Diabetes and Obesity Report for the Medicaid Managed Care Program

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

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Contents

Executive Summary

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

This report is submitted pursuant to Act 210 of the 2013 Regular Legislative Session, which requires the Louisiana Department of Health (LDH) to submit an annual diabetes and obesity action plan to the Senate and House Committees on Health and Welfare after consulting with, and receiving comments from, the medical directors of each of its contracted Medicaid partners. Data presented on prevalence, utilization and costs of obesity and diabetes are based on 2018 data submitted by each of the five Healthy Louisiana managed care organizations (MCOs) and represent the managed care population only.

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

- *The State of Obesity* is a collaborative project of the Trust for America's Health and the Robert Wood Johnson Foundation that produces annual reports on national obesity trends. According to *The State of Obesity* 2019 report, Louisiana was ranked fourth in the nation with an adult obesity rate of 36.8%.[1] The following obesity summary was based on 2018 Healthy Louisiana MCO claims data:
    - In 2018, 149,172 enrollees, or 8.18%, of the Healthy Louisiana population had an obesity diagnosis; 5.51% of enrollees 21 years of age or younger (50,265 individuals) and 10.83% of enrollees over the age of 21 years (99,207 enrollees) were diagnosed with obesity. See Appendix B for a regional breakdown of obesity.
    - The total paid for medical claims associated with enrollees diagnosed with obesity at any time in 2018 was $722.63 million.
    - According to the *State of Obesity 2019* report, Louisiana was ranked fourth in the nation in 2018 with the rate of adult diabetes at 14.1%.
- The following diabetes summary was based on 2018 Healthy Louisiana MCO claims data:
    - In 2018, 8.58% (78,594 enrollees), of the adult Healthy Louisiana population had a diabetes diagnosis. Of all enrollees diagnosed with diabetes, 64.86% (53,849 enrollees) were female, and 35.14% (29,178 enrollees) were male. The largest percentage of people with diabetes in the Healthy Louisiana population regardless of age, resided in the Gulf region (31.58%). See Appendix C for a regional breakdown for diabetes.
    - Diabetes was the primary diagnosis for 11,229 inpatient hospital admissions, accounting for 6.04% of all inpatient admissions for Healthy Louisiana enrollees in 2018. The total paid for these inpatient stays was $57,355,962.

[1] *The State of Obesity in Louisiana*. (August 2019). Retrieved December 11, 2019, from https://www.tfah.org/state-details/louisiana/

- Diabetic ketoacidosis was the most common diabetic complication on hospital inpatient discharge claims for those 21 years of age or younger, accounting for 67.98% of all inpatient hospital discharges for this age group.
- There were 36,859 Emergency Department (ED) visits for Healthy Louisiana enrollees where a diabetic complication was the primary diagnosis. Most diabetic complication-related diagnosis codes submitted on ED visit claims occurred among enrollees older than 21 years of age (95.43%; 35,174 enrollees).
- When comparing diabetes to other chronic conditions, in 2018, the chronic condition with the highest average cost per enrollee was coronary congestive heart failure at $9,281.64. The average cost per enrollee diagnosed with diabetes in 2018 was $3,680.06.

- Notes on the limitations of data comparisons made in this report:

  The Healthy Louisiana numbers, cited in this paper, have been aggregated from Medicaid enrollment data and Medicaid medical claims data submitted by the five MCOs contracted by Louisiana Medicaid. The paper has cited widely accepted national reports on diabetes and obesity published by the Centers for Disease Control and Prevention (CDC), the Behavioral Risk Factor Surveillance System (BRFSS), and the Robert Wood Johnson Foundation. While the age groups in the national standards cited do not match the age groups used in this report, the national rates do give us the opportunity to compare reported results to national findings. Moreover, care should be taken when drawing conclusions about the comparisons. Nonetheless, the references may provide insight into how well prevalence can be captured using Medicaid managed care enrollment and medical claims data.

- Notes on production of this year's report:

  Because the information used to create this report was stored on a server affected by the ransomware attack in November 2019, a significant delay resulted in the production of this year's Act 210 Diabetes and Obesity Report. In addition, the Managed Care Organizations are instructed to review related claims with dates of service in the year prior to submission. In this report, MCOs submitted information to LDH in 2019 and the dates of service counted in their metrics were restricted to 2018. Therefore, there is a considerable lag between the metrics reported and the dissemination of this year's report.

1 Introduction

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

1.1 Report Methodology

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

1.2 Obesity Overview

1.2.1 National Prevalence

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

1.2.2 What is Obesity?

Obesity is a diagnosis given when an individual has accumulated enough body fat to have a negative effect on their health. If a person's body weight is at least 20% higher than it should be, they are considered obese. Obesity is calculated using a statistical measurement known as the Body Mass Index (BMI).[4]

1.2.3 What is the Body Mass Index?

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

Children with obesity are at higher risk of having other chronic health conditions and diseases that influence physical health. These include asthma, sleep apnea, bone and joint problems, Type 2 diabetes, and risk factors for heart disease. In the long term, a child with obesity is more likely to have obesity as an adult. An adult with obesity has a higher risk of developing heart disease, Type 2 diabetes, metabolic syndrome and many types of cancer.[6]

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

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

[4] *BMI and Obesity. (2012, December 1). Retrieved February 17, 2017, from http://www.ahrq.gov/news/newsroom/audio-video/bmieng.html*

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

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

Despite the growing efforts of government and public health officials, the observed change in prevalence between 2013–2014 and 2015–2016 was not significant among youth or adults.[7]

1.3 Diabetes Overview

1.3.1 National Prevalence

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

1.3.2 What is Diabetes?

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

1.3.3 Types of Diabetes

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

Type 2 diabetes (previously called "non-insulin-dependent diabetes" or "adult-onset diabetes") develops with "insulin resistance," a condition in which cells (e.g., liver, muscles) of the body do not use insulin properly. As the body resists its own insulin, the pancreas begins to lose the ability to make enough of it. In adults, Type 2 diabetes accounts for about 90% to 95% of all diagnosed cases of diabetes.[13] The risk factors for developing this type of diabetes include older age, obesity, family history of diabetes, personal history of gestational diabetes, physical inactivity and race/ethnicity. African Americans, Hispanic/Latino Americans, American Indians, some Asian Americans and some Pacific Islanders are at a higher risk for development of Type 2 diabetes and its complications. Type 2 diabetes may be preventable through modest lifestyle changes. [14]

[7] Hales CM, Carroll MD, Fryar CD, Ogden CL. Prevalence of obesity among adults and youth: United States, 2015–2016. NCHS data brief, no 288. Hyattsville, MD: National Center for Health Statistics. 2017.
[8] Centers for Disease Control and Prevention. National Diabetes Statistics Report, 2017. Atlanta, GA: Centers for Disease Control and Prevention, U.S. Dept of Health and Human Services; 2017.
[9] Heron M. Deaths: Leading causes for 2016. National Vital Statistics Reports; vol 67 no 6. Hyattsville, MD: National Center for Health Statistics. 2018.
[10] *National Diabetes Statistics Report, 2014* (pp. 1-12, Rep.). (2014). Atlanta, GA: Centers for Disease Control and Prevention.
[11] Statistics About Diabetes. (n.d.). Retrieved February 17, 2017, from http://www.diabetes.org/diabetes-basics/statistics/
[12] Diabetes. (2018, November 27). Retrieved November 29, 2018, from https://www.cdc.gov/diabetes/basics/diabetes.html
[13] Diabetes. (2018, November 27). Retrieved November 29, 2018, from https://www.cdc.gov/diabetes/basics/diabetes.html
[14] *Who's at Risk (2017, July 25). Retrieved November 29, 2018, from http://www.cdc.gov/diabetes/basics/risk-factors.html*

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

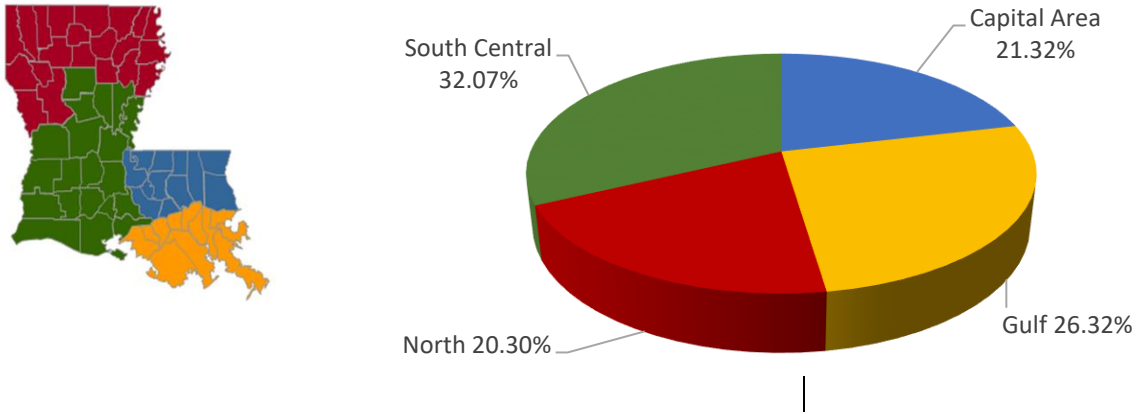
[15] Gestational Diabetes and Pregnancy. (2015, September 16). Retrieved February 17, 2017, from http://www.cdc.gov/pregnancy/diabetes-gestational.html

2 The Scope of Obesity in the Healthy Louisiana Program

Based on 2018 claims data, the prevalence of obesity among Healthy Louisiana enrollees was 8.18% out of 1,827,756 enrollees; 10.83% of adults (n=915,727) and 5.51% of enrollees 21 years of age or younger (n=912,029); where n represents the number of enrollees in the percentage denominator. However, the Trust for America's Health and the Robert Wood Johnson Foundation's *State of Obesity* report that Louisiana's adult obesity rate was 36.8% in 2018, and ranked fourth highest in the United States.[16] Given our reported obesity rates, it appears that obesity is under-coded as a diagnosis in Louisiana Medicaid claims data and yields an artificially low prevalence rate when exclusively using Louisiana Medicaid medical claims data to calculate the rate.

