, and lifestyle coaching and management. Members can move between disease and case management depending on their changing needs during the time they are in the program.

The case management staff include registered nurses (RNs) who have experience and training working with children and high risk maternity members as well as adults with co-morbidities. Many of the nurses have extensive experience specific to diabetes and all RNs have experience with care coordination and monitoring along with the case management processes. Many of the staff hold certifications in case management from nationally recognized credentialing organizations.

Disease management nurses have varying expertise levels with the diseases that we manage, including diabetes. They also have experience with care coordination.

Another way to identify members who require management is through the utilization management process. Due to the difficulty in reaching this population, identifying the at-risk members through the UM process assists the case management team in being able to connect with the member while they are in the hospital. The process includes the following:

- UM staff identifies the diabetic members who are hospitalized
- The member is then referred to a case manager who will contact the member while in the hospital, either telephonically or in person.
- An assessment will be done and discharge planning will be done in collaboration with the hospital discharge planning staff.
- The case manager will follow up with the member upon discharge and reinforce diabetic teaching and lifestyle management so that the member can avoid complications and re-hospitalizations.

Once care has been appropriately coordinated and the member is stable at home, disease management may take over the educational process with the member. Conversely, members in disease management could be transferred into case management if the need arises for additional coordination of care. All members in case or disease management have a plan of care developed for them with their goals established.

Once those goals are met and/or the member is stable and able to manage their own care, utilize healthcare resources appropriately, and can navigate the healthcare system (resource identification) to obtain needed services, they are discharged from the program. They can re-enter either program at any time and all members in case/disease management are given the program resources so that members can get in touch with a nurse.

The organization has social work staff on-site in LA as well. These social workers primarily deal with the behavioral health issues common to diabetics and work closely with the member and the nurse on these cases to provide the member with resources to work through these issues. We know that healthcare costs greatly increase when there are significant behavioral health or social issues compounding the medical condition. Social workers are also available assist the members with access to care, referral to community resources, removing barriers to appropriate care, and identifying financing mechanisms.

The disease management nurse provides education with the use of:

- Printed material
 - Twelve session program to review the disease process and lifestyle changes necessary to maintain a healthy life and reduce the risk of complications and comorbid conditions.
 - Referral to a diabetic education program within their community
 - Experience in diabetes education and motivational interviewing
- Support services including:
 - Reinforcing adherence to the treatment plan recommended by the PCP
 - Using medication(s) safely and for maximum therapeutic effectiveness
 - Monitoring blood glucose and how to use the results for self- management
 - Recognition of signs and symptoms of acute complications
 - Incorporating nutritional management into lifestyle
 - Incorporating physical activity into lifestyle
 - Identify resources in the community
 - Address psychosocial issues and concerns
 - Lipid management
 - Recognition and treatment of complications
 - Recommended screenings
 - Tobacco cessation
 - Monitoring positive progress
 - Goal setting
 - Tracking effectiveness

CHS Goals for 2014:

1. Increase the number of diabetics enrolled in disease management and case management by 5%. (Baseline for 2013: 216 enrolled)
2. Increase the number of diabetic members completing disease management and case management goals by 5% (Baseline for 2013: 12 completed)

3. Reduce hospital and emergency room utilization by diabetic members by 5%. (Baseline for 2013: 276 admitted to the hospital, 398 presented to ER for treatment)

CHS 2014 Obesity Management Action Plan:

Community Health Solutions of Louisiana is developing an Obesity Disease Management program. The program will be part of the assessment and education of all members in case and disease management (Current total is 1161). Each member will be assessed for obesity utilizing BMI (body mass index) {gathered from the health risk assessment} and other data relative to claims and physical assessment. Each of the members identified for the program will have assessments related to obesity as well as lifestyle habits such as diet and exercise. Levels of risk will be identified including those that are at-risk for obesity, those that are obese with co-morbid conditions and those that are obese with co-morbid conditions and are medically unstable. Obesity management will be incorporated into their care plans, and educational resources will be extended to the member based on their level of risk for obesity.

Considering nearly 90% of the Community Health Solutions of Louisiana members are pediatric age, specific intervention targeted to this population are being initiated.

