Diabetes and Obesity Report for the Medicaid Managed Care Program

Report Prepared in Response to Act 210 of the 2013 Regular Legislative Session

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Contents

Executive Summary

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

This report is submitted pursuant to Act 210 of the 2013 Regular Legislative Session, which requires the Louisiana Department of Health (LDH) to submit an annual diabetes and obesity action plan to the Senate and House Committees on Health and Welfare after consulting with, and receiving comments from, the medical directors of each of its contracted Medicaid partners. Data presented on prevalence, utilization and costs of obesity and diabetes are based on 2017 data submitted by each of the five Healthy Louisiana Managed Care Organizations (MCOs) and represent the managed care population only.

Data from each MCO was compiled and self-reported, but has not been validated. Below are some highlights from this year's report:

- *The State of Obesity* is a collaborative project of the Trust for America's Health and the Robert Wood Johnson Foundation that produces annual reports on national obesity trends. According to *The State of Obesity* 2018 report, even though the rate has remained relatively constant, Louisiana dropped from first in 2015 (36.2 percent) to sixth (36.2 percent) in 2017 among all states for adult obesity.[1] The following obesity summary was based on 2017 Healthy Louisiana MCO claims data:
    - In 2017, 132,950 enrollees, or 8.73 percent, of the Healthy Louisiana population had a claim for obesity; 36.45 percent (48,454 individuals) of those diagnosed with obesity were 21 years of age or younger. The Gulf region had the most enrollees with an obesity diagnosis (37,152). See Appendix B for a regional breakdown of obesity.
    - The Healthy Louisiana MCOs paid $368.8 million for obesity-related services.
- According to the *State of Obesity 2018* report, Louisiana was ranked fourth in the nation in 2017 with the rate of adult diabetes at 13.6 percent. The following diabetes summary was based on 2017 Healthy Louisiana MCO claims data:
    - In 2017, 91,006 adult enrollees, or 13.29 percent, of the adult Healthy Louisiana population had a claim for diabetes. Of all enrollees diagnosed with diabetes, 67.59 percent (70,318 individuals) were female and 32.41 percent (33,716) were male. The highest percentage of people with diabetes, regardless of age, resided in the Gulf region (31.01 percent). See Appendix C for a regional breakdown for diabetes.
    - The average cost of treating a pregnancy complicated by diabetes ($2,226) was one and one-half times higher than the average cost of treating a pregnancy without diabetes complications ($1,468).
    - Diabetes was the primary diagnosis for admission to an inpatient hospital stay for 8,050 Healthy Louisiana enrollees, accounting for 6.01 percent of all inpatient stays for enrollees in 2017. The total paid for these inpatient stays was $23,922,214.

[1] *The State of Obesity in Louisiana*. (August 2017). Retrieved November 17, 2018, from http://www.stateofobesity.org/states/la

- Diabetic ketoacidosis was the most common diabetic complication on hospital inpatient discharge claims for those 21 years of age or younger, accounting for 61.31 percent of all inpatient hospital discharges for this age group.
- There were 34,223 Emergency Department (ED) visits for Healthy Louisiana enrollees that had a primary diagnosis of diabetes. The majority of ED visits occurred among enrollees older than 21 years of age.
- When comparing diabetes to other chronic conditions, in 2017, the chronic condition with the highest average cost per enrollee was coronary heart disease at $7,246.05. The average cost per enrollee diagnosed with diabetes in 2017 was $4,366.24.

1 Introduction

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

1.1 Report Methodology

Each MCO was required to provide data on prevalence and other clinical data that summarize diabetes and obesity among their enrollees. Additionally, each MCO submitted details of its diabetes and obesity action plans. In response to Act 210, Louisiana Medicaid aggregated the data and information submitted by each of the MCOs to create the *Diabetes and Obesity Action Report for the Healthy Louisiana Program*.

1.2 Obesity Overview

1.2.1 National Prevalence

Although national, state and local governments and many private employers and payers have increased their efforts to address obesity since 1998,[2] more than one-third (39.8 percent) of U.S. adults and 18.5 percent of U.S. children and adolescents were considered obese in 2015-2016.[3]

1.2.2 What is Obesity?

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

1.2.3 What is the Body Mass Index?

The Body Mass Index (BMI) is derived from an individual's height and weight. If an adult's BMI is between 25 and 29.9, a person is considered overweight. If the adult's BMI is 30 or greater, the individual is classified as obese.[4] A child's weight status is determined using an age- and sex-specific percentile for BMI rather than the BMI categories used for adults because children's body composition varies by age and sex. In children and adolescents ages 2 to 20 years, obesity is defined as a BMI at or above the 95th percentile of the sex-specific Centers for Disease Control and Prevention's (CDC) BMI-for-age growth charts.[5]

Children with obesity are at higher risk of having other chronic health conditions and diseases that influence physical health. These include asthma, sleep apnea, bone and joint problems, Type 2 diabetes, and risk factors for heart disease. In the long term, a child with obesity is more likely to have obesity as an adult. An adult with obesity has a higher risk of developing heart disease, Type 2 diabetes, metabolic syndrome and many types of cancer.[6] Despite the growing efforts of government and public health officials, the observed change in prevalence between 2013–2014 and 2015–2016 was not significant among youth or adults.[7]

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

[3] Hales CM, Carroll MD, Fryar CD, Ogden CL. Prevalence of obesity among adults and youth: United States, 2015–2016. NCHS data brief, no 288. Hyattsville, MD: National Center for Health Statistics. 2017.

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

[5] *About Child & Teen BMI. (2018, October 4). Retrieved November 29, 2018, from https://www.cdc.gov/healthyweight/assessing/bmi/childrens_bmi/about_childrens_bmi.html*

[6] *Childhood Obesity Facts. (2018, January 29). Retrieved November 29, 2018, from https://www.cdc.gov/healthyschools/obesity/facts.htm*

[7] Hales CM, Carroll MD, Fryar CD, Ogden CL. Prevalence of obesity among adults and youth: United States, 2015–2016. NCHS data brief, no 288. Hyattsville, MD: National Center for Health Statistics. 2017.

1.3 Diabetes Overview

1.3.1 National Prevalence

Diabetes is a common disease: the CDC reports that more than 30 million Americans are living with diabetes, and another 84 million are living with prediabetes; further, about 90 percent to 95 percent of diagnosed cases are Type 2, and about 5 percent are Type 1.[8] In the United States, diabetes was the seventh leading cause of death in 2016.[9]

1.3.2 What is Diabetes?

The food we eat is usually turned into glucose, a type of sugar, and our pancreas makes a hormone called insulin to help the glucose get into the cells of our bodies so it can be used for energy. Diabetes is a disease in which the body either does not make enough insulin or cannot use its own insulin as well as it should, causing sugar to build up in the blood. When the amount of sugar circulating in the blood is too high, it causes damage to many parts of the body including the eyes, heart, blood vessels, kidneys and nerves. This damage makes diabetes the leading cause of adult blindness, end-stage kidney disease and amputations of the foot and/or leg. People with diabetes are also at a greater risk for heart disease and stroke.[10, 11]

1.3.3 Types of Diabetes

Type 1 diabetes (previously called "juvenile diabetes" or "insulin-dependent diabetes") develops when the body produces little to no insulin due to destruction of the pancreas cells that make insulin. To survive, people with Type 1 diabetes must have insulin delivered by injection or through an insulin pump. This form of diabetes usually occurs in children and young adults, although disease onset can occur at any age. In adults, Type 1 diabetes accounts for approximately 5 percent of all diagnosed cases of diabetes. There is no known way to prevent Type 1 diabetes.[12]

Type 2 diabetes (previously called "non-insulin-dependent diabetes" or "adult-onset diabetes") develops with "insulin resistance," a condition in which cells (e.g., liver, muscles) of the body do not use insulin properly. As the body resists its own insulin, the pancreas begins to lose the ability to make enough of it. In adults, Type 2 diabetes accounts for about 90 percent to 95 percent of all diagnosed cases of diabetes.[13] 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 some Pacific Islanders are at a higher risk for development of Type 2 diabetes and its complications. Type 2 diabetes may be preventable through modest lifestyle changes. [14]

Gestational diabetes is a type of diabetes that is first seen in a pregnant woman who did not have diabetes before she was pregnant. The risk factors for gestational diabetes are similar to those for Type 2 diabetes. Gestational diabetes requires treatment to lessen the risk of complications such as preterm births, larger babies requiring cesarean sections, preeclampsia, birth defects, and increased risk of Type 2 diabetes for both the mother and the child once she/he reaches adulthood. Often, gestational diabetes can be controlled through eating healthy foods and regular exercise. Sometimes a woman with gestational diabetes must also take insulin.[15]

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[8] Centers for Disease Control and Prevention. National Diabetes Statistics Report, 2017. Atlanta, GA: Centers for Disease Control and Prevention, U.S. Dept of Health and Human Services; 2017.
[9] Heron M. Deaths: Leading causes for 2016. National Vital Statistics Reports; vol 67 no 6. Hyattsville, MD: National Center for Health Statistics. 2018.
[10] *National Diabetes Statistics Report, 2014* (pp. 1-12, Rep.). (2014). Atlanta, GA: Centers for Disease Control and Prevention.
[11] Statistics About Diabetes. (n.d.). Retrieved February 17, 2017, from http://www.diabetes.org/diabetes-basics/statistics/
[12] Diabetes. (2018, November 27). Retrieved November 29, 2018, from https://www.cdc.gov/diabetes/basics/diabetes.html
[13] Diabetes. (2018, November 27). Retrieved November 29, 2018, from https://www.cdc.gov/diabetes/basics/diabetes.html
[14] *Who's at Risk (2017, July 25). Retrieved November 29, 2018, from http://www.cdc.gov/diabetes/basics/risk-factors.html*
[15] Gestational Diabetes and Pregnancy. (2015, September 16). Retrieved February 17, 2017, from http://www.cdc.gov/pregnancy/diabetes-gestational.html

2 The Scope of Obesity in the Healthy Louisiana Program

Based on 2017 claims data, the prevalence of obesity among Healthy Louisiana enrollees was 8.73 percent out of 1,523,145 enrollees. However, the Trust for America's Health and the Robert Wood Johnson Foundation's *State of Obesity 2018* report stated that among all states, Louisiana's adult obesity rate moved from first in 2015 (36.2 percent), to fifth highest in 2016 (35.5 percent), to sixth highest in 2017 (36.2 percent).[16] Given these consistently reported high rates, it appears that obesity is under-coded as a diagnosis in Louisiana Medicaid claims data, leading to an underrepresentation of the burden of obesity in available claims data.

Of the Healthy Louisiana enrollees diagnosed with obesity, 36.45 percent (n=48,454) were 21 years of age or younger. The Healthy Louisiana obesity prevalence for the same group, 21 years and younger, was 5.78 percent. Of the Healthy Louisiana enrollees diagnosed with obesity, 63.55 percent (n=84,496) were greater than 21 years of age. The Healthy Louisiana obesity prevalence for the same group, greater than 21 years of age, was 8.73 percent. The geographic and age group breakdown of obesity among the four Louisiana regions is shown in Maps 2.1 and 2.2. For the 21 years or younger group, the South Central (31.51 percent) and Capital Area (24.84 percent) regions had the highest number of enrollees with obesity. For Healthy Louisiana enrollees older than 21, the Gulf (30.16 percent) and Capital Area (25.37 percent) regions had the most enrollees with obesity. The Northern region had the lowest percentage of individuals diagnosed with obesity in both age groups. For parish level information, please see Appendix C.