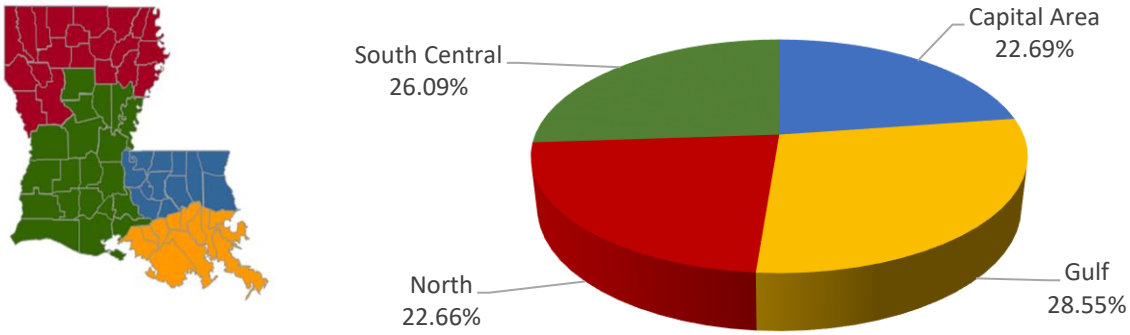
Of the Healthy Louisiana enrollees diagnosed with obesity, 33.63% (n=50,265) were 21 years of age or younger and, 66.37% (n=99,207) were older than 21 years of age. The geographic and age group breakdown of obesity among the four Louisiana regions is shown in Charts 2.1 and 2.2. For the 21 years of age or younger group, the South Central (32.07%) and Gulf (26.32%) regions had the highest percentage of enrollees with obesity. For Healthy Louisiana enrollees older than 21 years of age, the Gulf (28.55%) and South Central (26.09%) regions had the most enrollees with obesity. The Northern region had the lowest percentage of individuals diagnosed with obesity in both age groups. For parish level information, please see Appendix C.

Chart 2.1: Geographical Distribution of Healthy Louisiana Enrollees with Obesity, Age ≤ 21 Years, 2018 (n = 50,265)



[16] *The State of Obesity in Louisiana*. (September 2019). Retrieved October 10, 2019, from http://www.stateofobesity.org/states/la

Chart 2.2: Geographical Distribution of Healthy Louisiana Enrollees with Obesity, Age > 21 Years, 2018
(n = 99,207)



The 2018 financial burden of obesity is shown in Table 2.1. Healthy Louisiana MCOs paid $63.65 million for medical claims that included a diagnosis code for obesity. The total paid for medical claims associated with enrollees diagnosed with obesity at any time in 2018 was $722.63 million.

Table 2.1: Financial Burden of Obesity in 2018 among Healthy Louisiana Enrollees

Age Group	Obesity Service-Related Payments *	Obesity-Related Payments**
≤ 21 years	$10,854,070	$118,547,537
>21 years	$52,795,682	$604,084,487
Total	$63,649,752	$722,632,024

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

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

This section of the report provides data on the scope of diabetes among children and adults in the state, and within the five Healthy Louisiana MCOs. Data from the BRFSS describes how adult Louisiana residents with diabetes compare nationally in meeting clinical and self-care measures.

Based on the annual BRFSS survey, Louisiana's results in Figure 3.1 shows the 17-year trend of diagnosed diabetes in Louisiana adults (age 18 and over). With some fluctuation, the rate trended upward from a low of 7.15% in 2002 to a high of 14.1% in 2018. In the 2017 publication of the Diabetes Report Card based on 2015 data, the CDC reported that 9.1% of adults in the U.S. and 11.8% of adults in Louisiana were diagnosed with diabetes in 2015.[17]

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

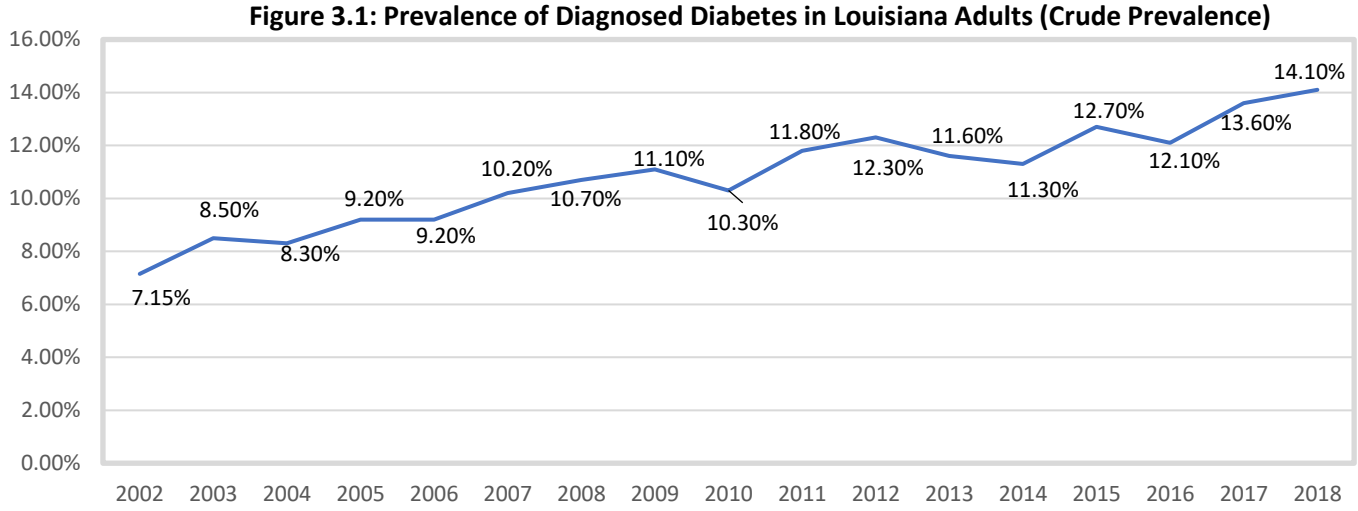


Figure 3.2 shows adult diabetes prevalence by gender in the overall Louisiana population and in the Healthy Louisiana population. The Healthy Louisiana populations show a slightly lower prevalence in males (8.25%) than in females (8.77%). This is in agreement with the CDC, where the overall Louisiana prevalence was higher among adult females (14.70%) than adult males (13.50%).[18]

Figure 3.3 displays how diabetes prevalence for Healthy Louisiana enrollees is distributed across age groups and gender. Healthy Louisiana's 2018 diabetes prevalence is highest in adult females (8.77%; 51,198) and is followed closely by adult males (8.25%; 27,396). The prevalence of diabetes in Healthy Louisiana enrollees who are 21 years of age or younger is less than 1% for both males and females.

[17] Centers for Disease Control and Prevention. Diabetes Report Card 2017. Atlanta, GA: Centers for Disease Control and Prevention, US Dept of Health and Human Services; 2018. Retrieved December 11, 2019 from https://www.cdc.gov/diabetes/pdfs/library/diabetesreportcard2017-508.pdf

[18] Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Division of Population Health. BRFSS Prevalence & Trends Data [online]. 2015. Retrieved December 11, 2019 from https://www.cdc.gov/brfss/brfssprevalence/.

Figure 3.2: Healthy Louisiana Compared to CDC Behavioral Risk Factor Surveillance System (BRFSS)
2018 Adult Diabetes Prevalence by Gender

