Diabetes and Obesity Action Report for the Healthy Louisiana Program

Report Prepared in Response to ACT 210

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Executive Summary

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

This report is submitted pursuant to ACT 210 of the 2013 Legislative Session. Per Louisiana Revised Statute (RS) 46:2616 and RS 46:2617, the Louisiana Department of Health (LDH) is required to submit an annual diabetes and obesity action plan to the Senate and House Committees on Health and Welfare after consulting with, and receiving comments from, the medical directors of each of its contracted Medicaid partners. Data presented on prevalence, utilization, and costs of obesity and diabetes are based on data submitted by each of the five Healthy Louisiana Managed Care Plans and cover the managed care population only.

Below are some highlights from this year's report:

- In 2015, 4.29 percent or 63,756 of the Healthy Louisiana members had a claim for obesity; 51.24 percent (32,669) were 21 years of age or younger. The area with the highest number was the Capital region *(see appendices C and D for regional breakdowns)* with 32.9 percent (10,747).
    - The Healthy Louisiana Plans paid just under $120 **million** for obesity-related services.
- The prevalence of diabetes increased by 1.4 percent from 2014 to 2015.
    - The majority of Healthy Louisiana members with diabetes were older than 21 years of age.
    - The majority of people with diabetes, regardless of age, resided in the Gulf region.
- The costs to the Healthy Louisiana plans for pregnancies complicated by diabetes were slightly over 50 percent higher than those not complicated by diabetes.
- A total of 2,803 inpatient hospital discharges noted diabetes as the main diagnosis for admission.
    - The total financial cost associated with these inpatient diabetes-related hospital discharges was **$9,141,376.06.**
- Diabetic ketoacidosis was the most common diabetic complication on admission for those 21 years of age or younger, accounting for almost 65 percent of all inpatient hospital discharges for this age group.
- In 2015, a total of 28,059 Emergency Department (ED) visits occurred for Healthy Louisiana members for which diabetes was the primary diagnosis.
    - The majority of ED visits occurred among members older than 21 years of age.
- Similar to 2013 and 2014, diabetes again was the third most common chronic condition identified among Healthy Louisiana Plan members.
- As in 2014, in 2015 the top medical condition related to diabetes that resulted in the most expensive cost per member was *congestive heart failure* at **$6,992.89** per member.

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 Healthy

Louisiana Plans on ways to empower the community, promote self-management training and monitor health outcomes.

LDH and Healthy Louisiana Plans' Recommendations:

- Appropriately fund outpatient nutritional services provided by registered dietitians for all patients for all diagnoses, not just those diagnosed with diabetes and obesity. Currently, primary care physicians that take care of people with, or who are at risk for, obesity or diabetes are unable to adequately counsel and educate parents, children, and adults about nutrition during routine visits. To properly educate parents, children, and adults regarding nutrition, recurring appointments with a registered dietitian are necessary. Some of these appointments can occur in a group setting. However, if there is no ability for the registered dietitian to recover the cost of providing the service, they (or their employer) are unable to provide the service.

- Appropriately fund diabetes self-management education. The following table shows the current diabetes self-management education (DSME) reimbursement rate comparing Louisiana's rate to the Medicare allotted amount, and to the rate reimbursed by Mississippi's Medicaid program. Improving this reimbursement rate would have significant impact on self-management education and ultimately on the cost spent by Louisiana on diabetes care. Reimbursement for group sessions may offer an alternative that would be cost-effective for providers.

Comparison of reimbursement rates for diabetes self-management education				
Code	*Description*	*Medicare*	*Louisiana Medicaid*	*Mississippi Medicaid*
G0108	Diabetes outpatient self-management training services, individual, per 30 minutes	$54.19	$14.53	$45.03
G0109	Diabetes outpatient self-management training, group session (2 or more), per 30 minutes	$14.71	$8.18	$12.15

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

Section 1 – Healthy Louisiana Response to ACT 210

1.1 – Introduction

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

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

Report Development

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

Overview of Obesity Impact

Although national, state and local governments, and many private employers and payers have increased their efforts to address obesity since 1998[1], more than one-third (36 percent) of U.S. adults, and 17 percent of U.S. children and adolescents, were considered obese during the 2011-2014 time period[2].

What is Obesity?

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

What is Body Mass Index?

The Body Mass Index (BMI) is derived from an individual's height and weight. If the BMI is between 25 and 29.9, a person is considered overweight. If the BMI is 30 or greater, the individual is classified as obese.[3] A child's weight status is determined using an age- and sex-specific percentile for BMI rather than the BMI categories used for adults because children's body composition varies by age and sex. In children and adolescents age two to 19 years, obesity is defined as a BMI at or above the 95th percentile of the sex-specific Centers for Disease Control and Prevention's (CDC) BMI-for-age growth charts.[4]

[1] 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

[2] Ogden, C. L., Fryer, M. D., & Flegal, K. M. (2015). Prevalence of Obesity Among Adults and Youth: United States, 2011-2014. *NCHS Data Brief,219*, 1-8. Retrieved February 17, 2017.

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

[4] Childhood Obesity Facts. (2016, December 22). Retrieved February 17, 2017, from http://www.cdc.gov/obesity/data/childhood.html

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

Overview of Diabetes Impact

Diabetes is a common disease; the CDC reports that more than 29 million Americans are living with diabetes with another 86 million living with prediabetes. About 90 to 95 percent of diagnosed cases are type 2, with about 5 percent as type 1. In the United States, diabetes was the seventh leading cause of death in 2013. The CDC also reports that more than 20 percent of health care spending is for people with diabetes.[5]

What is Diabetes?

Food we eat is usually turned into glucose, or sugar, and our pancreas makes a hormone called insulin to help the glucose get into the cells of our bodies so it can be used for energy. Diabetes is a disease in which the body either doesn't make enough insulin, or can't use its own insulin as well as it should, causing sugar to build up in the blood. When the amount of sugar circulating in the blood is too high, it causes damage to many parts of the body including the eyes, heart, blood vessels, kidneys and nerves. This damage makes diabetes the leading cause of adult blindness, end-stage kidney disease and amputations of the foot and/or leg. People with diabetes are also at a greater risk for heart disease and stroke.[67]

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 injections or an insulin pump. This form of diabetes usually occurs in children and young adults, although disease onset can occur at any age. In adults, type 1 diabetes accounts for approximately 5 percent of all diagnosed cases of diabetes. There is no known way to prevent type 1 diabetes.[5]

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

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[5] Diabetes. (2016, July 25). Retrieved February 17, 2017, from https://www.cdc.gov/chronicdisease/resources/publications/aag/diabetes.htm

[6] *National Diabetes Statistics Report, 2014* (pp. 1-12, Rep.). (2014). Atlanta, GA: Centers for Disease Control and Prevention.

[7] Statistics About Diabetes. (n.d.). Retrieved February 17, 2017, from http://www.diabetes.org/diabetes-basics/statistics/

Gestational Diabetes is a type of diabetes that is first seen in a pregnant woman who did not have diabetes before she was pregnant. The risk factors for gestational diabetes are similar to those for type 2 diabetes. Gestational diabetes requires treatment to lessen the risk of complications such as preterm births, larger babies requiring cesarean sections, preeclampsia, birth defects, and increased risk of type 2 diabetes for both the mother and the child once she/he reaches adulthood. Often, gestational diabetes can be controlled through eating healthy foods and regular exercise. Sometimes a woman with gestational diabetes must also take insulin.[8]

