John Bel Edwards
GOVERNOR

Rebekah E. Gee MD, MPH
SECRETARY

State of Louisiana

Department of Health and Hospitals
Office of the Secretary

February 18, 2016

The Honorable Fred H. Mills, Jr., Chairman
Senate Health and Welfare Committee
P.O. Box 94183, Capitol Station
Baton Rouge, LA 70804

The Honorable Frank A. Hoffmann, Chairman
House Health and Welfare Committee
P.O. Box 94062, Capitol Station
Baton Rouge, LA 70804

Subject: DHH response to ACT 210 of the 2013 Legislative Session

Dear Honorable Chairs:

The Louisiana Department of Health and Hospitals (DHH) has reviewed ACT 210 of the 2013 Regular Session and we are submitting the attached Bayou Health Diabetes and Obesity report to the Senate and House Committees on Health and Welfare to comply with the provisions of the act.

If you have further questions or concerns regarding this report or any healthcare matter, please contact Anita Dupuy at (225) 342-1400 or anita.dupuy@la.gov.

Sincerely,

Frank A. Opelka
Chief of Staff

FAO/apd

cc: The Honorable Members of the Senate Health and Welfare Committee
The Honorable Members of the House Health and Welfare Committee
David R. Poynter Legislative Research Library

Obesity and Diabetes Action Report for the Bayou Health Program

Report Prepared in Response to Act 210

Louisiana Department of Health and Hospitals

Prepared by: Medicaid Quality Management, Statistics and Reporting

Louisiana Medicaid Program

Mary TC Johnson, Medicaid Quality Management, Statistics and Reporting

Beverly Hardy-Decuir, Medicaid Quality Management, Statistics and Reporting

Ekwutosi Okoroh, Medicaid Quality Management, Statistics and Reporting

February 2016

Bienville Building ▪ 628 N. 4th Street ▪ P.O. Box 629 ▪ Baton Rouge, Louisiana 70821-0629
Phone #: 225/342-9509 ▪ Fax #: 225/342-5568 • WWW.DHH.LA.GOV

Table of Contents

Executive Summary

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

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

Below are some highlights from this year's report:

- In 2014, 3 percent or 27,401 of the Bayou Health members had a claim for obesity; 56.1 percent (15,379) were 21 years of age or younger most of whom resided in the Gulf region.
    - The Bayou Health Plans paid around **$13 million** for obesity related services.
- The prevalence of diabetes decreased by 0.4 percent from 2013 to 2014;
    - The majority of Bayou Health members with diabetes were older than 21 years of age.
    - The majority of people with diabetes, regardless of age, resided in the Gulf region.
- Pregnancies complicated by diabetes cost the Health Plans, on average, almost twice as much as those not complicated by diabetes.
- A total of 1,879 inpatient hospital discharges noted diabetes as the main diagnosis for admission.
    - The total financial cost associated with these inpatient diabetes-related hospital discharges was **$4,061,261.40.**
- Diabetic ketoacidosis was the most common diabetic complication on admission for those 21 years of age or younger, accounting for 99 percent of all inpatient hospital discharges for this age group.
- In 2014, a total of 31,133 Emergency Department (ED) visits occurred for Bayou Health members in which diabetes was the primary diagnosis.
    - The majority of ED visits occurred among members older than 21 years of age.
- Similar to 2013, diabetes again was the third most common chronic condition identified among Bayou Health Plan members.
- The top medical conditions related to diabetes that resulted in the most expensive cost per member was *congestive heart failure* at **$7,489.19** per member.

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

DHH and Bayou Health Plans' Recommendations:

- Appropriately fund outpatient nutritional services provided by registered dieticians for all patients for all diagnoses, not just those diagnosed with diabetes and obesity. Currently, primary care physicians that take care of people with or at risk for obesity or diabetes are unable to adequately counsel and educate parents, children and adults about nutrition during routine visits. To properly educate parents, children and adults regarding nutrition, recurring appointments with a registered dietician are necessary. Some of these appointments can occur in a group setting. However, if there is no ability for the registered dietician to recover the cost of providing the service, they (or their employer) are unable to provide the service.
- Appropriately fund diabetes self-management education. The following table shows the current diabetes self-management education (DSME) reimbursement rate comparing Louisiana's rate to the Medicare allotted amount and the rate reimbursed by Mississippi and Kentucky. Improving this rate would have significant impact on self-management education and ultimately on the cost spent by Louisiana on diabetes care.

Comparing reimbursement rates for diabetes self-management education				
Code	*Medicare*	*Louisiana Medicaid*	*Mississippi Medicaid*	*Kentucky Medicaid*
G0108	$51.60	$15.20	$45.05	$50.50
G0109	$13.88	$8.55	$12.13	$13.92

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

Introduction

Purpose of the Report

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

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

Report Development

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

Overview of Obesity Impact

Although national, state and local governments and many private employers and payers have increased their efforts to address obesity since 1998[1] more than one-third (34.9 percent or 78.6 million) of U.S. adults and 17 percent or 12.7 million U.S. children and adolescents are still obese.[2]

What is Obesity?

Obesity is diagnosed when an individual has accumulated enough body fat to have a negative effect on their health. If a person's bodyweight is at least 20 percent higher than it should be, he or she is considered obese. It is calculated using a statistical measurement known as the Body Mass Index.[3]

What is Body Mass Index?

The Body Mass Index (BMI) is derived from an individual's height and weight. If the BMI is between 25 and 29.9 a person is considered overweight. If the BMI is 30 or greater, the individual is classified as obese.[3] 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 age two to 19 years, obesity is defined as BMI at or above the 95th percentile of the sex-specific Centers for Disease Control and Prevention's (CDC) BMI-for-age growth charts.[4]

According to the American Diabetes Association, children who are overweight and obese and unfit are at increased risk of developing high blood pressure, abnormal lipid levels, inflammation in their blood vessels and higher than normal blood sugar levels. Obesity is a precursor of diabetes and adult-onset cardiovascular disease. Despite the growing efforts of government and public health officials, the number of overweight and obese youth continues to remain stable.[2, 3]

Overview of Diabetes Impact

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

What is Diabetes?

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

Types of Diabetes

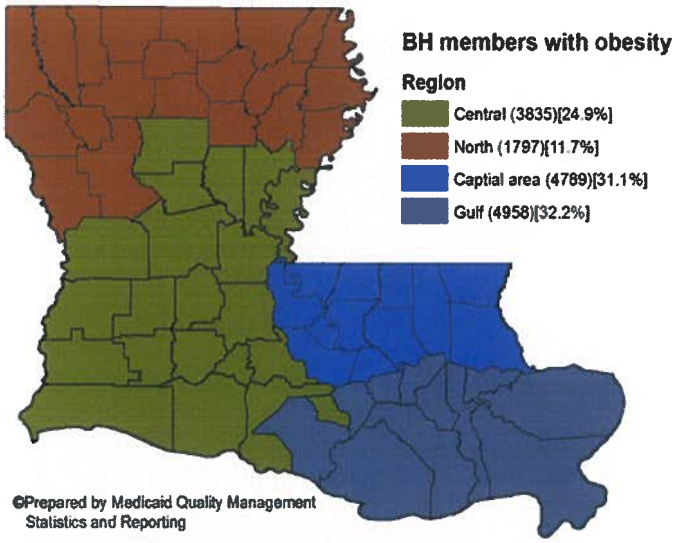
Type 1 diabetes (previously called "juvenile diabetes" or "insulin-dependent diabetes") develops when the body produces little to no insulin due to destruction of the cells that make insulin in the pancreas. To survive, people with type 1 diabetes must have insulin delivered by injections or an insulin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

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

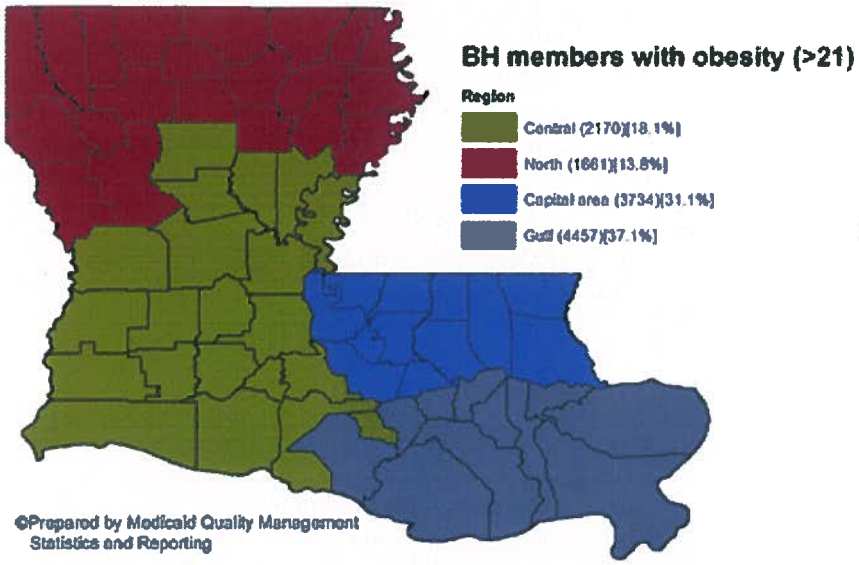
Gestational Diabetes is a type of diabetes that is first seen in a pregnant woman who did not have diabetes before she was pregnant. The risk factors for it are similar to those for type 2 diabetes. Gestational diabetes requires treatment to lessen the risk of complications such as preterm births, larger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

The Scope of Obesity in Louisiana

Based on 2014 claims data, the prevalence of obesity among Bayou Health members was 3 percent, representing 27,401 enrollees. Considering that the overall prevalence of obesity in Louisiana is 35 percent, these results clearly show an underrepresentation of the burden of obesity by using claims data. Of the members with obesity, 56.1 percent (15,379) were 21 years of age or younger. The geographic and age group breakdown of obesity among the four regions are shown in Maps 1 and 2. For both age groups, the Gulf region had the most residents with obesity, followed by the Capital region. The region with the least amount of residents with obesity was the Northern region. (Map1 and Map 2) For parish level information, please see Appendix C.