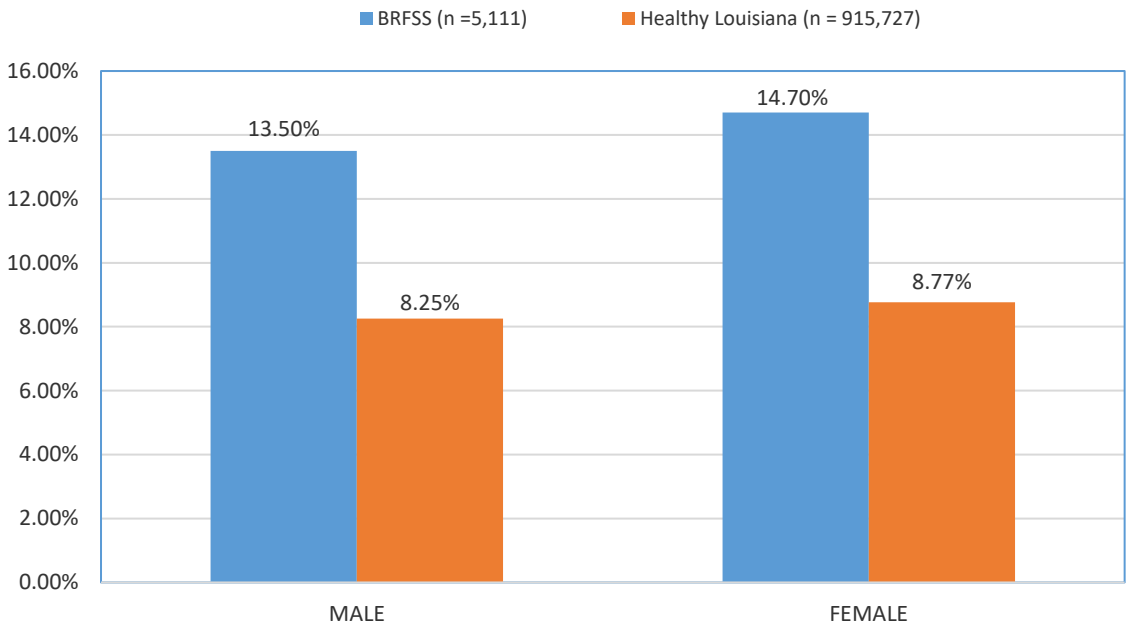


Figure 3.3 Healthy Louisiana 2018 Diabetes Prevalence by Age Group and Gender

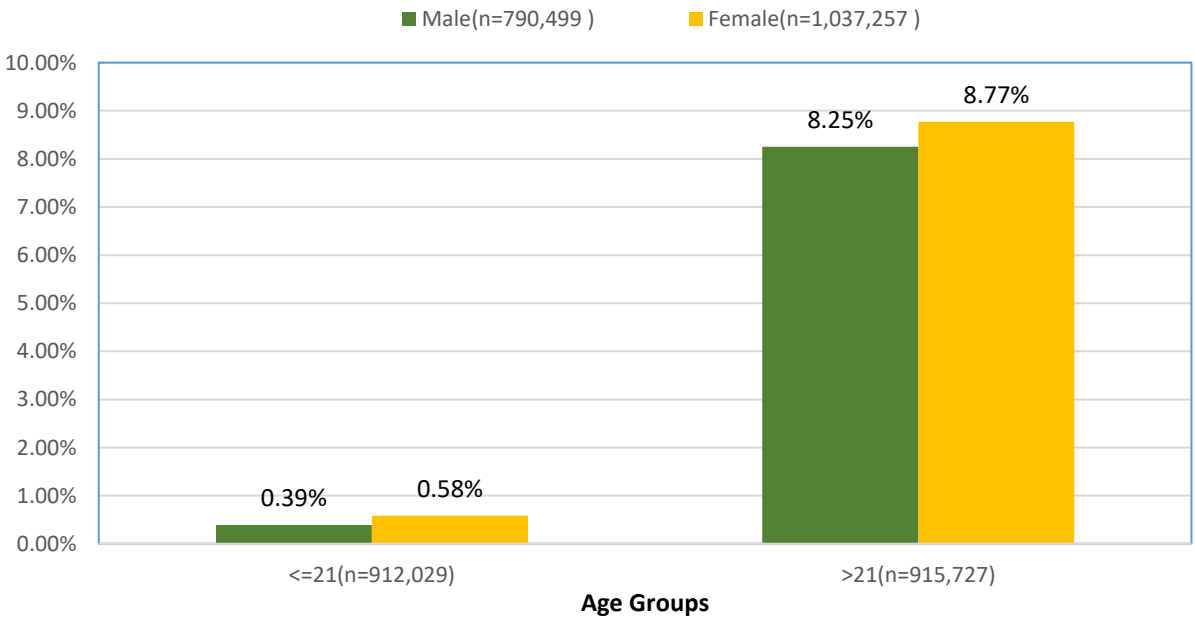


Table 3.1 details how enrollees in Healthy Louisiana compared with state and national levels for preventive practices recommended for patients with diabetes. Louisiana's BRFSS percentages were slightly less than the 2015 national numbers for most of the listed preventive care practices. The Healthy Louisiana plans' dilated eye exam rate was considerably higher than the 2015 national median (72.38% versus 61.6%). Healthy Louisiana's HbA1c testing was slightly higher than the U.S. median (74.36% versus 71.4%). However, Healthy Louisiana enrollees scored considerably lower than the 2015 national median on self-management education and daily glucose monitoring.

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

Preventive Care Practice	Healthy Louisiana Adults (2018) †	BRFSS Louisiana (2015)	U.S. (2015)††
Annual dilated eye exam	72.38%	56.5%	61.6%
Received one or more HbA1c in current (2018) year	74.36%	64.8%**	71.4%**
Received a flu shot in current (2018) year	14.70%	***	***
Ever received a pneumonia shot	7.76%	***	***
Daily self-blood glucose monitoring	36.55%	56.7%	63.0%
Ever had self-management education	0.18%	46.1%	54.4%

†Because Healthy Louisiana enrollees may receive immunizations from organizations outside of the normal healthcare delivery settings and who may offer the vaccines free or nearly free, the claims data will produce artificially low rates for flu and pneumonia vaccines.
††2017 represents the most recent year of data available from the CDC *Diabetes Report Card*. Available at: https://www.cdc.gov/diabetes/pdfs/library/diabetesreportcard2017-508.pdf
**Rate reported by BRFSS in the CDC Diabetes Report Card reflects two or more HbA1c tests in the last year.
***Rates not included in *CDC's Diabetes Report Card 2017.*

The geographic and age group breakdown of individuals diagnosed with diabetes among the four regions is shown in Chart 3.1 for those age 21 years of age or younger and Chart 3.2 for those over the age of 21. Of the people with diabetes in Healthy Louisiana, the largest percentage of enrollees with diabetes in both age groups resided in the Gulf Region: 39.45% for those 21 years of age or younger and 31.13% for those older than 21 years of age. Of the people with diabetes in Healthy Louisiana, the smallest percentage of enrollees 21 years or younger with diabetes resided in the Capital region (18.42%), while the smallest percentage of adults with diabetes resided in the North region (21.87%). For parish-level data, please see Appendix C.

Chart 3.1: Geographical Distribution of Healthy Louisiana Enrollees with Diabetes, Age ≤ 21 Years, 2018 (n =4,360)

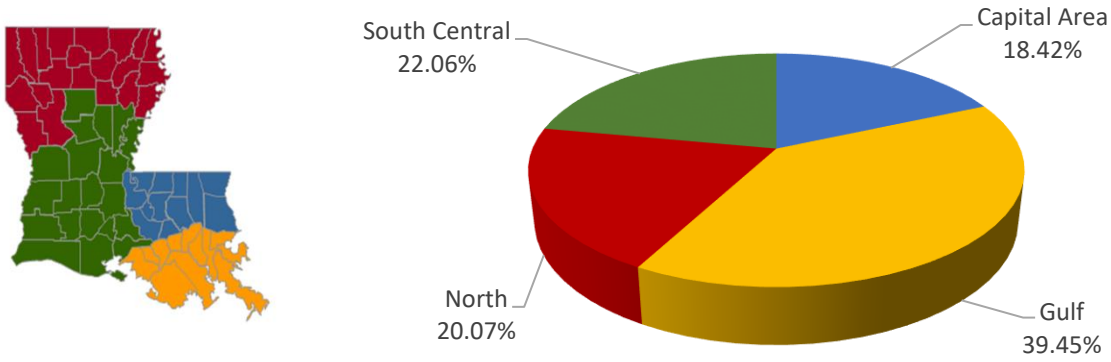
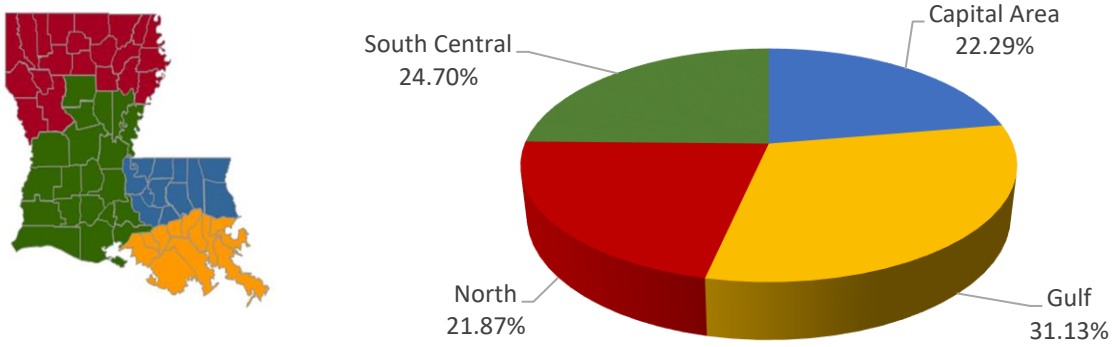


Chart 3.2: Geographical Distribution of Healthy Louisiana Enrollees with Diabetes, Age > 21 Years, 2018 (n = 77,511)



3.1 Diabetes and Pregnancy

Table 3.1.1 shows the percentage of Healthy Louisiana enrollee pregnancies complicated by diabetes in 2018 and the financial burden on Healthy Louisiana. Five percent of Healthy Louisiana enrollee pregnancies involved diabetes. The average paid, per member, for a pregnancy with diabetes was over one and one-half times that paid for pregnancies without diabetes ($1,582 vs. $995).

Table 3.1.1: Burden of Diabetes* on Pregnancies in 2018 among Healthy Louisiana Enrollees

Pregnancy Type	Number of Pregnancies	Total Amount Paid	Average Amount Paid per Member
Pregnancies with diabetes	5,927(5.09%)	$9,375,121.24	$1,581.77
Pregnancies without diabetes	110,472(94.91%)	$109,905,832.05	$994.88

*Includes gestational diabetes and diabetes pre-existing in pregnancy

3.2 The Financial Impact of Diabetes and Its Complications

The American Diabetes Association estimates that the largest component of medical expenses attributed to diabetes is for hospital inpatient care, at 30% of total medical costs.[19] Examining Louisiana's diabetes hospitalization costs serves as a reflection of how well diabetes is, or is not, managed by the health care system.

3.2.1 Hospitalization Costs Due to Diabetes

Table 3.2.1 shows, by age group, the number of inpatient hospital discharges, the percentage of overall hospital discharges, and Healthy Louisiana plan payments for admissions in which diabetes was a primary (principal) diagnosis. In 2018, there were 11,229 inpatient hospital discharges with a principal diagnosis of diabetes. Diabetes hospital discharges were 6.04% of the overall inpatient hospital discharges for Healthy Louisiana enrollees. Most (92.58%) of these discharges were for enrollees older than 21 years of age. The total paid by Healthy Louisiana MCOs for inpatient hospital discharges where diabetes was a principal diagnosis amounted to $57,355,962.

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

Table 3.2.1: 2018 Inpatient Hospital Discharges with Diabetes as the Primary Diagnosis* Among Healthy Louisiana Enrollees by Age Group

Age Group	Number of Diabetes Discharges	Percent of Overall Discharges Due to Diabetes	Total Paid for Diabetes Hospitalizations
≤ 21 years	833	1.49%	$3,770,881.64
> 21 years	10,396	7.99%	$53,585,080.43
Total	11,229	6.04%	$57,355,962.07

* Diabetes noted in the first three diagnosis listings

3.2.2 Specific Diabetes Complications as Principal Diagnosis for Inpatient Hospital Discharges

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

[19] Cost of Diabetes. (2018, April 30). Retrieved December 20, 2019, from https://www.diabetes.org/resources/statistics/cost-diabetes

Table 3.2.2 shows, by age group, inpatient hospital discharges in 2018 where a complication of diabetes was a primary diagnosis. This table also provides, by age group, the total percent of inpatient hospital discharges due to a diabetes complication and the total amount paid by the Healthy Louisiana MCOs for these complications.

For enrollees 21 years of age or younger, the most frequent diabetes complication associated with an inpatient hospital discharges was diabetic ketoacidosis (DKA). DKA is a life-threatening complication in which ketones (fatty acids) build up in the blood due to a lack of insulin. DKA accounted for 67.98% of all inpatient hospital discharges due to a diabetic complication for this age group and cost a total of $2,461,432.