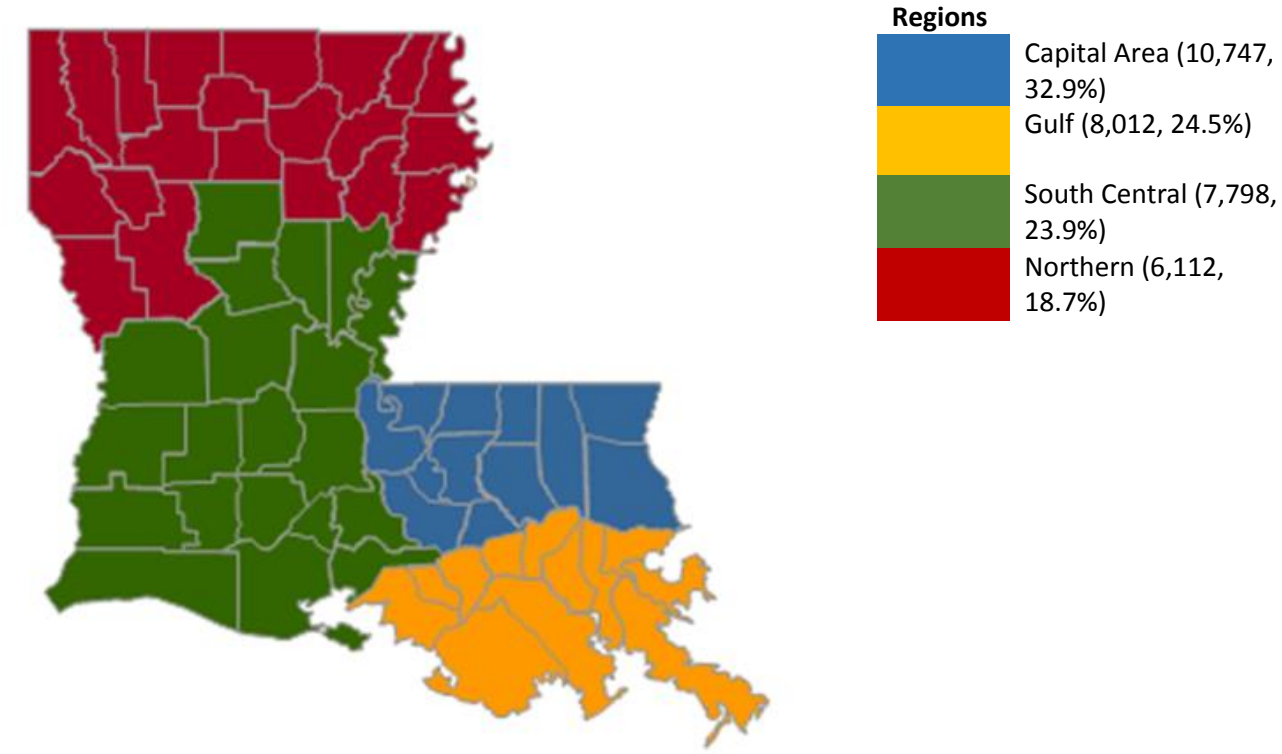
1.2 – The Scope of Obesity in Louisiana

Based on 2015 claims data, the prevalence of obesity among Healthy Louisiana members was 4.29 percent, representing 63,756 enrollees. However, the Trust for America's Health and the Robert Wood Johnson Foundation's *State of Obesity 2016* report stated that Louisiana had the highest adult obesity rate among all states, at 36.2 percent.[9] Women, Infant, and Children (WIC) participants ages 2-4 years old had an obesity rate of 13.2 percent, while 10-17 year olds had a 21.1 percent obesity rate. Given these reported high rates, it appears that obesity is under-coded as a diagnosis in Medicaid claims data, leading to an underrepresentation of the burden of obesity in available claims data. Of the members with obesity, 51.24 percent (32,669) were 21 years of age or younger. The geographic and age group breakdown of obesity among the four regions are shown in Maps 1.2.1 and 1.2.2. For both age groups, the Capital region had the most residents with obesity, followed by the Gulf region. The region with the fewest number of enrollees with obesity was the Northern region. For parish level information, please see Appendix C.

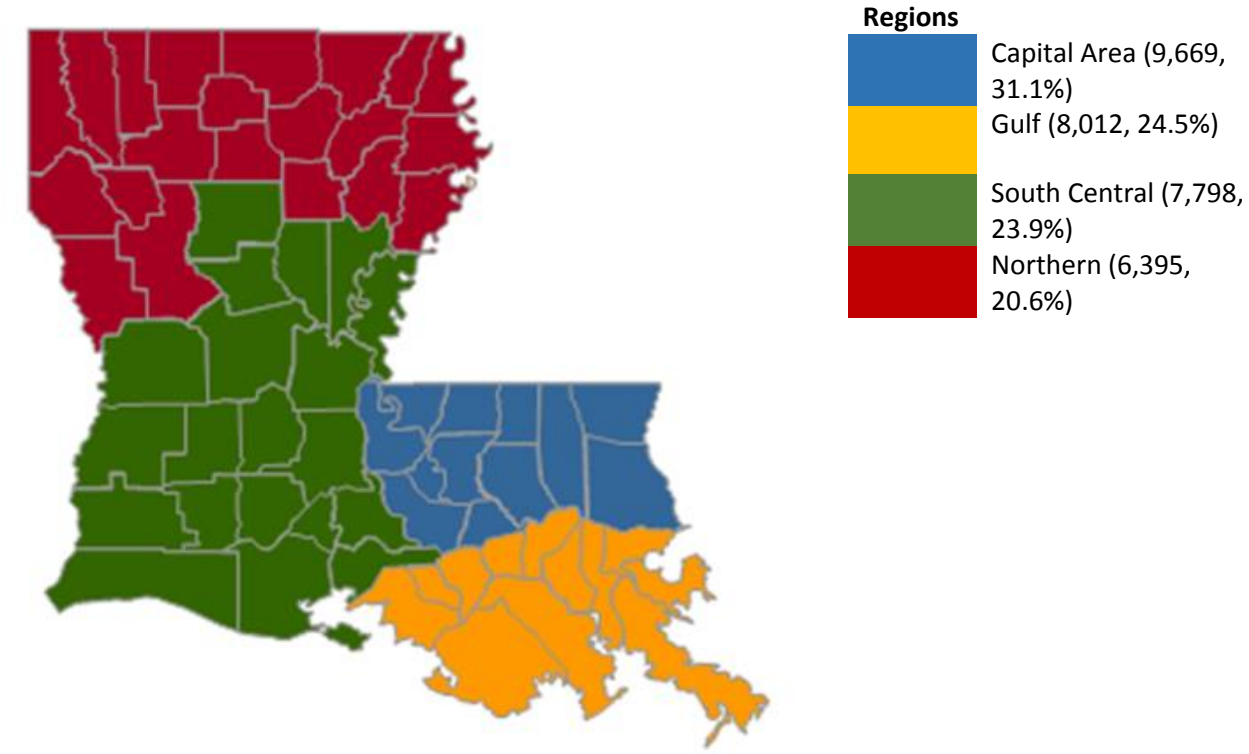
[8] Gestational Diabetes and Pregnancy. (2015, September 16). Retrieved February 17, 2017, from http://www.cdc.gov/pregnancy/diabetes-gestational.html

[9] The State of Obesity in Louisiana. (n.d.). Retrieved February 17, 2017, from http://www.stateofobesity.org/states/la

Map 1.2.1: Geographical Distribution of Healthy Louisiana Members with Obesity, Age ≤ 21 Years, 2015



Map 1.2.2: Geographical Distribution of Healthy Louisiana Members with Obesity, Age >1 Year, 2015



The 2015 financial burden of obesity is shown in Table 1.2.1, reflecting that the Healthy Louisiana Plans paid around $22 million for service-related claims for obesity. The amount paid for anyone identified with obesity and other related conditions totaled over $100 million.

Table 1.2.1: Financial Burden of Obesity in 2015 among Healthy Louisiana Plan Members

Age group	Service-related payments for obesity*	Total obesity-related payments**
≤ 21 years	$2,721,328.29	$16,966,329.27
> 21 years	$19,359,028.51	$101,397,155.50
Total	$22,080,356.80	$118,363,484.77

*Service-related payments are defined as claims with obesity as one of the diagnoses
**Total payments are defined as all claims related to members identified as obese but may not have been in diagnosis

1.3 – The Scope of Diabetes in Louisiana

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

Figure 1.3.1, based on Louisiana's results of the annual BRFSS survey, shows the 14-year trend of diagnosed diabetes in Louisiana. Although the prevalence of diabetes jumped from 8.5 percent in 2003 to 10.6 percent in 2008, and to 12.7 percent in 2015, there were also some periods of decline. From 2003 to 2004, the rate declined from 8.5 percent to 8.3 percent; the rate also declined from 2009 to 2010, from 11.1 percent to 10.3 percent. More recently, there were two consecutive years of decline when the rate declined from 12.3 percent in 2012 to 11.6 percent in 2013, and to 11.3 percent in 2014. However, after the two years of decline, the most recent rate (2015) rose to a 14-year high to 12.7 percent. Although the rate of diagnosed diabetes may decline slightly in one year, the chart clearly shows the steady increase in the prevalence of diabetes in the state. This increase mirrors the steady increase seen throughout the United States. The CDC reported in *Long-term Trends in Diabetes* that the percentage of the U.S. population diagnosed with diabetes rose from 0.93 percent in 1958 to 7.02 percent in 2014.[10]

[10] *Long-term Trends in Diabetes* [PDF]. (2016, April). Centers for Disease Control and Prevention Division of Diabetes Translation.

Figure 1.3.1: Prevalence of Diagnosed Diabetes in Louisiana (Crude Prevalence)[11]

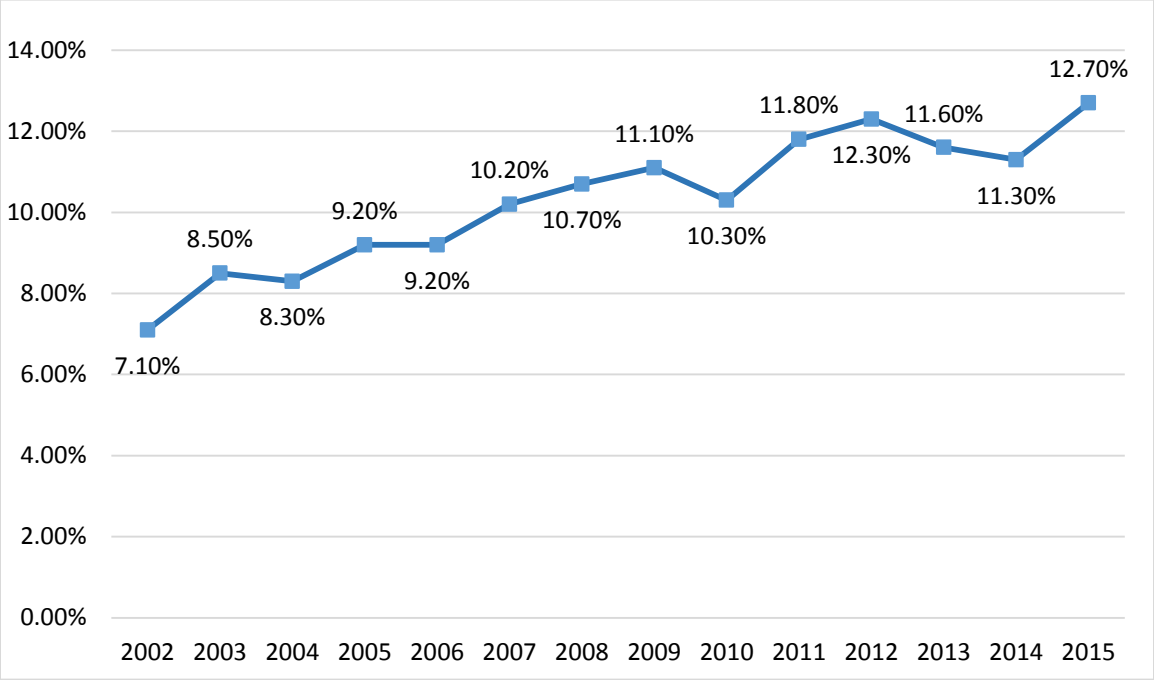


Figure 1.3.2 shows diabetes prevalence by sex and age in the overall Louisiana population and in the Healthy Louisiana Plan population. For those over the age of 21, both Louisiana and the Healthy Louisiana Plan populations show a higher prevalence in females than in males. However, in the overall Louisiana population age 21 and under, males had a higher prevalence than females (Males, 0.6% vs. Females, 0.3%), while the reverse is true for the Healthy Louisiana population.