Map 2.1: Geographical Distribution of Healthy Louisiana Enrollees with Obesity, Age ≤ 21 Years, 2017 (n = 48,454)

Region	
	Capital Area 12,035; 24.84%
	Gulf 11,671; 24.09%
	Northern 9,480; 19.56%
	South Central 15,268; 31.51%

[16] *The State of Obesity in Louisiana*. (August 2017). Retrieved November 17, 2018, from http://www.stateofobesity.org/states/la

Map 2.2: Geographical Distribution of Healthy Louisiana Enrollees with Obesity, Age > 21 Years, 2017 (n = 84,496)

Region	
	Capital Area 21,438; 25.37%
	Gulf 25,481; 30.16%
	Northern 17,525; 20.74%
	South Central 20,052; 23.73%

The 2017 financial burden of obesity is shown in Table 2.1, reflecting that the Healthy Louisiana MCOs paid around $47.37 million for service-related claims for obesity. The amount paid for anyone identified with obesity and other related conditions totaled more than $368 million.

Table 2.1: Financial Burden of Obesity in 2017 among Healthy Louisiana Enrollees

Age Group	Obesity Service-Related Payments *	Obesity-Related Payments**
≤ 21 years	$6,932,740	$69,380,660
>21 years	$40,444,818	$299,439,705
Total	$47,377,558	$368,820,365

*Claims with obesity as one of the diagnoses
**All claims related to enrollees identified as obese, where obesity may not have been a diagnosis on the claim

3 The Scope of Diabetes in Louisiana and the Healthy Louisiana Program

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

Based on Louisiana's results of the annual BRFSS survey, Figure 3.1 shows the 16-year trend of diagnosed diabetes in Louisiana. With some fluctuation, the rate trended upward from a low of 7.15 percent in 2002 to a high of 13.6 percent in 2017. Louisiana's trend mirrors the long-term trends published by the CDC, which reported that 12.2 percent of adults in the U.S. were diagnosed with diabetes in 2015.[17]

Figure 3.1: Prevalence of Diagnosed Diabetes in Louisiana (Crude Prevalence)

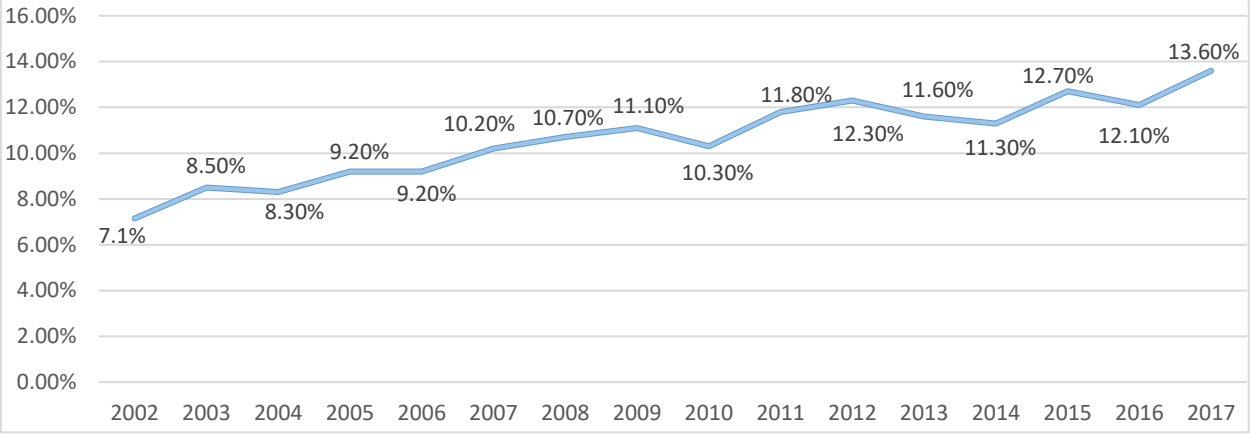

Figure 3.2 shows adult diabetes prevalence by gender in the overall Louisiana population and in the Healthy Louisiana population. The Healthy Louisiana populations show a slightly lower prevalence in males (12.77 percent) than in females (13.53 percent). This is in agreement with the Centers for Disease Control, where the overall Louisiana prevalence was higher among adult females (14.3 percent) than adult males (12.8 percent).[18]

Figure 3.3 displays how diabetes prevalence for Healthy Louisiana enrollees is distributed across age groups and gender. Healthy Louisiana's 2017 diabetes prevalence is highest in adult females (13.53 percent; 62,600) and is followed closely by adult males (12.77 percent; 28,406). The prevalence of diabetes in Louisiana enrollees who are 21 years of age or younger is less than 2 percent for both males and females.

[17] Centers for Disease Control and Prevention. Diabetes Report Card 2017. Atlanta, GA: Centers for Disease Control and Prevention, US Dept of Health and Human Services; 2018.

[18] Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Division of Population Health. BRFSS Prevalence & Trends Data [online]. 2015. [accessed Nov 16, 2018]. URL: https://www.cdc.gov/brfss/brfssprevalence

Figure 3.2: Healthy Louisiana Compared to CDC BRFSS 2017 Adult Diabetes Prevalence by Gender

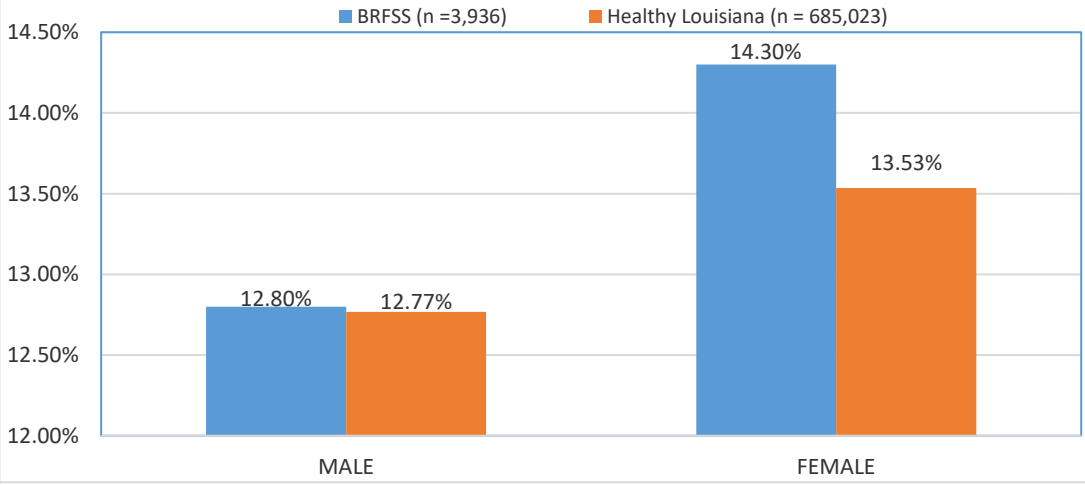

Figure 3.3 Healthy Louisiana 2017 Prevalence by Age Group and Gender

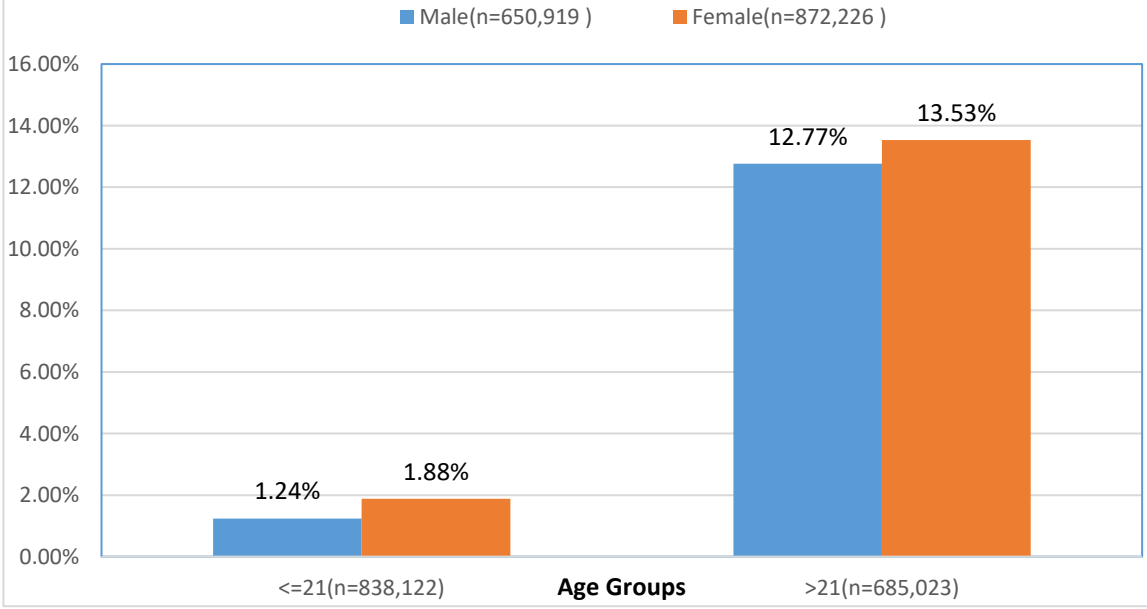

Table 3.1 details how enrollees in Healthy Louisiana compared with state and national levels for preventive practices recommended for patients with diabetes. Louisiana's BRFSS percentages were slightly less than the 2015 national numbers for most of the listed preventive care practices. The Healthy Louisiana plans' dilated eye exam rate was considerably higher than the 2015 national median (80.57 percent versus 61.6 percent). However, Healthy Louisiana scored considerably lower on self-management education and daily glucose monitoring.

Table 3.1: Reported Rates of Diabetic Care Practices Among Adults with Diabetes: Healthy Louisiana MCOs, Louisiana and the United States

Preventive Care Practice	Healthy Louisiana (2017)†	BRFSS Louisiana (2015)	U.S. (2015)††
Annual dilated eye exam	80.6%	56.5%	61.6%
Received one or more HbA1c in current (2017) year	68.1%	64.8%**	71.4%
Received a flu shot in current (2017) year	12.2%	***	***
Ever received a pneumonia shot	6.3%	***	***
Daily self-blood glucose monitoring	29.1%	56.7%	63.0%
Ever had self-management education	0.1%	46.1%	54.4%

†Because Healthy Louisiana enrollees may receive immunizations from organizations outside of the normal healthcare delivery settings and who may offer the vaccines free or nearly free, the claims data will produce artificially low rates for flu and pneumonia vaccines.
††2015 represents the most recent year of data available from the CDC *Diabetes Report Card*. Available at: https://www.cdc.gov/diabetes/pdfs/library/diabetesreportcard2017-508.pdf
**Rate reported by BRFSS in the CDC Diabetes Report Card reflects two or more A1c tests in the last year.
***Rates not included in *CDC's Diabetes Report Card 2014.*

The geographic and age group breakdown of individuals diagnosed with diabetes among the four regions is shown in Map 3.1 for those age 21 years or younger and Map 3.2 for those over the age of 21. The Gulf region had the largest number of enrollees with diabetes in both age groups; 29.28 percent for those 21 years of age or younger and 31.26 percent for those older than 21 years of age. The Northern region had the fewest number of enrollees with diabetes in both age groups with 19.12 percent for those aged 21 or under and 20.63 percent for those older than 21 years of age. For parish-level data, please see Appendix D.

Map 3.1: Geographical Distribution of Healthy Louisiana Enrollees with Diabetes, Age ≤ 21 Years, 2017 (n =13,028)

Region	
	Capital Area 3,346; 25.68%
	Gulf 3,814; 29.28%
	Northern 2,491; 19.12%
	South Central 3,377; 25.92%

Map 3.2: Geographical Distribution of Healthy Louisiana Enrollees with Diabetes, Age > 21 Years, 2017 (n = 90,903)

Region	
	Capital Area 20,727; 22.80%
	Gulf 28,414; 31.26%
	Northern 18,751; 20.63%
	South Central 23,011; 25.31%

3.1 Diabetes and Pregnancy

Table 3.1.1 shows the percentage of pregnancies in 2017 complicated with diabetes and the financial burden on Healthy Louisiana. Nearly 7 percent of pregnancies involved diabetes. The average paid, per member, for a pregnancy with diabetes was one and one-half times that paid for pregnancies without diabetes ($2,226 vs. $1,468).