Map 1. Geographical distribution of Bayou Health (BH) members with obesity for age ≤ 21 years old



Map 2. Geographical distribution of Bayou Health (BH) members with obesity for age >21 years old

The 2014 financial burden of obesity is shown in Table 1. Although Bayou Health Plans paid around $13 million, for service-related claims for obesity. The total amount paid for anyone identified with obesity and other conditions totaled almost $100 million. (Table 1)

Table 1: Financial burden of obesity in 2014 among Bayou Health Plan members

Age group	Service-related payments for obesity*	Total obesity related payments**
≤ 21 years	$2,693,667.92	$16,600,322.47
>21 years	$10,326,048.33	$81,746,571.77
Total	$13,019,716.25	$98,346,894.24

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

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

The Scope of Diabetes in Louisiana

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

Figure 1 shows the 12-year trend in diagnosed diabetes in Louisiana. Although the prevalence of diabetes jumped from 8.5 percent in 2003 to 10.6 percent in 2008 to 11.2 percent in 2014; there was also some periods of decrease. From 2013 to 2014, there was a 0.4 percent decrease from 11.6 percent to 11.2 percent. The greatest decline, however, occurred from 2009 to 2010 when it went from 11 percent to 10.3 percent. (Figure 1)

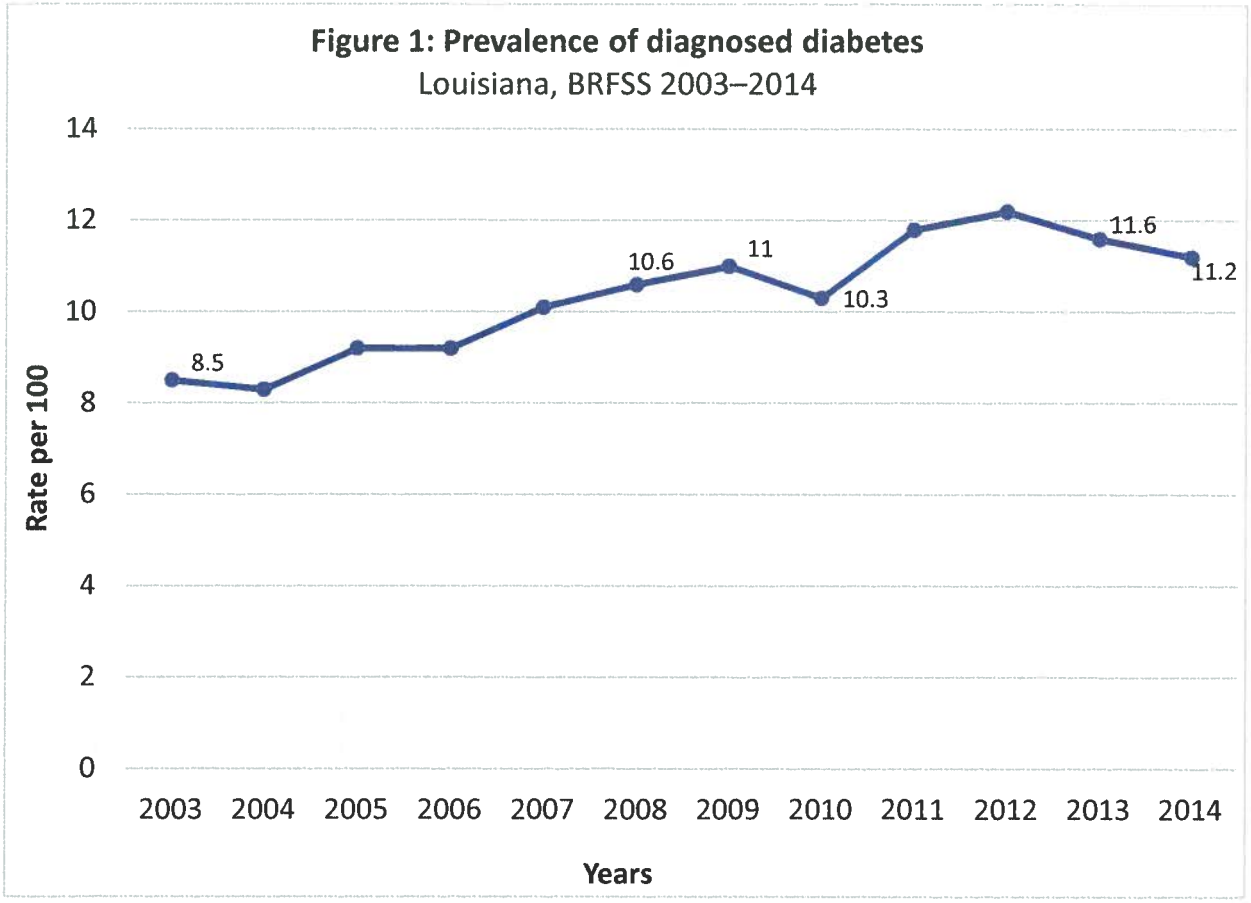


Figure 2 shows the rate per 100 by sex and age among those with diabetes in the overall Louisiana population and among the Bayou Health Plan population. For both the Louisiana population and the Health Plan population, more females than males had diabetes and more people older than 21 years had diabetes. (Figure 2)

Figure 2: Percentage breakdown for males and females by age, among those with diabetes, in the Louisiana and Health Plan populations

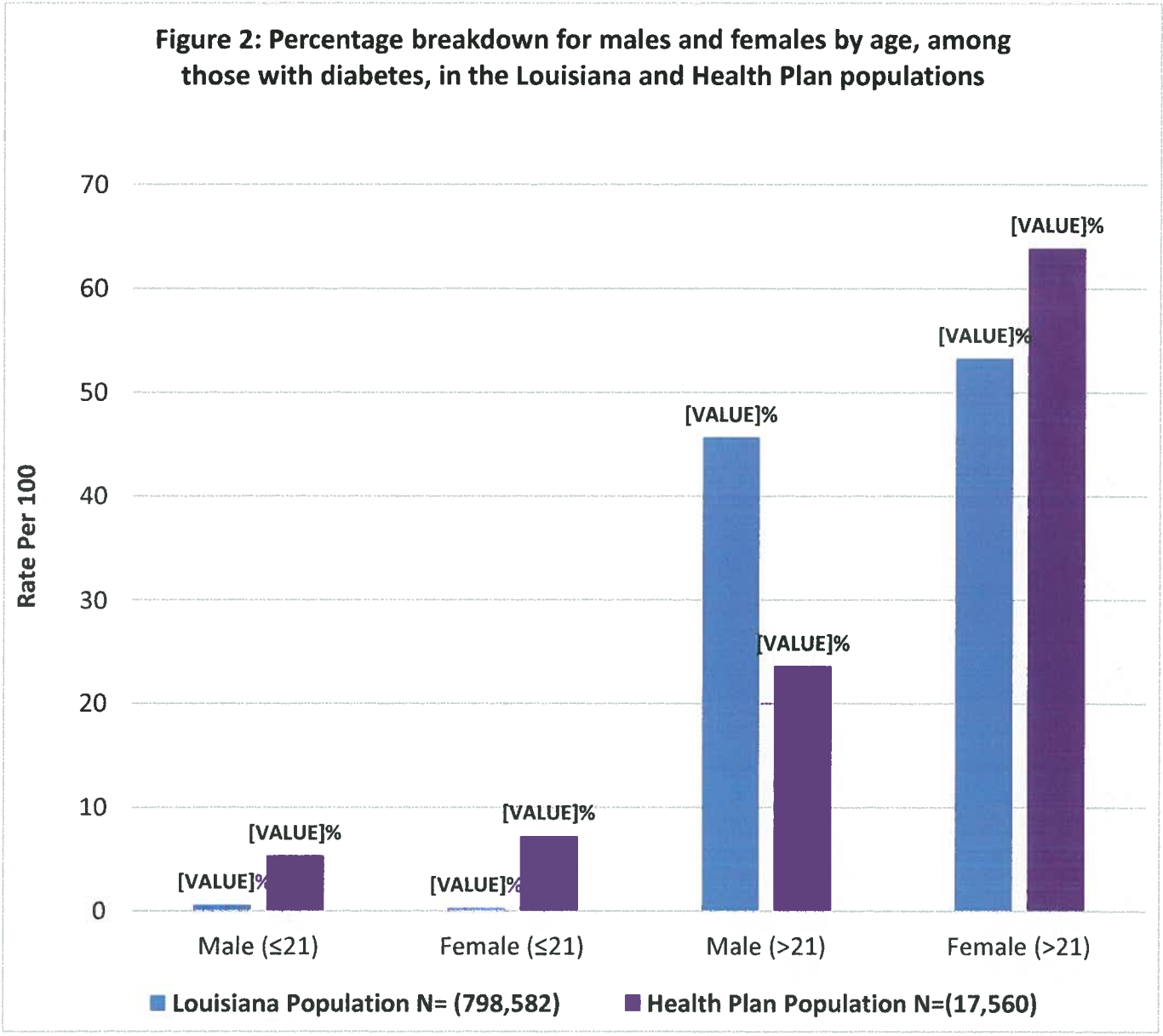


Table 2 details how members in Bayou Health compared with the state and national levels for preventive practices. Nationally, Louisiana's BRFSS percentages are slightly below the 2013 national numbers for most of the listed preventive care practices. Louisiana, however, had a higher self-management education percentage than the national average. Although the Health Plans have a smaller percentage of those with diabetes in the state, the majority of their preventive care practices were up. However, they had lower preventive care practices for a member ever receiving a pneumonia shot or for self-management. A possible reason for these low findings among the Bayou Health members is varying degree of available historical data for qualified members per plan. It is also important to note that