[11] BRFSS Prevalence & Trends Data. (2017, January 3). Retrieved February 17, 2017, from https://www.cdc.gov/brfss/brfssprevalence/

Figure 1.3.2: Diabetes Prevalence by Sex by Age Group, Healthy Louisiana and Louisiana[11]

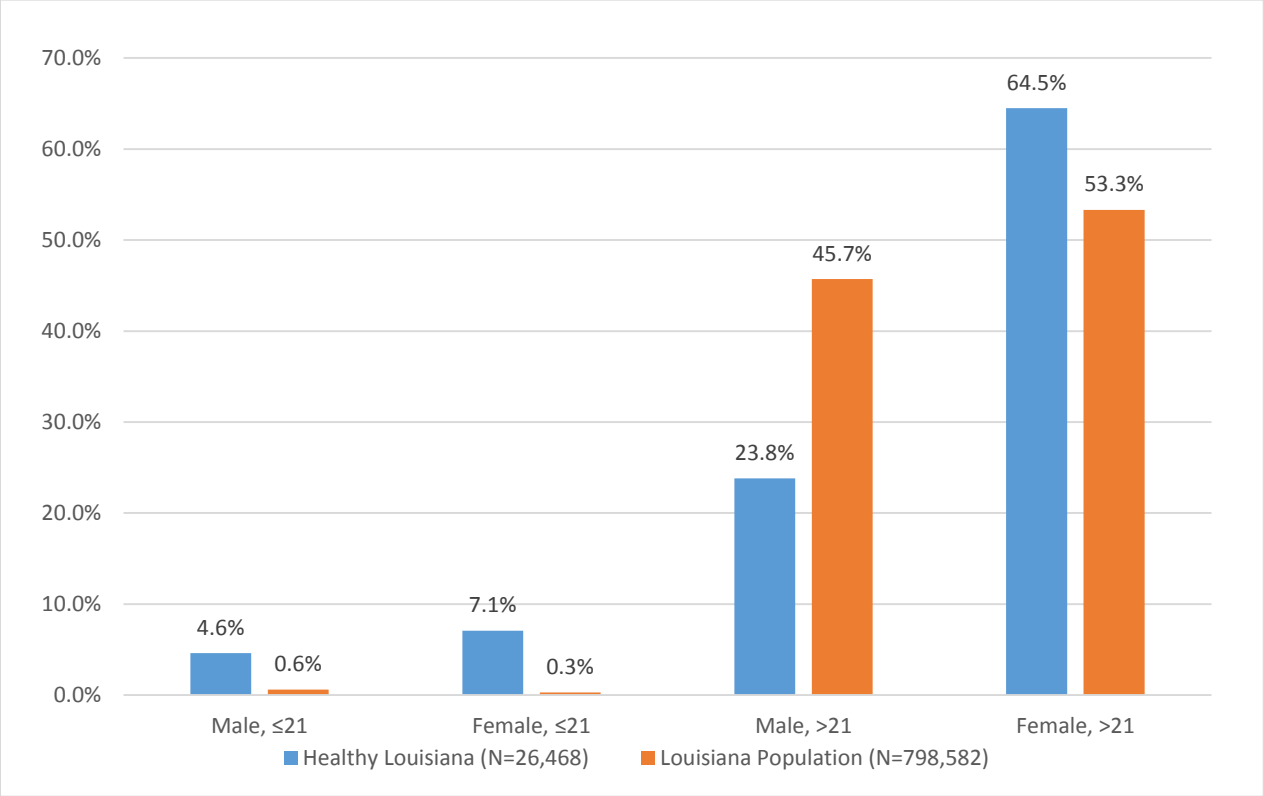


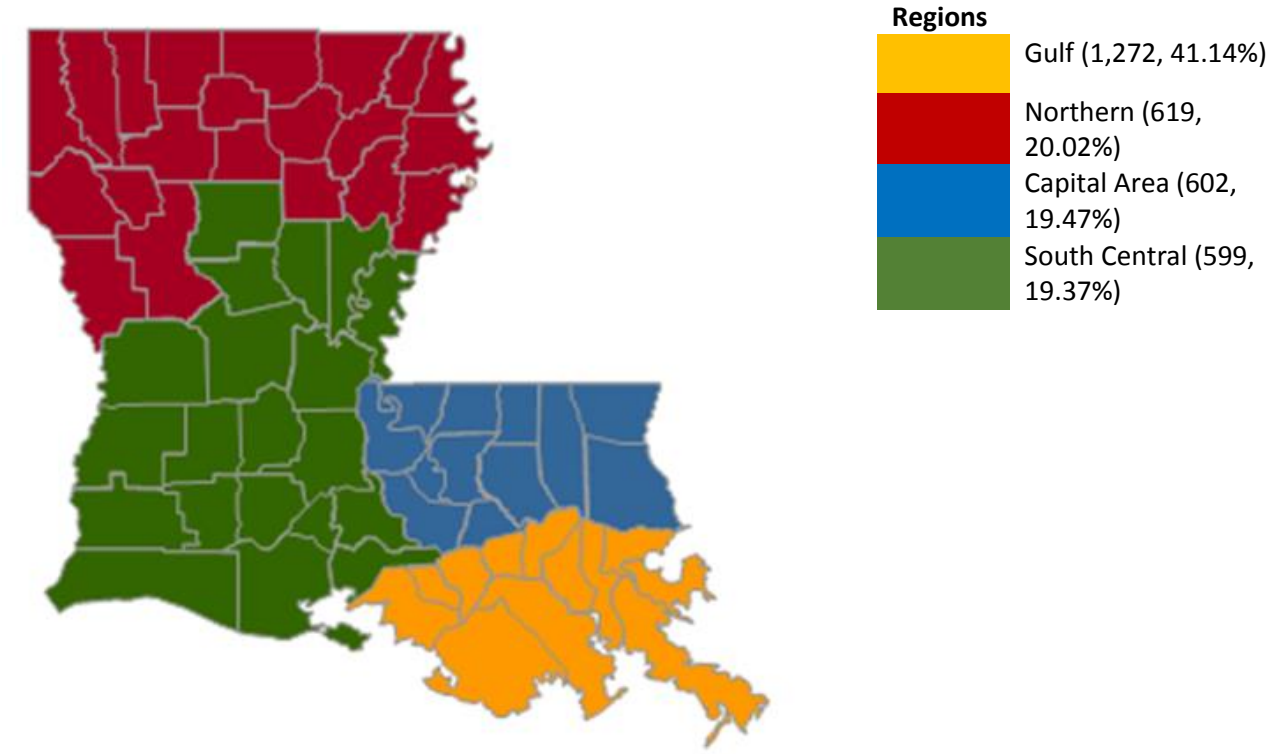
Table 1.3.1 details how members in Healthy Louisiana compared with state and national levels for preventive practices recommended for patients with diabetes. Nationally, Louisiana's BRFSS percentages were slightly below the 2013 national numbers for most of the listed preventive care practices. Louisiana, however, had a higher self-management education percentage than the national average. Although the Health Plans have a smaller percentage of those with diabetes in the state, the majority of their preventive care practices increased. However, the Health Plans had lower preventive care practices for a member ever receiving a pneumonia shot or for self-management. A possible reason for these low findings among the Healthy Louisiana members is varying degrees of available historical data for qualified members per plan. It is also important to note that for pneumonia vaccination and self-management education, lack of reimbursement to providers for the administration of the vaccine and lack of payment to educators likely contributed to the low numbers. In addition, as these are self-reported numbers and subject to recall bias, it is possible that some members may not have remembered receiving the vaccine or the education. Regardless of the reasons, these low numbers provide an opportunity for improvement.

