DEPARTMENT OF HEALTH AND HOSPITALS

BAYOU HEALTH DIABETES and OBESITY ACTION PLAN REPORT

REPORT PREPARED IN RESPONSE TO ACT 210

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

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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.

This report is submitted pursuant to ACT 210 of the 2013 Legislative Session. Per Louisiana Revised Statute (RS) 46:2616 and RS 46:2617 the Department of Health and Hospitals (DHH) is required to submit an annual diabetes and obesity action plan to the Senate and House Committees on Health and Welfare after consulting with and receiving comments from the medical directors of each of its contracted Medicaid partners.

Below are some highlights from this report:

- In 2013, Bayou Health Plans identified 37,559 unique recipients whom a provider had diagnosed as obese. The most costly complication for those identified as obese was type 2 *diabetes* at **$9,475,359**.
- In 2012, 29.1 million Americans, or 9.3% of the population, had diabetes. This represents about one out of every 11 people.
- In Louisiana, the prevalence of diabetes jumped from 8.5% in 2003 to 11.6% in 2013 which is a 37% increase over the last 10 years.
- 21,131 Bayou Health adult enrollees were identified with diabetes in 2013; 28.7% were male and 71.3% were female.
- Three parishes (East Baton Rouge, Jefferson and Orleans) each had more than 1,000 total Bayou Health members identified with diabetes.
- A total of 1,946 inpatient hospital discharges noted diabetes as the main diagnosis at discharge.
    - The parish with the most diabetes-related discharges was Tangipahoa with 139 discharges followed by Orleans with 128.
    - The total financial cost associated with these inpatient diabetes-related hospital discharges was **$8,964,244.79.**
- Pregnancies complicated by diabetes cost the Health Plans over $**23 million** in 2013.
- Diabetic Ketoacidosis was the most common diabetic complication on admission. It is a life-threatening complication in which ketones (fatty acids) build up in the blood due to a lack of insulin.
- In 2013, a total of 2,056 Emergency Department (ED) visits occurred for Bayou Health members in which diabetes was the primary diagnosis.
- The parish EDs that got paid the most by the Health Plans for diabetes related ED visits were in Orleans parish at over **$51,000.**
- Diabetes was the third most common chronic condition identified among Bayou Health Plan members in 2013.
- The top two medical conditions related to diabetes that resulted in the most expensive cost per member were *congestive heart failure* at **$93,539.19** per member and *coronary heart disease* at **$50,291.35** per member.

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

DHH and Bayou Health Plan Recommendations:

- Appropriately fund outpatient nutritional services provided by registered dieticians for all patients for all diagnoses, not just those diagnosed with diabetes and obesity. Currently, primary care physicians that take care of people with or at risk for obesity or diabetes are unable to adequately counsel and educate parents, children and adults about nutrition during routine visits. To properly educate parents, children and adults regarding nutrition, recurring appointments with a registered dietician are necessary. Some of these appointments can occur in a group setting. However, if there is no ability for the registered dietician to recover the cost of providing the service, they (or their employer) are unable to provide the service
- Appropriately fund diabetes self-management education. While provider note that this is currently billable, the reimbursement amount is not considered adequate.
- Implement educational reforms aimed at improving diabetes and obesity outcomes in Louisiana. These could include:
    - Enforce Louisiana's physical activity law, currently applicable to kindergarten through eighth grade classes.
    - Expand Louisiana's physical activity law to the high school system.
    - Adequately fund school systems to teach basic nutrition in the classroom at all schools and for all ages.
    - Provide continuing education units (CEUs) to educators through subject matter experts (e.g. kinesiologist or exercise science experts) in order to increase their understanding about the methodology of correctly providing physical activity and nutritional education in the school setting.

Introduction

Purpose of the Report
This report will give an overview of obesity and diabetes within the Bayou Health Plans and describe the scope of the diabetic epidemic in Louisiana and in the Health Plans, the cost and complications of diabetes, and how DHH along with its contracted Medicaid partners will address diabetes and obesity in the populations they serve. In addition, the report discusses recommendations on how to improve the health of Louisiana residents with, or at risk for, developing diabetes and obesity.

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

Report Development
A committee with representatives from each of the entities named in the legislation was assembled to review the legislation and develop the report. The group met to share data about diabetes in the populations each entity serves, to discuss how diabetes and obesity were addressed by each entity, and to develop a plan for future efforts. (See **Appendix B** Committee Members.)

The National Association of Chronic Disease Directors (NACDD) worked with Louisiana through this process. A representative from the NACDD, Marti Macchi, was invited to address the Louisiana group to offer background information from the national perspective and share experience from other states implementing similar legislation.

Overview of Obesity Impact
Although national, state and local governments and many private employers and payers have increased their efforts to address obesity since 1998[1] more than one-third (34.9% or 78.6 million) of U.S. adults are obese.[2] In 2013, providers diagnosed 37,559 Bayou Health enrollees with obesity. This represents roughly3.2% of those enrolled at any time during that year.[3] The value of obesity-related services paid for by the Health Plans totaled $39,036,864 (including complications related to obesity).[3] 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).[3]

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

What is Body Mass Index?
The Body Mass Index is derived from an individual's height and weight. If the Body Mass Index is between 25 and 29.9 a person is considered overweight. If the BMI is 30 or greater, the individual is classified as obese.[4] Although the Body Mass Index is considered to be a useful way to estimate healthy body weight, it does not measure the percentage of body fat and the measurement can sometimes be misleading. For example a muscular man or woman may have a high BMI but have much less fat than an unfit person whose BMI is lower. However, in general, the BMI measurement can be a useful indicator for the average person.[4]

According to the American Diabetes Association, children who are overweight and obese and unfit are at increased risk of developing high blood pressure, abnormal lipid levels, inflammation in their blood vessels and higher than normal blood sugar levels. Obesity is a precursor of diabetes and adult-onset cardiovascular disease. Despite the growing efforts of government and public health officials, the number of overweight and obese youth continues to increase.[4]

Overview of Diabetes Impact

Diabetes is a common disease. In 2012, 29.1 million Americans, or 9.3% of the population, had diabetes which is about one out of every 11 people. It is also one of the leading causes of death and disability in the U.S. It is the seventh leading cause of death. [5, 6]

What is Diabetes?

Food we eat is usually turned into glucose, or sugar, and our pancreas makes a hormone called insulin to help the glucose get into the cells of our bodies so it can be used for energy. Diabetes is a disease in which the body either doesn't make enough insulin or can't use its own insulin as well as it should causing sugar to build up in the blood. When the amount of sugar circulating in the blood is too high, it causes damage to many parts of the body including the eyes, heart, blood vessels, kidneys and nerves. This damage makes diabetes the leading cause of adult blindness, end-stage kidney disease and amputations of the foot and/or leg. People with diabetes are also at greatly increased risk for heart disease and stroke.[5, 6]

Types of Diabetes

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

Type 2 diabetes (previously called "non-insulin-dependent diabetes" or "adult-onset diabetes") develops with "insulin resistance," a condition in which cells (e.g., liver, muscles) of the body do not use insulin properly. As the body resists its own insulin, the pancreas begins to lose the ability to make enough of it. In adults, type 2 diabetes accounts for about 90% –95% of all diagnosed cases of diabetes. The risk factors for developing this type of diabetes include: older age, obesity, family history of diabetes, personal history of gestational diabetes, physical inactivity and race/ethnicity. African Americans, Hispanic/Latino Americans, American Indians, some Asian Americans and Native Hawaiians or other Pacific Islanders are at particularly high risk for development of type 2 diabetes and its complications. Type 2 diabetes may be preventable through modest lifestyle changes.[5]

Gestational Diabetes is a type of diabetes that is first seen in a pregnant woman who did not have diabetes before she was pregnant. The risk factors for it are similar to those for type 2 diabetes. Gestational diabetes requires treatment to lessen the risk of complications such as preterm births, larger babies requiring cesarean sections, preeclampsia, birth defects and increased risk of type 2 diabetes for both the mother and the child once she/he reaches adulthood. Often gestational diabetes can be controlled through eating healthy foods and regular exercise. Sometimes a woman with gestational diabetes must also take insulin.[5, 7]

Economic Effects of Diabetes

Diabetes is an expensive disease. According to the Centers for Disease Control and Prevention (CDC), in 2012, diabetes cost the nation $245 billion with $176 billion being direct medical costs. It also reduced productivity by $69 billion. This amount does not account for those that have not been diagnosed with type 2 diabetes, or the 35% that currently have pre-diabetes and will soon have diabetes if changes are not made. Other costs associated with diabetes include:

- More than $1 of every $10 spent on health care in the U.S. goes directly toward diabetes and its complications, and more than $1 of every $5 spent on health care in the U.S. goes to the care of people with diagnosed diabetes. [8]
- The absolute cost of hospital inpatient care for people with diabetes has risen from $58 billion in 2007 to $76 billion in 2012.[8]
- For 2012, Louisiana had an 8.3% prevalence of diabetes with a total medical cost of $4.19 billion. Of that sum, $1.18 billion is contributed to indirect costs(e.g., workdays missed, reduced work productivity and a reduced work force).[9]

How is Diabetes Managed?

Diabetes affects many parts of the body and can lead to serious complications such as blindness, kidney damage, lower-limb amputations and other debilitating conditions that make its management complex. Generally, diabetes is managed by a combination of appropriate clinical care from a health care provider who understands diabetes care, combined with individual responsibility of the person with diabetes for taking medications as directed, making changes to their food choices and developing a regular pattern of physical activity in order to control blood sugars. Controlling blood sugars to near normal levels is vital to prevent the development of complications of diabetes.[10]

Data from the Behavioral Risk Factor Surveillance System (BRFSS) compares how Louisiana residents with diabetes fare nationally in meeting clinical and self-care measures. The results are noted in Table 1. Although Louisiana is below the 2010 national numbers for these key management practices, it is important to note that for pneumonia vaccination and self-management education, lack of reimbursement to providers for the administration of the vaccine and lack of payment to educators contribute significantly to the low numbers. In addition, these are self-reported numbers and, due to recall bias, it is possible that some members may have received the vaccine or the education and do not remember. Regardless, these low numbers provide an opportunity for improvement in all areas for 2015 and beyond.