Table 3.1.1: Burden of Diabetes* on Pregnancies in 2017 among Healthy Louisiana Enrollees

Pregnancy Type	Number of Enrollees	Total Amount Paid	Average Amount Paid per Member
Pregnancies with diabetes	4,620 (6.83%)	$ 10,284,157.84	$ 2,226
Pregnancies without diabetes	63,032 (93.17%)	$ 92,553,363.25	$1,468

*Includes gestational diabetes and diabetes pre-existing in pregnancy

3.2 The Financial Impact of Diabetes and Its Complications

The American Diabetes Association estimates that the largest component of medical expenses attributed to diabetes is for hospital inpatient care, at 30 percent of total medical costs.[19] Given that inpatient hospital care is such a large component of diabetes costs, examining Louisiana's data on diabetes hospitalization costs is important to understanding its impact on individuals, families and the state. These data also serve as a reflection of how well diabetes is, or is not, managed by the health care system.

3.2.1 Hospitalization Costs Due to Diabetes

Table 3.2.1 shows, by age group, the number and percentage of inpatient hospital discharges, the percentage of overall hospital discharges, and Healthy Louisiana plan payments for admissions in which diabetes was the primary (principal) diagnosis. In 2017, there were 8,050 inpatient hospital discharges with a principal diagnosis of diabetes. Diabetes hospital discharges were 6.01 percent of the overall inpatient discharges for Healthy Louisiana enrollees.

[19] Cost of Diabetes. (2018, April 30). Retrieved November 29, 2018, from https://www.diabetes.org/advocacy/news-events/cost-of-diabetes.htm

Most (89.4 percent) of these discharges were for enrollees older than 21 years of age. The total paid by Healthy Louisiana MCOs for diabetes-related inpatient discharges amounted to $23,922,214.

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

Table 3.2.1: 2017 Inpatient Discharges with Diabetes as the Primary Diagnosis* Among Healthy Louisiana Enrollees by Age Group

Age Group	Number of Diabetes Discharges	Percent of Overall Discharges Due to Diabetes	Total Paid for Diabetes Hospitalizations
≤ 21 years	847	1.91%	$2,633,857
> 21 years	7,203	8.05%	$21,288,357
Total	8,050	6.01%	$23,922,214

* Diabetes noted in the first three discharge diagnosis listings

3.2.2 Specific Diabetes Complications as Principal Diagnosis for Inpatient Hospital Discharges

Hospitalizations for diabetes may occur due to complications of the disease. The complications discussed in this section of the report were identified from the principal diagnosis code assigned by the physician during the hospital stay. Again, the principal diagnosis is defined as the condition responsible for admission of the patient to the hospital.

Table 3.2.2 shows, by age group, inpatient discharges in 2017 where a complication of diabetes was the primary diagnosis. This table also provides the total percent of inpatient discharges due to a diabetes complication and the total amount paid by the Healthy Louisiana MCOs for these complications.

For enrollees 21 years or younger, the most frequent diabetes complication associated with an inpatient hospital discharge was diabetic ketoacidosis (DKA). DKA is a life-threatening complication in which ketones (fatty acids) build up in the blood due to a lack of insulin. DKA accounted for 61.31 percent of all inpatient hospital discharges due to a diabetic complication for this age group and cost a total of $2,419,724.

For enrollees older than 21 years of age, the most frequent inpatient stay caused by complications of diabetes was “with other specified manifestations.” It accounted for 39.31 percent of diabetes complication discharges for a total cost of $12,746,384.

Table 3.2.2: Inpatient Hospital Discharges in 2017 by Age Group Where a Diabetes Complication Was the Primary Diagnosis*

	Number of Discharges **	Percent of Diabetes-Related Discharges Due to Complication	Total Amount Paid for Diabetes Complication	Number of Discharges **	Percent of Diabetes-Related Discharges Due to Complication	Total Amount Paid for Diabetes Complications
	≤21 years			>21 years		
Ketoacidosis	439	61.31%	$2,419,724	1,028	30.20%	$6,562,260
Hyperosmolarity	12	1.68%	$23,881	140	4.11%	$1,178,028
With Other Coma	12	1.68%	$141,327	27	0.79%	$368,605
With Renal Manifestations	6	0.84%	$17,691	207	6.08%	$4,785,583
With Ophthalmic Manifestations	0	0.00%	$0	15	0.44%	$138,664
With Neurological Manifestations	17	2.37%	$60,374	293	8.61%	$5,343,086
With Peripheral Circulatory Disorders	5	0.70%	$0	106	3.11%	$3,060,997
With Other Specified Manifestations	205	28.63%	$573,483	1,338	39.31%	$12,746,384
With Unspecified Complications	20	2.79%	$26,089	250	7.34%	$529,748

*Diabetes noted in the first three discharge diagnosis listings

**Total diabetes-related inpatient hospital discharges for ≤21 years of age are 847. Total diabetes-related inpatient hospital discharges for >21 years of age are 7,203 (See Table 3.2.1.)

3.2.3 Emergency Department Visits Due to Diabetes

Table 3.2.3 displays, by age group, the number of ED visits with a primary diagnosis of diabetes, the percent of overall ED visits due to diabetes and the resulting amount paid for these ED visits. In 2017, diabetes was the primary diagnosis for 34,223 ED visits and amounted to 5.98 percent of all ED visits for Healthy Louisiana enrollees. Similar to inpatient discharges, the majority of ED visits occurred among those older than 21 years of age. In total, Healthy Louisiana paid $9.9 million for diabetes-related ED visits in 2017.

Table 3.2.3: 2017 ED Visits Where Diabetes was the Primary Diagnosis* By Age Group

Age Group	Number of ED Visits Due to Diabetes	Percent of Overall ED Visits Due to Diabetes	Total Paid for Diabetes ED Visits
≤ 21 years	16,024	6.88%	$4,736,642
> 21 years	18,199	5.33%	$5,170,371
Total	34,223	5.98%	$9,907,013

*Diabetes noted in the first three discharge listings

Table 3.2.4 shows the distribution ED visits in 2017, by age group, where the primary diagnosis was a complication of diabetes. Of the total diabetes-related ED visits with complications across both age groups (n=26,437), 73.58 percent (19,452) were attributed to "diabetes with other specified manifestations." For those who were aged 21 years or

under and had an ED visit due to complications of diabetes, the second most common complication was ketoacidosis at 21.1 percent. For enrollees older than age 21 admitted to the ED because of a diabetes complication, the second most frequent complication was "diabetes with neurological manifestations" at 11.26 percent.

Table 3.2.4: 2017 Emergency Department Visits Where Diabetes Complication Was the Diagnosis* By Age Group

Diabetic Complications	Total Visits for Ages ≤ 21 years	Total Visits for Ages > 21 years
Ketoacidosis	504	910
Hyperosmolarity	5	163
With Other Coma	8	26
With Renal Manifestations	5	1,409
With Ophthalmic Manifestations	4	152
With Neurological Manifestations	44	2,709
With Peripheral Circulatory Disorders	0	101
With Other Specified Manifestations	1,732	17,720
With Unspecified Complications	85	860

*Diabetes noted in the first three discharge diagnosis listings

3.2.4 Diabetes and Common Chronic Conditions

The statute that defines the content of this report requires a comparison of the financial burden or impact of diabetes to that of other common chronic conditions. Table 3.2.5 shows the number of Healthy Louisiana enrollees, average cost per enrollee and the total cost paid by the MCOs for diabetes and other chronic conditions.

In 2017, among Healthy Louisiana enrollees who were diagnosed with one of the reported chronic conditions, hypertension (147,843 enrollees) was the most common, followed by arthritis (139,980 enrollees) and asthma (111,497 enrollees). Diabetes was the fourth most common chronic condition, affecting 96,640 Healthy Louisiana enrollees. In 2017, for the reported chronic conditions, the highest average cost per enrollee was $7,246 for coronary heart disease. The average cost per enrollee diagnosed with diabetes was $4,366. In 2017, for the reported chronic conditions, the highest total paid by the managed care plans was $640,114,171 for arthritis. The total paid for diabetes during 2017 was $421,953,776.

Table 3.2.5: 2017 Chronic Conditions Prevalence and Cost Comparisons between Diabetes and Other Common Chronic Conditions

Chronic Condition	Number of Enrollees	Per Member Cost	Total Paid
Hypertension	147,843	$3,901	$576,721,762
Arthritis	139,980	$4,573	$640,114,171
Asthma	111,497	$3,545	$395,272,932
Congestive Heart Failure	104,326	$4,078	$425,487,714
Diabetes	96,640	$4,366	$421,953,776
COPD	52,621	$3,605	$189,695,732
Coronary Heart Disease	14,749	$7,246	$106,872,022

4 Conclusion

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

4.1 LDH and MCO Recommendations

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

- Seek legislative appropriation of funds for a new Medicaid covered service to allow Medicaid recipients to receive nutritional consultations and services provided by registered dietitians.

- Encourage the use of outpatient nutritional services provided by registered dietitians for all patients and all diagnoses, not just those diagnosed with diabetes and obesity.

- Promote the use of diabetes self-management education (DSME) programs or incorporate elements of these programs into case management activities for patients diagnosed with diabetes. DSME programs have been associated with improved health outcomes for patients diagnosed with diabetes.

- Implement reforms in the education system aimed at improving diabetes and obesity outcomes in Louisiana. These could include:

    - Enforcing the Louisiana law (RS 17:17.1) that requires physical activity in schools, currently applicable to kindergarten through eighth-grade classes.

    - Expanding Louisiana's physical activity law to the high school system.

    - Adequately funding school systems to teach basic nutrition in the classroom at all schools and for all ages.

    - Providing continuing education units (CEUs) to educators through subject matter experts (e.g. kinesiologists or exercise science experts) in order to increase their understanding about the methodology of correctly providing physical activity and nutritional education in the school setting.