For enrollees older than 21 years of age, the most frequent complication associated with inpatient hospital discharges was diabetes "with other specified manifestations." It accounted for 45.65% of diabetes complication discharges for a total cost of $12,860,578.

Table 3.2.2: Inpatient Hospital Discharges in 2018 by Age Group where a Diabetes Complication Was a Primary Diagnosis*

	Number of Discharges **	Percent of Diabetes-Related Discharges Due to Complication	Total Amount Paid for Diabetes Complication	Number of Discharges **	Percent of Diabetes-Related Discharges Due to Complication	Total Amount Paid for Diabetes Complications
	≤21 years			>21 years		
Ketoacidosis	620	67.98%	$2,461,432.20	2,095	13.58%	$7,834,955.87
Hyperosmolarity	5	0.55%	$33,667.12	249	1.61%	$926,160.75
With Coma	7	0.77%	$165,465.42	127	0.82%	$461,529.16
With Renal Manifestations	3	0.33%	$18,553.60	1,330	8.62%	$3,506,342.40
With Ophthalmic Manifestations	1	0.11%	$3,957.16	631	4.09%	$335,961.43
With Neurological Manifestations	23	2.52%	$62,696.25	2,391	15.49%	$4,833,985.76
With Peripheral Circulatory Disorders	0	0.00%	$0.00	679	4.40%	$4,433,062.91
With Other Specified Manifestations	246	26.97%	$663,164.89	7,045	45.65%	$12,860,577.53
With Unspecified Complications	7	0.77%	$10,003.37	885	5.73%	$904,248.36

*Diabetes noted in the first three diagnosis listings

**Total diabetes-related inpatient hospital discharges for ≤21 years of age are 833. Total diabetes-related inpatient hospital discharges for >21 years of age are 10,396 (See Table 3.2.1.)

3.2.3 Emergency Department (ED) Visits Due to Diabetes

Table 3.2.3 displays, by age group, the number of ED visits with a primary diagnosis of diabetes, the percent of overall ED visits due to diabetes and the resulting amount paid for these ED visits. In 2018, diabetes was the primary diagnosis for 75,598 ED visits and amounted to 4.29% of all ED visits for Healthy Louisiana enrollees.

Similar to inpatient hospital discharges, the majority of ED visits occurred among those older than 21 years of age. In total, Healthy Louisiana MCOs paid $33.9 million for diabetes-related ED visits in 2018.

Table 3.2.3: 2018 ED Visits Where Diabetes was the Primary Diagnosis* By Age Group

Age Group	Number of ED Visits Due to Diabetes	Percent of Overall ED Visits Due to Diabetes	Total Paid for Diabetes ED Visits
≤ 21 years	3,166	0.48%	$1,324,390.45
> 21 years	72,432	6.53%	$32,665,724.84
Total	75,598	4.29%	$33,990,115.29

*Diabetes noted in the first three diagnosis listings

Table 3.2.4 shows the distribution of diabetic complication-related codes submitted on ED visit claims in 2018 for the Healthy Louisiana population, by age group, where the complication was a primary diagnosis. Of the total diabetic complication-related diagnosis codes reported on ED visits during the measurement period across both age groups (n=36,859), 57.99% of the codes (21,373) were attributed to diabetes "with other specified manifestations." For enrollees who were 21 years of age or younger, the second most common diabetic complication-related diagnosis code reported was DK, diabetic ketoacidosis (25.82%). For enrollees older than 21 years of age, the second most common diabetic complication-related diagnosis code reported was diabetes "with neurological manifestations" (16.24%).

Table 3.2.4: 2018 Emergency Department Visits Where Diabetes Complication Was the Diagnosis* By Age Group

Diabetic Complications	Total Visits for Ages ≤ 21 years	Total Visits for Ages > 21 years
Ketoacidosis	435	1,561
Hyperosmolarity	9	335
With Coma	4	122
With Renal Manifestations	21	2,734
With Ophthalmic Manifestations	1	1,609
With Neurological Manifestations	35	5,712
With Peripheral Circulatory Disorders	0	678
With Other Specified Manifestations	1,112	20,261
With Unspecified Complications	68	2,162

*Diabetes noted in the first three diagnosis listings

3.2.4 Diabetes and Common Chronic Conditions

Table 3.2.5 shows the number of Healthy Louisiana enrollees, average cost per enrollee and the total cost paid by the Healthy Louisiana MCOs for diabetes and other chronic conditions. In 2018, among Healthy Louisiana enrollees who were diagnosed with one of the reported chronic conditions, hypertension (191,575 enrollees) was the most common, followed by asthma (94,594 enrollees) and diabetes (83,140 enrollees). In 2018, for the reported chronic conditions, the highest average cost per enrollee was $9,282 for congestive heart failure. The average cost per enrollee diagnosed with diabetes was $3,680. In 2018, for the reported chronic conditions, the highest total paid by the managed care plans was $450,935,406 for hypertension. The total paid for diabetes during 2018 was $305,960,463.

Table 3.2.5: 2018 Chronic Conditions Prevalence and Cost Comparisons between Diabetes and Other Common Chronic Conditions

Chronic Condition	Number of Enrollees	Per Member Cost	Total Paid
Hypertension	191,575	$2,353.83	$450,935,406.37
Asthma	94,594	$1,447.73	$136,946,274.40
Diabetes	83,140	$3,680.06	$305,960,462.92
Arthritis	54,684	$2,333.31	$127,594,795.23
COPD	24,328	$4,838.37	$117,707,961.57
Coronary Heart Disease	18,910	$6,400.91	$121,041,274.89
Congestive Heart Failure	14,559	$9,281.64	$135,131,407.11

4 Conclusion

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

4.1 LDH and MCO Recommendations

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

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

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

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

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

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

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

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

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

Appendix A –Act 210 of the 2013 Regular Legislative Session

RS 46:2616

CHAPTER 46. HEALTH ACTION PLANS

§2616. Diabetes annual action plan; submission; content

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

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

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

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

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

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

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

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

RS 46:2617

§2617. Obesity annual action plan; submission; content

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

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

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

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

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

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

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

Appendix B – Region and Parish Information for Enrollees with Obesity

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

PARISH	≤21 YEARS	>21 YEARS
Capital Region		
ASCENSION	923	1,929
EAST BATON ROUGE	3,703	7,725
EAST FELICIANA	402	670
IBERVILLE	382	1,198
LIVINGSTON	1,217	1,896
POINTE COUPEE	298	701
SAINT HELENA	145	282
SAINT TAMMANY	1,593	3,064
TANGIPAHOA	1,280	2,911
WASHINGTON	484	1,321
WEST BATON ROUGE	188	560
WEST FELICIANA	102	258
Total – Capital Region	10,717	22,515
Gulf Region		
ASSUMPTION	292	678
JEFFERSON	4,114	7,430
LAFOURCHE	1,490	2,664
ORLEANS	3,037	7,821
PLAQUEMINES	204	444
SAINT BERNARD	563	1,284
SAINT CHARLES	701	1,045
SAINT JAMES	356	845
SAINT MARY	593	1,651
ST JOHN THE BAPTIST	848	1,818
TERREBONNE	1,030	2,646
Total – Gulf Region	13,228	28,326
Northern Region		
BIENVILLE	165	533
BOSSIER	788	1,650
CADDO	2,028	4,795
CALDWELL	49	207
CLAIBORNE	87	342
DE SOTO	358	422
EAST CARROLL	187	424
FRANKLIN	263	877
JACKSON	166	449
LINCOLN	405	1,282
MADISON	174	304
MOREHOUSE	763	1,472
NATCHITOCHES	394	735
OUACHITA	2,586	4,939

PARISH	≤21 YEARS	>21 YEARS
RED RIVER	34	150
RICHLAND	536	972
SABINE	446	807
TENSAS	94	199
UNION	332	804
WEBSTER	203	743
WEST CARROLL	144	379
Total – Northern Region	10,202	22,485
South Central Region		
ACADIA	989	1,684
ALLEN	172	355
AVOYELLES	708	1,229
BEAUREGARD	243	442
CALCASIEU	1,048	3,146
CAMERON	27	39
CATAHOULA	178	372
CONCORDIA	143	747
EVANGELINE	588	876
GRANT	385	621
IBERIA	1,865	2,093
JEFFERSON DAVIS	469	652
LA SALLE	103	195
LAFAYETTE	3,472	4,220
RAPIDES	2,019	2,432
SAINT LANDRY	1,266	3,016
SAINT MARTIN	1,183	1,271
VERMILION	681	1,468
VERNON	132	417
WINN	447	606
Total – South Central Region	16,118	25,881

Appendix C – Region and Parish Information for Enrollees with Diabetes

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

PARISH	≤21 YEARS	>21 YEARS
Capital Region		
ASCENSION	63	1,288
EAST BATON ROUGE	252	6,081
EAST FELICIANA	14	436
IBERVILLE	40	697
LIVINGSTON	77	1,428
POINTE COUPEE	19	404
SAINT HELENA	24	786
SAINT TAMMANY	127	2,146
TANGIPAHOA	91	2,017
WASHINGTON	43	975
WEST BATON ROUGE	11	426
WEST FELICIANA	42	597
Total – Capital Region	803	17,281
Gulf Region		
ASSUMPTION	16	462
JEFFERSON	658	7,358
LAFOURCHE	52	1,443
ORLEANS	661	8,450
PLAQUEMINES	19	351
SAINT BERNARD	66	952
SAINT CHARLES	47	788
SAINT JAMES	32	518
SAINT MARY	36	1,106
ST JOHN THE BAPTIST	40	832
TERREBONNE	93	1,873
Total – Gulf Region	1,720	24,133
Northern Region		
BIENVILLE	18	355
BOSSIER	104	1,682
CADDO	228	4,690
CALDWELL	4	243
CLAIBORNE	19	290
DE SOTO	32	559
EAST CARROLL	12	292
FRANKLIN	25	461
JACKSON	39	441
LINCOLN	45	704
MADISON	15	347

PARISH	≤21 YEARS	>21 YEARS
MOREHOUSE	36	620
NATCHITOCHES	55	1,188
OUACHITA	111	2,297
RED RIVER	13	233
RICHLAND	12	426
SABINE	19	344
TENSAS	6	194
UNION	34	526
WEBSTER	32	745
WEST CARROLL	16	312
Total – Northern Region	875	16,949
South Central Region		
ACADIA	60	1,152
ALLEN	12	390
AVOYELLES	31	807
BEAUREGARD	24	574
CALCASIEU	179	2,780
CAMERON	2	46
CATAHOULA	6	224
CONCORDIA	17	438
EVANGELINE	28	748
GRANT	22	341
IBERIA	62	1,447
JEFFERSON DAVIS	26	530
LA SALLE	32	706
LAFAYETTE	132	2,620
RAPIDES	109	1,884
SAINT LANDRY	69	1,741
SAINT MARTIN	40	720
VERMILION	42	826
VERNON	54	776
WINN	15	398
Total – South Central Region	962	19,148

Appendix D – MCO Action Plan Summaries and MCO Action Plans

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

Links to MCO Action Plans Summaries

Links to Complete MCO Action Plans

Appendix D1
Aetna Better Health of Louisiana
Action Plan Summary

Executive Summary

Aetna Better Health of Louisiana's goal is to impact health outcomes within the membership and the community related to diabetes and obesity. Aetna Better Health of Louisiana (ABH of LA) works with members and the community to build trusting relationships that support collaboration and coordination for diabetes and obesity related activities.