Table 1: Reported Rate of Diabetes Care Practices among Adults with Diabetes, Louisiana and US (BRFSS from CDC Division of Diabetes Translation)

Preventive Care Practice	**LA(2013)**	**US(2010[1])**
Annual Dilated Eye Exam	43.5%	62.8%
Received one or more A1Cs in Current (2013) Year	52.0%	68.50%
Received a Flu Shot in Current (2013) Year	8.8%	50.10%
Ever Received a Pneumonia Shot[2]	3.9%	42.50%
Daily Self-Blood Glucose Monitoring	32.2%	63.60%
Ever had Self-Management Education	0.04%	57.40%

[1]2010 is the most recent year of data available from the CDC (www.cdc.gov/diabetes/statistics/preventive/fY_class.htm, Updated 10.2.2014).

[2]Level of follow-up and/or historical data for qualified members may differ by plan.

The Scope of Diabetes in Louisiana

This section of the report provides data on the scope of diabetes among adults in the state, and within the population covered by the five Health Plans specifically looking at the number of people with diabetes, its complications, its financial impact and its financial impact on the state as compared to other chronic diseases and conditions. When possible, we have provided data for women with either gestational diabetes or with pre-existing diabetes at the time of pregnancy.

Figure 1 shows the ten-year trend in diagnosed diabetes in Louisiana. From 2003 to 2013, the prevalence of diabetes jumped from 8.5% to 11.6% which is a 36.5% increase over the last 10 years (Figure 1).

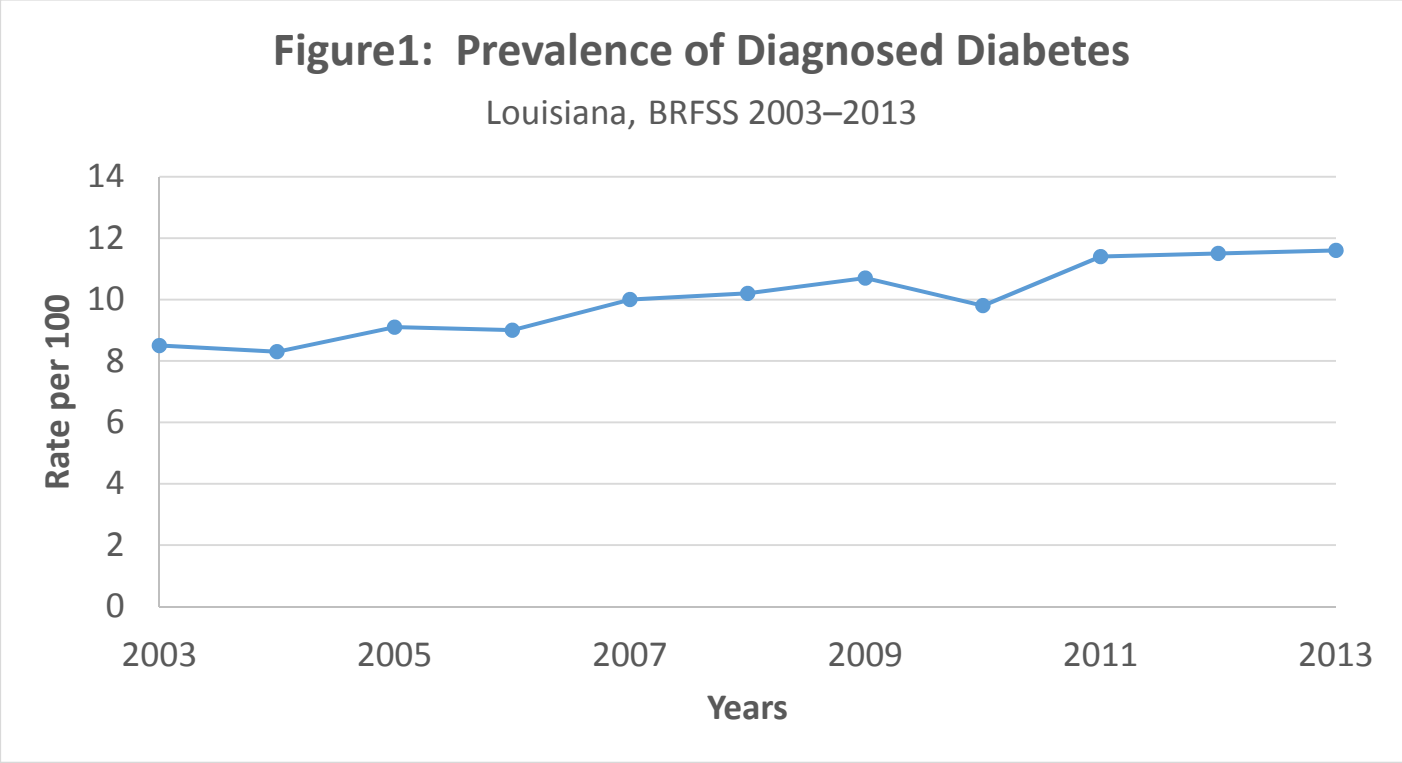

Figure 2 shows the percentile breakdown of men and women with diabetes in 2013 among those with diabetes in the overall Louisiana population and among the Health Plans. In 2013, 407,009 people had diabetes in the overall Louisiana population and 21,131 Health Plan adult enrollees were identified with diabetes. Of the Louisiana population with diabetes, 43.2% were male while 56.9% were female. For the Health Plan members identified, 28.7% were male while 71.3% of this group were female. (Figure 2)

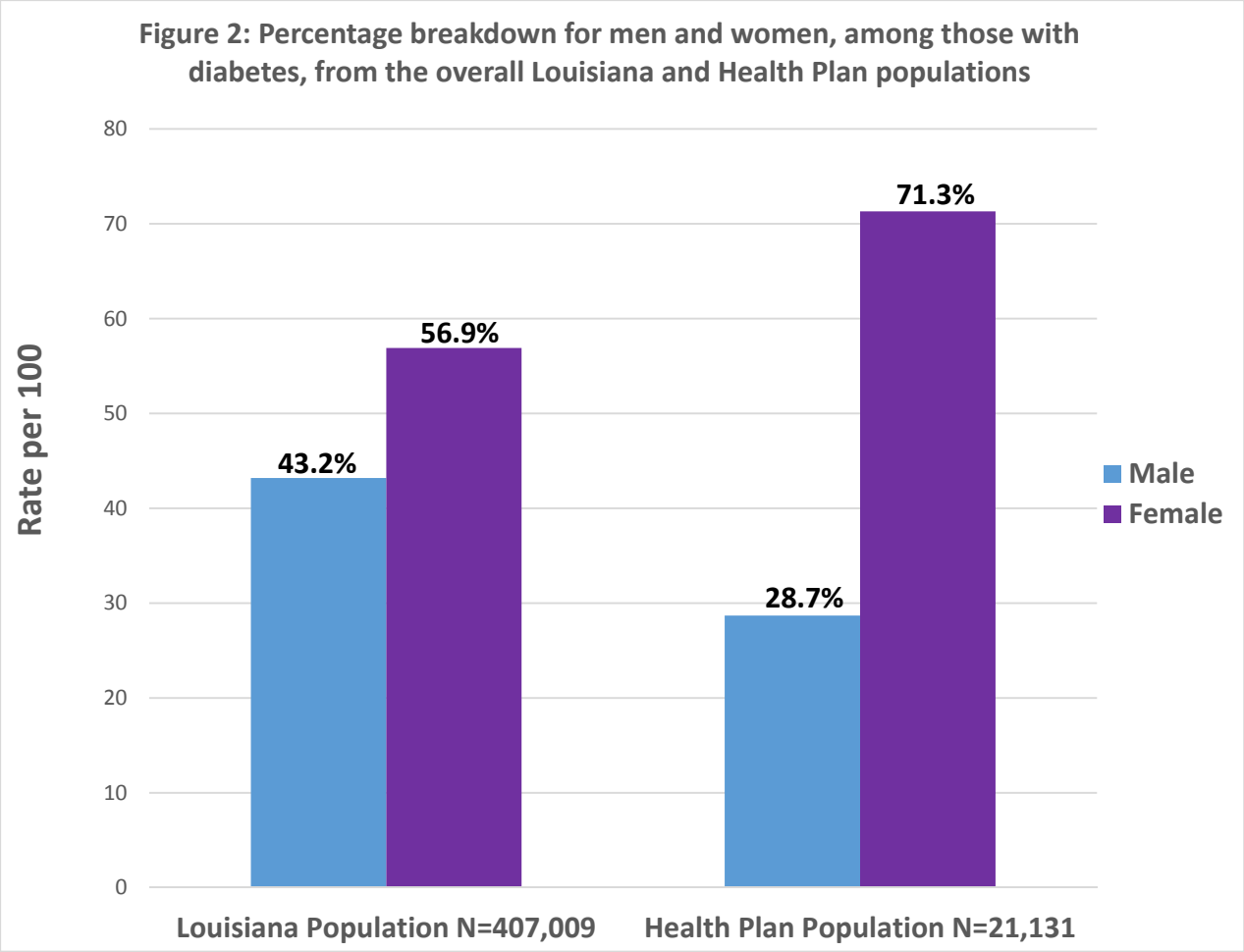

Table 2 shows the number of Health Plan members by parish and sex identified with diabetes. Overall, most parishes had more female members with diabetes than male members. Three parishes (East Baton Rouge, Jefferson and Orleans) had more than 1,000 total members identified with diabetes. (Table 2)

Table 2: Total Number of Health Plan Members with Diabetes in 2013 by Parish[1] and Sex

PARISH	FEMALE	MALE	TOTAL
TOTAL	**9,849**	**3,904**	**13,753**
Acadia	176	64	240
Allen	68	26	94
Ascension	165	48	213
Assumption	70	21	91
Avoyelles	120	56	176
Beauregard	66	17	83
Bienville	49	16	65
Bossier	160	57	217
Caddo	553	239	792

Calcasieu	315	133	448
Caldwell	14	10	24
Cameron	2	1	3
Catahoula	37	19	56
Claiborne	48	19	67
Concordia	77	20	97
DeSoto	40	19	59
East Baton Rouge	**736**	**304**	**1,040**
East Carroll	42	8	50
East Feliciana	60	33	93
Evangeline	116	49	165
Franklin	57	21	78
Grant	37	20	57
Iberia	211	71	282
Iberville	112	37	149
Jackson	25	13	38
Jefferson	**826**	**340**	**1,166**
Jefferson Davis	55	26	81
Lafayette	330	138	468
Lafourche	189	43	232
LaSalle	26	10	36
Lincoln	54	28	82
Livingston	169	67	236
Madison	49	7	56
Morehouse	94	24	118
Natchitoches	103	43	146
Orleans	**1,100**	**544**	**1,644**
Ouachita	324	136	460
Plaquemines	47	20	67
Pointe Coupee	53	20	73
Rapides	358	153	511
Red River	12	6	18
Richland	60	22	82
Sabine	33	21	54
St. Bernard	107	47	154
St. Charles	70	27	97
St. Helena	31	18	49
St. James	49	11	60
St. John	125	18	143
St. Landry	193	68	261
St. Martin	88	49	137
St. Mary	169	62	231
St. Tammany	283	131	414

Tangipahoa	493	176	669
Tensas	18	5	23
Terrebonne	285	85	370
Union	41	14	55
Vermilion	138	38	176
Vernon	71	37	108
Washington	203	66	269
Webster	96	38	134
West Baton Rouge	57	21	78
West Carroll	41	10	51
West Feliciana	27	5	32
Winn	26	9	35

1- Data does not add up to 21,131 due to missing parish data.