Appendix A –Act 210 of the 2013 Regular Legislative Session

RS 46:2616

CHAPTER 46. HEALTH ACTION PLANS

§2616. Diabetes annual action plan; submission; content

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

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

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

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

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

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

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

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

RS 46:2617

§2617. Obesity annual action plan; submission; content

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

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

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

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

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

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

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

Appendix B – Region and Parish Information for Enrollees with Obesity

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

PARISH	≤21 YEARS	>21 YEARS
Capital Region		
ASCENSION	1,129	2,094
EAST BATON ROUGE	4,804	7,890
EAST FELICIANA	489	640
IBERVILLE	401	1,059
LIVINGSTON	1,627	1,934
POINTE COUPEE	303	807
SAINT HELENA	123	222
SAINT TAMMANY	1,338	2,633
TANGIPAHOA	1,156	2,173
WASHINGTON	352	1,108
WEST BATON ROUGE	231	685
WEST FELICIANA	82	193
Total – Capital Region	***12,035***	***21,438***
Gulf Region		
ASSUMPTION	344	590
JEFFERSON	3,899	8,010
LAFOURCHE	1,074	1,650
ORLEANS	2,698	7,587
PLAQUEMINES	185	421
SAINT BERNARD	496	1,275
SAINT CHARLES	733	984
SAINT JAMES	292	612
SAINT MARY	559	1,163
ST JOHN THE BAPTIST	568	1,226
TERREBONNE	823	1,963
Total – Gulf Region	***11,671***	***25,481***
Northern Region		
BIENVILLE	118	392
BOSSIER	970	1,519
CADDO	1,926	4,241
CALDWELL	56	183
CLAIBORNE	99	317
DE SOTO	238	415
EAST CARROLL	75	213
FRANKLIN	272	654
JACKSON	215	439
LINCOLN	336	764
MADISON	145	233
MOREHOUSE	685	1,045
NATCHITOCHES	363	686
OUACHITA	2,427	3,363
RED RIVER	45	135

PARISH	≤21 YEARS	>21 YEARS
RICHLAND	449	620
SABINE	470	691
TENSAS	66	152
UNION	205	454
WEBSTER	199	758
WEST CARROLL	121	251
Total – Northern Region	***9,480***	***17,525***
South Central Region		
ACADIA	920	1,292
ALLEN	185	332
AVOYELLES	662	698
BEAUREGARD	275	362
CALCASIEU	1,090	2,567
CAMERON	32	30
CATAHOULA	187	334
CONCORDIA	150	611
EVANGELINE	497	608
GRANT	313	373
IBERIA	1,893	1,701
JEFFERSON DAVIS	626	489
LA SALLE	2,117	1,198
LAFAYETTE	1,033	2,007
RAPIDES	1,735	1,728
SAINT LANDRY	1,265	2,592
SAINT MARTIN	1,026	891
VERMILION	669	1,332
VERNON	149	466
WINN	444	441
Total – South Central Region	***15,268***	***20,052***

Appendix C – Region and Parish Information for Enrollees with Diabetes

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

PARISH	≤21 YEARS	>21 YEARS
Capital Region		
ASCENSION	147	1,361
EAST BATON ROUGE	750	7,111
EAST FELICIANA	118	532
IBERVILLE	72	870
LIVINGSTON	304	1,776
POINTE COUPEE	37	481
SAINT HELENA	44	195
SAINT TAMMANY	545	2,767
TANGIPAHOA	1,001	3,579
WASHINGTON	229	1,335
WEST BATON ROUGE	56	531
WEST FELICIANA	43	189
Total – Capital Region	***3,346***	***20,727***
Gulf Region		
ASSUMPTION	29	461
JEFFERSON	1,502	8,890
LAFOURCHE	163	1,608
ORLEANS	1,229	10,327
PLAQUEMINES	45	394
SAINT BERNARD	133	1,082
SAINT CHARLES	148	716
SAINT JAMES	55	479
SAINT MARY	130	1,446
ST JOHN THE BAPTIST	142	1,016
TERREBONNE	238	1,995
Total – Gulf Region	***3,814***	***28,414***
Northern Region		
BIENVILLE	50	416
BOSSIER	261	1,557
CADDO	547	4,749
CALDWELL	26	267
CLAIBORNE	37	325
DE SOTO	58	667
EAST CARROLL	26	276
FRANKLIN	105	649
JACKSON	67	413
LINCOLN	135	818
MADISON	52	321
MOREHOUSE	118	736

PARISH	≤21 YEARS	>21 YEARS
NATCHITOCHES	78	706
OUACHITA	556	3,644
RED RIVER	17	176
RICHLAND	61	648
SABINE	74	394
TENSAS	12	171
UNION	55	483
WEBSTER	106	980
WEST CARROLL	50	355
Total – Northern Region	***2,491***	***18,751***
South Central Region		
ACADIA	128	1,347
ALLEN	57	462
AVOYELLES	164	1,094
BEAUREGARD	70	606
CALCASIEU	713	3,766
CAMERON	3	57
CATAHOULA	31	268
CONCORDIA	63	512
EVANGELINE	57	865
GRANT	77	390
IBERIA	290	1,732
JEFFERSON DAVIS	67	677
LA SALLE	368	2,204
LAFAYETTE	72	1,287
RAPIDES	610	2,467
SAINT LANDRY	233	2,215
SAINT MARTIN	116	944
VERMILION	137	1,123
VERNON	81	677
WINN	40	318
Total – South Central Region	***3,377***	***23,011***

Appendix D – MCO Action Plans

This section contains action plans submitted by each MCO Plan. The action plans describe MCO initiatives to address diabetes and obesity in the Louisiana Medicaid enrollee population. The next few pages contain brief summaries of each MCO action plan. The summaries are followed by the complete action plans submitted by each MCO and which can be accessed directly in the hyperlinks table below.

Links to Complete MCO Action Plans

Appendix D1	Aetna Better Health of Louisiana Action Plan
Appendix D2	AmeriHealth Caritas of Louisiana Action Plan
Appendix D3	Healthy Blue Action Plan
Appendix D4	Louisiana Healthcare Connections Action Plan
Appendix D5	United Healthcare Action Plan

Aetna Better Health of Louisiana Diabetes and Obesity Action Plan Summary

The ABH Diabetes and Obesity program creates new innovative ways to increase member participation and engagement through establishment of health care objectives and goals.

Goal: Improve Health Outcomes for the member diagnosed with Diabetes

- ABH developed multiple member-facing programs to improve our member engagement in the services they may receive. These include:
- Integrated Care Management Diabetes and Obesity program
- Secure Member Portal for self-management of their Diabetes and/or weight management
- Member Outreach through interactive telephone calls, mailers, member gift cards, text messaging, newsletters
- Ted E. Bear Program for child and adolescent members that includes health fairs, free giveaways, free swimming lessons, mailed recipe cards, cooking and nutrition classes, gardens planted in differing locations
- Care4Life Program web-based self-management program that addresses support
- Marketing and Community Outreach, including Diabetes walks and community health fairs
- Collaboration with Community Partners
- Lifeline Smartphone, ABH offers assistance in completion of the federally funded Lifeline phone application
- Text Messaging, targeted messages are sent to our members of services and testing needed
- Diabetes Newsletters are mailed twice a year
- Cultural and Linguistic, our mailers include a notice that material will be made available in the member's preferred language

Goal: Educate Providers on evidence-based clinical practice guidelines and HEDIS performance measures

- ABH has also developed multiple provider-facing programs to improve their knowledge of evidence-based practice guidelines and to ensure necessary tests and services are rendered to our members. These include:
- Clinical Practice Guidelines are distributed to the practitioner by web and provider newsletter of updates made by the American Diabetes Association
- Provider Education, ABH conducts in-person and web-based training sessions with practitioners on best practice and adherence to evidence-based clinical practice and preventive health guidelines, including distribution of HEDIS Tip Sheets.
- Gap in Care Reports are generated each month and distributed to practitioners and IPA Provider Groups
- Provider Incentive Programs are provided to practitioners and IPA Provider Groups to ensure quality care delivery to our members

Goal: Improve member initiation and engagement in our care management program

- ABH conducts multiple on-site trainings with our care management staff to ensure that our members are actively engaged and participate in their plan of care.
- Motivational Interviewing Education Program

AmeriHealth Caritas Louisiana 2017 Diabetes and Obesity Action Plan Summary

AmeriHealth Caritas Louisiana works to address care gaps and foster health equity with our integrated health care management (IHCM) program, a member-centric support system with a multidisciplinary approach to drive communication and care plan development. The IHCM program integrates physical health, behavioral health, and social and environmental support needs. Care Managers then coordinate with departments such as Rapid Response and Outreach Team, Quality Management, Community Health Education, and Provider Network Management to address the various needs of our members and to develop a comprehensive plan of care tailored for the individual.

Members are identified for participation in different IHCM programs to prevent and manage diabetes and obesity using several mechanisms, such as member self-enrollment, health risk assessment data, claims analyses, state agency referrals, and provider referrals. The programs include Episodic Care Management, Complex Care Management, Community Care Management, Bright Start Maternity Management, and Make Every Calorie Count, a support plan for adults and children to live at a healthy weight. The Community Health Education department makes calls to non-compliant diabetic members identified by providers. Providers are offered face-to-face or online provider trainings to better serve their members, and specific providers also are targeted by the Quality department to receive education and training to address member care gaps based on current HEDIS rates. AmeriHealth Caritas further encourages providers to enhance member outcomes through PerformPlus, a suite of innovative value-based contracting programs, and the Quality Enhancement Program (QEP), supplement primary care reimbursement through a performance incentive payment based on the provider's scores on various quality and efficiency measures.

All members have access to our member portal to find and to store their health information. They also receive a biannual newsletter which provides information on plan resources and member education topics such as diabetes, nutrition, and weight management. Our automated calls and text messaging processes send reminders for annual well visits. Members diagnosed with diabetes can receive rewards for completing regular diabetic screenings. Mailings are sent to all newly identified diabetic members with follow-up care information and relevant phone numbers. Diabetic members engaged in case management receive emergency room follow-up. The Rapid Response and Outreach Team also provides emergency room follow-up for members who are not engaged in case management and reviews calls to the 24/7 Nurse Helpline for supplemental outreach. The Community Health Education Team supports members through education and engagement at our Community Wellness Centers as well as targeted health screenings and community events across the state.

Healthy Blue Diabetes and Obesity Prevention Action Plan Summary

To prevent diabetes and obesity Healthy Blue identified key performance measure that include Adult, Children and disease comorbidities by monitoring, implementing initiatives and interventions that engage our members and providers.

Our goal is to achieve the 50th percentile NCQA benchmark based off the 2017 Quality Compass Scores for the following measures:

- Weight Assess & Counseling for Nutrition & Physical Activity Members 3-17
- Adult BMI Screening Members 18-64
- Comprehensive Diabetes Care A1C Testing, Eye Exam, Attention for Medical Nephropathy, Poor Control (>9.0%)
- Diabetes Short-term complication
- Diabetes monitoring for people with Diabetes & Schizophrenia
- Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications

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

- Provider Education/Provider Incentives- to align with state performance measures
- Quality Care Coordination/Member Incentive
- Education Classes- Diabetes Educator
- Case Management Care Coordination
- Disease Management Program
- Community Engagement

By strategically collaborating with other departments within the Health Plan we can drive positive outcomes that will result in better health for the members.

Louisiana Healthcare Connections Diabetes and Obesity Action Plan Summary

Louisiana Healthcare Connections is dedicated to improving the health of our members diagnosed with diabetes and/or obesity. The Health Plan has developed specialized health coaching programs to assist these member populations with reaching their health goals. Referrals to each of these programs can come from multiple sources including, but not limited to, claims data, physician referral, and member self-referral.

The Diabetes Management Program provides telephonic outreach, education, and support services to adult and pediatric members identified as having diabetes. The goal of this program is to assist members to improve blood glucose levels, blood pressure and lipid levels, which should minimize the development and/or progression of diabetic complications. Each member enrolled in the program is assigned to a health coach (certified diabetes educator) or RN Case Manager, as appropriate, for ongoing education and monitoring according to evidence-based clinical guidelines.

The Weight Management Programs offered by the Health Plan are separate for adult and pediatric members. The adult program provides telephonic outreach, education and support services to members of the Health Plan in order to improve nutrition and exercise patterns to manage weight and minimize health risk factors. Adults must meet certain criteria to be eligible for this one-year program. The pediatric weight management program, Raising Well®, helps overweight and obese children achieve long-term physical health improvement by targeting and working with parents to achieve permanent healthy lifestyle habits. Each member enrolled in these programs is assigned to a health coach (a Registered Dietitian Nutritionist or an Exercise Physiologist) for ongoing education and monitoring according to evidence-based clinical guidelines.

United Healthcare Diabetes and Obesity Action Plan Summary

United designs better care for each member by inviting him or her to complete a Health Risk Assessment (HRA) upon enrollment. The HRA can be completed during the welcome call. Members, who cannot be reached, receive a postcard inviting them to call in, or complete the assessment online. Those who complete their assessment within 90 days of enrollment receive a thank you gift card. Member's needs can also be identified by way of Whole Person Care Modeling, a software application that predicts health risks and assess utilization so that members can be identified, and invited to participate in care management programs, such as diabetes, if warranted. New members and newly diagnosed members with diabetes or obesity among other conditions, receive educational materials and newsletters with diabetic, and or weight management specific information, including recommended routine appointment frequency, health logs, monitoring and self-care. Expectant members identified with diabetes are offered the Healthy First Steps maternal management program to improve maternal and infant health outcomes.