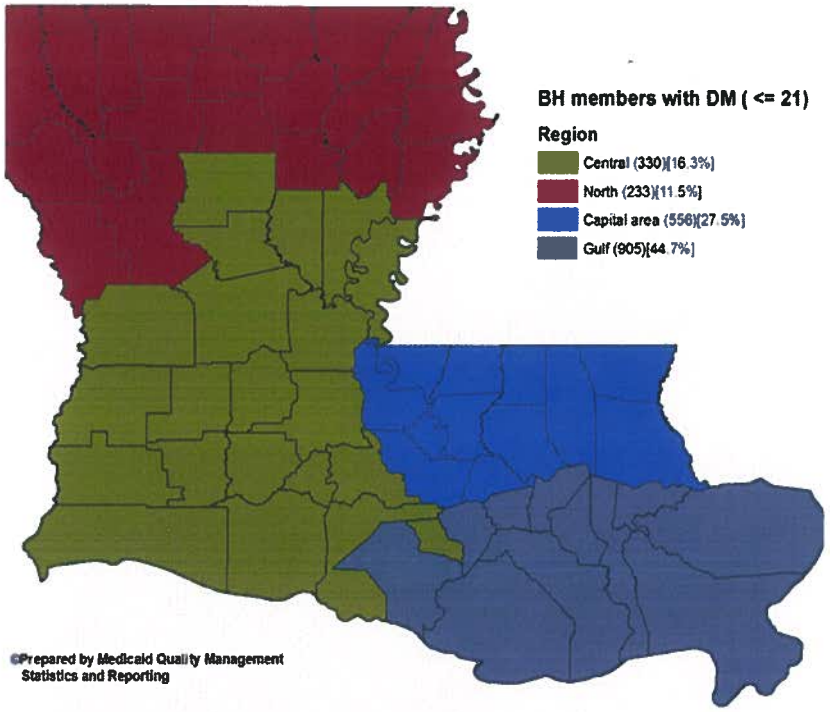
for pneumonia vaccination and self-management education, lack of reimbursement to providers for the administration of the vaccine and lack of payment to educators likely contributed to the low numbers. In addition, these are self-reported numbers and due to recall bias, it is possible that some members may have received the vaccine or the education and not remembered. Regardless the reasons, these low numbers provide an opportunity for improvement.

Table 2: Reported rate of diabetes care practices among adults with diabetes, Louisiana and US (BRFSS from CDC division of diabetes translation)

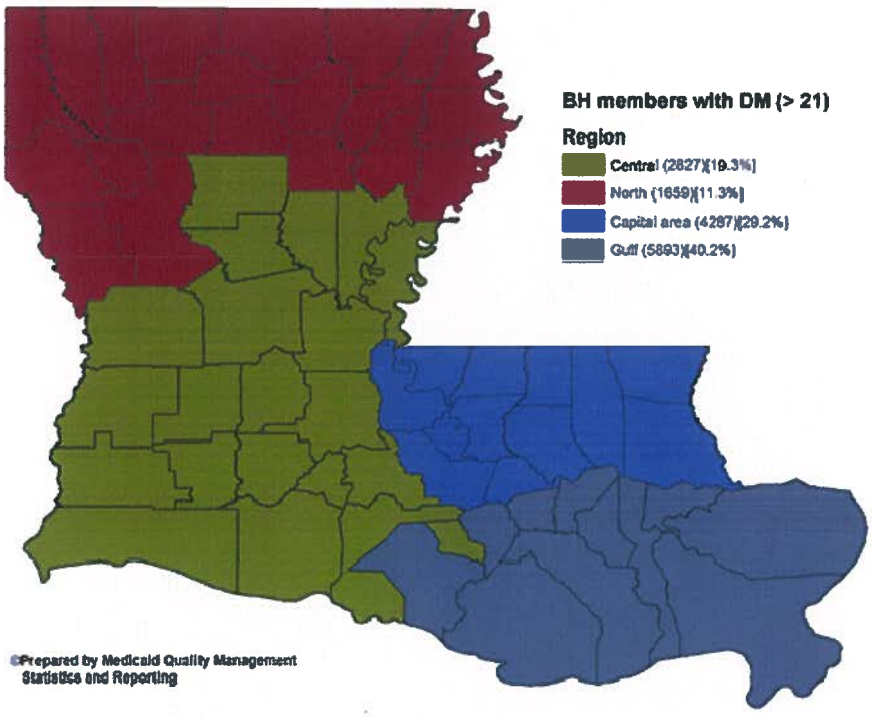
Preventive care practice	BH(2014)[1]	LA(2013)	US(2013)[2]
Annual dilated eye exam	50.1	66.6	67.4
Received one or more A1Cs in current (2014) year	52.9	88.1	90.5
Received a flu shot in current (2014) year	10.2	60.2	55.1
Ever received a pneumonia shot[3]	6.3	53.1	57.9
Daily self-blood glucose monitoring	36.8	61.9	63.5
Ever had self-management education[3]	0.1	54.1	53.9

[1]The majority of Bayou Health Plan members are children and pregnant women, so the percentage of those with diabetes will be less than the state numbers.
[2]2013 represents the most recent year of data available from the CDC
[3]Level of follow-up and/or historical data for qualified members may differ by plan.

The geographic and age group breakdown of diabetes among the four regions are shown in Maps 3 and 4. Similar to the obesity findings, the Gulf region had the most residents with diabetes, for both age groups. The region with the least amount of residents with diabetes was the Northern region. (Map 3 and Map 4) For parish level information, please see Appendix D.



Map 3. Geographical distribution of Bayou Health (BH) members with diabetes (DM) for age ≤ 21years old



Map 4. Geographical distribution of Bayou Health (BH) members with diabetes (DM) for age >21 years old

Diabetes and Pregnancy

Table 3 shows the 2014 prevalence of pregnancies complicated with diabetes. The financial burden on Bayou Health is also listed. Although the majority of pregnancies that occurred in 2014 were not complicated with diabetes, the average paid, per member, for pregnancies with diabetes was almost twice of that paid for pregnancies without diabetes ($3,832 vs. $2,047).

Table 3: Burden of diabetes* on pregnancies in 2014 among Bayou Health Plan members

Pregnancy type	# of members	Total amount paid	Average total paid per member
Pregnancies with diabetes	11,516	$44,136,965.51	$3,832.66
Pregnancies without diabetes	38,470	$78,777,834.99	$2,047.77

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

The Financial Impact of Diabetes and its Complications

Estimated Costs of Diabetes

The American Diabetes Association estimates that the largest component of medical expenses attributed to diabetes is for hospital inpatient care at 43 percent of the total medical cost.[5] 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. This data also serves as a reflection of how well diabetes is, or is not, managed by the health care system.

Hospitalization Costs Due To Diabetes

An inpatient hospital discharge record includes all information from admission to discharge. An ED record includes visits to an ED that do not result in an inpatient admission. ED records also include data of patients that are held for an observation stay but not admitted as an inpatient to a hospital. This report includes hospital discharge and ED visit data for 2014.

Table 4 shows the number of inpatient hospital discharges in which diabetes was coded, on the discharge paperwork, as the primary (principal) diagnosis for admission by age group. The principal diagnosis or primary diagnosis is defined in the Uniform Hospital Discharge Data Set (UHDDS) as "that condition established after study to be chiefly responsible for occasioning the admission of the patient to the hospital for care". The principal diagnosis is not always the admitting diagnosis, but the diagnosis found after workup or even after surgery that proves to be the reason for admission; it is the condition that is most serious and/or resource intensive during that hospitalization.

Table 4 also shows the percent of overall inpatient discharges that was due to diabetes and the amount paid by Bayou Health, by age group, for these hospitalizations. In 2014, there were a total of 1,879 inpatient hospital discharges for

which the principal diagnosis was diabetes; this was 14 percent of the overall inpatient discharges for Bayou Health members in 2014. The majority of these inpatient discharges for diabetes occurred among Bayou Health members older than 21 years of age. The total paid by Health Plans for diabetes related inpatient admissions amounted to $4,061,261.40. (Table 4)

It is important to note that the costs reported in this table do not include costs that may be related to diabetes but were not coded in the claim as 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 4: Inpatient hospital discharges among Bayou Health Plan members in 2014 by age group with diabetes as the primary diagnosis*

Age group	# of diabetes discharges	Percent of overall discharges due to diabetes	Total paid for diabetes hospitalization
≤ 21 years	453	6.0	$817,131.10
>21 years	1,426	8.2	$3,244,130.30
Total	1,879	14.0	$4,061,261.40

*Primary diagnosis is defined as diabetes noted in the first 3 discharge diagnosis listing.

Specific Diabetes Complications as Principal Diagnosis for Inpatient Hospital Discharges

Hospitalizations for diabetes may occur due to complications of the disease. All of the complications discussed in this section of the report are identified from the principal diagnosis code assigned by the physician during the hospital stay. Again, the principal diagnosis is defined as the condition responsible for admission of the patient to the hospital for care. Table 5 shows inpatient discharges in 2014 where a complication of diabetes was the primary diagnosis as well as the total percent of inpatient discharges that was due to a diabetes complication and the total paid by the Health Plans for these complications. All were grouped by age group of older than 21 years or 21 years or younger.

The most frequent diabetes complication associated with an inpatient hospital discharge was diabetic ketoacidosis or DKA for those 21 years or younger. It accounted for 99 percent of all inpatient hospital discharges due to a diabetic complications for this age group. (Table 5) DKA is a life-threatening complication in which ketones (fatty acids) build up in the blood due to a lack of insulin.

For members older than 21 years, "diabetes without mention of complication" was the most frequent diabetic complication causing hospitalization at 73 percent. The total cost for these two complications were $471,069.29 and $ 831,889.82 respectively. (Table 5)

Table 5: Inpatient hospital discharges in 2014 by age group where a diabetes complication was the primary diagnosis*

Diabetes complications	# of discharges	Total percent of overall discharges due to complications	Total amount paid for diabetes complications	# of discharges	Total percent of overall discharges due to complications	Total amount paid for diabetes complications
	≤21 years			>21 years		
(250.0) Without mention of complication	118	1.56	$99,420.75	635	3.6	$879,577.56
(250.1) Ketoacidosis	366	4.85	$471,069.29	388	2.2	$831,889.82
(250.2) Hyperosmolarity	3	0.04	$1,048.40	66	0.4	$159,118.45
(250.3) With other coma	2	0.03	$858.97	7	0.0	$37,001.26
(250.4) With renal manifestations	1	0.01	$0.00	30	0.2	$86,121.41
(250.5) with ophthalmic manifestations	0	0.00	$0.00	5	0.0	$16,075.45
(250.6) With neurological manifestations	4	0.05	$1,450.02	155	0.9	$417,066.28
(250.7) With peripheral circulatory disorders	0	0.00	$0.00	45	0.3	$174,227.14
(250.8) With other specified manifestations	13	0.17	$29,901.73	174	1.0	$706,019.84

*Primary diagnosis is defined as diabetes noted in the first 3 discharge diagnosis listing.