Diabetes and Pregnancy

Diabetes is a complication that can be seen during pregnancy. Gestational diabetes is the more familiar complication of pregnancy, but more commonly, pregnancies are occurring in women with pre-existing type 1 or type 2 diabetes. Women with gestational diabetes or pre-existing diabetes are at increased risk for cesarean sections (c-sections). Table 3 shows the number of women in 2013 with pre-existing diabetes and gestational diabetes and the way (vaginal or c-section) that their baby was born among Health Plan members. Gestational diabetes was more commonly identified (2,248 vs. 1,308) than pre-existing diabetes. For both groups, women tended to have a c-section delivery more than a vaginal delivery. (Table 3)

Table 3: Number of Pregnancies in 2013 Identified with Pre-existing Diabetes and Gestational Diabetes and Delivery Route

	Pre-existing Diabetes[1]	**Gestational Diabetes**
Total # of pregnancies complicated	1,308	2,248
Vaginal Deliveries (including forceps and vacuums)[2]	433	588
Cesarean Section Deliveries[2]	517	697

[1] One member had two births during 2013, one vaginal and one c-section

[2] Since not all pregnancies resulted in a delivery the total # of pregnancies may not add up with total # of deliveries

The Health Plans also reported on the costs of pre-existing diabetes and gestational diabetes pregnancies compared to all pregnancies for their population (See Table 4). The highest cost per member was associated with members with gestational diabetes at $7,007 compared to $5,995 for pre-existing diabetes (Table 4). Pregnancies complicated by all diabetes (pre-existing diabetes and gestational diabetes) cost the Health Plans more than $23 million in 2013.

Table 4: Total Amount Paid in 2013 for Pre-existing Diabetes, Gestational Diabetes and all Pregnancies

Pregnancy Type	# of Members	Total Amount Paid	Average Total Paid per Member
Pre-existing Diabetes with Pregnancy	1,106	$6,630,727.21	$ 5,995.23
Gestational Diabetes with Pregnancy	2,367	$16,585,975.37	$ 7,007.17
Diabetes Complicated Pregnancies	3,473	$23,216,702.58	$ 13,002.40
All Pregnancies	41,638	$282,289,306.48	$ 6,779.61

The Financial Impact of Diabetes and its Complications

Estimated Costs of Diabetes

The American Diabetes Association estimates that the largest component of medical expenses attributed to diabetes is for hospital inpatient care at 43% of the total medical cost.[4] Given that inpatient hospital care is such a large component of diabetes costs[4], examining Louisiana's data on diabetes hospitalization costs is important to understanding its impact on individuals, families and the state. This data also serves as a reflection of how well diabetes is, or is not, managed by the healthcare system.

Hospitalization Costs Due To Diabetes

An inpatient hospital discharge record includes all information from admission to discharge. An ED record includes visits to an ED that do not result in an inpatient admission. ED records also include data of patients that are held for an observation stay but not admitted as an inpatient to a hospital. This report includes hospital discharge and ED visit data for 2013.

Table 5 shows the number of inpatient hospital discharges in which diabetes was coded, on the discharge paperwork, as the primary (principal) diagnosis for admission by parish. The principal diagnosis or primary diagnosis is defined in the Uniform Hospital Discharge Data Set (UHDDS) as "that condition established after study to be chiefly responsible for occasioning the admission of the patient to the hospital for care". The principal diagnosis is not always the admitting diagnosis, but the diagnosis found after workup or even after surgery that proves to be the reason for admission most serious and/or resource intensive during that hospitalization.

Table 5 also shows the percent of overall inpatient discharges that was due to diabetes and the amount paid by Bayou Health for these hospitalizations. In 2013, there were total of 1,946 inpatient hospital discharges for which the principal diagnosis was diabetes which was 10% of the overall inpatient discharges in 2013. The parish with the most diabetes related discharges was Tangipahoa with 139 discharges followed by Orleans with 128. (Table 5) The total paid by Health Plans for diabetes related inpatient admission amounted to $ 8,964,244.79.

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

Table 5: Inpatient Hospital Discharges by Parish[1] with Diabetes as the Primary Diagnosis

Parish	Discharges	% of Overall Discharges Due to Diabetes	Total Paid for Diabetes Hospitalization[2]
TOTAL	**1,940**	**9.8%**	**$ 8,964,244.79**
Acadia	22	7.3%	$ 121,947.54
Allen	20	29.2%	$ 198,783.48
Ascension	21	5.3%	$ 30,384.99
Assumption	6	12.5%	$ 6,938.05
Avoyelles	21	18.7%	$ 226,299.68
Beauregard	5	3.6%	$ 27,631.96
Bienville	3	8.3%	$ 6,781.13
Bossier	23	14.5%	$ 150,627.46
Caddo	94	15.8%	$ 426,900.54
Calcasieu	73	15.1%	$ 388,409.10
Caldwell	5	0.0%	$ 19,041.26
Cameron	0	0.0%	$ -
Catahoula	5	20.8%	$ 47,580.92
Claiborne	7	2.9%	$ 22,035.26
Concordia	16	19.0%	$ 147,824.99
DeSoto	7	12.5%	$ 24,334.47
East Baton Rouge	105	16.0%	$ 645,268.05
East Carroll	7	7.0%	$ 41,623.06
East Feliciana	10	17.2%	$ 55,574.00
Evangeline	43	27.5%	$ 312,934.60
Franklin	4	6.1%	$ 37,710.29
Grant	8	9.1%	$ 50,542.38
Iberia	41	10.9%	$ 99,687.05
Iberville	13	26.8%	$ 74,319.42
Jackson	2	3.2%	$ 1,040.81
Jefferson	119	24.0%	$ 865,174.60
Jefferson Davis	8	4.9%	$ 36,303.42
Lafayette	52	5.4%	$ 223,737.56
Lafourche	13	6.3%	$ 79,375.60
LaSalle	25	35.2%	$ 26,115.81
Lincoln	20	18.8%	$ 82,366.48
Livingston	31	14.6%	$ 110,341.68
Madison	14	11.4%	$ 56,878.08
Morehouse	22	27.0%	$ 93,959.80
Natchitoches	15	15.0%	$ 89,769.31
Orleans	128	14.0%	$ 703,451.68
Ouachita	84	21.2%	$ 428,081.65

Plaquemines	10	21.4%	$	65,147.39
Pointe Coupee	2	0.0%	$	3,535.34
Rapides	67	18.2%	$	312,642.34
Red River	5	8.0%	$	44,854.42
Richland	5	7.6%	$	15,897.83
Sabine	3	0.0%	$	7,070.68
St. Bernard	31	8.5%	$	85,742.86
St. Charles	10	13.6%	$	109,883.01
St. Helena	9	21.8%	$	57,871.28
St. James	17	38.5%	$	62,324.14
St. John	27	19.2%	$	220,875.92
St. Landry	28	14.2%	$	278,890.74
St. Martin	6	4.4%	$	18,682.08
St. Mary	15	14.3%	$	24,914.47
St. Tammany	65	17.9%	$	171,618.02
Tangipahoa	139	17.4%	$	781,069.20
Tensas	0	0.0%	$	-
Terrebonne	30	11.6%	$	183,401.21
Union	13	20.4%	$	79,687.87
Vermilion	9	4.5%	$	49,913.48
Vernon	16	8.6%	$	35,234.71
Washington	7	5.5%	$	44,766.12
Webster	30	12.8%	$	142,336.41
West Baton Rouge	0	0.0%	$	-
West Carroll	24	10.6%	$	157,725.85
West Feliciana	5	22.7%	$	50,383.26
Winn	1	2.5%	$	-

1-Not all Health Plans reported data by parish 2- Dashes represent parishes without a payment for 2013

Specific Diabetes Complications as Principal Diagnosis for Inpatient Hospital Discharges

Hospitalizations for diabetes may occur due to a variety of common complications of the disease. All of the complications discussed in this section of the report are identified from the principal diagnosis code assigned by the physician during the hospital stay. Again, the principal diagnosis is defined as the condition responsible for admission of the patient to the hospital for care. Table 6 shows inpatient discharges in 2013 where a complication of diabetes was the primary diagnosis as well as the total percent of inpatient discharges that was due to a diabetes complication and the total paid by the Health Plans for these complications.

The most frequent diabetes complication associated with an inpatient hospital discharge was diabetic ketoacidosis or DKA which accounted for 55% of all inpatient hospital discharges due to diabetic complications. (Table 6) DKA is a life-threatening complication in which ketones (fatty acids) build up in the blood due to a lack of insulin. DKA related hospitalizations had a total cost of $ 1,533,219.95.

Table 6: Inpatient Hospital Discharges in 2013 where a Diabetic Complication was the Primary Diagnosis

Diabetic Complications	Discharges	Total % of Overall Discharges Due to Complications[1]	Total amount Paid for Diabetes Complications
(250.1) Ketoacidosis	691	54.8	$ 1,533,219.95
(250.0) Without Mention of Complication	169	19.9	$ 310,422.03
(250.8) With Hypoglycemic Manifestations	157	10.7	$ 985,003.97
(250.6) With Neurological Manifestations	117	9.5	$ 345,256.86
(250.2) Hyperosmolarity	41	2.2	$ 243,335.82
(250.7) With Peripheral Circulatory Disorders	40	1.6	$ 553,484.54
(250.4) With Renal Manifestations	14	1.1	$ 40,808.52
(250.9) With Unspecified Complications	13	1.2	$ 3,942.70
(250.3) With Other Coma	7	0.2	$ 2,401.41
(250.5) With Ophthalmic Manifestations	2	0.0	$ -

1- Due to rounding the total may not equal 100 2- Dashes represent parishes without a payment for 2013

The second and third most frequent diabetic complication causing hospitalization were "diabetes without mention of complication" at 20% and "diabetes with hypoglycemic manifestations," at 11% of all discharges related to these complications. The total cost for these two complications were $310,422.03 and $ 985,003.97 respectively.