By collaborating with community partners, United works towards improving the health of its members. Members are invited to YWCA diabetic Lunch'n'Learn venues, and in Baton Rouge, the Pennington Wellness Day, which focuses on healthy lifestyles to reduce obesity, and mitigate health risks from diabetes. United provides grants for 4H clubs to support healthy-living programs, events and other activities that encourage young people and their families to eat more nutritious foods and exercise regularly. Sesame Street Food for Thought toolkits were provided to venues such as Head Start for families with young children dealing with food insecurity.

United strives to lower costs by helping people live healthier lives. United programs such as Heart Smart Sisters are designed to empower women to make positive changes to help reduce their risk of developing heart disease. The program includes monthly classes to educate women about heart disease, diabetic risk, and the benefits of healthy diet along with the importance of regular exercise. United staff educates care providers on the importance of members with diabetes receiving HBA1c testing, retinal eye exams, attention for nephropathy and blood pressure control. Care providers are also educated regarding the health risks for members who are obese, and how to work with members towards a healthier lifestyle. United's Dr. Health E. Hound provides a non-threatening way to educate children and their families about healthy living, including healthy eating habits, and the value of dental hygiene.

Appendix D1 - Aetna Better Health of Louisiana
Diabetes and Obesity Action Plan

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 healthcare costs. [20]

Aetna Better Health of Louisiana (ABH) is required to submit a Diabetes and Obesity action plan annually to the Louisiana Department of Health (LDH), as required by our state contract.

Obesity is defined as weight that is higher than what is considered as a healthy weight for a given height. Body Mass Index, or BMI, is used as a screening tool for overweight or obesity.[21] For children and teens obesity is defined as a BMI at or above the 95th percentile of those with the same age and sex.[22]

Obesity has many health risks associated with it for adults, teens and children. This multiplies due to lack of physical activity and poor dietary habits. For the person who is obese, the risks of developing diabetes, high blood pressure, increased fat in their blood, and inflammation of their arteries, veins and capillaries increases.

Diabetes is a disease in which blood glucose levels are above normal. There are three main type of diabetes:

Type 1 diabetes is usually diagnosed in children and teens, and accounts for 5 percent of all diagnosed cases of diabetes in adults.

Type 2 diabetes accounts for 90 percent to 95 percent of all diagnosed cases of diabetes in adults. Type 2 diabetes is increasingly being diagnosed in children and adolescents.

Gestational diabetes occurs in 2 percent to 10 percent of pregnancies. Women who have had gestational diabetes have a 35 percent to 60 percent chance of developing diabetes, mostly Type 2, in the following 10 to 20 years.

Prediabetes is a condition in which individuals have blood glucose levels high than normal but not high enough to be classified as diabetes. People with prediabetes have an increased risk of developing Type 2 diabetes, heart disease and stroke.

Diabetes can lead to serious complications and premature death, but people with diabetes can take steps to control the disease and lower the risk of complications. Managing diabetes is possible with proper medical care, support and motivation. [23]

Background

Quality management, care management and evaluation are key components of managing the services and care provided to our members. We evaluate the effectiveness of our quality and care management programs annually and based on the results, implement interventions to improve member health outcomes. A successful integrated

[20] April 2018 Diabetes and Action Report for Health Louisiana Program, Executive Summary, Page 3
[21] https://www.cdc.gov/obesity/adult/defining.html
[22] https://www.cdc.gov/obesity/childhood/defining.html
[23] https://www.cdc.gov/diabetes/diabetesatwork/diabetes-basics/what.html

program results in outcomes as intended based on program design. Outcomes studied include but are not limited to [refer to Appendix A]:

- Reported rates of diabetes care practices among adults with diabetes
- Diabetes prevalence by sex and age group
- Total unduplicated number of MCO members with diabetes in reporting period by region, parish and age groups
- Total unduplicated number of MCO members with obesity in reporting period by region, parish and age group
- Burden of obesity among MCO members
- Burden of diabetes on pregnancies among MCO members
- Inpatient hospital discharges among MCO members by age with diabetes as a primary diagnosis
- Inpatient hospital discharges by age where a diabetes or diabetic complication was the primary diagnosis
- Total ED visits by age group where diabetes mellitus was the primary diagnosis
- Comparison of prevalence and cost between diabetes and other common chronic diseases
- HEDIS measurements for diabetes and obesity health outcomes, adult BMI assessment, and controlling blood pressure, comprehensive diabetes care, well-child visit, and weight assessment and counseling for nutrition and physical activity for children/adolescents

Quality Management

Our Quality Assessment and Improvement Program (QAPI) is designed to facilitate a member's access to high-quality medical and/or behavioral healthcare, access to primary and specialty care, continuity and coordination of care across settings, and culturally competent care, including quality and appropriateness of care furnished to members with diabetes and obesity.

With our QAPI, we measure and track key aspects of care and services delivered to our members, use data-driven monitoring to identify improvement opportunities, implement interventions and analyze data to determine overall intervention effectiveness in improving clinical care and member outcomes.

We strive for continuous improvement and innovation in meeting members' healthcare needs and work to facilitate members' access to high-quality healthcare in the right place, at the right time and in the most effective and efficient manner possible. We obtain feedback from key stakeholders, members and their families/caregivers and providers, using feedback to make recommendations to improve performance.

Diabetes and Obesity Action Plan Goals

- Improve member health outcomes among underserved regions
- Create community environments that promote and support health lifestyle choice
- Prevention of obesity through education and weight management programs
- Reduce the onset and severity of diabetes-related complications
- Reduce financial burden for diabetes and obesity related conditions
- Practitioner adherence to evidence-based clinical practice guidelines
- Expansion of practitioner and MCO role in obesity prevention

Diabetes and Obesity Action Plan Objectives

- Improve member health outcomes among underserved regions by ensuring needed services and testing are completed each year
- Provide care management and needed resources for our members diagnosed with diabetes and/or obesity
- Distribution of current evidence-based clinical practice guidelines, and ongoing provider education to ensure adherence to best practice
- Increase provider and member awareness by promoting earlier adoption of prevention behaviors through distribution of member and provider newsletters, disease-specific targeted mailers, outreach calls and text messages to ensure services are completed, and web-based interactive programs for self-management
- Implementation of the Ted E. Bear child and teen nutrition and physical activity program to ensure healthy food choices and weight management
- Increase member participation in the care management program and other services provided by the MCO, including health fairs and value added benefits
- Increase member access to diabetes self-management education to reduce the onset and severity of diabetes-related complications

Interventions

ABHLA conducted a root cause and barrier analysis to identify specific reasons for member noncompliance in receiving the necessary services and tests needed to keep them healthy. The major causes are:

1. Knowledge deficit – The member is unaware of how to adequately monitor and track their blood sugar levels, as many have not received education and training and/or do not know the resources available to them through the MCO.
2. Noncompliance to recommended diet, medication, treatment and exercise programs secondary to personal practices, financial and/or regional dietary patterns influencing health outcomes.
3. Lack of transportation to medical appointments and testing. Many of the members are living at or below poverty level. They do not own a car and rely on public transportation. Members with young children living at home cannot leave them and are either unable to take them to appointments and/or cannot pay to hire a babysitter.
4. Linkage to care management and the resources available to them. We improved communication regarding the services the MCO provides to the members. The MCO physician and member educational materials now detail the services and resources available to our members with diabetes and obesity.
5. Member self-reported health risk assessment by interactive telephone calls (IVR). Conducting the assessment by IVR causes a break in communication. Members hang up on the initial call and/or during the call. The questions asked may not be answered correctly and the member may experience technical difficulty during transmission.
6. Auto-assignment process – The member has not established care with a primary care physician and/or endocrinologist. Many members are assigned a physician as their primary practitioner and are unaware of the assignment or elect to not use them.

1 ***Knowledge Deficit***

ABHLA educates our members and their family members about how to better manage their health condition. We use mobile technology, web-based programs and text messages as part of our chronic care management programs.

Care4Life™

Provides our diabetics members with diabetes education and support self-management tools:

- The program addresses support for healthy eating by providing members with access to healthy recipes, nutrition tips and videos. Video topics include: Alcohol, Quit Smoking, Blood Glucose Monitoring, Hypoglycemia, Avoid Sugary Drinks, Creating a Healthy Plate, Count Your Carbs, Dining Out, Watch What You Add to Food, Hidden Salt, Eating at Fast Food Restaurants, Quick Snack Ideas, Quick Breakfast, Move More, Aerobic Exercise, Strength Exercise, Insulin and Exercise and many more
- Provides support for self-managing their condition through reminders for medications and appointment
- Provides members an avenue to track blood pressure and blood glucose
- Provides support for physical activity by enabling members with access to track exercise and weight goals
- Members may print off their health record and share with their doctor

Members may use Care4life through an app, text messages or a website. Members get personalized messages based on the information they provide. Care4Life was developed in collaboration with the American Diabetes Association.

Lifeline Smartphone

ABH launched the Lifeline Smartphone to link members to improved phone services for better communication between the plan, their physician and our care management team. The MCO now has new smartphone options for eligible members. The smartphone options include set amount of voice minutes and data, and unlimited texting each month.

Wellpass Text Messaging

This educational text messaging program consists of the Lifeline Smartphone and targeted messages to ensure members get tests and screenings done. It sends routine reminders to members to complete recommended diabetes tests, and provides information regarding the weight management programs available to them.

Diabetes and Obesity Member Newsletters

Diabetes and Obesity Newsletters are sent to members twice a year. Currently, ABHLA is modifying the newsletters and providing additional information for how the member can better manage their disease; tips about preventive health care; their pharmacy benefits; information about medical complications that could occur; available resources; and how to access care management for assistance.

Diabetes Education and Empowerment Program (DEEP)

A new initiative for 2018, the curriculum is designed to help people with prediabetes and existing diabetes gain a better understanding of how to manage their care. Each class is approximately one-and-a-half to two hours in length with eight modules covered over a period of six weeks. They are:

Module 1: Beginning Sessions and Understanding the Human Body
Module 2: Understanding Risk Factors for Diabetes
Module 3: Monitoring Your Body
Module 4: Get up and Move! Physical Activity and Diabetes
Module 5: Controlling Diabetes through Nutrition
Module 6: Diabetes Complications: Identification and Prevention
Module 7: Learning about Medications and Medical Care
Module 8: Living with Chronic Disease: Mobilizing Family and Friends

Certified Diabetes Educators

ABH Care Management staff members attended diabetes educator courses and a total of 12 staff members became certified diabetes educators. Our diabetes educators will conduct trainings sessions in each region at a minimum of one time per year. A parish will be selected in each region identified with an increased volume of eligible members. Members will be notified of classes available to them and the training dates. Notifications will be sent by mail and direct member telephone calls by the Care Management team.

Information Health Line

The Information Health Line (IHL) gives members 24-hour, toll-free access to a team of registered nurses experienced in providing information on a variety of health topics. IHL also features an audio/video health library, a recorded collection of more than 2,000 health topics available in both English and Spanish. The audio/video health library contains information about specific health issues, including diabetes, obesity, weight loss and much more. The IHL can also be accessed by email. Reports on members accessing the health information line are integrated into the Care Management program, allowing care managers the ability to open member activity tracking events for follow-up.