Emergency Department Visits Due to Diabetes

Table 6 displays, by age group, the number of ED visits due to diabetes, percent of overall ED visits due to diabetes, and the amount paid for ED visits by the Health Plans in which diabetes was the primary diagnosis. In 2014, a total of 31,133 ED visits occurred in which diabetes was the primary diagnosis, amounting to 30 percent of all ED visits for the Bayou Health members. Similar to inpatient discharges, the majority of ED visits, occurred among those older than 21 years. In total, Bayou Health paid almost $3 million for diabetes related ED visits in 2014. (Table 6)

Table 6: Total ED visits by age group where diabetes was the primary diagnosis*

Age group	# of ED visits due to diabetes	Percent of overall ED visits due to diabetes	Total paid for diabetes ED visits
≤ 21 years	5,599	3.9	$1,316,641.55
>21 years	25,534	26.5	$1,619,031.14
Total	31,133	30	$2,935,672.69

*Primary Diagnosis is defined as diabetes noted in the first 3 discharge diagnosis listing.

Table 7 shows ED visits in 2014, by age group, where a complication of diabetes was the primary diagnosis for the visit. A total of 31,540 ED visits for a diabetes complication occurred in 2014. The most common diabetic complication leading to an ED visit was "diabetes without mention of complication" at 90 percent for those members 21 years or younger and for 96 percent of members older than 21 years. For the younger members with diabetes, DKA was the second most common reason for going to the ED while neurological based reasons were the second most common reasons for those older than 21 years of age. (Table 7)

Table 7: Emergency department visits in 2014 by age group where Diabetes complication was the primary diagnosis*

Diabetic complications	Total visits for ages ≤ 21 years	Total visits for ages > 21 years
(250.0) Without mention of complication	2,566	27,500
(250.1) Ketoacidosis	178	135
(250.2) Hyperosmolarity	1	19
(250.3) With other coma	1	0
(250.4) With renal manifestations	0	27
(250.5) With ophthalmic manifestations	0	20
(250.6) With neurological manifestations	9	353
(250.7) With peripheral circulatory disorders	57	12
(250.8) With other specified manifestations	27	560
(250.9) With unspecified complications	14	61
Total	**2,853**	**28,687**

*Primary diagnosis is defined as diabetes noted in the first 3 discharge diagnosis listing.

Diabetes and other Common Chronic Conditions

Comparing the Burden of Diabetes with other Common Chronic Conditions
The statute which defines the content of this report requires a comparison of the financial burden or impact of diabetes to that of other common chronic conditions. This section of the report looks at the relationship between diabetes and other common chronic conditions, by comparing its prevalence, cost per member and total paid with other chronic disease as shown in Table 10.

Among the members of the Health Plans with chronic conditions, asthma was the most prevalent among 55,007 members followed by hypertension among 48,672 members. Diabetes was the third most common chronic conditions among 21,295 Bayou Health members.

Table 10: Comparison of prevalence and cost between diabetes and other common chronic diseases.

Chronic Disease	# of Members	Per Member Cost	Total Paid
Asthma	55,007	$1,037.10	$57,047,768.51
Hypertension	48,672	$2,129.16	$103,630,253.98
Diabetes	21,295	$2,925.00	$62,287,866.52
COPD	12,504	$2,426.83	$30,345,056.47
Arthritis	9,389	$4,335.65	$40,707,401.15
Coronary Heart Disease	6,578	$4,017.47	$26,426,926.77
Congestive Heart Failure	4,683	$7,489.19	$35,071,869.22

It is always important to remember that diabetes does not exist in a vacuum – people with diabetes often have additional chronic illnesses that impact their ability to self-manage therefore providing additional diabetes management challenges to their doctor. The top medical conditions that resulted in the most expensive cost per member was congestive heart failure at $7,489.19. This condition can also be found among people with diabetes. In terms of total cost, the most expensive chronic conditions, among members for 2014 was hypertension at $103,630,253.98. (Table 10)

Current Diabetes Management Efforts

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

Office of Public Health – Health Promotion Team

DHH's Health Promotion Team understands the financial and lifestyle burden of diabetes and obesity in Louisiana. To address these concerns, the Health Promotion Team's efforts and funds are focused on improving health outcomes through environmental approaches, health system interventions and community-clinical linkages strategies. These goals are achieved by the following interventions:

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

In addition, the team's obesity prevention efforts emphasize place-based interventions in schools, worksites and early childhood education sites. These outcomes are achieved through the promotion of nutrition standards and physical activity through professional development, technical assistance, and program development. The Health Promotion Team engages with schools, child care sites and worksites around the state through the following activities (Table 11):

Table 11: Health Promotion Team Activities

Place	*Activities*
Schools	• School Health Collaborative: partnership building with state-level stakeholders • School Health Training Cadre: training and education for schools on physical activity and nutrition • Well-Ahead Louisiana: resources and technical assistance for schools to reach WellSpot designation
Child Care Sites	• Nutrition And Physical Activity Self-Assessment for Child Care (NAP SACC): evidence based program for child care sites focused on obesity prevention • Well-Ahead Louisiana: resources and technical assistance for child care sites to reach WellSpot designation
Worksites	• Worksite Wellness Program: implementation of a worksite wellness program at state agencies and current WellSpots • Healthy Vending: implementation of healthy vending in state buildings and facilities • Well-Ahead Louisiana: resources and technical assistance for worksites to reach WellSpot designation

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

Community Mobilization:
The Health Promotion Team has had great success in mobilizing partnerships to identify and address diabetes and obesity-related issues. The team has developed partnerships with numerous stakeholders across the scope of its programmatic activities. Developing and maintaining active partnerships at the state and local levels are essential to jointly pursue issues related to diabetes and obesity prevention in communities and among health care providers. Those partnerships are summarized below in Table 12.

Table 12: Health Promotion Team Partners

Place	*Partners*
Diabetes	• Louisiana Diabetes Collaborative • Louisiana Obesity Prevention and Management Commission • BlueCross BlueShield of Louisiana • Medicaid • Louisiana Health Care Quality Forum • Louisiana 2-1-1 • Baton Rouge Capital Area and Greater New Orleans Area YMCAs.
Schools	• Louisiana Department of Education • School Health Collaborative • School Nutrition Association of Louisiana • Louisiana Association for Health, Physical Education, Recreation and Dance • Alliance for a Healthier Generation • Louisiana Public Health Institute
Child Care Sites	• Louisiana Department of Education • Pennington Biomedical Research Center • Tulane Prevention Research Center • Office of Public Health – Bureau of Family Health • University of North Carolina at Chapel Hill
Worksites	• Office of Group Benefits • Louisiana Workforce Commission • Randolph Sheppard Blind Vendors

Diabetes Self-Management Education and Prevention:
A variety of educational programs/classes are available in communities across Louisiana to educate and support people with, or at risk for, diabetes. Diabetes Self-Management Education programs provide information, tools and resources to assist people with type 1 or type 2 diabetes manage their disease. The National Diabetes Prevention Program (NDPP) is an evidence-based Lifestyle Change Program for persons who are identified as pre-diabetic and at risk for developing type 2 diabetes. Currently there are 48 AADE and/or ADA self-management programs and seven NDPP programs across the state in hospital, clinics and community settings. The Health Promotion team has worked diligently to develop strategies to increase awareness about diabetes and all other chronic diseases in Louisiana. Some of this work includes the following strategies and partnerships:

- The Health Promotion Team is an active member of the Diabetes Collaborative that is coordinated by the Louisiana Business Group on Health. This collaborative brings together representatives from national and community-based organizations to advocate for policy, clinical needs and community outreach to improve diabetes prevention and education.

- The Health Promotion Team has built a relationship with the Medicaid Quality Improvement, Statistics and Reporting program to develop the Diabetes and Obesity Annual report for the legislature in partnership with the Medicaid Bayou Health Plans. Through this partnership, the team is actively working with Medicaid to develop a state plan amendment proposal to increase Medicaid reimbursement rate for DSME programs. These essential programs teach diabetics how to manage their disease and prevent an early onset of complications from diabetes. Increasing reimbursement for this service will enhance sustainability for DSME programs across the state.

- The team is also collaborating with the DHH human resources professionals to support the Office of Group Benefits (OGB) health screenings. The OGB screenings, conducted by Catapult Health, include biometric tests. These tests screen for hypertension, diabetes and pre-diabetes for all participating state employees. Additionally, any state employee identified as pre-diabetic is eligible for participation in the Omada Health Prevent program. The Prevent program is an online diabetes prevention curriculum created by the National Institutes of Health that is designed to provide participants with tools and resources to prevent the onset of type 2 diabetes.

Public Awareness and Education:
On April 14, 2014, DHH launched a campaign aimed at improving the health and wellness of Louisiana residents. Well-Ahead Louisiana is a statewide initiative and designation program that promotes and recognizes environments that help Louisiana residents make smart choices in the spaces and places where they live and work. Well-Ahead is a core component of Louisiana's strategy for impacting healthy environmental change. The initiative works to make it easier for people to make healthier choices. The Well-Ahead Louisiana Team works closely with restaurants, schools, child care sites, worksites, local governments, hospitals and universities on a number of obesity prevention efforts, from implementing tobacco-free policies to ensuring healthy lunch options or supporting work place fitness programs. Places that commit to improving the health of their environment are recognized by DHH as WellSpots. As of October 2015, more than 1,000 organizations in Louisiana are designated WellSpots.

As the outward reaching brand of the Health Promotion Team, Well-Ahead plays a significant role in the public awareness and education of the team's diabetes and obesity prevention efforts around the state. Well-Ahead is launching a media campaign that will promote the awareness of diabetes and encourage healthy living in our state. The team will work with designated WellSpots to increase access to Diabetes Self-Management Education Programs and Diabetes Prevention Programs for their employees. Similar promotion is being done with schools, child care sites and worksites.

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

Surveillance and Evaluation:
The Health Promotion Team works closely with the DHH Center for Public Health Informatics (CPHI) and Pennington Biomedical Research Center to enhance and assess data and evaluate program efforts across the state. A key part of this effort is the addition of a pre-diabetes module to the Louisiana Behavioral Risk Factor Surveillance System. Additional surveillance activities are supported through a partnership with the Department of Education (DOE). DOE manages and implements the School Health Profiles (SHP) survey along with the Youth Risk Behavior Survey (YRBS), two surveys that inform the team's school health work.