Diabetes and Obesity Action Plan Objectives

- Improve member health outcomes by ensuring needed services, screenings, and tests are completed each year
- Provide care management and needed resources for our members diagnosed with diabetes and/or obesity
- Increase member participation in the care management program
- Increase member access to diabetes self-management education to reduce the onset and severity of diabetes-related complications; including web-based interactive programs for self-management
- Promote and distribute current evidence-based clinical practice guidelines, and ongoing provider education to ensure adherence to best practice
- Increase provider and member awareness of care needs by promoting earlier adoption of prevention behaviors through distribution of member and provider newsletters, disease-specific mailers, outreach calls and text messages to ensure services are completed
- Increase member participation in Ted E. Bear, M.D. Kids Club, a weight management program for children and young adults, and other services provided by the health plan, including health fairs and value-added benefits
- Create community environments that promote and support health lifestyle choice
- Reduce financial burden for diabetes and obesity related conditions

Impact

ABH of LA's programs and activities have positively impacted our HEDIS rates and the quality of care and service for our members.

HEDIS Rates Adults:	**MY 2017 rate(s)**	**MY 2018 rate(s)**
Adult BMI	79.32%	85.40%
Diabetes – BP Control <140/90	45.74%	45.74%
Diabetes - A1c Testing	84.67%	87.83%
Diabetes – A1c Control (<8)	42.09%	47.93%
Diabetes – Monitoring Nephropathy	90.75%	91.24%
Diabetes – A1c Poor Control (>9) (Inverse measure)	51.09%	44.53%
Diabetes – Retinal Eye Exam	48.91%	54.99%

Controlling Blood Pressure	39.17%	50.36%
HEDIS Rates Child/Adolescent:	**MY 2017 rate(s)**	**MY 2018 rate(s)**
Child/Adolescent BMI (WCC)	52.31%	65.45%
Counseling on Physical Activity (WCC)	39.66%	47.69%
Counseling Nutrition (WCC)	49.39%	56.45%

Appendix D2
AmeriHealth Caritas Louisiana
Action Plan Summary

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

In 2018, AmeriHealth Caritas Louisiana utilized outcome analysis data to develop a Diabetes and Obesity Action Plan. The plan was used to implement strategic programs and interventions to achieve the following objectives:

- Identify barriers and opportunities for improvement
- Increase engagement in our Integrated Care Management programs
- Meet or exceed NCQA Quality Compass Medicaid 50th Percentile for Comprehensive Diabetes Care, Adult BMI Assessment and Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents measures
- Increase member/provider education and engagement

Appendix D3
Healthy Blue
Action Plan Summary

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

Our goal is to achieve the 50th percentile NCQA benchmark based off the 2018 Quality Compass Scores for the following measures:

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

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

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

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

Appendix D4
Louisiana Healthcare Connections
Action Plan Summary

Diabetes and weight management programs are comprehensive, providing members access to telephonic health coaches, online resources, and other tools to encourage self-management of conditions. A suite of certified and licensed clinical and medical professionals provide evidence-based coaching for members needing support to achieve their weight management goals and better manage their diabetes. Members are identified for participation in these programs utilizing their claims histories. In collaboration with Louisiana Healthcare Connections, external care managers and contracted providers can refer members directly to the programs, connecting them with a qualified health coach. The health coach will complete an assessment and develop an individualized care plan based on the member or caregiver's knowledge of the member's condition, lifestyle behaviors, and readiness to change. Members are then assigned to the appropriate intervention level, which will determine the frequency of coaching calls.

These programs are designed to educate, motivate and activate the individual to address underlying barriers to better health. This comprehensive, holistic approach combines the best of traditional condition management programs with day-to-day life assistance. Members are encouraged by their health coaches who provide support for:

- Setting SMART goals
- Participation in targeted, customized health challenges
- Access to self-management education
- Education on nutrition and meal planning
- Promotion of established treatment guidelines, preventative health
- Coping mechanisms

Expert health coaches build rapport with the individual members from one interaction to the next. Members also have access to unlimited inbound calls, so if assistance is required or questions about their condition management arise, the health coaches are available for members as needed. Just as importantly, the health coaches speak the language of the member and the health plan to ensure the clinical notes are shared across the enterprise to better integrate care with the plan. Members may participate in the program as long as they remain medically eligible, are receiving primary health care coverage with LHCC and have not requested to be dis-enrolled from the program.

Appendix D5
United Healthcare
Action Plan Summary

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

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

United strives to lower costs by helping people live healthier lives. United programs such as Heart Smart Sisters are designed to empower women to make positive changes to help reduce their risk of developing heart disease. The program includes monthly classes to educate women about heart disease, diabetic risk, and the benefits of healthy diet along with the importance of regular exercise. United staff educates care providers on the importance of members with diabetes receiving HbA1ctesting, retinal eye exams, medical attention for nephropathy and blood pressure control. Care providers are also educated regarding the health risks for members who are obese, and how to work with members towards a healthier lifestyle. United's Dr. Health E. Hound provides a non-threatening way to educate children and their families about healthy living, including healthy eating habits, and the value of dental hygiene.

Appendix D6
Aetna Better Health of Louisiana 2018 Diabetes and Obesity Action Plan

Diabetes can lead to serious complications and premature death, but people with diabetes can take steps to control the disease and lower the risk of complications. Managing diabetes is possible with proper medical care, support and motivation. [20]

- **Background**

  Quality management, care management, and evaluation are key components of managing the services and care provided to our members. We evaluate the effectiveness of our quality and care management programs annually and based on the results, implement interventions to improve member health outcomes. A successful integrated program results in outcomes as intended based on program design. Outcomes studied include but are not limited to:

  - Reported Rates of Diabetes Care Practices among Adults with Diabetes
  - Diabetes Prevalence by Sex and Age Group
  - Total Unduplicated Number of Health Plan Members with Diabetes in Reporting Period by Region, Parish, and Age Groups
  - Total Unduplicated Number of Health Plan members with Obesity in Reporting Period by Region, Parish, and Age Group
  - Burden of Obesity among Health Plan Members
  - Burden of Diabetes on Pregnancies among Health Plan Members
  - Inpatient Hospital Discharges among Health Plan Members by Age with Diabetes as a Primary Diagnosis
  - Inpatient Hospital Discharges by Age Where a Diabetes or Diabetic Complication Was the Primary Diagnosis
  - Total ED Visits by Age Group Where DM was the Primary Diagnosis
  - Comparison of Prevalence and Cost Between Diabetes and Other Common Chronic Diseases
  - HEDIS measurements for Diabetes and Obesity health outcomes, Adult BMI Assessment, and Controlling Blood Pressure, Comprehensive Diabetes Care, Well-Child visit, and Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents

- **Quality Management**

  Our Quality Assessment and Improvement Program (QAPI) is designed to facilitate a member's access to high-quality medical and/or behavioral healthcare, access to primary and specialty care, continuity and

[20] https://www.cdc.gov/diabetes/diabetesatwork/diabetes-basics/what.html

coordination of care across settings, and culturally competent care, including quality and appropriateness of care furnished to members with diabetes and obesity.

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

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

- **Diabetes and Obesity Action Plan Goals**
  - Improve member health outcomes among underserved regions
  - Create community environments that promote and support healthy lifestyle choices
  - Prevention of obesity through education and weight management programs
  - Reduce the onset and severity of diabetes-related complications
  - Reduce financial burden for diabetes and obesity related conditions
  - Practitioner adherence to evidence-based clinical practice guidelines
  - Expansion of practitioner and MCO role in obesity prevention
- **Diabetes and Obesity Action Plan Objectives**
  - Improve member health outcomes among underserved regions by ensuring needed services and testing are completed each year
  - Provide care management and needed resources for our members diagnosed with diabetes and/or obesity
  - Distribution of current evidence-based clinical practice guidelines, and ongoing provider education to ensure adherence to best practice
  - Increase provider and member awareness, by promoting earlier adoption of prevention behaviors through distribution of member and provider newsletters, disease-specific targeted mailers, outreach calls and text messages to ensure services are completed, and web-based interactive programs for self-management
  - Increase member participation in Ted E. Bear, M.D. Kids Club, a weight management program for children and young adults
  - Increase member participation in the care management program and other services provided by the MCO, including health fairs and value-added benefits
  - Increase member access to diabetes self-management education to reduce the onset and severity of diabetes-related complications

- **Interventions**

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

  1. **Knowledge deficit,** the member is unaware of how to adequately monitor and track their blood sugar levels, as many have not received education and training and/or do not know the resources available to them through the MCO.

  2. **Non-compliance** to recommended diet, medication, treatment, and exercise programs secondary to personal practices, financial, and/or regional dietary patterns influencing health outcomes.

  3. **Lack of transportation** to medical appointments and testing. Many of the members are living at or below poverty level. They do not own a car and rely on public transportation. Members with young children living at home cannot leave them and are either unable to take them to appointments and/or cannot pay to hire a babysitter.

  4. **Linkage to care management** and the resources available to them. We improved communication regarding the services the health plan provides to the members. The provider and member educational material details the services and resources available to our members with diabetes and obesity.

  5. **Member Self-reported** health risk assessment by interactive telephone calls (IVR). Conducting the assessment by IVR causes a break in communication. Members hang up on initial call, and/or during the call. The questions asked may not be answered correctly and the member may experience technical difficulty during transmission.