1. CHS Care Management staff will receive training regarding pediatric healthy lifestyle approach to weight management, developed from the text “Trim Kids: The Proven 12-Week Plan that has Helped Thousands of Children Achieve a Healthier Weight,” and other proven resources available for pediatric obesity management. This education will assist the team in assisting/coaching their patients who need support.
2. A pilot treatment and prevention program for pediatric diabetes and obesity is being developed. The intent is to identify and partner with outpatient pediatric center(s) to provide a family centered, multi-disciplinary treatment team approach to healthy lifestyle while attaining weight management.

CHS Goals for 2014:

1. Report on BMI for 75% of the population enrolled in disease management or case management.
2. Identify pilot practice(s) for outpatient pediatric diabetes and obesity prevention project.
3. Increase the number of pediatric members (currently enrolled in active disease management or case management) by 10% in the pediatric obesity disease/case management program. The program will be based upon Trim Kids or other proven resources for pediatric obesity prevention and management.

LOUISIANA HEALTHCARE CONNECTIONS (LHC)
2014 Diabetes & Obesity Response



January 15, 2014

Joshua Hardy
Chief Medicaid Quality Management Statistics and Reporting
Louisiana Department of Health and Hospitals
628 N. 4th St.
Baton Rouge, LA 70809

Re: Diabetes and Obesity Plan for Louisiana

Dear Sir:

Louisiana Healthcare Connections is pleased to endorse this proposed plan as a resource to combat the rising prevalence of diabetes and obesity in Louisiana.

Louisiana Healthcare Connections is actively engaged and committed to developing innovative programs which address population health issues in the state of Louisiana. Medical Affairs and Medical Management at Louisiana Healthcare Connections collects and analyzes data daily to determine the best approaches to disease management in the state. Clearly diabetes is one of our largest healthcare problems. Nationally the state of Louisiana continues to have one of the highest incidences of obesity, and secondary to the obesity are the co-morbidities that include diabetes, sleep related breathing disorders, congestive heart failure, end stage renal disease and others.¹ Louisiana Healthcare Connections utilizes the services of many specialty companies^{2,3} and our internal case facilitators to develop a transitions of care program that integrates all of the needs of our patients. We also develop relationships with community and business partners to assist us in making healthcare more accessible and understandable to our members. Providers in our state are asked to participate in our medical home program. Obstetricians and Pediatricians are contacted and the service of our Start Smart program for present and future mothers and their babies is made available to improve our delivery outcomes.

This proposal is important and we recognize that as the dynamics of healthcare change the approach to disease management will also need modification. With the assistance of our proprietary analytics we will monitor the progress of the interventions to achieve the best outcome.

Louisiana Healthcare Connections is fully committed and endorses the proposal and looks forward to the collaboration.



Sincerely:

A handwritten signature in black ink, appearing to read "D. Thomas", with a long horizontal line extending to the right.

David Thomas MD, PhD
Chief Medical Director
Louisiana Healthcare Connections
8585 Archives Boulevard, 3rd Floor Baton Rouge, La 70809

1. <http://www.cdc.gov/obesity/index.html>
2. <http://www.centene.com/specialty-companies/>
3. <http://www.centene.com/innovations/>

LHC 2014 Diabetes Program

Program Objective

The Diabetes 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:

- A diagnosis of diabetes or pre-diabetes with any of the following ICD-9 codes: 250.xx, 357; and
- A search of pharmacy claims finds one or more medications for the class glucose regulator.

Members with more than one eligible condition will be enrolled in the appropriate program based on the Provider's Hierarchy of Disease algorithm.

Enrollment

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

An introductory mailing is sent to targeted Members and health plan physicians announcing the Program and informing Members they will receive a phone call. Telephonic outreach begins seven (7) days after the introductory mailing is sent. Several (at least 3, but could be more) attempts to contact a Member 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, education needs and assign the Member to the appropriate Health Coach (a Certified Diabetes Educator).

