



AGENDA

State and Public School Life and Health Insurance Board Quality of Care Sub-Committee Meeting

April 10, 2018

1:00 p.m.

EBD Board Room – 501 Building, Suite 500

- I. Call to Order.....Margo Bushmaier, Chair*
- II. Approval of October 10, 2017 Minutes.....Margo Bushmaier, Chair*
- III. HRA UpdateMike Motley, Izzy Whittington, ACHI*
- IV. Naturally Slim Sandy Schneck, Dr. Tim Church, ACAP Health*
- V. Director’s Report..... Chris Howlett, EBD Executive Director*

Upcoming Meetings

May 15, 2018, June 12, 2018, July 10, 2018

NOTE: All material for this meeting will be available by electronic means only [ASE-PSE BOARD@dfa.arkansas.gov](mailto:ASE-PSEBOARD@dfa.arkansas.gov). Please silence your cell phones. Keep your personal conversations to a minimum.

State and Public School Life and Health Insurance Board

Quality of Care Sub-Committee Minutes

April 10, 2018

Date | time 4/10/2018 1:00 PM | Meeting called to order by Margo Bushmiaer, Chair

Attendance

Members Present

Dr. John Vinson

Zinnia Clanton

Cindy Gillespie

Margo Bushmiaer - Chair

Pam Brown

Arlo Kahn

Dr. Terry Fiddler

Michelle Murtha – Vice-Chair – Proxy – Shaneca Smith

Dr. Namvar Zoohoori

Chris Howlett, EBD Executive Director, Employee Benefits Division

Members Absent

Frazier Edwards

Melissa Moore

Others Present:

Eric Gallo, Rhoda Classen, Terri Freeman, Allie Barker, EBD; Mike Motley, Elizabeth Whittington, ACHI; Sandra Wilson, AHM; Sean Seago, Merck; Marc Watts, ASEA; Jessica Akins, HA; Ronda Walthall, ARDOT; Treg Long, ACS; Frances Bauman, NovaNordisk; Sandy Schenk, ACAP Health

Approval of Minutes by: Margo Bushmiaer, Chair

Bushmiaer asked for a motion to approve the February 13, 2018 minutes. Dr. Fiddler motioned for approval of the minutes. Vinson seconded. All were in favor.

Motion Approved.

ACHI Updates by: Mike Motley, Elizabeth Whittington, ACHI

Whittington and Motley presented follow-up answers from previous questions, an HRA update analyses, and diabetic population profile. Some of the takeaways for the analysis are:

- Tobacco use is likely underreported.
- Obesity and physical activity responses are more likely to be accurate.
- Self-reported obesity rates are higher than the statewide average within the EBD population.
- If we were able to reduce risks within the EBD population, the Plan could appreciate significant cost savings and better health outcomes for members.

Discussion:

Zoohoori questioned the EBD cost linked to obesity. What that really means is costs of obese people not, attributed to obesity specifically?

Motley stated that, yes, a clearer definition would be that cost of those individuals that is self-reported, height and weight, put them in a category which we then calculated them to be obese.

Zoohoori stated that the increase in cost with obesity with age for obese and non-obese. Part of it is just because of age.

Gillespie questioned what have we tried in the past to promote physical activity?

Howlett stated that the landscape is broad and open. Most of it has been member centric from an initiative standpoint. Giving credit to ACHI, from a public policy standpoint, for some of the schools and agencies taking on the Arkansas fitness challenge sponsored by BlueCross have provided some analytics from that. Something we run into, from a plan perspective, is mandating versus voluntary. Presenting opportunities that we are looking at with our partners with Silver Sneakers and other opportunities for different groups. One of the approaches we have been reviewing is finding ways to partner and use the ARBenefits website to house some kind of discount page for fitness/health clubs for state and school employees. Trying not to obligate the plan but also to reach out and provide opportunity that if someone wants to go there we can be a resource for that.

Vinson stated that last year we spent time looking at the bariatric program, making sure that we had centers of excellence and criteria that would define where patients that needed that procedure could have it done. There was a subcommittee created to help find a way to accomplish this. We worked on a wellness plan and a way that we could get objective real data and not just the self-reported HRA. I would like for our committee look to into what the Department of Health has been studying with the DPP program and explore about what to do next.