Funding:
OPH receives funds from the Centers for Disease Control and Prevention (CDC) to support coordinated chronic disease work as it relates to diabetes, hypertension, heart disease and stroke, school health and nutrition, physical activity and obesity prevention. CDC funds are used to support state-level personnel and operating costs, epidemiological and evaluation efforts and special projects. OPH receives approximately $1 million in coordinated chronic disease funding from the CDC National Center for Chronic Disease Prevention and Health Promotion.

References

1. http://content.healthaffairs.org/content/28/5/w822.full.pdf+html

2. Ogden CL, Carroll MD, Kit BK, Flegal KM. Prevalence of Childhood and Adult Obesity in the United States, 2011-2012. JAMA. 2014;311(8):806-814. doi:10.1001/jama.2014.732

3. BMI and Obesity, December 2012. Agency for Healthcare Research and Quality, Rockville, MD. http://www.ahrq.gov/news/newsroom/audio-video/bmieng.html

4. (http://www.cdc.gov/obesity/data/childhood.html)

5. Centers for Disease Control and Prevention. National Diabetes Statistics Report: Estimates of Diabetes and Its Burden in the United States, 2014. Atlanta, GA: US Department of Health and Human Services; 2014 http://www.cdc.gov/diabetes/pubs/statsreport14/national-diabetes-report-web.pdf

6. http://www.diabetes.org/diabetes-basics/statistics/

7. http://www.cdc.gov/pregnancy/diabetes-gestational.html

8. American Diabetes Association. Standards of Medical Care in Diabetes – 2014; Diabetes Care January 2014 vol. 37 no. Supplement 1 S14-S80.

Conclusion

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

Acknowledgments

Author:
Mary T.C. Johnson, Medicaid Quality Management, Statistics and Reporting
Beverly Hardy-Decuir, Medicaid Quality Management, Statistics and Reporting
Ekwutosi Okoroh, Medicaid Quality Management, Statistics and Reporting
Dawn Love, Medicaid Policy and Compliance
Caroline Brazeel, Office of Public Health
Jamila Freightman, Office of Public Health
Kate Holmes, Office of Public Health

Louisiana Department of Health and Hospitals
Kathy Kliebert, Secretary
W. Jeffrey Reynolds, Undersecretary
J. Ruth Kennedy, Louisiana Medicaid Director
Christine Peck, Legislative and Governmental Relations Director

APPENDIX A- ACT 210 Legislation

RS 46:2616

CHAPTER 46. HEALTH ACTION PLANS

§2616. Diabetes annual action plan; submission; content

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

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

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

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

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

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

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

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

RS 46:2617

§2617. Obesity annual action plan; submission; content

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

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

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

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

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

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

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

APPENDIX B- Committee Members

Diabetes/Obesity Committee Members: 2015–2016

Committee Member	Organization	Title
Rebekah Gee, MD	DHH	Medicaid Medical Director
Mary T.C. Johnson	DHH	Section Chief
Beverly Hardy-Decuir	DHH	Medicaid Quality Program Director
Dawn Love	DHH	Medicaid Policy & Compliance
Ekwutosi Okoroh	DHH-CDC	CDC-Medicaid Medical Epidemiologist
Takeisha Davis, MD	OPH	OPH Medical Director
Caroline Brazeel	OPH	Health Promotion/Chronic Disease Director
Jamila Freightman	OPH	1305 CDC Public Health Advisor
Lee Reilly	ABHLA	Director of Quality Management
Erin Hall	ABHLA	Data Encounters Analyst
Salli Duncan	ABHLA	Chief Executive Officer
John Robinson, MD	ABHLA	Chief Medical Officer
Mary Scorsone	ACLA	Director of Quality Management
Kyle Viator	ACLA	Market President
Letty Russell	ACLA	Manager of Medical Economics
Agnes Robins	ACLA	Quality Performance Specialist Clinical
Yolanda Spooner, MD	ACLA	Medical Director
Rhonda Baird	ACLA	Quality Performance Specialist Clinical
Aundria Toussaint	Amerigroup	Business Analyst
Lani Roussell	Amerigroup	Director of Quality Management
Brenda Tompkins	Amerigroup	Director of Healthcare Management Services
Raymond Poliquit, MD	Amerigroup	Medical Director
Marcus Wallace, MD	LHCC	Senior Vice President of Medical Affairs
David Thomas, MD	LHCC	Chief Medical Director
Arlene Goldsmith	LHCC	Manager of Accreditation
Erin Hawley	LHCC	Project Manager II
Melder Burton	LHCC	Manager of Quality Improvement Analytics
FeLisa Carpenter	LHCC	Workforce Analyst II
William Dalton	LHCC	Data Analyst IV
Ryan Jenkins	LHCC	Lead Data Analyst
Ann Logarbo, MD	United	Medical Director
Angela Olden	United	Director of Quality Management
Linda Rintala	United	Director of Health Services
Deborah Junot	United	Quality Manager

APPENDIX C- Region and parish information for members with obesity

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

Region	Parish	≤ 21 years	>21 years
CAPITAL	ASCENSION	464	435
CAPITAL	EAST BATON ROUGE	2,499	1,332
CAPITAL	EAST FELICIANA	107	66
CAPITAL	IBERVILLE	245	147
CAPITAL	LIVINGSTON	331	302
CAPITAL	POINTE COUPEE	114	206
CAPITAL	SAINT HELENA	30	24
CAPITAL	SAINT TAMMANY	474	508
CAPITAL	TANGIPAHOA	219	406
CAPITAL	WASHINGTON	180	213
CAPITAL	WEST BATON ROUGE	98	66
CAPITAL	WEST FELICIANA	28	29
CAPITAL	**TOTAL**	**4,789**	**3,734**
GULF	ASSUMPTION	50	93
GULF	JEFFERSON	1,862	1,345
GULF	LAFOURCHE	175	211
GULF	ORLEANS	1,438	1,527
GULF	PLAQUEMINES	72	65
GULF	SAINT BERNARD	166	164
GULF	SAINT CHARLES	256	222
GULF	SAINT JAMES	99	81
GULF	ST JOHN THE BAPTIST	330	197
GULF	SAINT MARY	175	225
GULF	TERREBONNE	335	327
GULF	**TOTAL**	**4,958**	**4,457**
NORTH	BIENVILLE	52	71
NORTH	BOSSIER	564	283
NORTH	CADDO	1,058	921
NORTH	CALDWELL	26	31
NORTH	CLAIBORNE	102	54
NORTH	DE SOTO	90	71
NORTH	EAST CARROLL	17	25
NORTH	FRANKLIN	100	89
NORTH	JACKSON	83	44
NORTH	LINCOLN	158	175
NORTH	MADISON	25	27
NORTH	MOREHOUSE	181	165
NORTH	NATCHITOCHES	261	140

NORTH	OUACHITA	842	847
NORTH	RED RIVER	9	18
NORTH	RICHLAND	118	101
NORTH	SABINE	69	97
NORTH	TENSAS	23	21
NORTH	UNION	83	106
NORTH	WEBSTER	167	121
NORTH	WEST CARROLL	19	18
NORTH	**TOTAL**	**1,797**	**1,661**
SOUTH CENTRAL	ACADIA	159	171
SOUTH CENTRAL	ALLEN	53	44
SOUTH CENTRAL	AVOYELLES	93	75
SOUTH CENTRAL	BEAUREGARD	57	62
SOUTH CENTRAL	CALCASIEU	307	416
SOUTH CENTRAL	CAMERON	2	3
SOUTH CENTRAL	CATAHOULA	59	67
SOUTH CENTRAL	CONCORDIA	101	136
SOUTH CENTRAL	EVANGELINE	80	114
SOUTH CENTRAL	GRANT	79	53
SOUTH CENTRAL	IBERIA	522	279
SOUTH CENTRAL	JEFFERSON DAVIS	55	44
SOUTH CENTRAL	LAFAYETTE	721	525
SOUTH CENTRAL	LA SALLE	33	35
SOUTH CENTRAL	RAPIDES	496	259
SOUTH CENTRAL	SAINT LANDRY	518	329
SOUTH CENTRAL	SAINT MARTIN	421	273
SOUTH CENTRAL	VERMILION	614	241
SOUTH CENTRAL	VERNON	62	61
SOUTH CENTRAL	WINN	314	71
SOUTH CENTRAL	**TOTAL**	**3,835**	**2,170**

APPENDIX D- Region and parish information for members with diabetes

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

Region	Parish	≤ 21 years	>21 years
CAPITAL	ASCENSION	49	314
CAPITAL	EAST BATON ROUGE	240	1,477
CAPITAL	EAST FELICIANA	10	100
CAPITAL	IBERVILLE	27	185
CAPITAL	LIVINGSTON	44	325
CAPITAL	POINTE COUPEE	20	138
CAPITAL	SAINT HELENA	6	28
CAPITAL	SAINT TAMMANY	70	509
CAPITAL	TANGIPAHOA	24	463
CAPITAL	WASHINGTON	27	358
CAPITAL	WEST BATON ROUGE	31	285
CAPITAL	WEST FELICIANA	8	105
CAPITAL	TOTAL	556	4,287
GULF	ASSUMPTION	10	137
GULF	JEFFERSON	226	1,605
GULF	LAFOURCHE	35	349
GULF	ORLEANS	448	2,318
GULF	PLAQUEMINES	10	81
GULF	SAINT BERNARD	36	161
GULF	SAINT CHARLES	19	132
GULF	SAINT JAMES	15	130
GULF	ST JOHN THE BAPTIST	31	222
GULF	SAINT MARY	24	338
GULF	TERREBONNE	51	420
GULF	TOTAL	905	5,893
NORTH	BIENVILLE	5	88
NORTH	BOSSIER	48	281
NORTH	CADDO	151	1,151
NORTH	CALDWELL	5	43
NORTH	CLAIBORNE	15	49
NORTH	DE SOTO	18	109
NORTH	EAST CARROLL	5	59
NORTH	FRANKLIN	13	115
NORTH	JACKSON	8	69
NORTH	LINCOLN	25	152
NORTH	MADISON	3	42