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 their condition, lifestyle behaviors, and readiness to change. Internal clinical guidelines are developed from nationally recognized evidence-based guidelines published by The American Diabetes Association and the American Association of Clinical Endocrinologist. Components of the Program include:

- medication comprehension and compliance
- self-blood glucose monitoring
- recognizing signs of low and high blood glucose levels
- nutrition counseling for 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

- Consults with Specialty Health Coaches for Members at high risk for, or diagnosed with heart disease, COPD or asthma. Health Coaches include Registered Nurses and Certified or Registered Respiratory Therapists.

Throughout the Program, the Health Coach works with the Member/or caregiver to identify barriers to care plan compliance and will address questions or regarding condition management.

Members who are not interested in telephonic counseling at enrollment will receive quarterly newsletters and may call in to speak with a Health Coach at any time to ask questions or to opt into telephonic counseling.

Pediatric Members

Pediatric specific internal clinical guidelines are used for Members under the age of eighteen (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 participant 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 disenrolled from the program.

Referral Services

Subject to applicable law and regulations, PROVIDER may refer Members to other disease management programs offered by 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. PROVIDER will also establish a referral system to allow referrals directly from case management.

Disenrollment

Members may be disenrolled from the Program under the following circumstances

- Member dies;
- Member's health care coverage with MCO terminates or MCO no longer provides the Member's primary coverage as determined under applicable coordination of benefits rules by MCO and communicated PROVIDER;
- Member attending physician or MCO requests Disenrollment;
- Member is no longer capable of participation in the Program, in the reasonable determination of PROVIDER;
- Member has End Stage Renal Disease (ESRD); or
- Member has enrolled in a Hospice Program.

Example of Measurement

Quarterly Outcomes Report - 2013
Plan: Louisiana Healthcare Connections
Program: Diabetes

Measurement Period Ending - Q2 2013



Measure	Objective	Method Reported ^A	Q1 - 2013	Q2 - 2013	Q3 - 2013	Q4 - 2013	YTD *	Prior Calendar Year	Client Last 12 Months	BoB Last 12 Months	75th Percentile
			JAN-MAR	APR-JUN	JUL-SEP	OCT-DEC		12 MOS	12 MOS	12 MOS	12 MOS
Diabetes Absenteeism	↑	S									
Diabetes ACE/ARB Use	↑	C									
Diabetes Acute Episodes	↓	C									
Diabetes Annual Eye Exam	↑	S,C,P									
Diabetes Annual Foot Exam	↑	S,C,P									
Diabetes Body Mass Index (Adult)	↑	S									
Diabetes Body Mass Index (Child)	↑	S									
Diabetes BP Control	↑	S,P									
Diabetes BP Screening	↑	S,P									
Diabetes Exercise Program	↑	S									
Diabetes Flu Vaccination	↑	S,C									
Diabetes HBA1C Control	↑	S,P									
Diabetes HBA1C Screening	↑	S,C,P									
Diabetes HDL Control	↑	S,L,P									
Diabetes Kidney Disease Screening	↑	S,C,P									
Diabetes LDL-C Control	↑	S,L,P									
Diabetes LDL-C Screening	↑	S,C,P									
Diabetes Self Monitored Blood Sugar	↑	S									
Diabetes Smoking Cessation	↑	S									
Diabetes Triglyceride Control	↑	S,P									
Diabetes ER Visits per 1000	↓	C									
Diabetes IP Admits per 1000	↓	C									

^A (S)elf, (C)laims, (L)ab, (P)rovider

Absence = % of participants indicating a reduction in absenteeism
 ACE/ARB Use = % of participants with evidence of an ACE/ARB medication
 Acute Episodes = % of participants utilizing IP/ER services
 Eye Exam = % of participants with evidence of a retinal exam
 Foot Exam = % of participants with evidence of a foot exam
 BMI (Adult) = % of participants who report a value of less than 25
 BMI (Child) = % of participants in the 85th percentile
 BP Control = % of participants who report BP at 130/80 or lower
 BP Screening = % of participants with evidence of a BP screening
 Exercise Program = % of participants getting at least 150 minutes/week of aerobic exercise
 Flu Vaccinations = % of participants receiving a flu vaccination

HBA1C Control = % of participants with evidence of test score within recommended range

HBA1C Screening = % of participants with evidence of an HBA1C test

HDL Control = % of participants with an HDL higher than 40 mg/dl

Kidney Disease Screening = % of participants with evidence of a microalbumin test