Gillespie stated that this is an employer based plan. How much have we engaged the employer side on this? From this perspective, my agency is 7,500 people and I haven't seen anything that shows the breakdown of what my agency looks like in terms of cost. It takes a concerted effort by the employer to motivate the individuals. I'm just wondering if that is an appropriate piece of a tactic since that's not the plan itself.

Howlett stated that breaking down agencies regardless of size, internally to the plans perspective we can look at certain things, but disclosing that you are getting outside of that minimum threshold of the 20,000 where it would be legally viewed as inappropriate. I will take this and see if there is another approach to do that and provide that in an aggregate and somehow try to de-identify it in a better way. The statutory compliance and obligation that EBD has laid out before it, we make use of HIR's in respective agencies and school districts that act as a front end for EBD. Mainly for the servicing of the members from an enrollment, limited benefits, and other mechanisms that they would be fit to handle. It can sometimes cause a problem if they are not as engaged. What we run against is the HIR's in respective schools and agencies are doing their EBD function as a supporting role without pay in addition to their normal roles. There may not always have the bandwidth to keep that initiative going. That lead us to the next presenter for them to come present to try to at least start equipping towards that initiative. The bottom line that we run into is who is going to facilitate it.

Kahn stated that he believed that we engaged ComPsych or some other vendor and they were supposed to help people with their weight, smoking, etc.

Howlett reported that ComPsych does offer those services but they are still voluntary, so we can't be critiqued for not offering it, but we have no skin in the game to drag them along. It is under their lifestyle coaching.

Kahn questioned if we had any statistics as to how successful it is.

Howlett reported that he can give some hard numbers and percentages. Not long ago, we met and looked at those respective numbers, one thing that we did notice, after we added the strengthened wellness criteria around tobacco cessation, we saw 634% increase in the population approaching the lifestyle coaching in and around eating, dietary, nutrition, and losing weight. They attributed most of that to the fact that in 2019 we will be approaching that. Based on the exit surveys on the calls we are getting ahead of that game. I can provide that back to you after de-identifying it.

Vinson stated that Nabholz had two approaches to these challenges we are faced with: activity-based and outcome-based. The activity was nice to say we did this fitness challenge. But if you didn't measure to see your baseline in comparison with your finish outcomes are as a result of the activity, then the activity is not worth as much. When you have someone that encourages the employees to be active then you will have a better outcome, but not everyone has that.

Gillespie stated that it does take a group around you and a culture to motivate activity. How do you put that culture in place? Otherwise, the person is going to work every day and the culture around them is not reinforcing movement and activity.

Smith questioned on if we had ever tried any incentive-based programs? Such as monetary incentives.

Howlett stated there is presently an incentive that is geared on a wellness program, but not related to exercise and things mentioned here.

Gillespie stated that the state already has AHELP which is where you can log activities and get a reward from those points earned. When you say that almost half of our population is obese, self-reported.

Zoohoori stated that there is a 50% discrepancy in studies done that are self-reported. When the self-measured says 31% the actual is 45%.

Gillespie stated so we are over 50% if that's the case. It implies an actual how do you go reach them where they are in mass, because you can't do that in a lot of one-offs.

Vinson stated that there is AHELP and CHELP, which is a worksite wellness. Are those successful and being used? Is there someone that is an expert in those that can come and we could take an advantage of?

Zoohoori stated that those are run by the Health Department and we could definitely have someone to come and give a report on that. CHELP is community-based that can subscribe to the program and AHELP is for governmental and state agencies.

Naturally Slim by: Sandy Schenck, ACAP Health

Howlett introduced Naturally Slim and stated that there was a motion for the Board from the Benefits meeting to move forward with this. The original piece was for borderline diabetic, which costs the plan \$12,000 to \$20,000 additional a year in average claims spend.

Schenck presented on the Naturally Slim program: how to eat, when to eat, and why you eat. They have an evidence-based treatment schedule that begins with a 10-week foundational skill-building program followed by skill reinforcement and maintenance for sustainable behavior change. Naturally Slim is trying to teach you how to lose weight and improve health while eating the foods you love.