NORTH	MOREHOUSE	13	145
NORTH	NATCHITOCHES	22	210
NORTH	OUACHITA	99	543
NORTH	RED RIVER	29	195
NORTH	RICHLAND	6	93
NORTH	SABINE	13	82
NORTH	TENSAS	8	52
NORTH	UNION	9	96
NORTH	WEBSTER	23	142
NORTH	WEST CARROLL	8	59
NORTH	**TOTAL**	**233**	**1,659**
SOUTH CENTRAL	ACADIA	37	283
SOUTH CENTRAL	ALLEN	12	99
SOUTH CENTRAL	AVOYELLES	18	219
SOUTH CENTRAL	BEAUREGARD	17	131
SOUTH CENTRAL	CALCASIEU	52	593
SOUTH CENTRAL	CAMERON	0	9
SOUTH CENTRAL	CATAHOULA	7	61
SOUTH CENTRAL	CONCORDIA	14	104
SOUTH CENTRAL	EVANGELINE	12	267
SOUTH CENTRAL	GRANT	13	89
SOUTH CENTRAL	IBERIA	42	313
SOUTH CENTRAL	JEFFERSON DAVIS	8	84
SOUTH CENTRAL	LAFAYETTE	73	540
SOUTH CENTRAL	LA SALLE	12	63
SOUTH CENTRAL	RAPIDES	57	500
SOUTH CENTRAL	SAINT LANDRY	44	518
SOUTH CENTRAL	SAINT MARTIN	26	194
SOUTH CENTRAL	VERMILION	28	252
SOUTH CENTRAL	VERNON	22	198
SOUTH CENTRAL	WINN	5	76
SOUTH CENTRAL	**TOTAL**	**330**	**2,827**

APPENDIX E- Health Plans' Action Plans

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

APPENDIX E1- AETNA BETTER HEALTH OF LOUISIANA (ABHLA)

Aetna Better Health of Louisiana Diabetes and Obesity Care Management Plan

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

Aetna Better Health of Louisiana's integrated care management is provided for any member identified with diabetes or obesity that needs or requests care management services. The member receives person-centered outreach and follow-up. We employ our member-focused approach for all members, from those who are healthiest to those who are the sickest or most at-risk. Our care management program is called Integrated Care Management (ICM), reflecting our belief that all care management must address the member's medical, behavioral and social needs in an integrated fashion and must address the continuum of acute, chronic and long term care needs. Our case managers assist members in coordinating medical and/or behavioral health services. There are also specific assessment modules to address care management for special populations. Integrated Care Management activities apply to all:

- Member populations, age groups, disease categories and special risk groups for both physical and behavioral health.
- Services, both clinical and non-clinical, provided to enrolled Medicaid members by a provider or delegated entity at any point in the continuum of care and at any level of care.

Case managers use condition-specific assessments and care plan options to help members with chronic disease management, thus including traditional "disease management" within the integrated care management process rather than as a separate program. Members with diabetes or obesity are identified by predictive modeling (CORE), claims, health risk questionnaires, care management assessments, concurrent review/prior authorization referral, as well as member and provider referral. Interventions include:

- 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,
- 24 x 7 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,
- care management collaboration (with member's consent) with providers and caregivers.

The overarching goal of our ICM process is to engage members to address their critical physical, behavioral, environmental and social needs in order to enhance resiliency and enable optimal self-management. We collaborate with the member/member supports to create a Plan of Care based on clinical practice guidelines and preventive

service guidelines that includes mutually agreed upon member-centered goals, actions for the member/member supports and the care manager, as well as services to be coordinated for the member. We team with our members, their families, community supports, community-based case managers and providers to enhance care outcomes. Every assessment and encounter includes attention to comorbidities and to reducing unhealthy behaviors. Members are identified who may benefit from care management, using predictive modeling, self-reported health risks (Health Risk Questionnaire, or HRQ, offered to every member) and referrals from a variety of sources (including state-identified and state-mandated populations).

Condition-Specific Assessments

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

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

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

ABHLA Interventions for Prevention and Wellness for Diabetes and Obesity

a. Outreach members as appropriate with initiatives to address members of these populations.
b. Care management collaborates with member services and quality departments to identify and develop outreach efforts for members with diabetes and obesity. Focusing efforts on:
    - Annual flu shot campaign
    - Annual dilated eye exam
    - LDL and A1C testing
    - Annual pneumonia shot
    - Daily self-blood glucose monitoring
    - BMI screening
    - Type 2 diabetes screening at prenatal visits
    - Self-management of condition
    - Nutrition
    - Exercise
    - Weight management
    - Gaps in care

c. Outreach techniques to members may include:
    - Telephone reminders
    - Text messages
    - Mailings (e.g., bi-annual newsletters for members identified regarding chronic disease management)
    - E-mail
    - Information on the plan web site
    - Satisfaction surveys
    - Provider and member portal (e.g. educational messaging, information and digital tools for condition management.)
    - Community health fair

- Link to community resources
- Partnership with Boy Scouts of America and Girl Scouts of Louisiana

Value-Add Benefits

Aetna Better Health affiliates have already started using mobile technology to inform and educate members and deliver personalized chronic care management programs. We have implemented Care4Life™, a diabetes coaching program with mobile, web-based and interactive, this program sends text messages to program enrollees on a variety of topics including:

- Diabetes education and support/personal care manager (Diabetes Care Management Booklet, Diabetes Recipe Guide Booklet, and Spotlight on the Care4Life Program in our quarterly Member Newsletter)
- Appointment and medication reminders
- Exercise and weight goal setting and tracking

The Care4Life Program works to increase compliance with HbA1C testing for members with diabetes. Care4Life is a mobile and web-based diabetes-coaching program that uses text messaging to discretely remind members about their need for HbA1C testing and other services for managing their diabetes. We send educational messages and routine reminders to members regarding completion of recommended diabetes testing. A diabetes-related health tip is also texted every month. Care4Life integrates the text alert system with their laboratory system that documents when a member receives their test and generates a congratulatory message for test completion. The goal of the program is to increase the percentage of diabetics receiving at least one HbA1C testing in a six-month intervention period.

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

a. yearly diabetic dilated eye exam
b. yearly diabetic blood testing (LDL and A1c)

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

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

APPENDIX E2- AMERIGROUP LOUISIANA, INC. (AMG)

AMG Disease Management & Louisiana Healthy Families Program

AMG Disease Management – Diabetes and Obesity

- Amerigroup's Disease Management (DM) Programs address the needs of members with conditions including diabetes and obesity. Members may receive clinical or non-clinical interventions based on their level of need and willingness to participate in the program.
- Non-clinical interventions include automated, interactive telephone messaging and mailings, which both include educational and condition-specific content. Clinical interventions include comprehensive health risk assessment, care planning, education and health coaching through a DM care manager.
    - Note: Specifically, this includes an initial and follow up general assessment along with specific diabetes and obesity assessments (when applicable). The Disease Management Health Risk Assessment (DM HRA) is a comprehensive set of questions that identifies needs across the continuum of care. It captures information regarding both physical and behavioral conditions and condition maintenance, special needs, health history, lifestyle behaviors, risk factors and activities of daily living. The DM HRA includes assessment of height and weight followed by a calculation of BMI (or BMI percentile for children). Results of the HRA are used to develop a tailored, member-centric plan of care and drive both the intensity and frequency of follow-up outreach. Members receive written and verbal educational materials and a My Health Solution Plan, which is the agreed upon care plan written in member friendly terms. The member's primary provider receives information on the program, key findings of the assessment and a copy of the plan of care along with the relevant clinical practice guideline.
- Care managers monitor and follow-up with members and collaborate with the health care team to adjust the care plan as appropriate based on the unique needs of the individual member. A follow up assessment is completed on subsequent contacts following initial enrollment. The plan of care, stratification and follow up schedule may be adjusted based on new information gathered during the follow up assessment process. Members receive periodic status letters and updated copies of their My Health Solution Plan when changes occur. Providers receive status update letters along with the care plan when changes in the member's status occur or when new issues are identified.
- Members that engage with a DM care manager complete a brief satisfaction survey upon completion of the program to provide feedback on various components of DM. **During 2014 (through November), 5,255 Louisiana members participated in these DM Programs.**
    - Note: The DM satisfaction survey is administered to members as they are completing the program. The survey is administered telephonically by non-clinical support staff after the DM nurse and member have had their final follow-up dialogue. While DM attempts to administer the survey on the total population completing the program, participation in the survey is voluntary.

- Among the Louisiana members who completed the program and were surveyed during 2014:
    - 99.3 percent report being satisfied with the responsiveness and courtesy of DM care managers
    - 96.7 percent report overall satisfaction with the DM Programs

- 81.3 percent feel the DM Programs facilitate better communication with their providers
- 86.0 percent perceive an overall improvement in their health since enrolling in the DM Programs
- Note: This is member reported data and reflects the members' perception of overall health since enrolling in their respective program. Enrolled members showed and average **BMI decrease of 7.3 percent**.

AMG Healthy Families – Weight Management

- Amerigroup's Healthy Families Program is designed to promote healthy lifestyles in an attempt to impact the growing obesity epidemic. The primary program focuses on members ages 7-13 that could benefit from healthy lifestyle education and are interested in goal setting and working toward that end. Amerigroup recognizes that the need for this program extends into the teenage population in Louisiana. As a result, Amerigroup launched a teen pilot targeting members ages 14-17 in late 2013 and continued the pilot into 2014. Amerigroup plans to continue the teen program into 2015. Note: Members are identified by their age and outreach is conducted to determine appropriateness and interest in the program. Members can also be referred to the program by their provider, self-referral or referral from another Amerigroup program such as Case Management. The program is not limited to members with certain PCPs; it is open to any member in the age range regardless of their PCP.
- Eligibility for the program is based on both age qualification and clinical assessment of height, weight, BMI, co-morbid conditions and family history in addition to readiness level and interest in the program. Built on evidence-based clinical guidelines, Healthy Families connects the member with a nurse coach who works with the family and the health care provider to engage the member in a six month program, which includes collaborative goal setting and action planning.
    - Note: Amerigroup assesses any co-morbid conditions common with obesity (HTN, diabetes) and conditions that might increase the risk of obesity (medications for behavioral health conditions). Family history considered under this program includes diabetes, heart disease, high blood pressure and obesity. Amerigroup uses its Clinical Practice Guidelines for childhood and adolescent obesity as evidence-based clinical guides.