Emergency Department Visits Due to Diabetes

Table 7 below shows, by parish, the number of ED visits from the Health Plans due to diabetes, percent of all ED visits in Louisiana, and the amount paid for ED visits from the Health Plans in which diabetes was the primary diagnosis. In 2013, a total of 2,055 ED visits occurred in which diabetes was the primary diagnosis, which amounted to 2% of all ED visits in Louisiana. The parish EDs that got paid the most for diabetes related visits were located in Orleans at over $51,000 with the next two highest paid amounts for ED visit due to diabetes coming from East Baton Rouge at $49,000 and Caddo at $38,000.

Table 7: Total ED Visits per Parish[1] where Diabetes was the Primary Diagnosis

Parish	# of ED Visits Due to Diabetes	% of Overall ED Visits in LA	Amount Paid for ED visits due to Diabetes
TOTAL	**2,055**	**2.2%**	**$ 576,135.60**
Acadia	35	0.038	$ 8,796.17
Allen	7	0.004	$ 3,119.08
Ascension	46	0.026	$ 15,306.52
Assumption	14	0.031	$ 3,600.58
Avoyelles	33	0.043	$ 12,897.40
Beauregard	14	0.016	$ 3,842.73
Bienville	1.1	0.003	$ 590.14

Bossier	28	0.033	$	6,541.93
Caddo	**149**	**0.143**	**$**	**38,617.85**
Calcasieu	96	0.100	$	29,695.37
Caldwell	3	0.004	$	2,883.90
Cameron	2	0.002	$	1,365.78
Catahoula	8	0.007	$	1,556.94
Claiborne	4	0.008	$	947.47
Concordia	16	0.010	$	4,565.57
DeSoto	4	0.009	$	724.56
East Baton Rouge	**207**	**0.245**	**$**	**49,637.00**
East Carroll	4	0.007	$	3,447.93
East Feliciana	0.1	0.000	$	88.63
Evangeline	35	0.039	$	10,938.90
Franklin	12	0.009	$	8,144.42
Grant	5	0.005	$	1,034.15
Iberia	47	0.052	$	9,435.64
Iberville	10	0.015	$	1,513.35
Jackson	3	0.006	$	983.10
Jefferson	124	0.126	$	33,789.60
Jefferson Davis	17.3	0.016	$	8,884.98
Lafayette	103	0.088	$	22,697.39
Lafourche	18	0.025	$	8,433.18
LaSalle	6	0.004	$	860.85
Lincoln	18	0.025	$	3,578.54
Livingston	19	0.025	$	5,460.90
Madison	2	0.006	$	939.23
Morehouse	8.3	0.006	$	2,764.59
Natchitoches	16	0.012	$	3,667.85
Orleans	**193**	**0.215**	**$**	**51,384.77**
Ouachita	81	0.062	$	18,812.37
Plaquemines	6	0.016	$	1,308.26
Pointe Coupee	11	0.006	$	6,733.20
Rapides	108	0.123	$	22,389.00
Red River	4	0.001	$	1,758.81
Richland	4	0.005	$	1,383.38
Sabine	9.3	0.010	$	1,965.06
St. Bernard	21	0.018	$	5,744.79
St. Charles	5	0.005	$	1,529.46
St. Helena	10	0.018	$	7,266.17
St. James	7.1	0.007	$	6,444.88
St. John	32	0.057	$	7,832.75
St. Landry	85	0.091	$	18,972.83
St. Martin	25	0.025	$	6,152.65

St. Mary	43	0.042	$	9,779.07
St. Tammany	42	0.048	$	14,338.49
Tangipahoa	86	0.076	$	24,900.37
Tensas	2	0.002	$	1,232.65
Terrebonne	47	0.033	$	9,630.73
Union	4	0.005	$	2,519.87
Vermilion	9	0.010	$	2,233.16
Vernon	33	0.034	$	18,043.75
Washington	31	0.032	$	12,442.75
Webster	14	0.014	$	4,368.75
West Baton Rouge	15	0.017	$	2,279.98
West Carroll	1	0.001	$	516.32
West Feliciana	4	0.004	$	1,222.62
Winn	8	0.007	$	1,596.49

1-Not all Health Plans reported data by parish

Table 8 shows ED visits in 2013 where a complication of diabetes was the primary diagnosis for the visit. A total of 3,622 ED visits for diabetes complications occurred in 2013. The most common diabetes complication causing an ED visit was "diabetes without mention of complication" at 58% which was followed by "diabetes with hypoglycemic manifestations," at 19% of all diabetic complication related ED visits in 2013.

Table 8: Emergency Department Visits in 2013 where a Diabetic Complication was the Primary Diagnosis

Diabetic Complications	**Total Visits**
(250.0) Without Mention of Complication	2,091
(250.8) With Hypoglycemic Manifestations	703
(250.1) Ketoacidosis	369
(250.6) With Neurological Manifestations	346
(250.9) With Unspecified Complications	59
(250.7) With Peripheral Circulatory Disorders	19
(250.2) Hyperosmolarity	16
(250.4) With Renal Manifestations	12
(250.5) With Ophthalmic Manifestations	6
(250.3) With Other Coma	1
Total	3,622

Diabetes and other Common Chronic Conditions

Comparing the Burden of Diabetes with other Common Chronic Conditions
The statute which defines the content of this report requires a comparison of the financial burden or impact of diabetes to that of other common chronic conditions. This section of the report looks at the relationship between diabetes and other common chronic conditions, by comparing its prevalence, cost per member and total cost for 2013 with other chronic disease as shown in Table 9.

Among the members of the Health Plans with chronic conditions, asthma was the most prevalent among 36,776 members followed by hypertension among 32,923 members. Diabetes was the third most common chronic conditions among 14,310 Bayou Health members.

Table 9: Comparison of Prevalence and Cost between Diabetes and Other Common Chronic Diseases

Chronic Disease	# of Members	Per Member Cost	Total Cost
Hypertension	32,923	$ 23,723.90	$ 168,114,064.30
Asthma	36,776	$ 15,443.18	$ 130,767,361.45
Diabetes	14,310	$ 39,780.60	$ 125,179,913.06
Arthritis	10,402	$ 25,911.49	$ 55,569,790.69
Congestive Heart Failure	2,922	$ 93,539.19	$ 54,904,451.75
COPD	6,281	$ 36,215.81	$ 54,636,513.53
Coronary Heart Disease	4,508	$ 50,291.35	$ 54,081,309.49

It is always important to remember that diabetes does not exist in a vacuum – people with diabetes often have additional chronic illnesses that impact their ability to self-manage their diabetes and which provide additional diabetes management challenges to their doctor. The top two medical conditions that resulted in the most expensive cost per member were for cardiovascular conditions which are related to diabetes and they are: congestive heart failure which cost $93,539.19 per member and coronary heart disease at $50,291.35 per member. (Table 9) In terms of total cost, the most expensive chronic conditions among members for 2013 was hypertension at $ 168,114,064.30. (Table 9)

Current Diabetes Management Efforts

The Department of Health and Hospitals, Bureau of Health Services Financing, and the Office of Public Health support a number of interventions related to diabetes.

Office of Public Health – Health Promotion Team

DHH's Health Promotion Team understands the financial and lifestyle burden of diabetes in Louisiana. To address these concerns, the Health Promotion Team's efforts and funds are focused on increasing the use of diabetes self-management programs in community settings, implementation of quality improvement processes in health systems and the use of team-based care in health systems. These goals will be achieved by the following interventions:

- Increase access, referrals and reimbursement for American Association of Diabetes Educators (AADE)-accredited, American Diabetes Association (ADA)-recognized, and state-accredited or certified DSME programs.
- Increase electronic health records (EHR) adoption and the use of health information technology (HIT) to improve performance.
- Increase the institutionalization and monitoring of aggregated/standardized quality measures at the provider and systems level.
- Increase engagement of non-physician team members in diabetes management in health systems.

The Health Promotion Team will work to implement these interventions by developing partnerships with internal and external agencies and programs. Current efforts are described below.

Community Mobilization: Create and maintain active partnerships at the state and local levels to jointly pursue issues related to diabetes in communities, among health care providers, persons with diabetes and those at risk for diabetes. The Health Promotion Team has had great success in mobilizing partnerships to identify and address diabetes-related issues. The Team has developed partnerships with the Louisiana Diabetes Coalition, Louisiana Obesity Prevention and Management Commission, Blue Cross Blue Shield of Louisiana, EQHealth Solutions, Louisiana Medicaid, Louisiana Health Care Quality Forum and the Baton Rouge and Greater New Orleans Area YMCAs.

Diabetes Self-Management Education and Support: A variety of educational programs/classes are available in communities across Louisiana to educate and support people with, or at risk for, diabetes. Classes include information, tools and resources to assist persons with diabetes to better manage their disease. The AADE and the ADA have self-management programs based across the state. The National Diabetes Prevention Program is an evidence-based Lifestyle Change Program for preventing type 2 diabetes funded by the CDC. The CDC selected AADE to assist in expanding the National Diabetes Prevention Program (DPP) by working within existing sites.

The Health Promotion Team has plans to collaborate with the OPH Bureau of Primary Care and Rural Health to implement the Diabetes Safe at School Bill with the School Based Health Centers across the state. Senate Bill 759 from the 2012 Louisiana Legislative Session authorizes a school nurse or unlicensed diabetes care assistant to provide care for a student with diabetes, or assist a student with the self-care of diabetes. An unlicensed diabetes care assistant is a school employee who volunteers to be trained to assist students with diabetes if a school nurse is not available.

Accredited DSME Programs in Louisiana		
ADA	AADE	DPP*
35	12	2

*Sites represented may be AADE and ADA accredited programs, but are funded by the AADE as a Diabetes Prevention Program (DPP).

Well-Ahead Program: On April 14, 2014, DHH launched a campaign aimed at improving the health and wellness of Louisiana residents. Well-Ahead is a core component of Louisiana's solution to environmental change to make it easier for people to make healthier choices. DHH staff work closely with restaurants, schools, worksites, local governments, hospitals and universities to implement tobacco-free policies, ensure healthy lunch options or support work place fitness programs toward the ultimate goal of becoming a designated Well Spot. As of January 2015, 75 organizations in Louisiana were designated Well-Spots.