  6. **Auto-assignment process,** the member has not established care with a primary care physician and/or endocrinologist. Many members are assigned a physician as their primary practitioner and are unaware of the assignment or elect to not use them.

Knowledge Deficit

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

Care4Life™

Provides our diabetic members with a diabetes education and self-management tools:

- The program addresses support for healthy eating by providing members with access to healthy recipes, nutrition tips, and videos. Video topics include: Alcohol, Quit Smoking, Blood Glucose Monitoring, Hypoglycemia, Avoid Sugary Drinks, Creating a Healthy Plate, Count Your Carbs, Dining Out, Watch What You Add to Food, Hidden Salt, Eating at Fast Food Restaurants, Quick Snack Ideas, Quick Breakfast, Move More, Aerobic Exercise, Strength Exercise, Insulin and Exercise and many more
- Provides support for self-managing their condition through reminders for medications and appointment

- Provides members an avenue to track blood pressure and blood glucose
- Provides support for physical activity by enabling members with access to track exercise and weight goals
- Members may print off their health record and share with their doctor

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

Lifeline Smartphone

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

WellTok Text Messaging

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

- ***Diabetes and Obesity Member Newsletters***

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

- ***Krames online***

  We utilize the most up to date information to assist our members in educating them on their disease process in an easy to understand format and language. Our Case Managers use Krames as a resource when providing educational materials to our newly diagnosed diabetic members in their preferred language. Our aim is to help our members gain understanding of what options they have regarding treatments as well as possible risks. We ensure that the materials we share with our members are congruent with their needs, culture, language and are comprehensive.

- ***Information Health Line (IHL)***

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

ABHLA actively participates in the Healthy Schools Training Krewe. We collaborate with Well-Ahead School Health on providing health education and "Smarter Lunchroom" workshops. The mission of the workshop is to enhance the knowledge & skills of those working directly with students on how to incorporate lunchroom strategies to improve healthy food choices.

- ***Marketing and Community Outreach***

  We support the American Diabetes Association Camp PowerUp and the Tour De Cure through community sponsorship and volunteer activities.

Non-Compliance

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

- ***Provider Education***

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

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

- ***Provider Notifications***

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

- ***Provider Incentives***

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

- ***Diabetes Member Mailers***

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

  - Control your diabetes letter includes the list of tests needed to be done, and the date of last claim received. They are also informed of gift cards available to them for getting the test done.

- Diabetes follow-up flyer informing the member that they are due for their A1c blood test, diabetes eye exam, and kidney test, including frequency. The flyer includes information on how to contact the member services department if they need help finding a physician or to schedule a visit.
- Diabetes retinopathy mailer recommending members schedule an appointment to get their eye exam done, and how to prevent vision loss through routine testing.

- ***Diabetes Reminder Phone Calls***

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

- ***Value Added Benefits***

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

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

- ***Ted E. Bear Weight Management Program***

  Aetna provides a weight management program for children and adolescents ages five (5) through twenty (20) years of age. Members who qualify are screened by their primary care provider for participation, based on the CDC BMI definition for being overweight and/or obese.

- ***Child and Teen Innovative Mailers***

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

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

- ***Ted E. Bear Wellness Fair***

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

During each event, we will:

- Provide new bike vouchers, helmets and proper safety instructions to increase child or teen physical activity.
- Celebrate with local celebrity chef, Jay Ducote, who has partnered with ABHLA by creating a short video of healthy eating tips which will be viewed on a large screen.
- Provide interactive "plant your own garden" educational demonstration, to encourage healthy eating. Free seeds will be provided.
- Give kid-friendly recipe cards to teach children how to make better, healthier choices.

Lack of Transportation

ABHLA will be partnering with Quest Diagnostic Labs/ Mobile Medical Examination Services "MedXm" to go to the member(s) home and provide preventive health screenings and lab tests.

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

- Diabetes Retinal Eye Exam
- Diabetes A1C Blood Test
- Diabetes Nephrology Testing
- Diabetes Blood Pressure
- Blood Pressure for member with a confirmed Hypertension diagnosis
- BMI assessment
- A1C testing for members with Schizophrenia and Bipolar Disorder

Health risk assessments to be performed include:

- Child Well-Child Visits for ages 3, 4, 5, and 6
- Adolescent Well-Child Visits
- Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents

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

Linkage to Care Management

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

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

- Intensive case management (complex case management),
- Individualized Case management
- Supportive case management
- Population health

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

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

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

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

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

- Improved telephonic and print education on self-monitoring,
- Member support through a secure member portal with website log-in link to evidence-based health appraisal and self-management tools and digital coaching programs,
- 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.

Member Portal

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

- 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.

Member Self-Reported Information

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

Auto-assignment Process

ABHLA selects or assigns a primary care doctor, or endocrinologist, if the member has not chosen one after enrollment with the MCO. Part of our process are:

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

Conclusion

In conclusion, ABHLA's programs have positively impacted our HEDIS rates and the quality of care and service our members need.

We did identify areas of improvement needed in the areas of care/disease management, member outreach, member and provider education, and member assignment. New processes were implemented, and education and training will continue throughout measurement year 2019 to improve our members' health outcomes and their experience with the services we render.

We also identified a need for improved communication and timeliness of communication between our care management and members. The importance of members knowing who to contact and ensuring timeliness of phone calls received was addressed with each staff member.

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

Appendix D7
AmeriHealth Caritas Louisiana 2018 Diabetes and Obesity Action Plan

- ***Objective: Identify Barriers and Opportunities for Improvement***

Member Barriers Addressed	Programs/Interventions
Member Education needed: Self-Management, Treatment, Benefits	• Integrated Health Care Management Programs • ACLA Community Center Access (Shreveport and New Orleans) • Member Benefits • Web Content • Member Portal • 24/7 Nurse Helpline Follow-Up Call • Automated Calls • Emergency Room Follow-Up • Mailings • Newsletters • Social Media • Member Mobile Apps • Text Messaging • Advanced Telehealth • Vheda Health • Mom's Meals NourishCare
Low Community Engagement	
High Ambulatory Emergency Department Rate	
Lack of education and finances makes eating healthier harder	
Lack of knowledge about the importance of preventative care visits	
Younger members tend to visit the doctor's office only when sick	
Members' access to reliable transportation impacts their ability to attend and keep appointments	
Member lives in a rural area with little or no access to preventative care	
Member is identified as having poor nutrition	

Note: Descriptions for Programs/Interventions are listed in the Member Education and Engagement section.

Provider Barriers Addressed	Programs/Interventions
Provider practice variation in adherence to recommended diabetes guidelines	• QEP • HEDIS Performance Measurements Summary
Provider unable to identify ACLA members who are noncompliant	

Historically low rate of lab results being submitted to the Health Plan by Providers	• NaviNet • AmeriHealth Caritas' PerformPlus • Provider Trainings • Targeted Provider Visits • Care Gap closure calls • HEDIS Coding and Documentation Guidelines • Web Content • Network News • Provider Incentives: CPT Category II codes
Provider lack of medical record documentation for HEDIS capture	
Provider difficulty with member management due to member noncompliance and high no-show rate	
Doctors' offices are often unaware of members who are assigned to them but have never visited their office.	

Note: Descriptions for Programs/Interventions are listed in the Provider Education and Engagement section.

- ***Objective: Increase Engagement in Our Integrated Health Care Management Programs***

AmeriHealth Caritas Louisiana works to address care gaps and foster health equity with our integrated health care management (IHCM) program. This program utilizes a member-centric support system with a multi-disciplinary approach to drive communication and care plan development. AmeriHealth Caritas Louisiana's IHCM program integrates physical health, behavioral health, and social and environmental support needs. Member conditions are combined into a comprehensive plan of care tailored for the individual. In 2018, a total number of 3,105 members were engaged in an Integrated Health Care Management program, including those with a primary diagnosis of diabetes or obesity - an increase of 14% from the previous year.

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

- **Participant Identification**

Several mechanisms are used to identify members for participation:

- **Health Risk Assessment Data**- Members responding positively to questions about diabetes on the Health Risk Assessment will be enrolled.
- **Claims Analysis**- Monthly medical, behavioral and pharmacy claim data is analyzed to identify members newly diagnosed with diabetes.
- **Provider Referral**- Information on the plan's program is contained in the Provider Manual, on the ACLA website and in periodic provider communications throughout the year. Providers can call or fax ACLA's IHCM Department to request enrollment of a member in the In Control Program.

- **Member Call or Contact**- Information on the plan's programs is contained in the Member Handbook, on member pages of ACLA's website and in periodic communications throughout the year. Members can call and request enrollment in the program. Additionally, ACLA's Call Center staff members who identify that a member has diabetes communicate the identification to the IHCM Department who enrolls the member.
- **State Referrals**- Any state agency can refer members via fax, phone, or reports.

Program overviews are listed below:

Episodic Care Management

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

Bright Start (Maternity Management)

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

Complex Care Management

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

Community Care Management Team

As an extension of our Care Management program, the Community Care Management Team responds to the needs of our highest-risk adult members with chronic conditions such as diabetes. AmeriHealth Caritas Louisiana's community-based team of nurses, social workers and community health workers utilize a high-touch, in-person approach to assist members in navigating the appropriate levels of health care. Their focus is on increasing access to necessary medical, behavioral health and social services. This team has expanded their territorial coverage to include Baton Rouge and surrounding parishes, the New Orleans area, Lafayette and Shreveport areas.

Let Us Know

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

Make Every Calorie Count

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

- One-on-one education and support from an assigned case manager.
- Make Every Calorie Count Welcome Packet which includes a pedometer, tape measure, daily food and activity logbook, portion control education and lifestyle tips.
- Up to two visits a year with a registered dietitian.
- Adults and children receive a one-year gym membership (with option for Home Program) through American Specialty Health's network of affiliated gyms.
- Children can also receive up to 8 swimming lessons through collaboration with the YMCA. Swimming lessons promote safety and the potential for members to become swimmers and incorporate this activity into their daily lives.

- ***Objective: Meet or Exceed NCQA Quality Compass 50th Percentile for CDC, ABA, and WCC Measures***
- **AmeriHealth Caritas Louisiana Calendar Year 2018 Rate Comparison with Prior Years**

HEDIS results provide a comprehensive picture of the clinical management of members with a diagnosis of diabetes and members at risk for obesity. In addition to the NCQA Quality Compass 50th Percentile goals, the plan set internal goals to ensure long standing, sustainable increases in HEDIS results for the Louisiana population served.