Table 1.3.1: Reported Rates of Diabetes Care Practices among Adults with Diabetes: Healthy Louisiana Plans, Louisiana and the United States			
Preventive care practice	**Healthy Louisiana (2015)[1]**	**Louisiana (2013)**	**U.S. (2012)[2]**
Annual dilated eye exam	72.09	66.6	64.9
Received one or more A1Cs in current (2015) year	74.13	88.1	72.8
Received a flu shot in current (2015) year	8.24	60.2	***
Ever received a pneumonia shot[3]	5.89	53.1	***
Daily self-blood glucose monitoring[3]	38.27	61.9	63.5
Ever had self-management education[3]	0.16	54.1	57.6

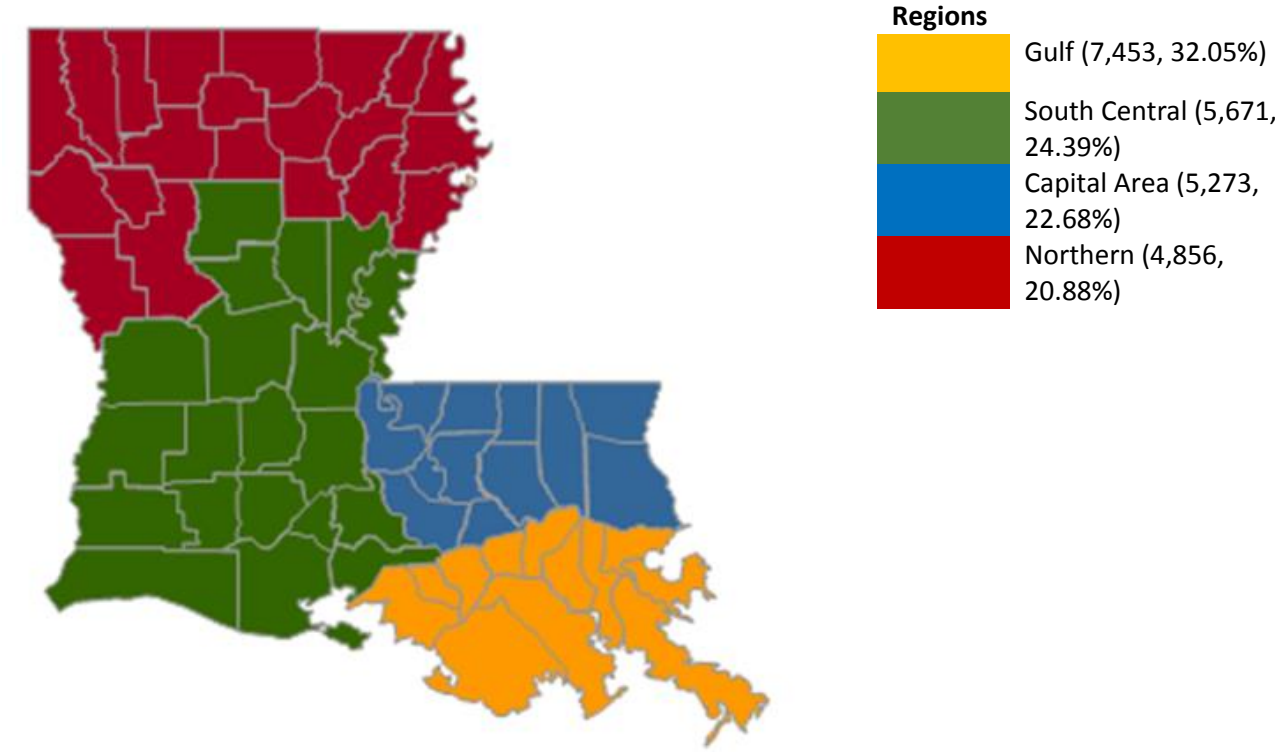
[1]The majority of Healthy Louisiana Plan members during 2015 were children and pregnant women, so the percentage of those with diabetes will be lower than state numbers.
[2]2012 represents the most recent year of data available from the CDC *Diabetes Report Card*. Available at: https://www.cdc.gov/diabetes/pdfs/library/diabetesreportcard2014.pdf
[3]Level of follow-up and/or historical data for qualified members may differ by plan.
***Rates not included in *CDC's Diabetes Report Card 2014.*

The geographic and age group breakdown of diabetes among the four regions are shown in Maps 1.3.1 and 1.3.2. Similar to the obesity findings, the Gulf region had the largest number of enrollees with diabetes, for both age groups. The region with the fewest number of Healthy Louisiana enrollees with diabetes age 21 and under was the South Central region, although both the Capital region and the Northern region had only slightly larger percentages (0.10 percent and 0.55 percent, respectively). For enrollees over the age of 21, the Northern region had the lowest number of enrollees with diabetes. For parish-level data, please see Appendix D.

Map 1.3.1: Geographical Distribution of Healthy Louisiana Members with Diabetes, Age ≤ 21 Years, 2015



Map 1.3.2: Geographical Distribution of Healthy Louisiana Members with Diabetes, Age > 21 Years, 2015



1.4 Diabetes and Pregnancy

Table 1.4.1 shows the 2015 prevalence of pregnancies complicated with diabetes. The financial burden on Healthy Louisiana is also listed. Although the majority of pregnancies that occurred in 2015 were not complicated with diabetes, the average amount paid, per member, for pregnancies with diabetes was almost twice that paid for pregnancies without diabetes ($3,832 vs. $2,047).

Table 1.4.1: Burden of diabetes* on pregnancies in 2015 among Healthy Louisiana Plan members

Pregnancy Type	Number of Members	Total Amount Paid	Average Amount Paid per Member
Pregnancies with diabetes	4,896 (7.9%)	$ 14,835,120.37	$3,030.05
Pregnancies without diabetes	56,722 (92.1%)	$108,022,648.55	$1,904.42

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

1.5 - The Financial Impact of Diabetes and its Complications

Estimated Costs of Diabetes

The American Diabetes Association estimates that the largest component of medical expenses attributed to diabetes is for hospital inpatient care, at 43 percent of total medical costs.[5] Given that inpatient hospital care is such a large component of diabetes costs, examining Louisiana's data on diabetes hospitalization costs is important to understanding its impact on individuals, on families, and [12]on the state. These data also serve as a reflection of how well diabetes is, or is not, managed by the health care system.

Hospitalization Costs Due to Diabetes

An inpatient hospital discharge record includes all information from admission to discharge. An Emergency Department (ED) record includes visits to an ED that do not result in an inpatient admission. ED records also include data of patients who are held for an observational stay but who are not admitted as inpatients to the hospital. This section of the report includes hospital discharge and ED visit data for 2015.

Table 1.5.1 shows the number of inpatient hospital discharges in which diabetes was coded on the discharge paperwork as the primary (principal) diagnosis for admission by age group. The principal diagnosis or primary diagnosis is defined in the Uniform Hospital Discharge Data Set (UHDDS) as "that condition established after study to be chiefly responsible for occasioning the admission of the patient to the hospital for care." The principal diagnosis is not always the admitting diagnosis, but is the

[12] United States, Department of Health and Human Service, Centers for Medicaid and Medicare Services. (2005). *Rules and Regulations* (Vol. 70, Ser. 87, pp. 24168-24261). Washington DC: Federal Register.

diagnosis found after workup, or even after surgery, that proves to be the reason for admission; it is the condition that is most serious and/or resource-intensive during that hospitalization.

Table 1.5.1 also shows the percent of overall inpatient discharges that were due to diabetes, and the amount paid by Healthy Louisiana, by age group, for these hospitalizations. In 2015, there were a total of 1,879 inpatient hospital discharges for which the principal diagnosis was diabetes; this was 14 percent of the overall inpatient discharges for Healthy Louisiana members in 2015. The majority of these inpatient discharges for diabetes occurred among Healthy Louisiana members older than 21 years of age. The total paid by Healthy Louisiana Plans for diabetes-related inpatient admissions amounted to $4,061,261.40.

It is important to note that the costs reported in this table do not include costs that may be related to diabetes, and thus, 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 1.5.1: Inpatient Hospital Discharges and Total Paid for Hospitalizations with Diabetes as the Primary Diagnosis* among Healthy Louisiana Plan Members in 2015 by Age Group

Age Group	Number of Diabetes Discharges	Percent of Overall Discharges Due to Diabetes	Total Paid for Diabetes Hospitalizations
≤ 21 years	673	1.82%	$1,475,531.32
> 21 years	2,130	4.52%	$7,665,844.74
Total	2,803	3.33%	$9,141,376.06

* Primary diagnosis is defined as diabetes noted in the first three discharge diagnosis listings.

Specific Diabetes Complications as Principal Diagnosis for Inpatient Hospital Discharges

Hospitalizations for diabetes may occur due to complications of the disease. All of the complications discussed in this section of the report 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 for care. Table 1.5.2 shows inpatient discharges in 2015 where a complication of diabetes was the primary diagnosis. Table 1.5.2 also presents the total percent of inpatient discharges due to a diabetes complication and the total amount paid by the Healthy Louisiana Plans for these complications. All were grouped by age group: less than or equal to 21 years or greater than 21 years.

For members 21 years or younger, the most frequent diabetes complication associated with an inpatient hospital discharge was diabetic ketoacidosis or DKA. DKA accounted for almost 65 percent of all inpatient hospital discharges due to a diabetic complication for this age group. DKA is a life-threatening complication in which ketones (fatty acids) build up in the blood due to a lack of insulin. For members older than 21 years, “diabetes without mention of complication” was the most frequent diabetic complication associated with over 45 percent of the hospitalizations. The total cost for these two complications were $1,081,478.28 and $2,017,063.63, respectively.

Table 1.5.2: Inpatient Hospital Discharges in 2015 by Age Group where a Diabetes Complication was the Primary Diagnosis*						
Diabetes Complications	**Number of Discharges**	**Percent of Overall Discharges Due to Complication**	**Total Amount Paid for Diabetes Complication**	**Number of Discharges**	**Percent of Overall Discharges Due to Complication**	**Total amount paid for diabetes complications**
	≤21 years			**>21 years**		
(250.0) Without mention of complication	183	25.3%	$239,434.68	1199	45.4%	$2,017,063.63
(250.1) Ketoacidosis	467	64.7%	$1,081,478.28	587	22.2%	$2,005,963.29
(250.2) Hyperosmolarity	4	0.6%	$19,777.93	71	2.7%	$195,925.60
(250.3) With other coma	5	0.7%	$9,699.73	5	0.2%	$24,519.70
(250.4) With renal manifestations	1	0.1%	$3,383.00	72	2.7%	$297,531.23
(250.5) with ophthalmic manifestations	1	0.1%	$2,125.28	11	0.4%	$59,006.94
(250.6) With neurological manifestations	17	2.4%	$13,565.78	289	10.9%	$974,356.81
(250.7) With peripheral circulatory disorders				52	2.0%	$362,509.36
(250.8) With other specified manifestations	43	6.0%	$888,998.36	348	13.2%	$1,440,360.37
(250.9) Diabetes with unspecified complication	1	0.1%		6	0.2%	$18,652.98
Totals	722	100.0	$1,458,363.04	2,640	100.0	$7,395,889.91

*Primary diagnosis is defined as diabetes noted in the first three discharge diagnosis listings.