Public Awareness and Education: The Health Promotion Team has partnered with the Baton Rouge and Greater New Orleans Area YMCAs and the DHH Bureau of Media and Communications to develop messages that improve awareness and utilization of the YMCA DPP programs for state employees. The team is also collaborating with DHH human resources professionals to support the Office of Group Benefits (OGB) health screenings. The OGB screenings, conducted by Catapult Health, included biometric tests. These tests screen for both diabetes and pre-diabetes. Additionally, any state employee identified as pre-diabetic is eligible for participation in the Omada Health Prevent program. The Prevent program is an online diabetes self-management curriculum created by the National Institutes of Health.

Professional Education and Health System Quality Improvement: The Health Promotion team will collaborate with the Louisiana Healthcare Quality Forum to increase adoption and use of HIT by hosting a series of webinars focused on hypertension management, diabetes management and prescription and medication adherence. The diabetes management sessions will be conducted three times during the project year and are focused on teaching clinicians how to optimize EHR functions to track their clinic's quality measures related to diabetes care.

Surveillance and Evaluation: The Health Promotion Team works closely with the DHH Center for Public Health Informatics (CPHI) and Pennington Research Center to enhance and assess data and evaluate program efforts across the state. A key part of this effort is the addition of a pre-diabetes module to the Louisiana state Behavioral Risk Factor Surveillance System.

Funding:

OPH receives CDC funds which are used to support state-level diabetes personnel and operating costs, support epidemiological and evaluation efforts and special projects. OPH receives $350,000 in diabetes-specific funding from the CDC National Center for Chronic Disease Prevention and Health Promotion.

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Conclusion

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

Acknowledgments

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APPENDIX A- ACT 210 Legislation

RS 46:2616

CHAPTER 46. HEALTH ACTION PLANS

§2616. Diabetes annual action plan; submission; content

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

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

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

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

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

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

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

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

RS 46:2617

§2617. Obesity annual action plan; submission; content

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

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

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

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

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

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

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

APPENDIX B- Committee Members

Diabetes/Obesity Committee Members— 2014–2015

Committee Member	Organization	Title
Rebekah Gee	DHH	Medicaid Medical Director
Joshua Hardy	DHH	Section Chief
Beverly Hardy-Decuir	DHH	Medicaid Quality Program Director
Dawn Love	DHH	Medicaid Policy & Compliance
Angela M. Marshall	DHH	Medicaid Program Manager
Ekwutosi Okoroh	DHH-CDC	CDC-Medicaid Medical Epidemiologist
Caroline Brazeel	OPH	Health Promotion/Chronic Disease Director
Takeisha Davis	OPH	OPH Medical Director
Jamila Freightman	OPH	1305 CDC Public Health Advisor
Trampas Cranford	ACLA	Medical Economics Data Analyst
Kathy Donohue	ACLA	Interim Director of Quality Management
Rebecca Engelman	ACLA	Market President
Fred Hill	ACLA	Regional Chief Medical Officer
Letty Russell	ACLA	Manager of Medical Economics
Agnes Robins	ACLA	Quality Performance Specialist Clinical
Yolanda Spooner	ACLA	Medical Director
Kyle Viator	ACLA	Director of Plan Operations and Administration
Quanetta Davenport	Amerigroup	Financial Analysis Manager
Deborah Junot	Amerigroup	Interim Director or Quality
Virginia Plaisance	Amerigroup	Director of Healthcare Management Services
Marcus Wallace, MD	Amerigroup	Manager Medical Director
Lawa Clouatre	CHS-LA	Clinical Services Manager
Stewart Gordon	CHS-LA	Chief Medical Officer
Joy Zylinski	CHS-LA	Quality and Healthcare Economics Analyst
Melder Burton	LHCC	Data Analytics and Reporting Manager
FeLisa Carpenter	LHCC	Workforce Analyst
William Dalton	LHCC	Data Analyst
Ryan Jenkins	LHCC	Data Analyst
Lani Roussell	LHCC	QI Manager
David Thomas	LHCC	Medical Director
Ann Logarbo	United	Medical Director
Angela Olden	United	Director of Quality Management
Linda Rintala	United	Director of Health Services

APPENDIX C- Health Plans' Action Plans

This section details the actionable items to address diabetes by each Health Plan.

APPENDIX C1- AMERIGROUP LOUISIANA, INC. (AMG)

AMERIGROUP LOUISIANA, INC. (AMG)

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 an initial and follow up general assessment along with specific diabetes and obesity assessments (when applicable). 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. The DM HRA includes assessment of height and weight followed by a calculation of BMI (or BMI percentile for children). Results of the HRA are used to develop a tailored, member-centric plan of care and drive both the intensity and frequency of follow-up outreach. Members receive written and verbal educational materials and a My Health Solution Plan, which is the agreed upon care plan written in member friendly terms. The member's primary provider receives information on the program, key findings of the assessment and a copy of the plan of care along with the relevant clinical practice guideline.
- Care Managers monitor and follow-up with members and collaborate with the health care team to adjust the care plan as appropriate based on the unique needs of the individual member. A follow up assessment is completed on subsequent contacts following initial enrollment. The plan of care, stratification and follow up schedule may be adjusted based on new information gathered during the follow up assessment process. Members receive periodic status letters and updated copies of their My Health Solution Plan when changes occur. Providers receive status update letters along with the care plan when changes in the member's status occur or when new issues are identified.
- 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 2014 (through November), 5,255 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 2014:
    - 99.3% report being satisfied with the responsiveness and courtesy of DM Care Managers
    - 96.7% report overall satisfaction with the DM Programs
    - 81.3% feel the DM Programs facilitates better communication with their providers
    - 86.0% 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 and average **BMI decrease of 7.3%**.

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 primary 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 and continued the pilot into 2014. Amerigroup plans to continue the teen program into 2015. Note: Members are identified by their age and outreach is conducted to determine appropriateness and interest in the program. Members can also be referred to the program by their provider, self-referral or referral from another Amerigroup program such as Case Management. 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.

Nurse coaches work with members to set goals and develop small, doable steps to meet the member where they are. 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 nurses 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 many 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. Our nurse coaches use regional lists of available programs and activities to guide the member to resources available in their area. Nurse coaches also collaborate with local resources 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.
- **72 Louisiana families** participated in the standard Healthy Families program in 2014; **ten Louisiana families** participated in the teen pilot in 2014.
    - Note: On average enrolled members have demonstrated the following during 2014:
- 9.27% decrease in consumption of sugary beverages
- 1.44% decrease in BMI percentile
- 3.46% increase in fruit/vegetable servings
- 3.20% increase in 8 ounce servings of water
- 0.62% decrease in screen time
- 0.52% increase in 30 minute activity sessions

APPENDIX C2- AMERIHEALTH CARITAS LOUISIANA (ACLA)

AMERIHEALTH CARITAS LOUISIANA (ACLA)

AmeriHealth Caritas Louisiana's (ACLA) mission is to assist people to get health care, stay well and build healthy communities with a special concern for those who are poor. To achieve this mission, the plan's top priority is multifaceted and includes a focus on quality programs and initiatives while promoting the development of partnerships with network providers and agencies that support the plan's clinical and service activities. AmeriHealth Caritas Louisiana has been successful in certain areas of quality improvement, while remaining challenged in others. The plan's improvements are attributed to strong interventions. ACLA continues to address the growing prevalence of diabetes in Louisiana as well as the economic burden of this disease. Key efforts are described below:

ACLA INITIATIVES

- **Integrated Care Management (Case Management):** ACLA's Integrated Care Management Program uses multiple facets to address the needs of the member at different levels of care. Our Rapid Response Outreach Team manages members with acute needs. The Complex Care Management team manages members needing more complex integrative interventions and extensive disease specific management. There is an additional resource, the Community Care Management Team (CCMT) which is triggered as needed for high risk members needing individualized face-to-face interventions sometimes in combination with telephonic care management.

  The primary focus of the disease management program is to identify and engage high risk members who have high ER utilization, frequent hospitalizations, poor medication adherence, inadequate health management and poor clinical outcomes. High risk members with diabetes are identified by both stratification methods utilizing data analysis and/or referrals. The goal of the disease management program is to assist members with diabetes to better manage their disease through collaboration between ACLA care managers, the patient, primary care provider, specialist and the community as needed. Ultimately, the care managers teach self-management skills and teach members to be self-sufficient. The care managers work one-on-one focusing on diabetes management, medication compliance, monitoring the member's response to treatment plan and self-management. The goal is to improve the member's clinical outcomes such as HgbA1C testing compliance, obtaining appropriate immunizations such as flu and pneumonia, compliance with preventive measures such as eye examinations. Please see attached blue prints which have been reviewed and approved by the Quality of Clinical Care committee consisting of ACLA medical directors and external providers.

- **Care Gaps:** ACLA utilizes all encounter opportunities to educate members concerning self-management as the various departments such as member services, rapid response and case management address care gaps related to diabetes. Providers are able to address care gaps through the use of a provider portal (Navinet).

- **Member/ Provider Incentives:** Promotion of incentives to members and providers to encourage better health maintenance. ACLA identifies members who are identified as having a gap in care (e.g. needs hgba1c testing) and incentivize those members to see their provider to have the test completed. ACLA identifies providers with members needing care gaps addressed and assists by having lists available in Navinet and/or provided by an account executive.

- **Quality Enhancement Programs**. Provider incentive payment for their performance relative to their peers of the same specialty type. ACLA collaborates with providers through support of the usage of Navinet's Clinical Summary Report and Care Gaps.

- **Professional Education and Health System Quality Improvement:** Conduction of HEDIS trainings for providers and practice managers to discuss HEDIS requirements and billing procedures. In addition, ACLA creates/distributes updated HEDIS Coding Guideline Cards to providers and high volume laboratories.

- **Community Mobilization:** Create/maintain active partnerships at the state and local levels to jointly pursue issues related to diabetes in communities, among health care providers, persons with diabetes and those at risk for diabetes. This is often accomplished by forming and maintaining local diabetes coalitions to address local needs. ACLA has had great success in mobilizing partnerships to identify and address diabetes-related issues. ACLA collaborates with a local vendor for a one day Diabetes Boot Camp for members to offer diabetes education and HbA1C screenings.

- **Public Awareness/Education:** Promote education campaigns and messages that improve awareness of diabetes prevention and control to the general public. This is currently being accomplished through the distribution of educational material to the general public, newspaper articles and media interviews.