LDL-C Control = % of participants who report an LDL-C below 100

LDL-C Screening = % of participants with evidence of an LDL panel

Self Monitored Blood Sugar = % of participants who reported SMBG testing

Smoking Cessation = % of participants who report that they had quit smoking

Triglyceride Control = % of participants who report triglyceride level less than 150 mg/dl

ER Visits - Rates are calculated as the annualized (monthly rate x 12) monthly rate x 1000 as follows:

(#ER Visits/sum of member months) x 12 x 1000

IP Admits - Rates are calculated as the annualized (monthly rate x 12) monthly rate x 1000 as follows:

(#IP Admits/sum of member months) x 12 x 1000

*Each reporting period represents unique individuals who had values in that period. Quarters will not aggregate to YTD or 12 month figures as individuals may have values in multiple quarters but will only be counted once for YTD and Last 12 Months

LHC 2014 Weight Management Program
(This Exhibit 2-K only applies if Weight Management is checked on Exhibit 1)

Weight Management is a Program (“Program”) provided to MCO Members by PROVIDER pursuant to PROVIDER’S policies and procedures as the same may be amended from time to time.

Eligibility Criteria

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

Age _ 18 and any of the following:

- BMI > 30
- History of BMI > 30 with need for weight maintenance support
- Referral from provider for weight management

Members with more than one eligible condition will be enrolled in the appropriate program based on PROVIDER’s Hierarchy of Disease algorithm.

Program Objective

The Program provides telephonic outreach, education, and support services to Members in order to improve nutrition and exercise patterns to manage weight and minimize health risk factors.

Enrollment

Members may be referred to the Program by a health plan physician, case manager or self-referral.

Members referred by providers or case managers will receive an introductory mailing announcing the program and informing them they will receive a phone call. Telephonic outreach begins within ninety (90) after the introductory mailing is sent. Three (3) call attempts are made to contact each candidate. Telephonic attempts to contact are made at alternate times of the day during the week and on the weekend. Candidates who are unable to be reached after the third call attempt are sent a post card encouraging enrollment. Members who are later identified again as a candidate for the program will be re-enrolled and process will start over. Once contact is made, the program is explained, eligibility is confirmed and a health assessment is initiated to identify clinical risk, education needs and assign the Member to the appropriate Lifestyle Coach or Health Coach (Registered Dietitian or nutritionist).

Ongoing Coaching

The Coach will complete the 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 the American Dietetic Association and the National

Institutes of Health. 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 of outbound calls.

Program Length

Program is one year in length and includes the following:

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

Referral Services

Subject to applicable law and regulations, PROVIDER may refer members to other disease management programs offered by 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. PROVIDER will also establish a referral system to allow referrals directly from case management.

Disenrollment

Members may be Dis-enrolled from the Program under the following circumstances

1. Member dies;
2. Member's health care coverage with MCO terminates or MCO no longer provides the Member's primary coverage as determined under applicable coordination of benefits rules by MCO and communicated PROVIDER;
3. Member attending physician or MCO requests disenrollment; unless State or plan regulations do not allow;
4. Member is no longer capable of participation in the Program, in the reasonable determination of PROVIDER;
5. Member has End Stage Renal Disease (ESRD);
6. Member has been enrolled in a Hospice Program; or
7. One (1) year has lapsed since Member's enrollment in the Program.

Example of Measurement

Quarterly Outcomes Report - 2013
Plan: Louisiana Healthcare Connections
Program: Weight Management

Measurement Period Ending - Q2 2013



Measure	Objective	Method Reported ^A	Q1 - 2013	Q2 - 2013	Q3 - 2013	Q4 - 2013	YTD *	Prior Calendar Year	Client Last 12 Months	BoB Last 12 Months
			JAN-MAR	APR-JUN	JUL-SEP	OCT-DEC		12 MOS	12 MOS	12 MOS
Weight Management Body Mass Index	↑	S								
Weight Management Waist Circumference	↑	S								
Weight Management Physical Activity	↑	S								
Weight Management Whole Grain Servings	↑	S								
Weight Management Fruit and Vegetable Servings	↑	S								
Weight Management Low Fat Dairy Servings	↑	S								
Weight Management High Fat Foods	↑	S								
Weight Management "How confident are you that you can make healthy food choices on a regular basis?"	↑	S								