Emergency Department Visits Due to Diabetes

Table 1.5.3 displays, by age group, the number of ED visits due to diabetes, percent of overall ED visits due to diabetes, and the amount paid for ED visits by the Health Plans in which diabetes was the primary diagnosis. In 2015, a total of 28,059 ED visits occurred in which diabetes was the primary diagnosis, amounting to 30 percent of all ED visits for the Healthy Louisiana members. Similar to inpatient discharges, the majority of ED visits occurred among those older than 21 years. In total, Healthy Louisiana paid almost $7 million for diabetes-related ED visits in 2015 (Table 6).

Table 1.5.3: Total ED Visits by Age Group Where Diabetes was the Primary Diagnosis*			
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	2,328	0.5%	$805,860.68
> 21 years	25,731	7.2%	$5,867,340.53
Total	28,059	3.5%	$6,673,201.21

* Primary Diagnosis is defined as diabetes notes in the first three discharge diagnosis listings.

Table 1.5.4 shows ED visits in 2015, by age group, where a complication of diabetes was the primary diagnosis for the visit. A total of 16,090 ED visits for a diabetes complication occurred in 2015. The most common diabetic complication leading to an ED visit was "diabetes without mention of complication" at 64.7 percent for those members 21 years or younger and 81.1 percent of members older than 21 years. For the younger members with diabetes, DKA was the second most common reason for going to the ED while "with other specified manifestations" was the second most common reason for those older than 21 years of age. See Table 7.

Table 1.5.4: Emergency Department Visits in 2015 by Age Group Where Diabetes Complication was the Diagnosis*

Diabetic complications	Total visits for ages ≤ 21 years	Total visits for ages > 21 years
(250.0) Without mention of complication	1,077	11,700
(250.1) Ketoacidosis	266	213
(250.2) Hyperosmolarity	11	110
(250.3) With other coma	6	23
(250.4) With renal manifestations	0	46
(250.5) With ophthalmic manifestations	2	20
(250.6) With neurological manifestations	24	617
(250.7) With peripheral circulatory disorders	0	25
(250.8) With other specified manifestations	262	1,567
(250.9) With unspecified complications	17	104
Total	**1,665**	**14,425**

*Primary diagnosis is defined as diabetes noted in the first three discharge diagnosis listings.

1.6 – Diabetes and Common Chronic Conditions

Comparing the Burden of Diabetes with other Common Chronic Conditions

The statute that defines the content of this report requires a comparison of the financial burden or impact of diabetes to that of other common chronic conditions. This section of the report looks at the relationship between diabetes and other common chronic conditions, by comparing its prevalence, cost per member, and total paid with other chronic disease, as shown in Table 1.6.1.

Among the members of the Healthy Louisiana Plans with chronic conditions, hypertension was the most prevalent, affecting 70,248 members, followed by asthma, which affects 44,460 members. Diabetes was the third most common chronic condition, affecting 26,392 Healthy Louisiana members.

Table 1.6.1: Comparison of Prevalence and Cost between Diabetes and Other Common Chronic Diseases			
Chronic Disease	**Number of Members**	**Per Member Cost**	**Total Paid**
Arthritis	12,662	$2,941.80	$37,249,123.40
Asthma	44,460	$1,190.00	$52,907,246.30
Congestive Heart Failure	6,066	$6,992.89	$42,418,854.16
COPD	13,674	$3,746.91	$51,236,081.82
Coronary Heart Disease	6,305	$5,603.00	$35,326,904.82
Diabetes	26,392	$3,069.15	$81,000,931.85
Hypertension	70,248	$2,120.35	$148,950,391.18

It is always important to remember that diabetes does not exist in a vacuum – people with diabetes often have additional chronic illnesses that affect their ability to self-manage, therefore providing additional diabetes management challenges to their doctors. The top medical condition that resulted in the most expensive cost per member was congestive heart failure at $6,992.89, a diagnosis that may also be found among people with diabetes. In terms of total cost, the most expensive chronic condition among members for 2015 was hypertension, at $148,950,391.18. See Table 8.

1.7 Current Diabetes Management Efforts

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

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

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

In addition, the team's obesity prevention efforts emphasize place-based interventions in schools, worksites, and early childhood education sites. These outcomes are achieved through the promotion of nutrition standards and physical activity through professional development, technical assistance, and program development. The Bureau of Chronic Disease Prevention and Health Promotion engages with schools, childcare sites and worksites around the state through the following activities (Table 1.6.2):

Table 1.6.2: Bureau of Chronic Disease Prevention and Health Promotion Activities

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

The Bureau of Chronic Disease Prevention and Health Promotion works to implement these interventions by developing partnerships with internal and external agencies and programs. Current efforts are described below.

Community Mobilization:

The Bureau of Chronic Disease Prevention and Health Promotion has had great success in mobilizing partnerships to identify and address diabetes and obesity-related issues. The team has developed partnerships with numerous stakeholders across the scope of its programmatic activities. Developing and maintaining active partnerships at the state and local levels are essential to jointly pursuing issues related to diabetes and obesity prevention in communities and among health care providers. These partnerships are summarized below in Table 1.6.3.

Table 1.6.3: Bureau of Chronic Disease Prevention and Health Promotion Partners	
Place	*Partners*
Diabetes	• Members of the Louisiana Diabetes Collaborative • Members of the Louisiana Diabetes Educators' Network • Louisiana Obesity Prevention and Management Commission • Louisiana Medicaid • Louisiana Health Care Quality Forum • 323-HELP, Inc. • Baton Rouge Capital Area and Greater New Orleans Area YMCAs.
Schools	• Louisiana Department of Education • School Health Collaborative • School Nutrition Association of Louisiana • Louisiana Association for Health, Physical Education, Recreation and Dance • Alliance for a Healthier Generation • Louisiana Public Health Institute
Child Care Sites	• Louisiana Department of Education • Pennington Biomedical Research Center • Tulane Prevention Research Center • Office of Public Health – Bureau of Family Health • University of North Carolina at Chapel Hill
Worksites	• Office of Group Benefits • Louisiana Workforce Commission • Randolph Sheppard Blind Vendors

Diabetes Self-Management Education and Prevention:

A variety of educational programs/classes are available in communities across Louisiana to educate and support people with, or who are at risk for, diabetes. Diabetes Self-Management Education programs provide information, tools, and resources to help people with type 1 or type 2 diabetes manage their disease. The National Diabetes Prevention Program (NDPP) is an evidence-based Lifestyle Change Program for persons who are identified as pre-diabetic and who are at risk for developing type 2 diabetes. Currently there are 57 AADE and/or ADA self-management programs and seven NDPP programs across the state in hospital, clinics, and community settings. The Bureau of Chronic Disease Prevention and Health Promotion has worked diligently to develop strategies to increase awareness about diabetes and all other chronic diseases in Louisiana. Some of this work includes the following strategies and partnerships:

- Bureau of Chronic Disease Prevention and Health Promotion is an active member of the Diabetes Collaborative. This collaborative brings together representatives from national and community-based organizations to advocate for policy, clinical needs and community outreach to improve diabetes prevention and education.
- The Bureau of Chronic Disease Prevention and Health Promotion has built a relationship with the Medicaid Quality Section to develop the Diabetes and Obesity Annual report for the legislature in partnership with the Medicaid Healthy Louisiana Plans. Through this partnership, the team is actively working with Medicaid to develop a state plan amendment proposal to increase Medicaid reimbursement rate for DSME programs. These essential programs teach diabetics how to manage their disease and prevent an early onset of complications from

diabetes. Increasing reimbursement for this service will enhance sustainability for DSME programs across the state.

- The Bureau of Chronic Disease Prevention and Health Promotion coordinates the Louisiana Diabetes Educator Network. The purpose of this network is to convene a group of individuals, including registered nurses, registered dietitians, pharmacists, and program coordinators dedicated to diabetes prevention and management education in Louisiana. Interested participants will have the opportunity to receive technical assistance, training, and network with other programs across the state through monthly webinars and quarterly meetings.

Public Awareness and Education:

On April 14, 2014, LDH launched a campaign aimed at improving the health and wellness of Louisiana residents. Well-Ahead Louisiana is a statewide initiative and designation program that promotes and recognizes environments that help Louisiana residents make smart choices in the spaces and places where they live and work. Well-Ahead is a core component of Louisiana's strategy for impacting healthy environmental change. The initiative works to make it easier for people to make healthier choices. The Well-Ahead Louisiana Team works closely with restaurants, schools, child care sites, worksites, local governments, hospitals, and universities on a number of obesity prevention efforts, from implementing tobacco-free policies to ensuring healthy lunch options, or supporting workplace fitness programs. Places that commit to improving the health of their environment are recognized by LDH as WellSpots. As of January 2017, more than 1,700 organizations in Louisiana are designated WellSpots.

As the outward-reaching brand of the Bureau of Chronic Disease Prevention and Health Promotion, Well-Ahead plays a significant role in the public awareness and education of the team's diabetes and obesity prevention efforts around the state. Well-Ahead is launching a media campaign that will promote the awareness of diabetes and encourage healthy living in our state. The team will work with designated WellSpots to increase access to Diabetes Self-Management Education Programs and Diabetes Prevention Programs for their employees. Similar promotion is being done with schools, child care sites and worksites. In addition, a benchmark has been added to all WellSpot designations that will encourage employees or university students to take a risk assessment for prediabetes and heart health.