Comprehensive Diabetes Care (CDC)					
	MY 2016	MY 2017	MY 2018	NCQA Quality Compass Percentile	Goal Met
Hemoglobin A1c (HbA1c) Testing	86.86%	85.16%	88.08%	50th Percentile	YES
Eye Exam (Retinal) Performed	53.77%	57.42%	61.31%	50th Percentile	YES
Medical Attention for Nephropathy	92.94%	92.21%	91.00%	50th Percentile	YES

Note: The CDC Hemoglobin A1C Testing measure moved from the 25th to the 50th percentile from MY 2017 to MY 2018. The CDC Medical Attention for Nephropathy measure decreased from the 75th to the 50th percentile from MY 2017 to MY 2018.

Adult BMI Assessment (ABA)					
	MY 2016	MY 2017	MY 2018	NCQA Quality Compass Percentile	Goal Met
Adult BMI Assessment	79.91%	80.29%	87.04%	50th Percentile	YES

Note: The ABA measure increased from the 25th to the 50th percentile from MY 2017 to MY 2018. This was a statistically significant change from MY 2017 to MY 2018.

Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)					
	MY 2016	MY 2017	MY 2018	NCQA Quality Compass Percentile	Goal Met
BMI Percentile Total	48.91%	56.20%	75.18%	50th Percentile	YES
Counseling for Nutrition Total	46.72%	51.58%	66.18%	25th Percentile	NO
Counseling for Physical Activity Total	35.28%	43.07%	55.96%	25th Percentile	NO

Note: The WCC BMI Percentile measure increased from the 25th to the 50th percentile from MY 2017 to MY 2018. The WCC Counseling for Nutrition and Counseling for Physical Activity measures increased from the 10th to the 25th percentile from MY 2017 to MY 2018. All WCC sub measures demonstrated statistically significant changes from MY 2017 to MY 2018.

- ***Objective: Increase Member/Provider Engagement***
- **Supporting Member Education and Engagement**

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

Member Benefits. Members diagnosed with diabetes can receive $10 loaded to their Care Card for each diabetic screening completed; $30 for completing all three: HbA1c test, nephropathy, and/or dilated eye exam. Members can receive up to $25 for completion of an annual well visit. This information is incorporated in all member communications (written or verbal).

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

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

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

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

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

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

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

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

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

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

Advanced Telehealth. HIPAA-approved telemedicine technology that provides the ability to provide services to members remotely. This technology gives providers the ability to expand the reach of their services and reduce patient 'no-show' rate by making services more accessible to the members served.

Vheda Health. A digital mobile disease management and data analytic service offered to members via a telehealth platform that monitors members with a diagnosis of diabetes. Eligible members receive an Apple iPhone 5c with internet biometric devices: weight scale, blood pressure cuff, pulse ox, and an AVIVA Connect glucometer.

Mom's Meals NourishCare. A unique and innovative home-delivery meal program provider. Mom's Meals prepare, package, and deliver meals directly to the member at any address.

- **Supporting Provider Education and Engagement**

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

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

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

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

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

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

Care Gap closure calls. Providers can contact the Community Health Education Department to schedule an appointment for an AmeriHealth Caritas Louisiana representative to make calls to non-compliant diabetic members in the office.

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

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

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

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

Appendix D8
Healthy Blue 2018 Diabetes and Obesity Prevention Action Plan

Healthy Blue continues to strive to enhance the quality of care provided to its members by focusing on key quality measures and implementing interventions to promote prevention of Diabetes and Obesity in the communities we serve.

Healthy Blue's goal is to prevent and decrease the prevalence of diabetes and obesity through data collection and monitoring of current performance measures. This data is used to identity populations and develop key initiatives and interventions that engage our members and providers to help drive enhanced performance outcomes.

Healthy Blue currently monitors the following HEDIS Quality Performance Measures related to diabetes and obesity:

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

Performance Measures are targeted to reach the 50th percentile NCQA Benchmark based off the 2018 Quality Compass Scores. This target is a goal set for monitoring the above performance measures which indicate outcomes relative to diabetes and obesity.

Measures	YOY Increase to Date
Adult BMI Screening	4.81%
Comprehensive Diabetes A1c testing	3.09%
Comprehensive Diabetes Poor Control <9%	5.41% (down)
Comprehensive Diabetes <8%	2.91%
Diabetes Short-term complication	0.58%
Diabetes & Schizophrenia	3.55%
Diabetes Screening Antipsychotic Meds	0.57%
Weight Assignment BMI	6.03%
Weight Assignment Nutrition	1.72%
Weight Assignment Physical	1.42%

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

- **Provider Education**- The health plan has identified providers with a high non-compliant population. Currently focusing on the top providers throughout Louisiana to provide:
    - HEDIS Education
    - Documentation & Coding Education
    - Development of Action plans with provider to improve performance outcomes
    - Provider Summits and Webinars
    - Certified Diabetes Instructor acts a Practice Consultant to top providers with performance gaps to provide on-going education and support

- **Provider Incentives-** Healthy Blue's Quality and Provider Network initiatives are aligned when developing Provider Incentive Programs to enhance primary care reimbursements through incentives tied to performance relative to measures which will drive performance improvement.

- **Member Incentives-** Members receive incentives for closing gaps in care related to diabetes and management of obesity.

- Member receives $10 for getting Diabetes Care, earning up to $30.00 in rewards
- Member can earn up to $25.00 for completing a well visit
- Members are eligible to receive A1C at home testing kits to enhance the monitoring of their A1C and assist with care coordination with their PCP

- **Educational Classes**
  - Healthy Blue provides diabetes classes to members with a diagnosis of diabetes conducted by a certified diabetes instructor
  - Educational Classes are also provided to community partners through individualized provider education, education performed at community event and valued partnerships with key stakeholders throughout the state of Louisiana

- **Quality Care Coordination**
  - Member outreach calls are made to members who are non-compliant for preventive services such as eye exams, HbA1c testing and adult BMI screenings. This outreach assists with connecting members to their PCP by offering assistance with scheduling and follow-up appointments
  - Text message campaigns are also a method for outreach which offers reminders via text for preventative services

- **Case Management Care Coordination**
  - Member outreach to members who were discharged from an inpatient facility with a shot-term diagnosis. The health plan goal is to get the member back to the PCP after discharge therefore to reduce hospital admissions and re-admissions

- **Diabetes Pharmacy MTM Program**
  - Pharmacists receive an extra reimbursement for educating members about their Disease Management drugs and open Comprehensive Diabetes Care HEDIS care gaps. The overall goal is to reduce adverse effects of medications prescribed concurrently

- **Community Partnerships**

- Hosting of community events to educate the population regarding the importance of prevention, management and follow-up care for obesity and diabetes
- Host clinic days to provide wellness/diabetic screenings

- Participation in state collaborative for Louisiana Diabetes
- American Academy for Diabetes Educators involvement
- Development of Diabetes Educational Public Service Announcements
- Partner with School Based Health Clinic's to offer support/resources for school aged children

- **Member Engagement**

- Educational tools and resources are sent to our members to provide additional teachings regarding diabetes and obesity
- Value added benefit to offer members Weight Watcher courses
- Zumba Classes offered to Healthy Blue members and the community to target management of diabetes and obesity

Appendix D9
Louisiana Healthcare Connections 2018 Diabetes and Obesity Action Plan

Diabetes Management Program and Plan of Action

- **Program Objective**

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

- **Eligibility Criteria**

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

Two or more primary or secondary diabetes or diabetes complications claims

One or more primary diabetes inpatient days

One claim for a glucose regulator and one or more primary or secondary diabetes claims

One pharmacy claim for a glucose regulator and no claim for polycystic ovaries

- **Enrollment**

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

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

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

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

- **Ongoing Coaching**

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

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

Medication comprehension and compliance

Self-blood glucose monitoring

Recognizing signs of low and high blood glucose levels

Nutrition counseling related to carbohydrate counting and weight management

Recommended annual screening for diabetic complications

Blood pressure and cholesterol management

Optimizing physical activity levels to meet recommended guidelines

Supporting tobacco cessation

Internal consults with specialty health coaches for participants at high risk for, or diagnosed with, another chronic condition (i.e. COPD, asthma, heart failure, heart disease, hypertension, hyperlipidemia). Specialty health coaches include Certified Diabetes Educators, Registered Nurses and Certified or Registered Respiratory Therapists.

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

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

- **Pediatric Members**

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

- **Program Length**

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

- **Referral Services**

Members may be referred to other disease management programs offered by the 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 referral system is also established to allow referrals directly from case management.

- **Dis-enrollment**

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

Member has a serious or life-threatening medical condition (including mental health issues), and will also be referred to case management

Member's health care coverage with the Health Plan terminates or the Health Plan no longer provides the member's primary coverage

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)

Member has enrolled in a hospice program

Member satisfies specified graduation criteria

Member dies

- **2018 Diabetes Program Outcome Highlights**

4,900 members were referred to the Diabetes Disease Management Program.

Approximately 24% of members referred were enrolled in telephonic coaching or agreed to receive educational mailings.

Diabetes Management coaching calls averaged 130 per month.

Member access to educational materials was expanded to include online resources for more immediate availability.

Weight Management Program and Plan of Action

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

- **Eligibility Criteria**

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

Body Mass Index (BMI) > 30

History of BMI > 30 with need for weight maintenance support

Referral from provider for weight management

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

- **Enrollment**

Members are identified for enrollment based on medical claims data. An MCO-contracted provider, case manager, external care manager or self-referral can be made for referring members into the program.

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

enrolled in the program, a member's physician will also be notified via letter that the member is active in the program.