^A (Self, (C)Home, (L)ab, (P)rovider

BMI = # of participants who report a reduction in BMI
 Waist Circumference = # of participants who report a waist circumference of <= 40 inches for men, or <= 35 inches for women
 Physical Activity = # of participants who report an increase in the amount of aerobic exercise
 Whole Grain Servings = # of participants who report an increase in whole grain servings
 Fruit and Vegetable Servings = # of participants who report an increase in fruit and vegetable servings
 Low Fat Dairy Servings = # of participants who report consuming 3 or more low fat dairy servings per day
 High Fat Foods = # of participants who report a decrease in high fat food consumption
 Making healthy food choices = # of participants who report a higher level of confidence regarding making healthy food choices

*Each reporting period represents unique individuals who had values in that period. Quarters will not aggregate to YTD or 12 month figures as individuals may have values in multiple quarters but will only be counted once for YTD and Last 12 Months

Program Activity as of 10-01-13

LHC - 2013 Nurtur Summary Report

Active	Q1 Total	Q2 Total	Q3 Total
<i>Members Became Active During Mo. (total)</i>			
Diabetes	200	40	61
Weight Management	24	7	7
Other Activities			
<i>Enrolled in Coaching (by month)</i>			
Diabetes	329	46	110
Weight Management	34	9	10
<i>Enrolled in Education (by month)</i>			
Diabetes	68	14	16
Weight Management	N/A	N/A	N/A
<i>Total Enrolled in Coaching</i>			
Diabetes	905	790	478
Weight Management	73	78	60
<i>Total Enrolled in Education</i>			
Diabetes	221	234	245
Weight Management	N/A	N/A	N/A
Members Became Unable to Locate During Mo. (total for all programs – not just these two)	3,579	1,781	1,266
Members in Phone Research (total for all programs – not just these two)	2,613	2,225	2,174

UNITED HEALTHCARE OF LA (UHC)
2014 Diabetes & Obesity Response



3838 North Causeway Boulevard
Suite 3225
Metairie, LA 70002

January 10, 2014

Mr. Joshua Hardy
Section Chief
Medicaid Quality Management, Statistics and Reporting
Louisiana Department of Health and Hospitals
628 N. 4th Street
Baton Rouge, Louisiana 70802

Dear Mr. Hardy:

UnitedHealthcare is pleased to submit this proposed plan to use our resources to help combat diabetes and obesity in Louisiana.

As part of our commitment to increasing the health status of the people of Louisiana, UnitedHealthcare screens every new member for conditions such as diabetes and obesity. We expend considerable resources to educate and manage the care of each member identified at risk for these conditions. We use predictive modeling software to help identify and place diabetic members into case management. We encourage expectant mothers to begin taking care of their babies from the beginning, with our Healthy First Steps Program. Clinical Practice Consultants call on physicians' offices to encourage diabetic screenings and anticipatory guidance for weight, nutrition and physical activity.

To combat obesity we collaborate with community partners, like the Louisiana 4-H Club, Boys and Girls Club and Playworks to raise awareness and promote healthy lifestyles. New for 2014 is our plan to partner with FQHCs and large clinics to promote weight control and healthy eating habits.

Please understand that the attached plan is just that, a plan. It is subject to revisions, additions and deletions as conditions change and as data dictate throughout the implementation. The concepts and action items presented here are still in development and existing programs are being reviewed for effectiveness. All plans must be approved by our Quality Management Committee. With these caveats, I can attest that these plans are submitted with my knowledge and consent.

Sincerely,

A handwritten signature in black ink, reading 'Ann Kay Cefalu Logarbo, M.D. F.A.A.P.' with a stylized flourish at the end.

Ann Kay Cefalu Logarbo, M.D. F.A.A.P.