ACLA ACCOMPLISHMENTS

- **"Make Every Calorie Count":** Our program targets members with diagnosis of Obesity and other co-morbidities such as diabetes. Members have to commit to engage in CM Program. Once engaged, they receive telephonic case management addressing Disease and weight management from an RN. Members receive a "Make Every Calorie Count" Welcome Packet which includes: pedometer, tape measure, welcome booklet and calorie/activity journals. These tools are used as teaching tools as the CM educate/motivate and develop individualized plans of care. Starting Feb. 1 2015, members engaged in "Make every calorie count" program will be eligible to receive nutritional counselling services.
- **Training in the care of members with Gestational Diabetes.** This specialized training was provided to our Care Managers by Alere which has enabled us to better manage our members who are expecting and have diabetes.
- **Expanded Medication Benefit:** Increased provider payments for Pneumonia vaccines which compensates for the total cost of the medication. This initiative increases the ability of members to obtain the needed vaccination.
- **Improvements in Diabetes specific performance measures for 2014.**
    - Decreased HgbA1C poor control rate by 10%
    - Improved HgbA1C <8 rate by 8%

- Improved BP level <140/90 rate by 1%

- **2014 Disease Management Satisfaction Survey:**
  - The percentage of members who responded that the care managers answered their questions about Asthma or diabetes was 79.11%.
  - The percentage of members who indicated that the Care Manager helped them learn about Asthma or diabetes was 83.33%.
  - The percentage of members who stated they felt they are better able to self-manage their diabetes or Asthma after speaking to a Care Manager was 81.33%.
  - The percentage of members who said they will contact the Care Manager if they had questions in the future was 87.63%.

ACLA ACTION PLAN

ACLA has identified significant opportunities as a call to action that builds upon past accomplishments, and takes full advantage of national, state and local efforts already underway to improve diabetes education, management and care in Louisiana.

- **Member Education:** There is an opportunity to increase the awareness and referrals to certified Diabetes Self-Management Education programs available statewide as well as the availability of ACLA's case management. In addition, ACLA is planning to distribute continuous outreach letters to members concerning gaps in care to improve treatment compliance.

  The data analysis report revealed that there should be a focus on our pregnant members diagnosed with gestational diabetes. ACLA's maternity program, Bright Start, can provide care management for these members.

- **Professional Education and Health System Quality Improvement:** Provide access to current continuing education for health care professionals, as well as, information and tools to assist providers in serving people with, and at risk for, diabetes. ACLA plans to participate with other groups in activities aimed at improving the quality of diabetes care. ACLA will also increase the promotion of preventive care guidelines for health care professionals to increase adherence.

- **Surveillance and Evaluation:** Monitor data to assess the impact of diabetes, plan appropriate interventions and evaluate program efforts. ACLA plans to share data about the impact of diabetes in Louisiana with the public via media, publications, presentations, websites, etc. ACLA will conduct geographical provider trending and analysis of care gaps, along with a statistical evaluation of social factors that may offer specific barriers in specific locations for members.

- **Enterprise Commitment**
  The management of our members who have diabetes has been recognized and moved to a heightened level in our corporate wide efforts. We have begun to work together as an enterprise to improve the care of our members who are diabetic with a focus on HbA1C testing, retinal eye exams, and the monitoring for nephropathy.

- **Collaboration with Governing Bodies**. ACLA will work with the DHH to meet the performance measure target for improvement of decreasing the number of discharges for diabetes short term complications for ages 18 and older.

  ACLA will continue to work with the DHH subcommittee to decrease non-emergent ER utilization.

- **Support Policies**. ACLA plans to support policies related to having laboratories, operating in Louisiana, submit the results of the key diabetes blood sugar test called A1C to Louisiana Health Information Exchange.

- **Collaboration with Governmental Agencies.** Support the collaboration of Health Plans with the Office of Public Health in the sharing of data information.

- **Investigation of Best Practices.** The identification of best practices, utilized across the nation, will assist us to better motivate members toward care.

ACLA remains very committed to identify ways to simultaneously reduce overall expenditures while improving the delivery of evidence-based, cost effective prevention and health services that improve population health. We believe that additional funding to support nutritional and Diabetes Self-Management Education (DSME) programs for members, along with appropriate educational in-services for educators by the experts will be very helpful. Given the increase in diabetes prevalence in Louisiana over the past decade, and the projected quadrupling by 2040, ACLA is concerned that escalating healthcare costs resulting from complications of poorly controlled diabetes will continue to put pressure on our ability to afford and sustain the health care delivery system. This poses a simultaneous threat at multiple levels: fiscally for the Legislature and Louisiana communities and to the health and quality of life of Louisianans. ACLA believes success can be achieved through systematic health screenings and preventive care, coordination of care management of chronic conditions and proactive health care education. It is through the plan's quality initiatives and the planned clinical and services activities that improvements in our members' health and quality of life can be realized.

Louisiana Diabetes Management Blueprint

Disease State	Diabetes
Importance to Louisiana	

Diabetes Mellitus

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 is a significant threat to these people's health.

According to the CDC in 2010, 25.8 million Americans of the United States population had diabetes (an 8.3% prevalence; 95% type 2), 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.[1] This increase in patients diagnosed with diabetes represents a 28% increase from 2005 alone.[2]

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. African American and Hispanic adults are twice and 1.7-times as likely as non-Hispanic white adults to have been diagnosed with diabetes by a physician.[3] The disease is also increasing in children, with a reported 3,600 newly diagnosed cases of pediatric type 2 diabetes between 2002 and 2005.[4]

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[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.

[1] CDC, 2011 National Diabetes Fact Sheet: Diagnosed and undiagnosed diabetes in the United States, all ages, 2010, Diabetes Public Health Resource, http://www.cdc.gov/Diabetes/pubs/estimates11.htm; accessed on 2/28/2014.

[2] CDC, Number (in Millions) of Civilian, Noninstitutionalized Persons with Diagnosed Diabetes, United States, 1980–2011, Diabetes Public Health Resource, http://www.cdc.gov/diabetes/statistics/prev/national/figpersons.htm; accessed on 2/28/2014.

[3] Schiller JS, Lucas JW, Ward BW, Peregoy JA. Summary health statistics for U.S. adults: National Health Interview Survey, 2010. National Center for Health Statistics. Vital Health Stat 10(252). 2012; Table 8.

[4] The SEARCH for Diabetes in Youth Study Group. The many faces of diabetes in American youth: type 1 and type 2 diabetes in five race and ethnic populations. Diabetes Care 2009;32(Suppl 2):S99–S147.

The total annual economic cost of diabetes in the United States in 2007 was estimated to be $174.4 billion. [5] 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. Thus, people with diagnosed diabetes, on average, have medical expenditures that are approximately 2.3 times higher than those without diabetes. 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.[6]

LA: In 2012, 12.3% of the Louisianan adult population aged 18 years and older was told by a doctor that they have diabetes.[7] In 2009–2010, only 71.1% and 68.5% of Louisianan adults diagnosed with diabetes had at least one prior-year foot examination and dilated eye examination, respectively; 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.[8]

In 2006, the total cost of diabetes to Louisiana was approximately $2.431 billion, includes $1.625 billion in direct medical costs and $806.2 billion in lost productivity.[9] In 2010, the total cost of hospital discharges for people with diabetes in Louisiana was approximately $231 million.[10] 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.

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: 7/2014

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

[5] American Diabetes Association. Economic costs of diabetes in the U.S. in 2007. Diabetes Care. 2008;31 (3):576–615.
[6] American Diabetes Association, 2008 http://www.diabetes.org/diabetes-basics/diabetes-statistics, accessed on 3/3/2014.
[7] America's Health Rankings. United Health Foundation. http://www.americashealthrankings.org; accessed on 3/3/2014.
[8] *Age-adjusted*; Centers for Disease Control and Prevention: National Diabetes Surveillance System. http://apps.nccd.cdc.gov/DDTSTRS/default.aspx; accessed on 3/3/2014.
[9] 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 3/3/2014.
[10] Louisiana Hospital Inpatient Discharge Data (LaHIDD), 2010.

<table>
<tr><td colspan="2">Program Goals</td></tr>
<tr><td colspan="2">

Reduce the number of inpatient hospitalizations and ER visits
Improve management of members identified with diabetes with respect to HEDIS metrics
Improve medication adherence
Increase member compliance to seasonal flu shot
Improve members' self-management skills related to chronic illness through targeted education and collaboration with healthcare providers.
Identify and close care gaps based on best practice and clinical guidelines
Decrease smoking rates among diabetic members
Reach and maintain recommended HgbA1c levels in the diabetic population

</td></tr>
<tr><td>Outcome Measurements</td><td>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)</td></tr>
<tr><td colspan="2">

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)
Nephropathy
Inpatient admissions/1000 members
Emergency room visits/1000 members
Percentage of members showing improvement in SF-12 score after 6 months of engagement

</td></tr>
<tr><td>Stratification & Interventions</td><td>Criteria used to identify diabetes within the population.

New diagnosis of diabetes
Claim diagnosis of diabetes
One Inpatient admission or ER visit in 12 months with primary diagnosis of diabetes.
Members with a diagnosis of diabetes and based on one or more of the following (this list is not inclusive):

Potentially preventable events or PPE (admissions, readmissions, ER visits)
Portion of Days Covered Rate (PDC)
Low Gaps in Care Closure Rate (GIC)

Criteria used to assign member to low- or high-risk group

Program components for low- and high-risk groups

New Members are identified monthly per criteria. Member stratification is updated as needed based upon identified needs as outlined below. Members can move from one level to another as individual needs change.</td></tr>
</table>

	Low Risk	High Risk
Stratification	Member Eligible and any of the following: • Claim Diagnosis of Diabetes (250.xx) on two occasions • New diagnosis of diabetes • Eligibility self-disclosure • No ER visits for diabetes in 1 year • No in-patient admissions for diabetes in 1 year • Pharmacy data showing test strip and/or hypoglycemic medication fill • New Member assessment disclosure of diabetes Prospective 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 criteria members are identified as high risk based on any of the following criteria: • Member with a diagnosis of diabetes with any IP/ER admission in last 3 months • Unstable medical, behavioral health or support situation if applicable per LOB • Pregnant members with an inpatient admission for a primary diagnosis of diabetes. • Member with a diagnosis of diabetes with no pharmacy data showing test strip and/or hypoglycemic medication fill • HgbA1C > 8.5% • No HgbA1C screening in the prior year • New diagnosis of diabetic complication
Interventions	• Welcome letter/educational material mailed to newly identified members • Focused educational Mailings • Monitoring for medication adherence • Annual reminders for flu/pneumonia vaccine • Access to Rapid Response Unit • Access to 24/7 Nurse Line • Smoking Cessation Program referral • Integrated Care Management Assessment per applicable department available upon request • Monitoring for lab screening and results	In addition to low risk interventions, Integrated Care Management services, including: • Comprehensive Assessment • Individualized Care Plan focusing on Priority Interventions (detailed below) • 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 Health risk assessments tools to monitor member outcomes • Provider contact and care plan collaboration • Provide high level supportive services and equipment • Identification, communication and intervention to resolve Gaps in Care • Connection to appropriate community resources and services • Outreach to members with HbA1C > 8.5% • Outreach to members with no HbA1C on file

Participation	☐ opt-in ☒ opt-out
Priority Intervention(s)	Top priorities – no more than 5 *Should reflect clinical guideline measures*

HgbA1c control

- Members should have HgbA1c test every six months
- If result is > 7.0, there should be collaboration with the treating provider re: any changes in treatment plan 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 collaboration with the treating provider re: any changes in treatment plan and a retest in 3 months.