Professional Education and Health System Quality Improvement:

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

Surveillance and Evaluation:

The Bureau of Chronic Disease Prevention and Health Promotion works closely with the Pennington Biomedical Research Center to evaluate program efforts across the state.

Funding:

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

Conclusion

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

Appendix A – Act 210 Legislation

RS 46:2616

CHAPTER 46. HEALTH ACTION PLANS

§2616. Diabetes annual action plan; submission; content

A. The Department of Health 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 and Hospitals, its contracted partners, and other stakeholders on activities, programmatic activities, and the level of communication on managing, treating, or preventing all forms of diabetes and its complications.

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

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

B. The Department of Health 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 – Committee Members

Diabetes/Obesity Committee Members: 2015–2016

Committee Member	Organization	Title
SreyRam Kuy, MD	LDH	Medicaid Medical Director
Piia Hanson	LDH	Quality Section Chief
David Peterson	LDH	Quality Initiatives Program Manager
Dawn Love	LDH	Medicaid Communications
Sandy Blake	LDH-ULM	Director, Outcomes Research, ULM
Parham Jaberi, MD	OPH	OPH Medical Director
Melissa Martin	OPH	Bureau of Chronic Disease Prevention and Health Promotion
Jamila Freightman	OPH	1305 CDC Public Health Advisor
Lee Reilly	ABHLA	Director of Quality Management
Laura Habetz	ABHLA	Project Manager
Richard Born	ABHLA	Chief Executive Officer
Madhavi Rajulapalli, MD	ABHLA	Chief Medical Officer
Mary Scorsone	ACLA	Director of Quality Management
Kyle Viator	ACLA	Market President
Trampas Cranford	ACLA	Manager of Medical Economics
Agnes Robins	ACLA	Quality Performance Specialist Clinical
Rodney Wise, MD	ACLA	Medical Director
Rhonda Baird	ACLA	Manager, Quality
Mia Bell	Amerigroup	Performance Improvement Lead/HEDIS Manager
Aundria Toussaint	Amerigroup	Business Analyst
Paula Nevels	Amerigroup	QM Interim Quality Director
Brenda Tompkins	Amerigroup	Director of Healthcare Management Services
Raymond Poliquit, MD	Amerigroup	Medical Director
Marcus Wallace, MD	LHCC	Senior Vice President of Medical Affairs
Gwen Laury	LHCC	Director of Quality
Carey Hotard	LHCC	Project Manager II
Melder Burton	LHCC	Manager of Quality Improvement Analytics
FeLisa Carpenter	LHCC	Data Analyst II
William Dalton	LHCC	Data Analyst IV
Ryan Jenkins	LHCC	Lead Data Analyst
Ann Logarbo, MD	United	Medical Director
Angela Olden	United	Director of Quality Management
Linda Rintala	United	Director of Health Services
Deborah Junot	United	Quality Manager

Appendix C – Region and Parish Information for Members with Obesity

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

REGION	PARISH	≤21 YEARS	>21 YEARS
OUT OF STATE	OUT OF STATE	120	106
CAPITAL	ASCENSION	889	1,112
CAPITAL	EAST BATON ROUGE	6,034	3,530
CAPITAL	EAST FELICIANA	212	151
CAPITAL	IBERVILLE	314	313
CAPITAL	LIVINGSTON	930	894
CAPITAL	POINTE COUPEE	177	336
CAPITAL	ST HELENA	104	115
CAPITAL	ST TAMMANY	863	1,074
CAPITAL	TANGIPAHOA	654	1,362
CAPITAL	WASHINGTON	333	555
CAPITAL	WEST BATON ROUGE	190	179
CAPITAL	WEST FELICIANA	47	48
CAPITAL	TOTAL		9,669
GULF	ASSUMPTION	141	183
GULF	JEFFERSON	2,769	2,664
GULF	LAFOURCHE	468	491
GULF	ORLEANS	2,290	2,684
GULF	PLAQUEMINES	121	152
GULF	ST BERNARD	304	331
GULF	ST CHARLES	308	309
GULF	ST JAMES	266	195
GULF	ST JOHN THE BAPTIST	481	267
GULF	ST MARY	250	321
GULF	TERREBONNE	614	634
GULF	TOTAL	8,012	8,231
NORTH	BIENVILLE	81	112
NORTH	BOSSIER	782	590
NORTH	CADDO	1,638	1,847
NORTH	CALDWELL	40	75

NORTH	CLAIBORNE	175	98
NORTH	DE SOTO	115	154
NORTH	EAST CARROLL	58	70
NORTH	FRANKLIN	143	152
NORTH	JACKSON	138	81
NORTH	LINCOLN	199	234
NORTH	MADISON	65	64
NORTH	MOREHOUSE	250	317
NORTH	NATCHITOCHES	350	228
NORTH	OUACHITA	1,236	1,342
NORTH	RED RIVER	54	99
NORTH	RICHLAND	185	166
NORTH	SABINE	93	204
NORTH	TENSAS	25	31
NORTH	UNION	142	163
NORTH	WEBSTER	302	284
NORTH	WEST CARROLL	41	84
NORTH	TOTAL	6,112	6,395
SOUTH CENTRAL	ACADIA	298	336
SOUTH CENTRAL	ALLEN	66	86
SOUTH CENTRAL	AVOYELLES	174	167
SOUTH CENTRAL	BEAUREGARD	130	151
SOUTH CENTRAL	CALCASIEU	555	1,010
SOUTH CENTRAL	CAMERON	2	14
SOUTH CENTRAL	CATAHOULA	114	121
SOUTH CENTRAL	CONCORDIA	129	208
SOUTH CENTRAL	EVANGELINE	201	195
SOUTH CENTRAL	GRANT	123	93
SOUTH CENTRAL	IBERIA	971	689
SOUTH CENTRAL	JEFFERSON DAVIS	153	126
SOUTH CENTRAL	LA SALLE	132	126
SOUTH CENTRAL	LAFAYETTE	1,347	1,120
SOUTH CENTRAL	RAPIDES	619	487
SOUTH CENTRAL	ST LANDRY	664	738
SOUTH CENTRAL	ST MARTIN	520	428
SOUTH CENTRAL	VERMILION	928	378
SOUTH CENTRAL	VERNON	110	169
SOUTH CENTRAL	WINN	562	150
SOUTH CENTRAL	TOTAL	7,798	6,792

Appendix D – Region and Parish Information for Members with Diabetes

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

REGION	PARISH	≤21 YEARS	≤21 YEARS
OUT OF STATE	OUT OF STATE		44
CAPITAL	ASCENSION	57	407
CAPITAL	EAST BATON ROUGE	220	1,743
CAPITAL	EAST FELICIANA	20	147
CAPITAL	IBERVILLE	30	231
CAPITAL	LIVINGSTON	66	426
CAPITAL	POINTE COUPEE	15	139
CAPITAL	ST HELENA	5	63
CAPITAL	ST TAMMANY	72	702
CAPITAL	TANGIPAHOA	61	815
CAPITAL	WASHINGTON	34	439
CAPITAL	WEST BATON ROUGE	18	114
CAPITAL	WEST FELICIANA	4	47
CAPITAL	TOTAL	602	5,273
GULF	ASSUMPTION	10	159
GULF	JEFFERSON	473	2,086
GULF	LAFOURCHE	34	458
GULF	ORLEANS	520	2,913
GULF	PLAQUEMINES	7	118
GULF	ST BERNARD	28	254
GULF	ST CHARLES	31	166
GULF	ST JAMES	18	111
GULF	ST JOHN THE BAPTIST	39	277
GULF	ST MARY	31	320
GULF	TERREBONNE	81	591
GULF	TOTAL	1,272	7,453
NORTH	BIENVILLE	9	122
NORTH	BOSSIER	55	371
NORTH	CADDO	170	1,390
NORTH	CALDWELL	8	61
NORTH	CLAIBORNE	18	84
NORTH	DE SOTO	16	148

NORTH	EAST CARROLL	7	67
NORTH	FRANKLIN	18	143
NORTH	JACKSON	14	80
NORTH	LINCOLN	38	218
NORTH	MADISON	5	65
NORTH	MOREHOUSE	21	216
NORTH	NATCHITOCHES	24	237
NORTH	OUACHITA	123	842
NORTH	RED RIVER	7	59
NORTH	RICHLAND	16	148
NORTH	SABINE	14	94
NORTH	TENSAS	3	48
NORTH	UNION	13	145
NORTH	WEBSTER	33	254
NORTH	WEST CARROLL	7	64
NORTH	TOTAL	619	4,856
SOUTH CENTRAL	ACADIA	48	367
SOUTH CENTRAL	ALLEN	9	130
SOUTH CENTRAL	AVOYELLES	24	255
SOUTH CENTRAL	BEAUREGARD	26	165
SOUTH CENTRAL	CALCASIEU	90	813
SOUTH CENTRAL	CAMERON	0	9
SOUTH CENTRAL	CATAHOULA	5	63
SOUTH CENTRAL	CONCORDIA	12	131
SOUTH CENTRAL	EVANGELINE	21	294
SOUTH CENTRAL	GRANT	17	103
SOUTH CENTRAL	IBERIA	37	358
SOUTH CENTRAL	JEFFERSON DAVIS	13	149
SOUTH CENTRAL	LA SALLE	10	73
SOUTH CENTRAL	LAFAYETTE	76	701
SOUTH CENTRAL	RAPIDES	66	668
SOUTH CENTRAL	ST LANDRY	55	664
SOUTH CENTRAL	ST MARTIN	32	194
SOUTH CENTRAL	VERMILION	28	270
SOUTH CENTRAL	VERNON	22	192
SOUTH CENTRAL	WINN	8	72
SOUTH CENTRAL	TOTAL	599	5,671

Appendix E – Health Plans' Action Plans

This section details the actionable items to address diabetes by Healthy Louisiana plans. Please note that not all plans submitted their action plans in a format and/or size that could be incorporated into this document. Additionally, one action plan contained information that was proprietary and confidential and was, therefore, not included in this appendix.