Nurse coaches work with members to set goals and develop small, doable steps to meet the member where they are. For example, one member/parent may have a goal of increasing fruit/vegetable intake while another may want to focus on increasing activity or reducing screen time. Amerigroup has care plan guidelines that are used by nurses for obesity as well as general guidelines for improving/maintaining health. The nurse will frequently use these and supplement for a member-centric plan. Amerigroup's nurses are specially trained in motivational interviewing and the goal is for them to assist members in developing a self-care plan, overcoming barriers and accessing resources rather than prescribing a specific type of nutrition or exercise plan. The nurses are also knowledgeable regarding the barriers and needs of the Medicaid population where finances are a barrier to many standard weight loss techniques.

- Healthy Families combines care management, education, coaching and community-based resources to support a healthy lifestyle not only for the member but the entire family. Members that participate in the program set goals related to increasing physical activity, incorporating healthy dietary habits and reaching a healthier weight. Amerigroup plans to introduce new written materials in 2014 to appeal to our target population to include graphic novel style materials with widely recognized characters.
    - Note: Examples of community-based resources include the YMCA sponsors, parks and recreation programs and school programs. Our nurse coaches use regional lists of available programs and activities to guide the member to resources available in their area. Nurse coaches also collaborate with local resources for information about community events.

Since parents make the decisions about what to buy at the grocery and what to prepare for dinner, any healthy behaviors naturally spill over to the rest of the family. Amerigroup's information about family engagement is anecdotal and is demonstrated in their Real Stories.

- Members that engage with a Healthy Families Case Manager complete a brief satisfaction survey upon completion of the program to provide feedback on various components of the program.
- **72 Louisiana families** participated in the standard Healthy Families program in 2014; **ten Louisiana families** participated in the teen pilot in 2014.
    - Note: On average, enrolled members have demonstrated the following during 2014:
- 9.27 percent decrease in consumption of sugary beverages
- 1.44 percent decrease in BMI percentile
- 3.46 percent increase in fruit/vegetable servings
- 3.20 percent increase in 8 ounce servings of water
- 0.62 percent decrease in screen time
- 0.52 percent increase in 30 minute activity sessions

APPENDIX E3- AMERIHEALTH CARITAS LOUISIANA (ACLA)

ACLA Current Diabetes/Obesity Initiative Activities

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

Member Incentives-Encourages members to obtain recommended screenings

- Collaborate with local vendors to facilitate one day diabetes focused event for members with an HgbA1C, nephropathy, and vision care gaps, in which diabetes education and screenings are performed along with exercise/nutrition counseling, blood pressure checks, and BMI assessments offering a $15 gift card and an opportunity for a $50 gift card raffle.
- $10 gift card for receiving HgbA1C, nephropathy and vision screenings

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

- Mailings to newly diagnosed members with diabetes with follow up care information and relevant phone numbers for health or medication questions, appointment assistance and transportation needs
- Combined member letter with gift card incentive for comprehensive diabetes care measures
- Telephonic outreach via case management to members regarding follow up care, transportation needs, appointment assistance, health or medication questions
- I Am Healthy educational member mailings and web content
- Integrated Healthcare Management (IHCM), Member Services, and Rapid Response utilize all encounter opportunities to educate members of all care gaps.
- Year to date mailing and sound blast to members with diabetes care gaps. Opportunities to direct connect to our Rapid Response Outreach Team, is provided with our sound blasts, which can assist the member with transportation, appointment scheduling and/or obtaining prescriptions.
- Monthly educational mailings to newly identified high risk members with diabetes.
- IHCM offers one on one teaching of self-management skills, for members who opt into the disease management program, which includes the importance of medication compliance, obtaining appropriate screenings such as HgbA1C testing, nephropathy screenings and eye examinations.
- Promote educational campaigns and messages that improve the awareness of diabetes prevention and control to our members and to the general public through the distribution of educational materials, newsletters, newspaper articles and media interviews.
- Our "Make Every Calorie Count" program targets members with a diagnosis of obesity and other co-morbidities such as diabetes. Once engaged, they receive telephonic case management addressing the

disease and weight management from a registered nurse. Members receive a "Make Every Calorie Count" welcome packet which includes a pedometer, tape measure, welcome booklet and calorie/activity journals. These tools are used as teaching tools, as the case managers educate, motivate and develop individualized plans of care. Starting Feb. 1, 2015, members engaged in the "Make Every Calorie Count" program became eligible to receive nutritional counselling services.

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

- Provide HEDIS training boot camps to discuss HEDIS requirements and billing procedures for DHH's incentive-based HEDIS measures
- Provide HEDIS training- regional trainings: discuss HEDIS requirements and billing procedures for DHH's incentive-based HEDIS measures
- Provide targeted provider visits to address member care gaps
- Educate providers regarding the use of the provider portal (Navinet) for electronic access of assigned member care gaps. If necessary, providers are directly provided the list of care gaps.
- Distribute guides to key HEDIS measures to providers
- I Am Healthy educational physician web content
- Planning a $10 incentive for billing CPT Category II code for low-risk retinopathy (no evidence of retinopathy in prior year) for eligible members

Data collection on comprehensive diabetes care measures and others such as adult BMI assessment, and weight assessment and counseling for nutrition and physical activity for children/adolescents outcome data, or other quality monitoring activities

- Trend and track HEDIS measures: Comprehensive diabetes care and other measures such as adult BMI assessment, and weight assessment and counseling for nutrition and physical activity for children/adolescents data collection and analysis from member telephonic outreach via case management for follow-up care
- Tracking of returned member mailings
- Comprehensive diabetes care quality improvement activity

APPENDIX E4- LOUISIANA HEALTHCARE CONNECTIONS (LHC)

Diabetes Action Plan

Program Objective

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

Eligibility Criteria

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

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

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

Enrollment

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

An introductory mailing is sent to targeted members and Health Plan physicians announcing the program and informing members they will receive a phone call. Telephonic outreach begins 14 days after the introductory mailing is sent. Several attempts to contact a member by telephone are made. Members who do not respond to telephone outreach are sent a post card encouraging enrollment.

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

Ongoing Counseling

The health coach will complete an assessment and develop an individualized care plan based on the member's or caregiver's knowledge of their condition, lifestyle behaviors and readiness to change. Internal clinical guidelines are developed from nationally recognized evidence-based guidelines published by The American Diabetes Association and the American Association of Clinical Endocrinologist. Components of the program include:

- medication comprehension and compliance
- self-blood glucose monitoring
- recognizing signs of low and high blood glucose levels
- nutrition counseling for carbohydrate counting and weight management
- recommended annual screening for diabetic complications
- blood pressure and cholesterol management
- optimizing physical activity levels to meet recommended guidelines
- supporting tobacco cessation

- internal consults with specialty health coaches for participants at high risk for, or diagnosed with another chronic condition program (COPD, asthma, heart failure, heart disease, hypertension, hyperlipidemia) purchased by the Health Plan. Specialty health coaches include certified diabetes educators, registered nurses and certified or registered respiratory therapists.

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

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

Pediatric Members

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

Program Length

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

Referral Services

Subject to applicable law and regulations, a provider may refer members to other disease management programs offered by the Health Plan (either internal or external), health management or case management programs as appropriate. Members who are at high risk for non-adherence to medical care or are in need of social or behavioral services will be referred to case management. In addition, the health coach can support the member in accessing local resources. A provider will also establish a referral system to allow referrals directly from case management.

Disenrollment

Members may be disenrolled from the program under the following circumstances

- Member dies;
- Member's health care coverage with the Health Plan terminates or the Health Plan no longer provides the member's primary coverage as determined under applicable coordination of benefits rules by the Health Plan and communicated through the provider;
- Member's attending physician or the Health Plan 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); or
- Member has enrolled in a Hospice Program.

Performance Measurements – 2015

Performance Measure/Target	Measurement Period
A target rate of 80 percent compliance with annual HbA1c screening or improvement to a compliance rate of at least the baseline rate, plus half of the difference between the	2/1/2015 – 12/31/2015

target rate and the baseline rate	
A target rate of 50 percent compliance with nephropathy monitoring or improvement to a compliance rate of at least the baseline rate, plus half of the difference between the target rate and the baseline rate	2/1/2015 – 12/31/2015
A target rate of 60 percent compliance with annual eye (retinal) exam or improvement to a compliance rate of at least the baseline rate, plus half of the difference between the target rate and the baseline rate	2/1/2015 – 12/31/2015

Weight Management Plan

Program Objective

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

Eligibility Criteria

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

- 18 years or older and
- Body Mass Index greater than or equal to 25 or
- History of BMI greater than or equal to 25 with need for weight maintenance support

Individuals are referred into the program by providers and case managers. Members may self-refer into the program if agreed to by client.

Enrollment

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

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

Ongoing Counseling

The health coach will complete an assessment and develop an individualized care plan based on the member's current status, including physical activity limitations, presence of co-morbidities and dietary intake Internal clinical

guidelines are developed from nationally recognized evidence based guidelines published by National Institutes of Health and American Dietetic Association. Components of the program include:

Registered dietitians provide coaching for:

- nutritional counseling for appropriate rate of weight loss
- role of fats, carbohydrates and protein in proper nutrition
- optimizing physical activity levels to meet recommended guidelines
- behavior modification skills for long term weight control
- food preparation and portion control methods
- label reading skills
- strategies when eating out
- benefits of physical activity
- lifestyle approaches to physical activity
- tips to keep motivated with exercise
- unlimited inbound calls
- education materials to enhance understanding and compliance

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

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

Referral Services

Subject to applicable law and regulations, a provider may refer members to other disease management programs offered by the Health Plan (either internal or external), health management or case management programs as appropriate. Members who are at high risk for non-adherence to medical care or are in need of social or behavioral services will be referred to case management. In addition, the health coach can support the member in accessing local resources. The provider will also establish a referral system to allow referrals directly from case management.