Behavioral Risk Management

Consistent message surrounding impact of:

- Diet- Member should have nutritionist visit for diet plan within last 6 months
- Exercise- Member should discuss exercise plan with PCP/ Specialist
- Cigarette smoking
- ETOH use
- Illicit Drug (e.g. cocaine) use

Self-Management

- Member will have a working glucometer and keep a log of blood glucose levels; have an understanding of when to call the PCP/Specialist
- Improve and increase Self-Management through a sick-day plan and understanding of when to call the PCP/Specialist

PCP visit schedule/screening measures recommendations

- Member with type II diabetes should see physician at least every 4 months; Evaluate need for HgbA1c screen
- Member with type I diabetes should see physician at least every 3 months; 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

Educational Topics and Corresponding Resources	List the topic and the source material: (NOTE: Education resources subject to ACHA approval)

Educational Material from Krames for the "Plan"

- For Kids Ages 12 to 17: Dealing with Diabetes *
- Do You Have Diabetes? *
- Diabetes and Your Child: Understanding Type 2*
- When Your Child Has Type 2 Diabetes *
- Diabetes and Your Child: Understanding Prediabetes*
- Diabetic Retinopathy: Controlling Your Risk Factors *
- Diabetes and Peripheral Arterial Disease (PAD)*
- Planning for Travel When You Have Diabetes *
- What is Gestational Diabetes? *
- Diabetes and Your Child: Safe Exercise *
- What Is Type 2 Diabetes?*
- Oral Medications for Type 2 Diabetes*
- Diabetes and Your Child: Understanding Type 1*
- Diabetes and Kidney Disease *
- Managing Your Glucose Level for Diabetes and Kidney Disease*
- Using a Blood Sugar Log *
- Your Diabetes Toolkit *
- Diabetes and Your Child: Preventing Diabetic Ketoacidosis (DKA)*
- Diabetes and Your Child: The A1c Test *
- Managing Type 1 Diabetes in Your Child: Getting Started*
- Resources for People with Diabetes*
- For Kids: High Blood Sugar*
- For Kids Ages 9 to 11: Dealing with Diabetes*
- Blood Glucose Screening During Pregnancy*
- Long-Term Complications of Diabetes*
- Diabetes: Ways to Take Medication*
- Prediabetes *
- Getting Support When You Have Diabetes*
- Understanding Type 2 Diabetes*
- For Parents: Diabetes Care (Newborn to 2 years)*
- Diabetes: Activity Tips*
- Gestational Diabetes: Getting Exercise*
- Gestational Diabetes: After Pregnancy*
- For Parents: Diabetes Care (6 to 10 years)*
- Gastroparesis*
- Taking Medication for Diabetes*
- For Parents: Diabetes Care (3 to 5 years)*
- Diabetes: Understanding Carbohydrates, Fats, and Protein*
- What is Type 1 Diabetes? *
- Diabetes: Living Your Life *

- Diabetes: Driving Issues *
- Diabetes and Periodontal Disease: An Increased Risk*
- Diabetes and Your Child: Considering an Insulin Pump*
- Diabetes: Sick-Day Plan *
- For Kids: Food Facts When You Have Type 1 Diabetes*
- High Cholesterol: Assessing Your Risk *
- A Sample Walking Program *
- Understanding Restless Legs Syndrome*
- How Your Kidneys Work*
- Healthy Kidneys*
- Understanding Pancreatitis*
- For Parents: Diabetes Care (11 to 17 years)*
- Diabetes and Your Child: Tests and Vaccinations*
- Blood Sugar Monitoring and Treatment in the NICU*
- Glucose Tolerance Lab Test *
- Managing Stress When You Have Diabetes *
- Understanding Ingrown Toenails *
- What Is Diabetic Retinopathy? *
- Diabetic Retinopathy: Evaluating Your Eyes*
- Understanding Blood Sugar During Pregnancy *
- Diabetic Retinopathy: Having Laser Treatment*
- Diabetes: Inspecting Your Feet *
- Diabetes and Your Child: Low Blood Sugar*

Many medication sheets are also available in Krames and can be produced upon request

*** (available in English and Spanish-some may be available in other languages)**

Educational Material from AmeriHealth Caritas Louisiana

- Diabetes Questionnaire
- Important Health Information for you
- Main Lifestyle Changes
- A Diabetes Checklist

APPENDIX C3- COMMUNITY HEALTH SOLUTIONS (CHS)

COMMUNITY HEALTH SOLUTIONS (CHS)

The below is a summary of effectiveness and next steps based upon Community Health Solutions of Louisiana (CHS-LA) 2014 Diabetes & Obesity Action Plan report submitted January 17, 2014.

*After further analysis of the CHS-LA data during the 2014 calendar year, it was necessary to modify some of the baseline numbers presented in our January 17, 2014 submission.

Effectiveness:

Diabetes Management Results for CY 2014:

1. Goal was for a 5% increase in diabetic members enrolled in Disease Management/Case Management.
    a. Enrollment for:
        - 2013 was 105
        - 2014 was 496
            - 372% increase in diabetic members enrolled in diabetes/CM

2. Increase number of members completing Disease Management/Case Management goals as noted in their care plans by 5%.
    a. Number of members completing goals:
        - In 2013 was 4
        - In 2014 was 13
            - 225% increase in members completing diabetes/CM goals

3. Reduce hospital and emergency room utilization by diabetic members by 5%.
    a. Diabetic members admitted to the hospital
        - In 2013 was 203
        - In 2014 was 172
            - 15% reduction in diabetic members admitted to the hospital
    b. Diabetic members seeking treatment via emergency department:
        - In 2013 was 273
        - In 2014 was 251
            - 8% reduction in ED encounters with diabetes as primary diagnosis

Obesity Management Results for CY 2014:

1. Goal was to report BMI for 75% of members enrolled in Disease Management/Case Management
    a. This goal was achieved with precisely 75% of members enrolled in diabetes/CM having BMI data in their CHS record. Analysis of this data is ongoing.

2. Identify pilot practices for the establishment of an outpatient pediatric diabetes and obesity prevention and treatment project.
    a. CHS-LA successfully identified three interested and willing practices to work with us to establish a multidisciplinary approach to pediatric weight management in the medical home setting. The 6-month prevention and treatment program was to include medical management by a physician and/or nurse practitioner, nutrition education by a registered dietician, behavioral health services by licensed clinical child psychologist or licensed clinical social worker and physical activity education. The physician and behavioral health services are billable Medicaid encounters. However, nutritional services are not Medicaid billable encounters in the outpatient setting unless the patient has a diagnosis of diabetes. The lack of ability to recover these important nutritional services in the outpatient setting was the primary barrier to implementation of the above referenced project.
        i. An additional barrier to the above referenced project is the inability to cover the costs of the physical activity education of the patient. This service could be provided by physical therapists or exercise physiologists.

3. Increase number of pediatric members (who are currently in diabetes/CM) by 10%.
    a. We did not meet this goal because we were unable to fully develop a disease management/case management program specific to pediatric obesity.

<u>Accomplishments for CY 2014:</u>

- Educational training for the CHS-LA case management team by Melinda Sothern, PhD (LSUHSC School of Public Health Professor and Chair of Health Promotion in Behavioral & Community Health Sciences). Dr. Sothern educated the CHS-LA CM team as to the multi-disciplinary approach to a family-centered weight management program for children. This effort led to the CHS-LA CM team being able to assist members and member's families with their weight management concerns, especially those identified with elevated BMIs.

- CHS-LA provider service representatives educated CHS-LA network of primary care providers as to CHS-LA's care management team's ability and availability to assist their patients with weight management concerns.
    - CHS-LA case managers were made available to meet CHS members in their physician's offices in order to support the diabetic education efforts of the PCP.

- CHS-LA care managers trained regarding a revised process to assess BMI of high risk members at regular intervals.

- CHS-LA revised our assessment protocol to ensure BMI was a required component of the general assessment and disease specific assessments as needed. Because obstetrical members comprise a significant percentage of CHS membership, emphasis was placed upon pregnant members at risk for gestational diabetes.

- CHS-LA Social Work care managers targeted the CHS diabetic population for outreach in order to address barriers to access to care (i.e., transportation, child care, specialist referrals, medication management etc.)

- Work with DHH/OPH and other partners to develop and implement ideas to have nutritional services funded in the outpatient setting for pediatric aged patients.
    - Once accomplished, reach out to interested providers to implement a family-centered weight management program for children.
        - The 6-month (or longer, as indicated, depending on patient's condition) prevention and treatment program will include medical management by a physician and/or nurse practitioner, nutrition education by a registered dietician, behavioral health services by a licensed clinical child psychologist or licensed clinical social worker and physical activity education.

- Explore possibility of physical therapists and/or exercise physiologists providing the physical activity education component of the above referenced family centered weight management program AND having this valued service be a billable Medicaid expense.
    - Rationale:
        - Primary care physicians taking care of children with or at-risk for obesity and with or at-risk of diabetes are unable to adequately counsel and educate parents/children about physical activity during routine visits. To properly educate parents/children regarding physical activity, recurring appointments with a specialist in physical activity are necessary. Some of these appointments can occur in a group setting. However, if there is no ability for the physical activity specialist to recover the cost of providing the service, they (or their employer) are unable to provide the service.
        - Patients uneducated as to appropriate physical activity continue to become more obese and develop diabetes, thus driving an increase in health care costs.