Health Schools Training Krewe

ABHLA actively participates in the Healthy Schools Training Krewe, a take-off of the Smarter Lunchroom program headed out of Cornell University. We collaborate with school educators on providing health education, physical activity and Smarter Lunchroom trainings. The mission of the training is to enhance the knowledge and skills of those working directly with students on how to create healthier schools through child and teen increased physical activity and education prompting them to make healthier food choices. Collaborating organizations are:

- Well-Ahead Louisiana
- Department of Education, Louisiana Believes
- Louisiana Association for Health, Physical Education, Recreation and Dance
- Alliance for a Healthier Generation
- School Nutrition Association of Louisiana
- Louisiana Department of Health
- Action for Healthy Kids
- Eat Move Grow
- LA Fit Kids

Marketing and Community Outreach

We tailor our initiatives focusing on the diversity of the various parishes, cultures and ethnicities found within Louisiana. Diabetes and obesity health fairs bring information directly to the member and their family members through fun interactive activities. We also encourage our staff to volunteer and participate in the diabetes run/walks that occur each November in Shreveport, Baton Rouge and New Orleans, partnering with the American Diabetes Association.

2 ***Non-Compliance***

ABHLA strives to ensure all members receive the services they need. We outreach to each member or their legal guardian directly, and their physician about any gaps in care.

Provider Education

Clinical practice guidelines are distributed to the practitioner by web and provider newsletter of updates made by the American Diabetes Association.

We conduct in-person and web-based training sessions with practitioners on best practice and adherence to evidence-based clinical practice and preventive health guidelines. These sessions are scheduled throughout the year. We also distribute HEDIS tip sheets to them, which provide information about recommended diabetes and obesity health tests and screenings.

Provider Notifications

Each month ABHLA generates a list of members who have not received the needed services, tests, and screenings they need. The list is sent to their primary care physician and includes the names of members who have not had their annual wellness visit, need diabetes tests done and/or have not had a recent BMI calculated. We track and trend this data each month and outreach directly to the doctors to ensure gap closure.

Provider Incentives

We provide financial incentives to our physicians and Independent Physician Associations (IPA) groups that attain specific target goals for diabetes and obesity care. The value-based solutions (VBS) and population health team meet regularly with physicians, educating them on attainable incentives which are paid out each year. New VBS-based agreements are entered into each month with individual practitioners, hospitals and urgent care centers.

Diabetes Member Mailers

Three times each year, members receive a mailed notice informing them of the services and/or tests they need done. Mailings are sent in English and Spanish. The mailings include information about the monetary incentive they can receive if they complete the test.

- The control your diabetes letter includes the list of tests needed to be done and the date of last claim received. They are also informed of gift cards available to them for getting the test done.
- The diabetes follow-up flier informs the member that they are due for their A1c blood test, diabetes eye exam and kidney test, including frequency. The flier includes information on how to contact the member services department if they need help finding a physician or to schedule a visit.
- The diabetes retinopathy mailer recommends members schedule an appointment to get their eye exam done and how to prevent vision loss through routine testing.

Diabetes Reminder Phone Calls

IVR calls remind members to get their A1c test, nephropathy screening and/or retinal eye exam completed. Members are called each quarter if there is an open gap in care. During the call, the IVR data platform links the member directly to the member services department and/or transportation vendor to ensure their appointment is scheduled and/or they are able to get to their appointment. Members may also request to speak to the care management team; a list is auto-generated and sent to care management of all members they need to call back.

Value Added Benefits

ABHLA offers gift card incentives to our members when they get necessary screenings and tests done. The gift card encourages them to continue to get care and improves their experience with the MCO. Gift cards available to members are:

- $15 gift card for completion of the retinal eye exam
- $15 gift card for A1c blood test
- $25 gift card for children and teens annual wellness examination, which includes BMI calculation
- $15 - $30 for completion of their nutrition assessment/ physical activity assessment

Ted E. Bear Weight Management Program

Aetna provides a weight management program for children and adolescents ages 5 through 20 years of age. Members who qualify are screened by their PCP for participation, who meets the Center for Disease Control BMI definition for being overweight and/or obese.

In 2018, we identified approximately 1,300 children and teens who qualified. The program includes innovative mailers, wellness events, Ted E. Bear picnics and Ted E. Bear gardens.

Child and Teen Innovative Mailers

To motivate the child or teen, ABHLA is sending free gift items to the member to incentivize them to participate in the program. The types of gift items to be mailed and/or given out at health events are:

- Stuffed Ted E. Bear promotional toy
- Branded Ted E. Bear cookbook to teach healthy alternatives
- Healthy diet recipe cards
- Vegetable garden starter kit (ex. grow your own tomato garden)
- Jump ropes, basketballs and hopscotch kits

Ted E. Bear Wellness Fair

In collaboration with the Louisiana Department of Health Well-Ahead Louisiana program, we will promote healthy eating habits and physical activity by holding health fairs in nine regions.

During each event, we will:

- Provide new bike vouchers, helmets and proper safety instructions to increase child or teen physical activity
- Celebrate with celebrity chef Jay Ducote, who has partnered with ABHLA by creating a short video of healthy eating tips which will be viewed on a large screen
- Provide interactive “plant your own garden” educational demonstration to encourage healthy eating. Free seeds will be provided.

- Give kid-friendly recipe cards to teach children how to make better, healthier choices

Ted E. Bear Picnic
In coordination and partnership with school-based provider groups (example, RKM Primary Be-fit summer program) we will emphasize the importance of healthy eating and exercise. Healthy food and drink will be provided to the child, and their family members at the picnic.

Ted E. Bear Garden
ABHLA initiatives include a community garden and personal garden for the child or teen to maintain. The child or adult will learn how to grow their own fruit and vegetables for consumption and healthy eating habits.

- We are partnering with community gardens or sponsoring a garden in regions 1, 2, 4 and 9. These regions were identified as having the highest volume of obese child or adolescent members.
- A vegetable garden starter kit (ex. grow your own tomato garden) will be mailed to each member and/or handed out during the picnics and wellness fairs.

Members will also be linked to the Care Management program to assist in their weight loss goals. With ongoing monitoring of their progress, we anticipate these children and youth to live a longer and healthy life.

3 ***Lack of Transportation***
ABHLA is partnering with Quest Diagnostic Labs/ Mobile Medical Examination Services "MedXm" to go to the member(s) home and provide preventive health screenings and lab tests.

These services are provided and offered at no cost to the member. Visits will be made during the daytime, evening hours or weekends based on the member's needs. The results of the services and tests are forwarded to their physician and the care management team for coordination of care. The following tests and /or services will be provided to close gaps in care:

- Diabetes retinal eye exam
- Diabetes A1c blood test
- Diabetes nephrology testing
- Diabetes blood pressure
- Blood pressure for member with a confirmed hypertension diagnosis
- BMI assessment
- A1c testing for members with schizophrenia and bipolar disorder

Health risk assessments to be performed include:

- Well-child visits for children ages 3 through 6
- Well-child visits for adolescents
- Weight assessment and counseling for nutrition and physical activity for children and adolescents

Going to where the member resides will assist in alleviating any transportation or childcare barriers the member may have in preventing them from getting the services they need.

4 ***Linkage to Care Management***

ABHLA's integrated care management (ICM) program is a collaborative process of biopsychosocial assessment, planning, facilitation, care coordination, evaluation and advocacy for service and support options to meet members' comprehensive care needs to promote quality cost-effective outcomes.

The ICM program is stratified into three levels of care based on the complexity of member needs:

- Intensive case management (complex case management)
- Supportive case management
- Population health

Intensive care management is intended for people with complex conditions to help them receive coordinated care, based on a customized approach to each individual's unique circumstances. It includes a highly individualized range of interventions to help members and their families manage serious and complex conditions that are persistent and substantially disabling or life threatening. These conditions are marked by biological, psychological and/or social comorbidities that interfere with standard care delivery. Intensive care management interventions include chronic condition management education as appropriate as well as assistance with accessing care across the continuum for as long as necessary to stabilize or impact care outcomes.

Supportive care management includes problem-solving interventions that focus on improving access to, and effectiveness and safety of, standard health care for individual members. Supportive care management is targeted towards members who have lesser clinical and bio-psycho-social complexity or may be brief and condition focused for other members; including chronic conditions.

Population health level of care for chronic condition management includes monitoring and education for low-risk populations, which includes our member's with diabetes, obesity and other co-morbid conditions.

All levels of care management include assistance with the management of chronic conditions (disease management), education, encouragement to learn self-management skills and coordination of access to appropriate services and supports, including diabetes and obesity.

Case managers use condition-specific assessments and care plan options to help members with diabetes or obesity better manage their care. Members with diabetes or obesity are identified by predictive modeling (CORE), claims, health risk questionnaires, care management assessments and concurrent review/prior authorization referral, as well as member and provider referral. Interventions include:

- Improved telephonic and print education on self-monitoring,
- Member support through a secure member portal with website log-in link to evidence-based health appraisal and self-management tools and digital coaching programs,
- Health information line (24 hours, seven days a week) where nurses assist members with wellness and prevention information,
- Emphasis on exacerbation and complication prevention using evidence-based clinical guidelines and member engagement through care management activation strategies,
- Care management assistance with techniques to better adhere to medication regimens, clinical monitoring and treatment plans, and
- Care management collaboration (with member's consent) with providers and caregivers.

Member Portal

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

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

5 ***Member Self-Reported Information***

Currently, a health risk assessment (HRA) is completed by interactive telephone calls (IVR). Conducting the assessment by IVR causes a break in communication. ABHLA is moving toward using increased technology and improved communication to increase member compliance in completion. Through mobile apps, web-based HRAs, email, member mailers and live outreach calls we can ensure our members with diabetes and obesity are linked to the Care Management team to better evaluate their health risks and quality of life for our population health management.

6 ***Auto-assignment Process***

ABHLA selects or assigns a primary care doctor, or endocrinologist, if the member has not chosen one after enrollment with the MCO. We are currently reviewing our process to ensure members receive:

- A welcome packet that includes written materials to assist them with the selection process
- Mailed directory of doctors, clinics and health care services
- Information about how to contact the MCO to update or change the doctor assigned, including selection of an endocrinologist or weight specialist
- A telephone call to assist them in selecting a physician near their home, or specializes on their health care needs to provide the necessary services and tests they need.

Conclusion

ABHLA's programs have positively impacted our HEDIS rates and the quality of care and service our members need. With the interventions implemented, we saw a marked improvement in our HEDIS rating scores for MY 2017 for Adult BMI Assessment, and Controlling Blood Pressure, Comprehensive Diabetes Care, Well-Child visit, and Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents.

We did identify areas of improvement needed in the areas of care/disease management, member outreach, member and provider education and member assignment. New processes were implemented, and education and training has begun and will continue throughout MY 2018 to improve our members' health outcomes and their experience with the services we render.

We also identified a need for improved communication and timeliness of communication between our care management and members. The importance of members knowing who to contact and ensuring timeliness of phone calls received was addressed with each staff member. We forwarded an education and training course to the care managers referencing effective communication techniques, and requested completion by the end of Quarter 2, 2018.

Lastly, our clinical practice guidelines were reviewed by our chief medical officer with modification and additions made to ensure we are following and using evidenced-based practices. We anticipate that with the interventions and action plan developed we can achieve further improve health outcomes for our members this upcoming year.

Appendix D2 – AmeriHealth Caritas Louisiana 2017 Diabetes and Obesity Action Plan

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

AmeriHealth Caritas Louisiana works to address care gaps and foster health equity with our integrated health care management (IHCM) program. This program utilizes a member-centric support system with a multidisciplinary approach to drive communication and care plan development. AmeriHealth Caritas Louisiana's IHCM program integrates physical health, behavioral health, and social and environmental support needs. Member conditions are combined into a comprehensive plan of care tailored for the individual.

AmeriHealth Caritas Louisiana's care managers then coordinate with other departments such as Rapid Response and Outreach Team, Quality Management, Community Health Education and Provider Network Management to address the various needs of our members.