APPENDIX E1- Aetna Better Health of Louisiana

Aetna Better Health of Louisiana Diabetes and Obesity Care Management Plan

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

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

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

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

- telephonic and print education on self-monitoring,
- member support through a secure member portal with website log-in link to evidence-based health appraisal and self-management tools and digital coaching programs,
- 24 x 7 Health information line (24-hours, seven days a week) where nurses assist members with wellness and prevention information,
- emphasis on exacerbation and complication prevention using evidence-based clinical guidelines and member engagement through care management activation strategies,
- care management assistance with techniques to better adhere to medication regimens, clinical monitoring and treatment plans,
- care management collaboration (with member's consent) with providers and caregivers.

The overarching goal of our ICM process is to engage members to address their critical physical, behavioral, environmental and social needs in order to enhance resiliency and enable optimal self-management. We collaborate with the member/member supports to create a Plan of Care based on clinical practice guidelines and preventive service guidelines that includes mutually agreed upon member-centered goals, actions for the member/member supports and the care manager, as well as services to be coordinated for the member. We team with our members, their families, community supports, community-based case managers and providers to enhance care outcomes. Every assessment and encounter includes attention to comorbidities and to reducing unhealthy behaviors. Members are identified who may benefit from care management, using predictive modeling, self-reported health risks (Health Risk Questionnaire, or HRQ, offered to every member) and referrals from a variety of sources (including state-identified and state-mandated populations).

Condition-Specific Assessments

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

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

ABHLA Interventions for Prevention and Wellness for Diabetes and Obesity

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

c. Outreach techniques to members may include:
    - Telephone reminders
    - Text messages
    - Mailings (e.g., diabetic self-care letters and reminders, quarterly newsletters for members identified regarding chronic disease management)
    - E-mail
    - Information on the plan web site
    - Satisfaction surveys
    - Provider and member portal (e.g. Gaps in Care, educational messaging, information and digital tools for condition management.)
    - Community health fair
    - Link to community resources
    - Partnership with Boy Scouts of America and Girl Scouts of Louisiana

Value-Add Benefits

Aetna Better Health Louisiana uses mobile technology to inform and educate members and deliver personalized chronic care management programs. We have implemented Care4Life™, a diabetes coaching program with mobile and web-based interactive activities.

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

Members may engage in mobile and web-based activities that include:

- Diabetes education and support/personal care manager
- Diabetes nutritional tips and recipes
- Appointment and medication reminders
- Exercise and weight goal setting and tracking
- Blood glucose tracking
- Personalized text messages related to diabetes care

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

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

Aetna provides a weight management program for children and adolescents age 5 through 20. Members screened by their PCP for participation, who meet the CDC BMI requirement for being overweight and obese and who are enrolled in the Integrated Care Management program will receive

incentives for enrolling and participating in the program. Upon enrollment each member will receive a pedometer and exercise band. After enrollment, participants receive gift cards in graduated amounts as they meet the goals that they set when they enrolled.

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

Diabetes and Obesity Action Plan Objectives:

- To provide and promote telephonic and web-based interventions to high risk members identified with diabetes through our Care4Life self-management coaching program.
- To promote appropriate care of diabetes to diabetic members through targeted mailers and reminders.
- To increase awareness of our care management programs for diabetes and obesity through specific articles in member and provider newsletters.
- To reduce the number of children and adolescents at risk for increased BMI levels by promoting our weight management program in efforts to prevent juvenile obesity.

Appendix E2 – Amerigroup Louisiana, Inc.

Disease Management – Diabetes and Obesity - 2016 Report

Amerigroup's Disease Management (DM) Programs address the needs of members with conditions including diabetes and obesity. Members may receive clinical or non-clinical interventions based on their level of need and willingness to participate in the program.

- Non-clinical interventions consist of routine mailings, which include condition-specific education.
- Clinical interventions include comprehensive health risk assessment, care planning, education and health coaching through a DM Case manager.
    - Note: Specifically, this includes an initial and follow-up general assessment along with specific diabetes and obesity assessments (when applicable).
    - The Disease Management Health Risk Assessment (DM HRA) is a comprehensive set of questions that identifies needs across the continuum of care. It captures information regarding both physical and behavioral conditions and condition maintenance, special needs, health history, lifestyle behaviors, risk factors and activities of daily living. The DM HRA includes assessment of height and weight followed by a calculation of BMI (or BMI percentile for children).
    - Results of the HRA are used to develop a tailored, member-centric plan of care and drive both the intensity and frequency of follow-up outreach. Case managers review progress specific to care plan goals during follow-up contacts, as well as new areas of focus based on member needs and/or care alerts for missed services indicating Gaps in Care. Members receive written and verbal education to support meeting care plan goals. The member's primary provider receives information on the program notifying them of member enrollment and the option to review member DM information real-time via the provider portal including assessment data, care plan items, and relevant clinical practice guidelines.
    - Case managers monitor and follow-up with members and collaborate with the health care team to adjust the care plan as appropriate based on the unique needs of the individual member. A follow up assessment is completed on subsequent contacts following initial enrollment. The plan of care, stratification and follow up schedule may be adjusted based on new information gathered during the follow up assessment process. Case managers verbally review the agreed upon care plan goals and confirm member consent when changes occur. Providers receive telephonic notification when changes in the member's status occur or when new issues are identified.
- Members that engage with a DM Case manager complete a brief satisfaction survey after completing 90 days of active enrollment and upon completion of the program to provide feedback on various components of DM. **During 2016 (through September), 8,909 Louisiana members participated in these DM Programs.**
    - Note: The DM satisfaction survey is administered to members as they are completing the program. The survey is administered telephonically by non-clinical support staff after the DM nurse and member have had their final follow-up dialogue. While DM attempts to administer the survey on the total population completing the program, participation in the survey is voluntary.
- Among the Louisiana members who completed the program and were surveyed during 2016:

- 95.3% report being satisfied with the responsiveness and courtesy of DM Case managers
- 93.0% feel the DM Programs facilitates better communication with their providers
- 97.7% report overall satisfaction with the DM Programs
- 83.7% perceive an overall improvement in their health since enrolling in the DM Programs
- Note: This is member reported data and reflects the members' perception of overall health since enrolling in their respective program.

AMG Healthy Families – Weight Management

- Amerigroup's Healthy Families Program is designed to promote healthy lifestyles in an attempt to impact the growing obesity epidemic. The primary program focuses on members age 7-13 that could benefit from healthy lifestyle education and are interested in goal setting and working toward that end. Amerigroup recognizes that the need for this program extends into the teenage population in Louisiana. As a result, Amerigroup launched a teen pilot targeting members age 14-17 in late 2013 and continues the teen program today. Note: Members are identified by their age and outreach is conducted to determine appropriateness and interest in the program. Members can also be referred to the program by their provider, self-referral or referral from another Amerigroup program such as Case Management. The program is not limited to members with certain PCPs; it is open to any member in the age range regardless of their PCP.
- Eligibility for the program is based on both age qualification and clinical assessment of height, weight, BMI, co-morbid conditions and family history in addition to readiness level and interest in the program. Built on evidence-based clinical guidelines, Healthy Families connects the member with a nurse coach who works with the family and the health care provider to engage the member in a six month program, which includes collaborative goal setting and action planning.
    - Note: Amerigroup assesses any co-morbid conditions common with obesity (HTN, diabetes) and conditions that might increase the risk of obesity (medications for behavioral health conditions). Family history considered under this program includes diabetes, heart disease, high blood pressure and obesity. Amerigroup uses nationally endorsed, evidence-based guidelines from the American Academy of Pediatrics (AAP) as the basis of Clinical Practice Guidelines for childhood and adolescent obesity.
- Nurse Coaches work with members to set goals and develop small, doable steps to meet the member where they are. For example, one member/parent may have a goal of increasing fruit/vegetable intake while another may want to focus on increasing activity or reducing screen time. Amerigroup has care plan guidelines that are used by nurses for obesity as well as general guidelines for improving/maintaining health. The nurse will frequently use these to supplement for a member-centric plan. Amerigroup's nurses are specially trained in motivational interviewing and the goal is for them to assist members in developing a self-care plan, overcoming barriers and accessing resources rather than prescribing a specific type of nutrition or exercise plan. The nurses are also knowledgeable regarding the barriers and needs of the Medicaid population where finances are a barrier to many standard weight loss techniques.
- Healthy Families combines care management, education, coaching and community-based resources to support a healthy lifestyle not only for the member but the entire family. Members that participate in the program set goals related to increasing physical activity, incorporating healthy dietary habits and reaching a healthier weight. Amerigroup introduced new written

materials in 2014 to appeal to our target population to include graphic novel style materials with widely recognized characters.
    - Note: Examples of community-based resources include the YMCA sponsors, parks and recreation programs and school programs. Our nurse coaches use regional lists of available programs and activities to guide the member to resources available in their area. Nurse Coaches also collaborate with local resources for information about community events.
- Since parents make the decisions about what to buy at the grocery and what to prepare for dinner, any healthy behaviors naturally spill over to the rest of the family. In total, **61 Louisiana families** participated in the standard Healthy Families program in 2016; **17 of those Louisiana families** participated in the teen pilot in 2016.
    - Note: On average enrolled members have reported the following during 2016 (through September):
        - 26.3% decrease in consumption of sugary beverages
        - 7.7% increase in fruit/vegetable servings
        - 9.3% increase in 8 ounce servings of water
        - 6.7% increase in 30 minute activity sessions

APPENDIX E3- Amerihealth Caritas Louisiana

Amerihealth Caritas Current Diabetes/Obesity Initiative Activities

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

Member Incentives-Encourages members to obtain recommended screenings

- Collaborate with our Community Health Education team in organizing events for members with HgbA1C, Nephropathy and Vision care gaps, in which diabetes education and screenings are performed along with exercise/nutrition counseling, blood pressure checks, and BMI assessments. This opportunity will be also be used to educate our community. Members will be offered incentives for participation.
- $10 gift card for receiving HgbA1C, Nephropathy and Vision screenings.