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

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

- **Ongoing Coaching**

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

Nutritional counseling for appropriate rate of weight loss

Role of fats, carbohydrates and protein in proper nutrition

Optimizing physical activity levels to meet recommended guidelines

Behavior modification skills for long term weight control

Food preparation and portion control methods

Label reading skills

Strategies when eating out

Unlimited inbound calls

Education materials to enhance understanding and compliance

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

- **Program Length**

Program is one year in length and includes the following:

First call: 30 minutes; enrollment & initial assessment call

Ten coaching calls (over 12 months)

Unscheduled check in calls

- **Referral Services**

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

- **Dis-enrollment**

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

Member's health care coverage with the Health Plan terminates or the Health Plan no longer provides the member's primary coverage

Member's attending physician or the Health Plan requests disenrollment

Member is no longer capable of participation in the program

Member has End Stage Renal Disease (ESRD) or any complex medical condition

Member has enrolled in a hospice program

One (1) year has lapsed since member's enrollment in this program

Member dies

- **2018 Weight Management Program Outcome Highlights**

Ninety-six (96) members were referred to the Weight Management Program.

Approximately 94% of members referred in 2018 were successfully enrolled.

Weight Management Coaching calls averaged 20 per month.

Pediatric Weight Management Program and Plan of Action

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

- **Eligibility Criteria**

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

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

- **Enrollment**

Members are identified for enrollment based on medical and pharmacy claim data. Members are also referred to the program by a Health Plan-contracted provider, case manager, and external care manager or through self-referral.

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

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

- **Ongoing Coaching**

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

Promotion of physical activity

Parent training/modeling

Dietary coaching

Nutrition education

Exercise education

Behavioral coaching

Promoting and tracking regular physician visits

Unlimited inbound calls

Education materials to enhance understanding and compliance

Facebook private group for peer support

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

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

- **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 dis-enrolled from the program.

- **Disenrollment**

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

Members with serious or life-threatening medical conditions (including mental health issues), and will be referred to case management

Members' health care coverage with Health Plan terminates or Health Plan no longer provides the member's primary coverage

Member is no longer capable of participation in the program

Member exceeds age range for the program

Member dies

- **2018 Pediatric Raising Well® Program Outcome Highlights**

1,031 members were referred to Raising Well®.

Approximately 12% of pediatric members referred in 2018 were successfully enrolled.

Weight Management Coaching calls averaged 12 per month.

Appendix D10
United Healthcare of Louisiana 2018 Diabetes & Obesity 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 United Healthcare (UHC).	UHC's Hospitality, Assessment and Retention Center (HARC)	Ongoing in 2019

Process Measures:	2015 (Jan-Sept)	2016	2017	2018
# HRA's completed	23,783(66%)	58,433 (39.4%)	3090 (4.3%)	11,762 (23.5%)
# members reached	38,386 (78%)	116,875 (78.7%)	63,099 (81.1%)	42,850 (85.6%)

b. Use Whole Person Care Modeling		
Software designed to predict health risks and assess utilization so that members can be placed appropriately into care management programs, such as diabetes, if warranted.	Utilization Management Team	Ongoing in 2019

Process Measures:	2015	2016	2017	2018
# members identified, and in care management	639	887	597	1944

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 2019

Process Measures:	2015	2016 (Jan-Dec)	2017	2018
# Mailings to Adults	2014	6909	3154	7530
# Mailings to Children	165	140	56	269

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 2019

Process Measures:	2015	2016	2017	2018
# women attending Lunch'n'Learn	735	500	445	675
# Lunch'n'Learn events	15	11	12	10

e. Quality Outreach to Members		
Members identified and telephonically outreached on the importance of A1c testing adherence. The Quality team made live outbound calls to members to provide education and facilitate scheduling/attendance of the appointment.	Quality Management & Performance	
Process Measures: 2018 # members reached 100		

Overall Health Outcome Measures HEDIS® Comprehensive Diabetes Care					
Measures:	2015	2016	2017	2018	2019
HbA1c Testing:	80.54%	81.27%	73.97%	82.97%	86.13%
Eye Exam:	46.96%	47.45%	40.63%	55.23%	55.47%
Attention for Nephropathy:	78.10%	92.70%	87.59%	92.46%	91.97%

f. *Pilot program* Clinic based interdisciplinary approach to the treatment of diabetes and is in the New Orleans area.		
UHC Community Plan of Louisiana is in the process of negotiations with a New Orleans East hospital that has an established Diabetes Program that is partnered with the Cleveland Clinic. The program will generate outcomes, provides peer support, group appointments, evidence-based guidelines and population health standards.	Disease Management Team	2018 Diabetes Program Pilot in implementation phase

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	April 2017 –HFS is plan driven with corporate support. Ongoing in 2019

Process Measures:	2015 (Jan-Oct)	2016	2017	2018
# members identified	10,196	11,026	3945	10,595
# members qualified	8,407	9,756	3537	4,608
# members reached	3,374	6,089	1610	1,577
# members referred to case management	912	1,231	566	880

Overall Health Outcome Measures HEDIS® Prenatal and Postpartum Care					
Measures:	2015	2016	2017	2018	2019
Prenatal:	90.71%	79.85%	85.54%	82.24%	85.16%
Postpartum:	55.01%	58.72%	64.84%	64.48%	71.53%

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

Description	Responsible Party	Timeframe
Educate providers on current HEDIS® standards.		
The Clinical Practice Consultant (CPC) Program includes six nurses for the state of Louisiana. CPCs engage in educating primary care providers about Healthcare Effectiveness and Data Information Set (HEDIS®). To improve HEDIS® rates, the plan has shared information about evidence-based guidelines tailored for the providers' needs, based on their requests for condensed information. For those providers who chose to participate in the value based care initiative, provider scorecards which indicate whether providers have met their targets for HEDIS® measures were distributed by the CPCs, along with members of the leadership team in some cases. CPCs also distributed HEDIS® guidelines, and HEDIS® tip sheets to providers at individual offices as well as the Provider Expositions around the state. To help combat diabetes, the consultants will continue to educate providers on the importance of HbA1c testing, retinal eye exams, attention for nephropathy and blood pressure control. Diabetes and Obesity toolkits are also distributed to providers. In the case of retinal exams, CPCs assure the providers are aware of the vision vendor March Vision.	Director, Quality Management & Performance	Revised in 2016 Ongoing in 2019

Process Measures:	2016 (Jan - Oct)	2016	2017	2018
# offices visited	351	403	486	1,317
# members potentially impacted based on panel assignments	236,247	286,854	137,686	333,219

HEDIS® Overall Health Outcome Measures

HEDIS® Comprehensive Diabetes Care (CDC)

Measures:	2015	2016	2017	2018	2019
HbA1c Testing:	80.54	81.27	73.97	82.97	86.13
Eye Exam:	46.96	47.45	40.63	55.23	55.47
Attention for Nephropathy:	78.10	92.70	87.59	92.46	91.97

Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents (WCC)

Measures:	2015	2016	2017	2018	2019
BMI Percentage:	41.36	36.98	60.1	71.53	69.83
Counseling for Nutrition:	53.04	52.07	60.34	63.5	64.72
Counseling for Physical Activity:	41.61	31.14	43.80	51.34	57.18

Adult BMI Assessment (ABA)					
Measure:	2015	2016	2017	2018	2019
Adult BMI:	71.32	71.93	82.75	85.59	86.6

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

Description	Responsible Party	Timeframe
Refer members to Pennington for potential access to a physical fitness facility.		
Support local research on healthcare related issues as it relates to Diabetes. Pennington Wellness Day is to educate community of healthy lifestyles as it relates to obesity, diabetes, etc.	UHC Marketing and Community Outreach	**Did not participate in 2015 Did not participate in 2018**

Process Measures:	2014	2016	2017
# of events	1	1 (Oct)	9
# of members attending	500	300	2195

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 2018 Obesity Action Plan

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

Description	Responsible Party	Timeframe
a. Continue Eat4-H Partnership.		
Louisiana 4-H and UnitedHealthcare will continue their partnership, Eat4-Health, in 2014. Louisiana is one of 10 states participating in the campaign designed to empower youth to help fight the nation's obesity epidemic. Each state 4-H organization is receiving a grant funded by UnitedHealthcare to support healthy-living programs, events and other activities administered by 4-H that encourage young people and their families to eat more nutritious foods and exercise regularly. The partnership in Louisiana is being administered through the LSU Ag Center.	4-H and UHC Marketing and Community Outreach	Ongoing in 2019

Process Measures:	2015	2016	2017	2018
# Louisiana youth reached	3,225	3,675	4,740	2,560
# events	15	18	12	10

b. Continue 4-H Youth Voice: Food Smart Families (New)					
4-H's Youth Voice: Youth Choice provides grants to state-level 4-H programs and focuses on developing and enhancing healthy living at the community level through activities such as after-school programs, health fairs, camps, clubs, workshops and educational forums. Youth who participate in the programs are encouraged to take action for themselves and their families, and to promote healthy living in their communities.	4-H and UHC Marketing and Community Outreach	Ongoing in 2019			
Process Measures:	2015	2016	2017	2018	
# Louisiana youth reached	3,225	3,675	4,740	2560	
# events	15	18	12	10	

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		Did not participate in 2018
Process Measures:	2015	2016	2017
# Louisiana youth attending	1,385	500	0
# events	7	1	0

d. Distribute Sesame Street Food for Thought toolkits. /reading corners				
Food for Thought is a bilingual (English-Spanish) multimedia outreach initiative that helps families who have children between the ages of 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 2019		
Process Measures:	2015	2016	2017	2018
# toolkits distributed	1,350 (5 reading corners)	325	53	50

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 2019

Process Measures:	2015	2016	2017	2018
# events that Dr. Health E. Hound attended:	48	51	28	25
# of members	11,665	15,175	11,300	7,046

f. Participate in Louisiana Healthy Community Coalition /Parish Community Coalition activities/and Other

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 2019

Process Measures:	2015	2016	2017	2018
# events	53	49	76	31
# people attending	2,735	3,550	1,778	882

g. Educate Members Using "Weight Management Education Materials

Newly diagnosed and new members identified with Obesity receive educational materials and newsletters with weight management specific information, including recommended routine appointment frequency, health logs, monitoring and self- care. Materials are designed to empower each member to take responsibility for their health and to equip themselves with the information necessary manage their weight.	UHC Clinical	Initiated in 2018 Ongoing in 2019

Process Measures	2018
# Mailings to Members	3,910

UHC Program Goal 2: Facilitate healthy lifestyles.

Description	Responsible Party	Timeframe
a. Continue partnership with faith and community-based organizations to offer Heart Smart Sisters		
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 2019

Process Measures:	2015	2016	2017	2018
# member reached	735	1,895	550	307
# of events	22	16	2	10

Appendix E – Standards of Diabetes Care

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

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

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

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