Participant Identification

Several mechanisms are used to identify members for participation:

- **Health Risk Assessment Data** – Members responding positively to questions on diabetes on the Health Risk Assessment will be enrolled.
- **Claims Analysis** – Monthly medical, behavioral and pharmacy claim data is analyzed to identify members newly diagnosed with diabetes.
- **Provider Referral** – Information on the plan's program is contain in the provider manual, on the ACLA website and in periodic provider communications throughout the year. Providers can call or fax ACLA's IHCM Department to request enrollment of a member in the In Control Program.
- **Member Call or Contact** – Information on the plan's programs is contained in the member handbook, on member pages of ACLA's website and in periodic communications throughout the year. Members can call and request enrollment in the program. Additionally, ACLA's call center staff members who identify that a member has diabetes communicate the identification to the IHCM Department who enrolls the member.
- **State Referrals** – Any state agency can refer members via fax, phone or reports.

AmeriHealth Caritas Louisiana Calendar Year 2015, 2016 and 2017 Rate Comparison

Comprehensive Diabetes Care (CDC)				
	CY 2015 Rate	CY 2016 Rate	CY 2017 Rate	NCQA Quality Compass 2017 Percentile
Hemoglobin A1c (HbA1c)Testing	80.80%	86.86%	85.16%	25th Percentile
Eye Exam (Retinal) Performed	47.47%	53.77%	57.42%	50th Percentile
Medical Attention for Nephropathy	90.58%	92.94%	92.21%	75th Percentile

Note: There were no statistically significant changes in the rates from CY 2016 to CY 2017. The CDC *Eye Exam (Retinal) Performed* measure moved from the 25th to the 50th percentile from CY 2016 to CY 2017.

AmeriHealth Caritas Louisiana Programs to Prevent and Manage Diabetes and Obesity

In 2017, a total number of 2,720 members were engaged in an Integrated Health Care Management Program including those with a primary diagnosis of diabetes or obesity. Program overviews are listed below:

Episodic Care Management

The Episodic Care Management program functions within the Rapid Response and Outreach Team department to assist members with short-term and/or intermittent needs. The Rapid Response and Outreach Team care managers coordinate resolution of pharmacy, durable medical equipment (DME), transportation, referral and provider access issues, as well as provide community resource support.

Bright Start (Maternity Management)

Bright Start consists of a team of registered care managers and care connectors dedicated to our pregnant members. The care managers and care connectors outreach and engage pregnant members in the Bright Start program based on their risk categories determined by internal and external assessments. The care managers coordinate care, including depression screenings and pregnancy education, and address any issue that may arise throughout the member's pregnancy and postpartum period, such as gestational diabetes.

Complex Care Management

Complex Care Management (CCM) is a voluntary program for high-risk members with chronic conditions such as diabetes. CCM is focused on disease prevention and education, lifestyle choice awareness and treatment plan adherence. CCM is designed to support a member's plan of care by offering one-on-one education and support from an assigned care manager. The care manager works with the provider and the member or caregiver to develop an individualized care plan to facilitate the delivery and monitoring of appropriate medical, behavioral health and social services.

Community Care Management Team

As an extension of our Care Management program, the Community Care Management Team responds to the needs of our highest-risk adult members with chronic conditions such as diabetes. AmeriHealth Caritas Louisiana's community-based team of nurses, social workers and community health workers utilize a high-touch, in-person approach to assist members in navigating the appropriate levels of health care. Their focus is on increasing access

to necessary medical, behavioral health and social services. This team has expanded their territorial coverage to include Baton Rouge and surrounding parishes, the New Orleans area, Lafayette and Shreveport areas.

Let Us Know

2017 Member Intervention Requests: 353

The Let Us Know program is a partnership between AmeriHealth Caritas Louisiana and the provider community to collaborate in the engagement with and management of our chronically ill members. We have multiple support teams and tools available to assist providers in outreaching and educating these members, as well as clinical resources for provider in their care management.

Make Every Calorie Count

The Make Every Calorie Count program gives support to adults and children to live at a healthy weight. Engaged members receive:

- One-on-one education and support from an assigned case manager.
- Make Every Calorie Count welcome packet which includes a pedometer, tape measure, daily food and activity log book, portion control education and lifestyle tips.
- Up to two visits a year with a registered dietitian.
- Adults and children receive a one- year gym membership (with option for Home Program) through the American Specialty Health network of affiliated gyms.
- Children can also receive up to eight swimming lessons through collaboration with the YMCA. Swimming lesson promote safety and the potential for members to become swimmers and incorporate this activity into their daily lives.

Supporting Member Education and Engagement

AmeriHealth Caritas Louisiana Community Center Access and other targeted events to promote community health – The Community Health Education Team and CLAS organize events such as "Caritas on the Move," "Wellness Day," "Diabetes Destination Walks" targeting non-compliant members with an HbA1c test, nephropathy and/or dilated eye exam care gap(s). Diabetic education, exercise/nutrition counseling, blood pressure checks, BMI assessments and other screenings are offered at the event at no cost to the member.

Member Benefits – Members diagnosed with diabetes can receive $10 loaded to their Care Card for each diabetic screening completed; and $30 for completing all three: HbA1c test, nephropathy, and/or dilated eye exam. This information is incorporated in all member communication (written or verbal).

Web Content – Members can access the ACLA website **(http://www.amerihealthcaritasla.com)** to obtain educational information related to diabetes and obesity, community resources and case management.

Member Portal – Members can access the member portal to find and store health information. The portal contains information on medicines, medical history, provider directory, current member contact information, member handbook, programs, services, and other health and wellness information.

24/7 Nurse Helpline Follow-Up Call – Calls to the Nurse Help Line are reviewed by the Rapid Response and Outreach Team. Outreach is scheduled for all members who call for symptom counseling.

Automated Calls – The AmeriHealth Caritas Louisiana automated calls process sends members reminders for annual well visits and provides information about upcoming events in their community.

Emergency Room Follow-Up – Members engaged in case management receive emergency room follow-up. The Rapid Response and Outreach Team provides emergency room follow-up for members who are not engaged in case management.

Mailings – Mailings are sent to all newly identified diabetic members with follow-up care information and relevant phone numbers for health or medication questions, appointment assistance and transportation needs. Identified high- risk members are telephonically outreached as an attempt for engagement in case management. Members that opt out of case management are still included in quarterly mailings.

Newsletters – All members receive a biannual newsletter that provides information on plan resources and member education topics such as diabetes, nutrition and weight management.

Social Media – The AmeriHealth Caritas Louisiana social media presence helps to keep members up to date on upcoming events in their community.

Member Mobile Apps – The AmeriHealth Caritas Louisiana mobile app helps to keep members up to date on their health.

Text Messaging – The AmeriHealth Caritas Louisiana text messages process helps to keep members up to date on their health care information and sends reminders for annual well visits.

Supporting Provider Education and Engagement

Quality Enhancement Program (QEP) – The QEP supplements primary care reimbursement through a performance incentive payment, which is based on the provider's scores on various quality and efficiency measures as compared to his or her peers. The QEP quality measures include weight assessment and counseling for nutrition, comprehensive diabetes care and adult BMI that aligns with recommendations set by the Louisiana Department of Health (LDH).

HEDIS Performance Measurement Summary – The HEDIS Performance Measurement Summary shares monthly interim rates with providers on HEDIS measures such as weight assessment and counseling for nutrition, comprehensive diabetes care and adult BMI status. Providers can compare interim rates to end-of-year scores for the previous year and NCQA benchmarks.

Navinet – Secure provider portal in which providers can receive direct electronic access to assigned member information, access the members' plan of care and provide input. Providers can also use Navinet to refer members to a case management program, care gaps, hospital and ER admissions.

AmeriHealth Caritas' PerformPlus – A suite of innovative value-based contracting programs designed to enhance member outcomes, reward efficiencies' and promote accountability.

Provider Trainings – Providers can take orientation and training course to better serve their members. Trainings are offered face-to-face in a group setting, online, or providers can schedule an appointment in the office by contacting a provider network management account executive.

Targeted Provider Visits – Providers are targeted by the Quality department based on current HEDIS rates to receive education and training to address member care gaps.

Care Gap Closure Calls – Providers can contact the Community Health Education department to schedule an appointment for an AmeriHealth Caritas Louisiana representative to make calls to noncompliant diabetic members in the office.

HEDIS Coding and Documentation Guidelines – A guide developed based on individualized HEDIS measures. This guide also provides a description of the measures such as diabetic comprehensive care, documentation required and coding.

Web Content – Providers can access the ACLA website **(http://www.amerihealthcaritasla.com)** to obtain educational information related to diabetes and obesity, community resources and case management.

Network News – Providers can sign up for email alerts to get important health plan news and information.

Provider Incentives: CPT Category II codes – Providers are eligible for a supplemental reimbursement upon submission of CPT CAT II codes when care is provided to members with diabetes.

Appendix D3 – Healthy Blue
Diabetes and Obesity Prevention Action Plan

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

- Weight assess and counseling for nutrition and physical activity members 3-17
- Adult BMI screening members 18-64
- Comprehensive diabetes care HbA1c testing
- Comprehensive diabetes care eye exams
- Comprehensive diabetes care attention for medical nephropathy
- Comprehensive diabetes care poor control (>9.0 percent)
- Comprehensive diabetes care good control (<8.0 percent)
- Diabetes short-term complication
- Diabetes monitoring for people with diabetes and schizophrenia
- Diabetes screening for people with schizophrenia or bipolar disorder who are using antipsychotic medications

Goal: Performance measures are targeted to reach the 50th percentile NCQA benchmark based off the 2017 Quality Compass Scores.

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

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

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

Intervention	Intervention Detail
Provider Education	The MCO has identified providers with a high noncompliant population. Currently focusing on the top 200 providers to provide: • HEDIS education • Documentation & coding education • Development of action plans with provider to improve performance outcomes • Provider summits and webinars

Intervention	Intervention Detail
	• Certified diabetes instructor acts a practice consultant to top 50 providers with performance gaps to provide on-going education and support
Provider Incentives	• Provider incentive programs aligned with state performance measures
Member Incentive	• Member receives $10 for getting diabetes care, earning up to $30 in rewards • Member can earn up to $25 for completing a well visit
Educational Classes	• Healthy Blue providers diabetes classes to members with a diagnosis of diabetes conducted by a certified diabetes instructor • Educational classes provided to community partners
Quality Care Coordination	• Member outreach calls to members who are noncompliant for preventive services such as eye exams, HbA1c testing and adult BMI screenings
Case Management Care Coordination	• Member outreach to members who were discharged from an inpatient facility with a shot-term diagnosis. The health plan goal is to get the member back to the PCP after discharge, therefore reducing admissions.
Disease Management Program	• Educate and coach members with chronic conditions
Diabetes Pharmacy MTM Program	• Pharmacists will receive an extra reimbursement for educating members about their diabetes drugs and open CDC HEDIS care gaps. The overall goal is to reduce adverse effects.
Community Engagement	• Hosting of community events to educate the population regarding the importance of prevention, management and follow-up care for obesity and diabetes • Host clinic days to provide wellness/diabetic screenings • Participation in state collaborative for Louisiana Diabetes • American Academy for Diabetes Educators involvement • Development of diabetes educational public service announcements
Member Engagement	• Educational tools are sent to our members to provide additional teachings regarding diabetes and obesity • Innovative technological tool implemented to engage members via text messaging and IVR calls in order to provide education on care gaps and assistance with scheduling appointments • Value-added benefit to offer members Weight Watcher courses

Appendix D4 – Louisiana Healthcare Connections
Diabetes and Weight Management Programs and Action Plan (2017)

Diabetes Management Program and Plan of Action

Program Objective

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

Eligibility Criteria

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

- Two or more primary or secondary diabetes or diabetes complications claims
- One or more primary diabetes inpatient days
- One claim for a glucose regulator and one or more primary or secondary diabetes claims
- One pharmacy claim for a glucose regulator and no claim for polycystic ovaries

Enrollment

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

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

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

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

Ongoing Counseling

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

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

- Medication comprehension and compliance
- Self-blood glucose monitoring
- Recognizing signs of low and high blood glucose levels
- Nutrition counseling related to carbohydrate counting and weight management

- Recommended annual screening for diabetic complications
- Blood pressure and cholesterol management
- Optimizing physical activity levels to meet recommended guidelines
- Supporting tobacco cessation
- Internal consults with specialty health coaches for participants at high risk for, or diagnosed with, another chronic condition (i.e. COPD, asthma, heart failure, heart disease, hypertension, hyperlipidemia). Specialty health coaches include certified diabetes educators, registered nurses and certified or registered respiratory therapists.