APPENDIX C4- LOUISIANA HEALTHCARE CONNECTIONS (LHC)

LOUISIANA HEALTHCARE CONNECTIONS (LHC)

Diabetes Action Plan

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:

- One or more primary or secondary diabetes complication claims
- One or more primary or secondary diabetes claims
- 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 fourteen (14) days after the introductory mailing is sent. Several 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
- internal consults with Specialty Health Coaches for participants at high risk for, or diagnosed with another chronic condition program (COPD, asthma, heart failure, heart disease, hypertension, hyperlipidemia) purchased by the Health Plan. Specialty Health Coaches include Certified Diabetes Educators, Registered Nurses and Certified or Registered Respiratory Therapists.

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

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

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 participate in the Program as long as they remain medically eligible, are receiving primary health care coverage with the HMO and have not requested to be disenrolled from the program.

Referral Services

Subject to applicable law and regulations, PROVIDER may refer Members to other disease management programs offered by the Health Plan (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

- Member dies;
- Member's health care coverage with the Health Plan terminates or the Health Plan no longer provides the Member's primary coverage as determined under applicable coordination of benefits rules by the Health Plan and communicated PROVIDER;
- Member attending physician or the Health Plan 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.

Performance Measurements – 2015

Performance Measure/Target	Measurement Period
A target rate of 80% compliance with annual HbA1c screening or improvement to a compliance rate of at least the baseline rate, plus half of the difference between the target rate and the baseline rate	2/1/2015 – 12/31/2015
A target rate of 50% compliance with nephropathy monitoring or improvement to a compliance rate of at least the baseline rate, plus half of the difference between the target rate and the baseline rate	2/1/2015 – 12/31/2015
A target rate of 60% compliance with annual eye (retinal) exam or improvement to a compliance rate of at least the baseline rate, plus half of the difference between the target rate and the baseline rate	2/1/2015 – 12/31/2015

Weight Management Plan

Program Objective

The Weight Management 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.

Eligibility Criteria

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

- ≥18 years of age and
- Body Mass Index ≥25 or
- History of BMI ≥25 with need for weight maintenance support

Individuals are referred into the program by Providers and Case Managers. Members may self-refer into the program if agreed to by client.

Enrollment

Referred members are contacted by phone to explain the program, confirm eligibility and conduct an Initial Health Assessment (IHA). The Initial Health Assessment evaluates current health status by collecting information on current weight and presence of co-morbidities or other risk factors. A baseline call is then scheduled (or can be completed at that time) with a health coach specializing in weight management (Registered Dietitian). The member will then receive an introductory mailing with education materials.

A member who has a qualifying chronic condition such diabetes or heart disease will be offered enrollment into the appropriate chronic care program (when purchased by client) and provided weight loss coaching as part of the program.

Ongoing Counseling

The Health Coach will complete an assessment and develop an individualized care plan based on the Member's current status, including physical activity limitations, presence of co-morbidities and dietary intake Internal clinical guidelines are developed from nationally recognized evidence based guidelines published by National Institutes of Health and American Dietetic Association. Components of the Program include:

Registered Dietitians provide coaching for:

- 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
- benefits of physical activity
- lifestyle approaches to physical activity
- tips to keep motivated with exercise
- unlimited inbound calls
- education materials to enhance understanding and compliance

Exercise Physiologists (may be available to) provide coaching for:

- assessing contraindication to physical activities (i.e. joint problems)
- providing exercise recommendations (once cleared by primary physician)
- and education on safety precautions to avoid injury

Referral Services

Subject to applicable law and regulations, PROVIDER may refer Members to other disease management programs offered by the Health Plan (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 the Health Plan terminates or the Health Plan no longer provides the Member's primary coverage as determined under applicable coordination of benefits rules by the Health Plan and communicated PROVIDER;
- Member attending physician or the Health Plan 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 any complex medical condition
- Member has enrolled in a Hospice Program.

APPENDIX C5- UNITED HEALTHCARE OF LA (UHC)

UNITED HEALTHCARE OF LA (UHC)

UHC 2015 Diabetes Action Plan

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

Description	Responsible Party	Timeframe
a. Perform Health Risk Assessment for New Members		
A telephonic health risk assessment (HRA) which includes monitoring for risk of diabetes. Members who are unable to be contacted by phone are sent a postcard with a request to contact UnitedHealthcare (UHC).	UHC's Hospitality, Assessment and Retention Center (HARC)	Ongoing in 2015
Process Measures: # members reached # HRA's completed	30,032 (49%) Jan – Oct 2014 42,116 (82%) Jan – Nov 2013 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. (Level 1, 2, 3)	Utilization Management Team	Ongoing in 2015
Process Measures: 939 referrals in 2014 from Utilization Management to Care Management with diagnoses of diabetes		
c. Educate Members Using "Taking Charge" Disease Management Materials		
Members identified with diabetes receive educational materials and newsletters with diabetes specific information, including recommended routine appointment frequency, necessary testing/ monitoring and self-care. Materials are designed to empower each member to take responsibility for their health and to equip themselves with the information necessary manage their diabetes as successfully as possible and live a healthy lifestyle.	Disease Management Team	Ongoing in 2015
Process Measures: # Mailings to Adults # Mailings to Children	2013 257 23	2014 1521 196

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 in 2015
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: # women attending Lunch n' Learn events # Lunch n' Learn events	2013 279 10	2014 550 13
e. Silver Links Calls		
Continue with Silver Links "live" outreach to Diabetic members for Diabetic gap appointments with PCP appointments facilitated.	Director, Quality Management & Performance	Ongoing in 2015
Process Measures: # of members called		2014 (Nov – Dec) 1633
f. Cobranding		
Cobranding with high PCPs with high volume clinic members will receive mail outs and calls for Diabetic gaps in care	Director, Quality Management & Performance	New in 2015

Overall Health Outcome Measures

HEDIS 2014 Comprehensive Diabetes Care Measures:

Hba1c Testing – 77.62

Eye Exam – 47.80

Attention for Nephropathy – 76.40

LDL Screening – 79.66

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

Description	**Responsible Party**	**Timeframe**
Educate and refer pregnant women with diabetes to maternal care management.		
Healthy First Steps (HFS) is a maternal management program designed to reduce the risk of infant mortality. The program begins with a risk assessment for various conditions that may complicate pregnancy including diabetes.	Healthy First Steps Team	Ongoing in 2015
Process Measures: # members identified # members qualified # members reached # members referred to case management		2014 (Jan – October) 8,945 8,015 3,050 2,630

Overall Health Outcome Measures
HEDIS Prenatal and Postpartum Care

Prenatal – 83.21
Postpartum – 54.99

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

Description	Responsible Party	Timeframe
Educate providers on current HEDIS standards.		
The Clinical Practice Consultant (CPC) Program was expanded from three to five CPCs in 4th 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	Director, Quality Management & Performance	Ongoing in 2015
Process Measures:	2013 (Jan – Dec)	
# toolkits distributed	769	
# providers	524	
# members potentially impacted based on panel assignments	154,867	
*** Note toolkit became available on United Healthcare website in 2014*		

HEDIS 2014 Overall Health Outcome Measures
HEDIS Comprehensive Diabetes Care Measures:
Hba1c Testing – 77.62
Eye Exam – 47.90
Attention for Nephropathy – 76.40
LDL Screening – 79.26

Weight, Nutritional, and Physical Activity Counseling (BMI – 27.49/Nutrition 38.69) LDL Screening – 79.26
Adult BMI Assessment Rates – 64.72

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

Description	Responsible Party	Timeframe
Refer members to Pennington for potential access to a physical fitness facility.		
Support local research on healthcare related issues as it relates to Diabetes. Pennington Wellness Day is to educate community of healthy lifestyles as it relates to obesity, diabetes, etc.	UHC Marketing and Community Outreach	Ongoing in 2015
Process Measures: # of events # of members attending		2014 1 500

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.

Description	Responsible Party	Timeframe
a. Continue Eat4-H Partnership.		
Louisiana 4-H and UnitedHealthcare will continue their partnership, Eat4-Health, in 2014. Louisiana is one of 10 states participating in the campaign designed to empower youth to help fight the nation's obesity epidemic. Each state 4-H organization is receiving a grant funded by UnitedHealthcare to support healthy-living programs, events and other activities adiabetesinistered by 4-H that encourage young people and their families to eat more nutritious foods and exercise regularly. The partnership in Louisiana is being	4-H and UHC Marketing and Community Outreach	Ongoing in 2015
Process Measures: # Louisiana youth reached # events	In 2013 1,762 7	In 2014 (Jan – June) 8,061 21

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 in 2015
Process Measures: # Louisiana youth reached # events	In 2013 1,762 7	In 2014 (Jan – June) 8,061 21
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 in 2015
Process Measures: # Louisiana youth attending # events	2013 500 7	2014 (Jan – June) 450 3
d. Distribute Sesame Street Food for Thought toolkits./reading corners		
Food for Thought is a bilingual (English-Spanish) multimedia outreach initiative that helps families who have children between the ages of two and eight years cope with limited access to affordable and nutritious food (also known as food insecurity). The outreach is conducted in multiple venues including Head Start and Catholic Charities.	UHC Marketing and Community Outreach	Ongoing in 2015
Process Measures: # toolkits distributed	2013 15, 572	2014 (Jan – June) 3500 (30 FQHC)
e. Continue Dr. Health E. Hound visibility at community events.		
Dr. Health E. Hound is the friendly face of UnitedHealthcare Community Plan. As our mascot, he travels all across the country, making special appearances to engage with the public and help educate children, their families and the community about healthy living, including healthy eating habits.	UHC Marketing and Community Outreach	Ongoing in 2015
Process Measures: # events that Dr. Health E. Hound attended # of members	2013 4 520	2014 (Jan – June) 7 9, 220

f. Participate in Louisiana Healthy Community Coalition Awareness Event/Head Start/Other Community activities		
The mission of the Louisiana Healthy Community Coalition is to improve the health and quality of life of Louisianans by mobilizing communities to enact policy, system and environmental changes to create healthy communities.	UHC Marketing and Community Outreach	Ongoing in 2015
Process Measures: # people attending the event	2013 14,887	2014 (Jan – June) 6,570

UHC Program Goal 2: Facilitate healthy lifestyles.

Description	*Responsible Party*	**Timeframe**
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 in 2015
Process Measures: # enrollees Average pounds lost / enrollee # enrollees completing the program		In December 2013/2014 Call campaign 8,043 members Qualified based on BMI -139 Enrolled in class - 37
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 in 2015
Process Measures: # member reached # of events	2013 115 3	2014 (Jan - June) 405 7

c. Initiate UHC Small Steps Program (Eat for Health).		
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. In 2014 this program is under Eat for Health.	UHC Marketing and Community Outreach	Ongoing in 2015
Process Measures:	2013	2014 (Jan – June)
# of members reached	1587	350
# of events	14	1