Chief Medical Officer

UnitedHealthcare Community Plan

UHC 2014 Diabetes Action Plan

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

<i>Description</i>	<i>Responsible Party</i>	<i>Timeframe</i>
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's Hospitality, Assessment and Retention Center (HARC)	Ongoing
Process Measures: # members reached 42,116 (82%) Jan – Nov 2013 # HRA's completed 21,596 (42% of members reached) Jan – Nov 2013		
b. Use Predictive Modeling		
Software designed to predict health risks and assess utilization so that members can be placed appropriately into care management programs if warranted.	Utilization Management Team	Ongoing
Process Measures: # referrals from Utilization Management to Care Management with diagnoses of diabetes New metric for 2014		
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
Process Measures: In 2013 # Mailings to Adults 4,630 # Mailings to Children 521 # Mailings about the Care Management Program 155		
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	UHC Marketing and Community Outreach	Ongoing

the causes of heart disease, the benefits of healthy diet and the importance of regular exercise. The program also includes education on diabetes risk.		
Process Measures:		In 2013
# women attending Lunch'n'Learns		Compiling Data
# Lunch'n'Learn events		Compiling Data

Overall Health Outcome Measures

HEDIS Comprehensive Diabetes Care Measures:

- Hba1c Testing
- Eye Exam
- Attention for Nephropathy
- LDL Screening

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

<i>Description</i>	<i>Responsible Party</i>	<i>Timeframe</i>
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
Process Measures:		In 2013 through Nov
# pregnancies		16,882
Rate of pregnancies enrolled in HFS		
Levels 2 & 3		18.5%
Level 1		9.7%
Average case management days (from time of enrollment to time of delivery)		155

Overall Health Outcome Measures

HEDIS Prenatal and Postpartum Care

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

<i>Description</i>	<i>Responsible Party</i>	<i>Timeframe</i>
Educate providers on current HEDIS standards.		
The Clinical Practice Consultant (CPC) Program was expanded from three to five CPCs in 4 th Quarter 2013. CPCs engage in educating primary care providers about the Healthcare Effectiveness and Information Data Set (HEDIS®). To improve HEDIS® rates, the plan has shared information about evidence based guidelines for care by distributing its Evidence Based Guidelines Toolkits to practices. To help combat diabetes, the consultants will continue to educate providers on the importance of Hba1c testing, retinal eye exams, LDL screening, and attention for nephropathy.	Director, Quality Management & Performance	Ongoing
Process Measures: # toolkits distributed # providers # members potentially impacted based on panel assignments		In 2013 409 281 22,895* *(since Aug 1, 2013)

Overall Health Outcome Measures

HEDIS Comprehensive Diabetes Care Measures:

- Hba1c Testing
- Eye Exam
- Attention for Nephropathy
- LDL Screening

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

<i>Description</i>	<i>Responsible Party</i>	<i>Timeframe</i>
Refer members to Pennington for potential access to a physical fitness facility.		
Pennington Biomedical Research's ARTIIS study is designed to assess whether exercise can lower the risk of developing diabetes in African American males. Members of the program exercise group will receive a 5 month membership to a physical fitness facility. UnitedHealthcare will assist Pennington in recruitment and referral of study participants.	Director, Quality Management & Performance	1 st Quarter 2014
Process Measures: # men referred	New in 2014	

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 2014 Obesity Action Plan

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

<i>Description</i>	<i>Responsible Party</i>	<i>Timeframe</i>
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
Process Measures:	In 2013	
# Louisiana youth reached	22,000+	
# events	New metric for 2014	
b. Continue 4-H Youth Voice: Youth Choice Partnership.		
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
Process Measures:		
# Louisiana youth reached		
New metric for 2014		
c. Continue Partnership with the Boys & Girls Club and Playworks.		
As part of the Fit NOLA initiative, UnitedHealthcare will continue its partnership with Playworks and the Boys & Girls Club to sponsor Family Play Nights.	UHC Marketing and Community Outreach	Ongoing

<i>Description</i>	<i>Responsible Party</i>	<i>Timeframe</i>
Process Measures: # Louisiana youth attending # events	New metrics for 2014	
d. Distribute Sesame Street Food for Thought toolkits.		
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
Process Measures: # toolkits distributed	New metric for 2014	
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
Process Measures: # events that Dr. Health E. Hound attended	New metric for 2014	
f. Participate in Louisiana Healthy Community Coalition Awareness Event.		
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	January 14 in Region 7
Process Measures: # people attending the event	New for 2014	

UHC Program Goal 2: Facilitate healthy lifestyles.