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

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

Pediatric Members

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

Program Length

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

Referral Services

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

Disenrollment

Members may be disenrolled from the program under the following circumstances:

- Member dies
- Member with serious or life-threatening medical conditions including mental health will be referred to case management
- Member's health care coverage with the MCO terminates or the MCO no longer provides the member's primary coverage
- Member's attending physician or the MCO requests disenrollment
- Member is no longer capable of participation in the program, in the reasonable determination of the provider
- Member has End Stage Renal Disease (ESRD)
- Member has enrolled in a hospice program

- Member satisfies specified graduation criteria

2017 Diabetes Program Outcome Highlights

- A total of 2,448 members were referred to the Diabetes Disease Management Program.
- Approximately 26 percent of members referred were enrolled in telephonic coaching or agreed to receive educational mailings.
- Diabetes management coaching calls averaged 300 per month.
- Diabetes newsletters mailed averaged 682 per month.

Weight Management Program and Plan of Action

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

Eligibility Criteria

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

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

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

Enrollment

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

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

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

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

Ongoing Coaching

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

- Nutritional counseling for appropriate rate of weight loss

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

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

Program Length

Program is one year in length and includes the following:

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

Referral Services

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

Disenrollment

Members may be disenrolled from the program under the following circumstances:

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

2017 Weight Management Program Outcome Highlights

- A total of 280 members were referred to the Weight Management Program.
- Approximately 92 percent of members referred in 2017 were successfully enrolled.
- Weight Management Coaching calls averaged 44 per month.

Pediatric Weight Management Program and Plan of Action

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

Eligibility Criteria

A member of the Health Plan is considered medically eligible for the program if his/her BMI is > 85th percentile for age. The program is designed for members 2 to 17 years of age.

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

Enrollment

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

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

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

Ongoing Coaching

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

- Promotion of physical activity
- Parent training/modeling
- Dietary coaching
- Nutrition education
- Exercise education
- Behavioral coaching
- Promoting and tracking regular physician visits

- Unlimited inbound calls
- Education materials to enhance understanding and compliance
- Facebook private group for peer support

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

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

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.

Disenrollment

Members may be disenrolled from the program under the following circumstances:

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

2017 Pediatric Raising Well® Program Outcome Highlights

- A total of 303 members were referred to Raising Well®.
- Approximately 29 percent of pediatric members referred in 2017 were successfully enrolled.
- Weight management coaching calls averaged 35 per month.

Appendix D5 – UnitedHealthcare of Louisiana
2017 Diabetes & Obesity Action Plan

2017 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).	Hospitality, Assessment and Retention Center (HARC)	Ongoing in 2018

Process Measures:	**2015** (Jan.-Sept.)	**2016**	**2017**
# HRAs completed	23,783 (66%)	58,433 (39.4%)	3090 (4.3%)
# members reached	38,386 (78%)	116,875 (78.7%)	63,099 (87.1%)

b. Use Whole Person Care Modeling		
Software designed to predict health risks and assess utilization so that members can be placed appropriately into care management programs, such as diabetes, if warranted.	Utilization Management Team	Ongoing in 2018

Process Measures:	**2015**	**2016**	**2017**
# members identified, and in care management	639	887	597

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 2018

Process Measures:	**2015**	**2016** (Jan-Dec)	**2017**
# Mailings to Adults	2,014	6,909	3,154
# Mailings to Children	165	140	56

Description	Responsible Party	Timeframe
d. Continue Collaboration with the YWCA to Educate Members about Diabetes in Lunch'n'Learn Venues		
Heart Smart Sisters is a program designed to empower women in ethnic communities to make positive changes to help reduce their risk of developing heart disease. The program includes a series of monthly classes to educate women about the causes of heart disease, the benefits of healthy diet and the importance of regular exercise. The program also includes education on diabetes risk.	UHC Marketing and Community Outreach	Ongoing in 2018

Process Measures:	2015	2016	2017
# Women Attending Lunch'n'Learn Events	735	500	445
# Lunch'n'Learn Events	15	11	12

Overall Health Outcome Measures				
HEDIS® Comprehensive Diabetes Care Measures:	**2015**	**2016**	**2017**	**2018**
HbA1c Testing:	80.54	81.27	73.97	82.97
Eye Exam:	46.96	47.45	40.63	55.23
Attention for Nephropathy:	78.10	92.70	87.59	92.46

e. *Pilot program* Clinic based interdisciplinary approach to the treatment of diabetes located in the New Orleans area.		
UHC Community Plan of Louisiana is in the process of negotiations with a New Orleans East hospital that has an established diabetes program that is partnered with the Cleveland Clinic. The program will generate outcomes, provide peer support, group appointments, evidence-based guidelines and population health standards.	Disease Management Team	Did not participate in the DiAMC pilot 2018 Diabetes Program Pilot in planning phase

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

Description	Responsible Party	Timeframe
a. 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 April 2017 – HFS is plan driven with corporate support	Ongoing in 2018

Process Measures:	**2015** (Jan-Oct)	**2016**	**2017**
# members identified	10,196	11,026	3,945
# members qualified	8,407	9,756	3,537
# members reached	3,374	6,089	1,610
# members referred to case management	912	1,231	566

Overall Health Outcome Measures				
HEDIS® Prenatal and Postpartum Care Measures:	**2015**	**2016**	**2017**	**2018**
Prenatal:	90.71%	79.85%	85.54%	82.24%
Postpartum:	55.01%	58.72%	64.84%	64.48 %

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

Description	Responsible Party	Timeframe
a. Educate providers on current HEDIS® standards.		
The Clinical Practice Consultant (CPC) Program includes six nurses for the state of Louisiana. CPCs engage in educating primary care providers about Healthcare Effectiveness and Data Information Set (HEDIS®). To improve HEDIS rates, the plan has shared information about evidence-based guidelines tailored for the providers' needs, based on their requests for condensed information. For those providers who chose to participate in the value based care initiative, provider scorecards which indicate whether providers have met their targets for HEDIS® measures were distributed by the CPCs, along with members of the leadership team in some cases. CPCs also distributed HEDIS® guidelines, and HEDIS® tip sheets to providers at individual offices as well as the provider expositions around the state. To help combat diabetes, the consultants will continue to educate providers on the importance of HbA1c testing, retinal eye exams, attention for nephropathy and blood pressure control. Diabetes and obesity toolkits are also distributed to providers. In the case of retinal exams, CPCs assure the providers are aware of the vision vendor March Vision.	Director, Quality Management & Performance	Revised in 2016 Ongoing in 2018

Process Measures:	**2016** (Jan - Oct)	**2016**	**2017**
# offices visited	351	403	486
# members potentially impacted based on panel assignments	236,247	286,854	137,686

HEDIS® Overall Health Outcome Measures				
HEDIS® Comprehensive Diabetes Care (CDC)				
Measures:	**2015**	**2016**	**2017**	**2018**
HbA1c Testing:	80.54	81.27	73.97	82.97
Eye Exam:	46.96	47.45	40.63	55.23
Attention for Nephropathy:	78.10	92.70	87.59	92.46
Weight Assessment and Counseling for nutrition and Physical Activity for Children and Adolescents (WCC)				
Measures:	**2015**	**2016**	**2017**	**2018**
BMI Percentage:	41.36	36.98	60.1	71.53
Counseling for Nutrition:	53.04	52.07	60.34	63.5
Counseling for Physical Activity:	41.61	31.14	43.80	51.34
Adult BMI Assessment (ABA)				
Measure:	**2015**	**2016**	**2017**	**2018**
Adult BMI:	71.32	71.93	82.75	85.59

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

Description	Responsible Party	Timeframe
a. 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 an opportunity to educate the community about healthy lifestyles as it relates to obesity, diabetes, etc.	UHC Marketing and Community Outreach	Did not participate in 2015 Ongoing in 2018

Process Measures:	**2014**	**2016** (Oct)	**2017**
# of events	1	1	9
# of members attending	500	300	2,195

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.

2017 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's 4-H organization is receiving a grant funded by UnitedHealthcare to support healthy-living programs, events and other activities administered by 4-H that encourage young people and their families to eat more nutritious foods and exercise regularly. The partnership in Louisiana is being administered through the LSU Ag Center.	4-H and UHC Marketing and Community Outreach	Ongoing in 2018

Process Measures:	**2015**	**2016**	**2017**
# Louisiana youth reached	3,225	3,675	4,740
# events	15	18	12

b. Continue 4-H Youth Voice: Food Smart Families		
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 2018

Process Measures:	**2015**	**2016**	**2017**
# Louisiana youth reached	3,225	3,675	4,740
# events	15	18	12

c. Continue Partnership with the Boys & Girls Club and Playworks.		
UnitedHealthcare will continue its partnership with Playworks and the Boys & Girls Club to sponsor Family Play Nights.	UHC Marketing and Community Outreach	Ongoing in 2018

Process Measures:	**2015**	**2016**	**2017**
# Louisiana youth attending	1,385	500	0
# events	7	1	0

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 2 and 8 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 2018

Process Measures:	**2015**	**2016**	**2017**
# toolkits distributed	1,350 (5 reading corners)	325	53

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 2018

Process Measures:	**2015**	**2016**	**2017**
# events that Dr. Health E. Hound attended	48	51	28
# of members	11,665	15,175	11,300

f. Participate in Louisiana Healthy Community Coalition /Parish Community Coalition activities/and Other Community activities		
The mission of the Louisiana Healthy Community Coalition is to improve the health and quality of life of Louisianans by mobilizing communities to enact policy, system and environmental changes to create healthy communities.	UHC Marketing and Community Outreach	Ongoing in 2018

Process Measures:	**2015**	**2016**	**2017**
# events	53	49	76
# people attending	2,735	3,550	1,778

g. Educate Members Using Weight Management Education Materials		
Newly diagnosed and new members identified with obesity receive educational materials and newsletters with weight management specific information, including recommended routine appointment frequency, health logs, 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 to manage their weight.	UHC Clinical	Initiated in 2018

UHC Program Goal 2: Facilitate healthy lifestyles.

Description	Responsible Party	Timeframe
a. Continue partnership with faith and community based organizations to offer Heart Smart Sisters program.		
Heart Smart Sisters is a program designed to empower women in ethnic communities to make positive changes to help reduce their risk of developing heart disease. The program includes a series of monthly classes to educate women about the causes of heart disease, the benefits of healthy diet and the importance of regular exercise.	4-H and UHC Marketing and Community Outreach	Ongoing in 2018

Process Measures:	**2015**	**2016**	**2017**
# members reached	735	1,895	550
# of events	22	16	2

Appendix E – Standards of Diabetes Care

American Diabetes Association
Standards of Medical Care in Diabetes - 2018
http://care.diabetesjournals.org/content/diacare/suppl/2017/12/08/41.Supplement_1.DC1/DC_41_S1_Combined.pdf

Consensus Statement by the American Association of Clinical Endocrinologist and American College of Endocrinology on the Comprehensive Type 2 Diabetes Management Algorithm – 2018
https://www.aace.com/sites/all/files/diabetes-algorithm-executive-summary.pdf

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

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