Disenrollment

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

- Member dies;
- Member's health care coverage with the Health Plan terminates or the Health Plan no longer provides the member's primary coverage as determined under applicable coordination of benefits rules by the Health Plan and communicated through the provider;
- Member's attending physician or the Health Plan 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); or any complex medical condition
- Member has enrolled in a Hospice Program.

APPENDIX E5- UNITED HEALTHCARE OF LOUISIANA (UHC)

UHC 2015 Diabetes Action Plan

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

Description				Responsible Party	Timeframe
a. Perform Health Risk Assessment for New Members					
A telephonic health risk assessment (HRA) which includes monitoring for risk of diabetes. Members who are unable to be contacted by phone are sent a postcard with a request to contact UnitedHealthcare (UHC).				UHC's Hospitality, Assessment and Retention Center (HARC)	Ongoing in 2015
Process Measures:	2013 Jan.-Nov.	2014 Jan.-Oct.	2015 Jan.-Sept.		
# HRA's completed	21,596 (42%)		23,783 (66%)		
# members reached	42,116 (82%)	30,032 (49%)	38,386(78%)		
b. Use Person Centered Care Modeling					
Software designed to predict health risks and assess utilization so that members can be placed appropriately into care management programs if warranted.				Utilization Management Team	Ongoing in 2015
Process Measures: 939 referrals in 2014 from Utilization Management to Care Management with diagnoses of diabetes					
Referrals in 2015 from Utilization Management to Case Management with diagnoses of diabetes by quarter follow: 1st Qtr. 290, 2nd Qtr. 371, and 3rd Qtr. 277, total for three quarters is 938.					
c. Educate Members Using "Taking Charge" Disease Management Materials					
Members identified with diabetes receive educational materials and newsletters with diabetes specific information, including recommended routine appointment frequency, necessary testing/ monitoring and self-care. Materials are designed to empower each member to take responsibility for their health and to equip themselves with the information necessary manage their diabetes as successfully as possible and live a healthy lifestyle.				Disease Management Team	Ongoing in 2015

Process Measures:	2013	2014	2015*(Jan-Sept)
# Mailings to Adults	257	1521	1351
# Mailings to Children	23	196	114

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 2015

Process Measures:	2013	2014	2015
# women attending Lunch'n'Learn	279	550	735
# Lunch'n'Learn events	10	13	15

e. Silver Links Calls		
Continue with Silver Links "live" outreach to members with diabetes for diabetic gap appointments with PCP appointments facilitated.	Director, Quality Management & Performance	Ongoing in 2015

Process Measures:	2014 Nov.-Dec	2015 Feb.-Sept.
# of members called	1633	4594

f. Cobranding		
Cobranding with high PCPs with high volume clinic members will receive mail outs and calls for diabetic gaps in care	Director, Quality Management & Performance	New in 2015

Process Measures:
2015 # of members mailed 27
2015 # of cobranded practices 8

Overall Health Outcome Measures

HEDIS 2015 Comprehensive Diabetes Care Measures:

Hba1c Testing – 80.54
Eye Exam – 46.96
Attention for Nephropathy – 78.10

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

Description	Responsible Party	Timeframe
Educate and refer pregnant women with diabetes to maternal care management.		
Healthy First Steps (HFS) is a maternal management program designed to reduce the risk of infant mortality. The program begins with a risk assessment for various conditions that may complicate pregnancy including diabetes.	Healthy First Steps Team	Ongoing in 2015
Process Measures: # members identified # members qualified # members reached # members referred to case management		2014 (Jan – October) 8,945 8,015 3,050 2,630
Process Measures: # members identified # members qualified # members reached # members referred to case management		2015 (Jan – October) 10,196 8,407 3,374 912

Overall Health Outcome Measures

HEDIS Prenatal and Postpartum Care Measures:

Prenatal – 90.71

Postpartum – 55.01

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

Description	Responsible Party	Timeframe
Educate providers on current HEDIS standards.		
The Clinical Practice Consultant (CPC) Program was expanded from three to five CPCs in the 4th Quarter of 2013. CPCs engage in educating primary care providers about HEDIS. To improve HEDIS rates, the plan has shared information about evidence-based guidelines for care by distributing its evidence-based guidelines toolkits to practices. To help combat diabetes, the consultants will continue to educate providers on the importance of Hba1c testing, retinal eye exams, LDL screening and attention for nephropathy.	Director, Quality Management & Performance	Completed in 2014

Process Measures:	2013 (Jan – Dec)
# toolkits distributed	769
# providers	524
# members potentially impacted based on panel assignments	154,867

***** Note toolkit became available on United Healthcare website in 2014.***
CPCs demonstrate how to access the toolkits on the provider website during visits.
Upon request printed toolkits will be provided to providers during CPC visits.

HEDIS 2014 Overall Health Outcome Measures
HEDIS Comprehensive Diabetes Care Measures:
HEDIS 2015 Comprehensive Diabetes Care Measures:
Hba1c Testing – 80.54
Eye Exam – 46.96
Attention for Nephropathy – 78.10

Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents
BMI Percentage- 41.36
Counseling for Nutrition- 53.04
Counseling for Physical Activity- 41.61

Adult BMI Assessment Rates – 71.32

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

Description	Responsible Party	Timeframe
Refer members to Pennington for potential access to a physical fitness facility.		
Support local research on health care related issues as it relates to Diabetes. Pennington Wellness Day is an event designed to educate the community about healthy lifestyle choices as it relates to obesity, diabetes and other areas of concern.. .	UHC Marketing and Community Outreach	Did not participate in 2015
Process Measures: # of events # of members attending		2014 1 500
2015 Events made available to members if they wished to attend. Specific number of members attending not recorded at events.		

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

UHC 2014 Obesity Action Plan

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

Description	Responsible Party	Timeframe
a. Continue Eat4-H Partnership.		
Louisiana 4-H and UnitedHealthcare will continue their partnership, Eat4-Health, in 2014. Louisiana is one of 10 states participating in the campaign designed to empower youth to help fight the nation's obesity epidemic. Each state 4-H organization is receiving a grant funded by UnitedHealthcare to support healthy-living programs, events and other activities 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 Louisiana State University Ag Center.	4-H and UHC Marketing and Community Outreach	Ongoing in 2015
Process Measures: 2013 — 2014 Jan. – June — 2015 # Louisiana youth reached 1,762 — 8,061 — 3,225 # events 7 — 21 — 15		
b. Continue 4-H Youth Voice: Youth Choice Partnership.		
4-H's Youth Voice: Youth Choice provides grants to state-level 4-H programs and focuses on developing and enhancing healthy living at the community level through activities such as after-school programs, health fairs, camps, clubs, workshops and educational forums. Youth who participate in the programs are encouraged to take action for themselves and their families, and to promote healthy living in their communities.	4-H and UHC Marketing and Community Outreach	Ongoing in 2015
Process Measures: 2013 — 2014 (Jan.-June) — 2015 # Louisiana youth reached 1,762 — 8,061 — 3,225 # events 7 — 21 — 15		
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 2015
Process Measures: 2013 — 2014 (Jan.-June) — 2015 # Louisiana youth attending 500 — 450 — 1,385 # events 7 — 3 — 7		

d. Distribute Sesame Street Food for Thought toolkits./reading corners			
Food for Thought is a bilingual (English-Spanish) multimedia outreach initiative that helps families who have children between the ages of two and eight cope with limited access to affordable and nutritious food (also known as food insecurity). The outreach is conducted in multiple venues including Head Start and Catholic Charities.		UHC Marketing and Community Outreach	Ongoing in 2015
Process Measures:	2013	2014 Jan-June	2015
# toolkits distributed	15,572	3500 (30 FQHC)	1,350(5 reading corner)
e. Continue Dr. Health E. Hound visibility at community events.			
Dr. Health E. Hound is the friendly face of UnitedHealthcare Community Plan. As our mascot, he travels all across the country, making special appearances to engage with the public and help educate children, their families and the community about healthy living, including healthy eating habits.		UHC Marketing and Community Outreach	Ongoing in 2015
Process Measures:		2013	2014 Jan-June 2015
# events that Dr. Health E. Hound attended		4	7 48
# of member		520	9,220 11,665
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 2015
Process Measures:	2013	2014 Jan-June	2015
# events			53
# people attending	14,887	6,570	2,735

UHC Program Goal 2: Facilitate healthy lifestyles.

Description	*Responsible Party*	**Timeframe**
a. Continue JOIN for ME.		
JOIN for ME is a community-based, pediatric-obesity lifestyle-intervention program. It engages overweight and obese kids ages six to 17, along with their parents, in a series of evidence-based learning sessions to achieve healthier weights through balanced food choices, increased physical activity and tracking. The program will continue at the Boys and Girls Club in New Orleans. A second location in St. Tammany.	UHC Marketing and Community Outreach and Chief Medical Officer	Ongoing
Pilot Process Measures: # enrollees Average pounds lost / enrollee # enrollees completing the program		In December 2013/2014 Call campaign 8,043 members Qualified based on BMI -139 Enrolled in class - 37
2015 negotiations for partners across the State in process for continue development of this program.		
b. 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 2015

Process Measures:	2013	2014 Jan-June	2015
# member reached	115	405	735
# of events	3	7	22

c. Initiate UHC Small Steps Program (Eat for Health).		
UnitedHealthcare is partnering with large clinics and Federally Qualified Health Centers (FQHCs) to help fight obesity and encourage patients to make positive changes in their eating habits. This program is designed to assist health care professionals to increase awareness of weight control and healthier eating habits. Marketing materials will be co-branded with the health care professionals. The initiative also involves making fresh fruits and vegetables available at the site. In 2014 this program is under Eat for Health.	UHC Marketing and Community Outreach	Ongoing in 2015

Process Measures:	2013	2014 Jan-June	2015
# of members reached	1587	350	1000
# of events	14	1	4

UHC Program Goal 3: Facilitate self-management of obesity for members with a diagnosis of obesity.

b. Use Person Centered Care Modeling		
Software designed to predict health risks and assess utilization so that members can be placed appropriately into care management programs if warranted.	Utilization Management Team	Began in 2015
Process Measures: Referrals in 2015 from Utilization Management to Case Management with diagnoses of obesity by quarter follows: 1st Qtr. 45, 2nd Qtr. 15, 3rd Qtr. 13, total for three quarters 73.		