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

- Mailings to all newly identified diabetic members with follow up care information and relevant phone numbers for health or medication questions, appointment assistance, transportation needs. In addition, those identified as high risk are called in an attempt at engagement.
- Incorporate information regarding gift card incentives for Comprehensive Diabetes Care (CDC) measures during all member contact opportunities (mailings and verbal).
- Telephonic outreach via case management to members engaged in Integrated Healthcare Management (IHCM) regarding follow up care, transportation needs, appointment assistance, health or medication questions.
- "I Am Healthy" educational member mailings and web content.
- IHCM, member services and rapid response utilize all encounter opportunities to educate members of all care gaps.
- Year-to-date mailing and sound blast to members with diabetes care gaps. Opportunities to direct connect to our Rapid Response Outreach Team is provided with our sound blasts, which can assist the member with transportation, appointment scheduling and/or obtaining prescriptions.
- Quarterly educational mailings by IHCM to all members diagnosed with diabetes.
- IHCM offers one-on-one teaching of self-management skills for members who opt into the disease management program, which includes the importance of medication compliance, obtaining appropriate screenings such as HgbA1C testing, nephropathy screenings, and eye examinations.
- Promote educational campaigns and messages that improve the awareness of diabetes prevention and control to our members and to the general public through the distribution of educational materials, newsletters, newspaper articles, and media interviews.

- Our “Make Every Calorie Count” program targets members with a diagnosis of obesity and other co-morbidities such as diabetes. Once engaged, they receive telephonic case management addressing the disease and weight management from a registered nurse. Members receive a “Make Every Calorie Count” welcome packet which includes: a pedometer, tape measure and welcome booklet and calorie/activity journals. These tools are used as teaching tools, as the case managers educate/motivate and develop individualized plans of care. Members engaged in the “Make Every Calorie Count” program are eligible to receive nutritional counselling services.

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

- Quality Enhancement Program (QEP) which enhances primary care reimbursement through a performance incentive payment expanded to PCPs with 50 or more linkages.
- Providers receive QEP report cards and HEDIS Performance Summaries throughout the year to remain aware of their HEDIS status and care gaps.
- Provide Regional Provider Training- Discuss measure specification requirements and billing procedures for high priority measures which include LDH’s incentive-based measures.
- Provide targeted provider visits, by clinical staff and account executives to address member care gaps.
- Educate providers regarding the use of the provider portal (NaviNet) for electronic access of assigned member care gaps. If necessary, providers are directly provided the list of care gaps.
- Distribute updated HEDIS coding guidelines to providers.
- Provide “I Am Healthy” education to providers through provider web content.
- Provide a $10 incentive for billing CPT Category II code for Low Risk Retinopathy (no evidence of retinopathy in prior year) for eligible members and frequent reminders to providers regarding this initiative.

Data collection on CDC Measures and others such as Adult BMI Assessment, and Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents outcome data, or other quality monitoring activities

- Trend and track HEDIS measures: CDC and other measures such as Adult BMI Assessment, and Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents.
- Data analysis to determine impact of initiatives.
- Tracking of returned member mailings and members who are unable to contact using listed phone numbers.
- CDC Quality Improvement Activity.

Appendix E4 - Louisiana Healthcare Connections (LHC)

LOUISIANA HEALTHCARE CONNECTIONS (LHC) Diabetes and Weight Management Program and Action Planning (2016)

Diabetes Program and Plan of Action

Program Objective

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

Eligibility Criteria

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

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

Enrollment

Members are identified for enrollment based on medical and pharmacy claims data. Members may also be referred to the program by a Health Plan physician, case manager or self-referral. A member who has a qualifying chronic condition such as diabetes or heart disease will be offered enrollment into the appropriate chronic care program based on hierarchy of disease processes present.

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

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

Ongoing Counseling

The health coach will complete an assessment and develop an individualized care plan based on the member's or caregiver's knowledge of their condition, lifestyle behaviors and readiness to change. Internal clinical guidelines are developed from nationally recognized evidence-based guidelines published by The American Diabetes Association and the American Association of Clinical 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 for carbohydrate counting and weight management
- recommended annual screening for diabetic complications
- blood pressure and cholesterol management
- optimizing physical activity levels to meet recommended guidelines
- supporting tobacco cessation
- internal consults with specialty health coaches for participants at high risk for or diagnosed with another chronic condition program (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/or caregiver to identify barriers to care plan compliance and will address questions regarding condition management.

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

Pediatric Members

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

Program Length

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

Referral Services

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.

Disenrollment

Members may be disenrolled from the program under the following circumstances

- Member dies
- Member's health care coverage with the Health Plan terminates or the Health Plan no longer provides the member's primary coverage
- Member's attending physician or the Health Plan requests disenrollment
- Member is no longer capable of participation in the program, in the reasonable determination of the provider
- Member has End Stage Renal Disease (ESRD) or
- Member has enrolled in a Hospice Program
- Member satisfies graduation criteria

2015 Diabetes Program Outcome Highlights

- Total of 4,296 members were referred to the Disease Management Program
- Approximately 26% of members referred were enrolled
- HEDIS Rate for members in compliance with HbA1C: 79.72%

Weight Management Program and Plan of Action

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

Eligibility Criteria

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

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

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

Enrollment

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

A member who has a qualifying chronic condition such as diabetes or heart disease will be offered enrollment into the appropriate chronic care program based on hierarchy of disease processes present and 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 current status, including physical activity limitations, presence of co-morbidities and dietary intake. Internal clinical guidelines are developed from nationally recognized evidence based guidelines published by National Institutes of Health and American Diabetic Association. Components of the program include:

- nutritional counseling for appropriate rate of weight loss
- role of fats, carbohydrates and protein in proper nutrition
- optimizing physical activity levels to meet recommended guidelines
- behavior modification skills for long-term weight control
- food preparation and portion-control methods
- label-reading skills

- strategies when eating out
- unlimited inbound calls
- education materials to enhance understanding and compliance

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

Program Length

Program is one year in length and includes the following:

- First call: 30 minutes; enrollment and 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 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 supports the member in accessing local resources. A referral system is also established to allow referrals directly from case management.

Disenrollment

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

- Member dies
- Member's health care coverage with the 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 the Program

2015 Weight Management Program Outcome Highlights

- Total of 265 members were referred to the Disease Management Program
- Introduction of "Pediatric Weight Management Pilot Program," focusing on members Aged >2 and <18. Program pilot objective to provide telephonic outreach, education, social media group membership and support services to parents or caregivers of pediatric members. The goal of the pilot program is to help overweight and obese children achieve long-term physical health improvement through permanent health lifestyle habits.

Appendix E5 – United Healthcare of Louisiana (UHC)

UHC 2016 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 2016
Process Measures:	2015	2016 (Jan-Sept)
# Louisiana youth reached	3,225	3,675
# events	15	18

b. Continue 4-H Youth Voice: Youth Choice 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 2016
Process Measures:	2015	2016 (Jan-Sept)
# Louisiana youth reached	3,225	3,675
# events	15	18
c. Continue Partnership with the Boys & Girls Club and Playworks.		
UnitedHealthcare will continue its partnership with Playworks and the Boys & Girls Club to sponsor Family Play Nights.	UHC Marketing and Community Outreach	Ongoing in 2016
Process Measures:	2015	2016 (Jan-Sept)
# Louisiana youth attending	1,385	500
# events	7	1
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 2016
Process Measures:	2015	2016 (Jan-Sept)
# toolkits distributed	1,350 (5 reading corners)	200 kits

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 2016
Process Measures:	2015	2016 (Jan-Sept)
# events that Dr. Health E. Hound attended	48	51
# of members	11,665	15,175
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 2016
Process Measures:	2015	2016 (Jan-Sept)
# events	53	39
# people attending	2,735	3,332

UHC Program Goal 2: Facilitate healthy lifestyles.

Description	**Responsible Party**	**Timeframe**
a. Continue partnership with faith/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 2016
Process Measures:	2015	2016 (Jan-Sept)
# members reached	735	1,895
# of events	22	16

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. In the case of retinal exams, CPCs assure the providers are aware of the vision vendor March Vision.	Director, Quality Management & Performance	Revised for 2016
Process Measures:		2016 (Jan - Oct)
# offices visited		351
# members potentially impacted based on panel assignments		236,247

HEDIS Overall Health Outcome Measures

HEDIS Comprehensive Diabetes Care (CDC)

Measures:	2015	2016
Hba1c Testing:	80.54	81.27
Eye Exam:	46.96	47.45
Attention for Nephropathy:	78.10	92.70

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

Measures:	2015	2016

BMI Percentage:	41.36	36.98
Counseling for Nutrition:	53.04	52.07
Counseling for Physical Activity:	41.61	31.14

Adult BMI Assessment (ABA)

Measure:	2015	2016
Adult BMI:	71.32	71.93

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.

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