<i>Description</i>	<i>Responsible Party</i>	<i>Timeframe</i>
a. Continue JOIN for ME.		
JOIN for ME is a community-based, pediatric-obesity lifestyle-intervention program. It engages overweight and obese kids ages six to 17, along with their parents, in a series of evidence-based learning sessions to achieve healthier weights through balanced food choices, increased physical activity and tracking. The program will continue at the Boys and Girls Club in New Orleans. A second location in St. Tammany Parish is projected to launch by mid-year in 2014.	UHC Marketing and Community Outreach and Chief Medical Officer	Ongoing
Process Measures:	In 2013	
# enrollees	Compiling data	
Average pounds lost / enrollee	Checking on availability of data	
# enrollees completing the program	Compiling data	
b. Continue partnership with YWCA 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
Process Measures:		
# Louisiana youth reached metric for 2014		New
c. Initiate UHC Small Steps Program.		
UnitedHealthcare is partnering with large clinics and Federally Qualified Health Centers (FQHCs) to help fight obesity and encourage patients to make positive changes in their eating habits. This program is designed to assist health care professionals to increase awareness of weight control and healthier eating habits. Marketing materials will be co-branded with the health care professionals. The initiative also involves making fresh fruits and vegetables available at the site.	UHC Marketing and Community Outreach	New for 2014, plan to implement Small Steps in one FQHC.
Process Measures:	New for 2014	
# Small Steps implementations in FQHCs or large clinics		
# providers		
# potential members impacted based on panel assignments		

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

<i>Description</i>	<i>Responsible Party</i>	<i>Timeframe</i>
Educate providers on current HEDIS standards.		
The Clinical Practice Consultant (CPC) Program was expanded from three to five CPCs in 4 th Quarter 2013. CPCs engage in educating primary care providers about the Healthcare Effectiveness and Information Data Set (HEDIS [®]). To improve HEDIS [®] rates, the plan has shared information about evidence based guidelines for care by distributing its Evidence Based Guidelines Toolkits to practices. To help combat obesity, the consultants will continue to educate providers on the importance of anticipatory guidance for weight, nutrition, and physical activity; diabetes management; cholesterol management; and documentation of body mass index (BMI).	Director, Quality Management & Performance	Ongoing
Process Measures:		In 2013
# toolkits distributed		409
# providers		281
# members potentially impacted based on panel assignments		22,895*
		*(since Aug 1, 2013)

Overall Health Outcome Measures

HEDIS Measures:

Weight, Nutritional, and Physical Activity Counseling
 LDL Screening
 Adult BMI Assessment Rates

CONCLUSION

While Bayou Health has been fully operational for less than two years, its long term goal is improved quality of care and health outcomes for Louisiana's Medicaid and CHIP populations. The strategies described in this report serve as a foundation for healthier Louisiana residents. Bayou Health Plans manage the acute health care for nearly 900,000 Louisiana Medicaid recipients. They provide various approaches and are collectively working to address the impact of diabetes and obesity on Louisiana's Medicaid and CHIP recipients through education and awareness, incentivizing healthy lifestyle and behavioral choices, community based environmental strategies, and school and worksite improvements.

ACKNOWLEDGMENTS

Author:

Joshua Hardy, Medicaid Quality Management, Statistics and Reporting
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Caroline Brazeel, Office of Public Health
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Louisiana Department of Health and Hospitals

Kathy Kliebert, Secretary
Courtney Phillips, Deputy Secretary
Jerry Phillips, Undersecretary
J. Ruth Kennedy, Louisiana Medicaid Director
Mary TC Johnson, Medicaid Managed Care Deputy Director
Christine Peck, Legislative and Governmental Relations Director

BIBLIOGRAPHY

Various Act 210 reporting elements were collected through independent analysis of claims and encounters data by Medicaid Data Analysts in response to Act 210. The primary data source used for this analysis is the Management and Administrative Reporting Subsystem (MARS) Data Warehouse maintained and supported by the state's Fiscal Intermediary, Molina.

The diabetes and obesity related action plans were collected from each of the Bayou Health Plans.