Discussion:

Kahn stated that as a Quality of Care Sub-committee, we need to make decisions based on evidence and you referenced two studies on the slides. Both were long-term and longer than 20 weeks, and can we get the information from those both? The US Preventive Task Force sends out recommendations that adults and children be in counseling, but the programs that work last more than a year and generally have face-to-face contact meetings. My recommendation is to look at this program and compare to others.

Schenck stated that they are covered as an in-network provider because they follow the guidelines of the USPTF. Face-to-face contact is the best, but it is also the most expensive. The way to cut that down the cost is to provide lifetime on-line access.

Zoohoori asked if this is obesity treatment program or a prevention class, and Schenck stated that it was a preventative class and they also enroll people already with Diabetes. This is a lifestyle program.

Kahn pointed out that because we are ACA we are already paying for it.

Gillespie asked what the minimum class size, and Schenck stated that the University of Georgia launched the program with 1,000 spots. It filled up in two hours. We want to have a significant sample size, but there is no limit or maximum. Gillespie asked if they will get information from the people up front, and there is a follow up with the members. How do we check on them a year later?

Vinson asked if it was self-reported? Schenck said they send out surveys, so those answers are self-reported. We ask questions about how they feel about the weight loss? We also add in the Catapult screenings, and we work very closely with Catapult.

Gillespie asked when someone registers on-line, is it on personal email or government email?

The first email comes out to the work email, but it can switch to personal email. It is only about 30 minutes a week and a short behavioral quiz with setting goals for the next week. Most people use their personal email.

Vinson asked if employers allow time to do this at work, and Schenck said it is up to each employer. Many clients encourage employees to participate. A lot of participants organically come together or meet to discuss the lessons. Due to being in the public sector, some of the videos are not available.

Vinson asked about billing codes, and are you billing through telemedicine codes? Schenck replied it is the 98969 CPT code for on-line counseling from a non-physician provider. There is a system called BlueCart that routes the bill back to Arkansas when you meet with a counselor in another state.

Howlett stated that in a competitive bidding process that we sometimes have to go through with the procurement, it will be easier since they would be an in-network provider claim. We had some urging to do this on membership exploring. The population wants to know what we, EBD, plans to do to help them lose weight since we are looking at mandates next year. From a cost standpoint, other groups would need an RFP to come back, so this is the first of many discussions. This would produce tangible data at around ten weeks with an overall cost of \$280 per person. I would like to explore a pilot program, and the Benefits Sub-committee allowed to do 1,000 for ASE/PSE, totaling about \$280,000. This would mean that if 18 people with a Diabetic condition has shown improvement then it has paid for itself when comparing the total annual cost for the condition.

Vinson asked if we could set this up to view it on-line. Schenck replied that the easiest way to demonstrate the program would be to do a demo for them.

Gillespie asked if we set up a pilot, and we plan to insure this and be successful, is there any difference between the participants that are closer together than the ones that are further apart? Schenck stated that they do well with geographically dispersed agencies. We want to learn more about you, and we are very flexible. If you want to keep it more focused, we can only do this at a few departments with the 1,000 ASE/PSE. We will design it to make the most sense.

Howlett stated to please make a mental note of specifics that you want to see and please send it to the EBD Board. Rhoda and I will make sure that everything is covered and all questions are sent to Sandy, and he will come back with answers.

Director's Report by: Chris Howlett, EBD Executive Director

Howlett reported that we will have the requested information out to you as it becomes available. It may be available by next month.

Brown motioned to adjourn. Vinson seconded. All were in favor.

Meeting adjourned.

EBD Quality of Care Subcommittee Presentation

Mike Motley, MPH
Assistant Health Policy Director

Elizabeth Whittington, MPA
Policy Analyst



ARKANSAS CENTER FOR HEALTH IMPROVEMENT

April 2018

Objectives for Presentation

- **Discuss follow-up questions from February's Quality of Care meeting**
- **Review updated 2017 health risk assessment (HRA) analyses**
- **Discuss upcoming analysis—diabetic population profile**



Action Items from Previous Quality of Care Subcommittee Meeting

- **Bariatric surgery program analysis question:**
- **Where are the Centers of Excellence (COE) for bariatric surgery located in Arkansas and surrounding states?**

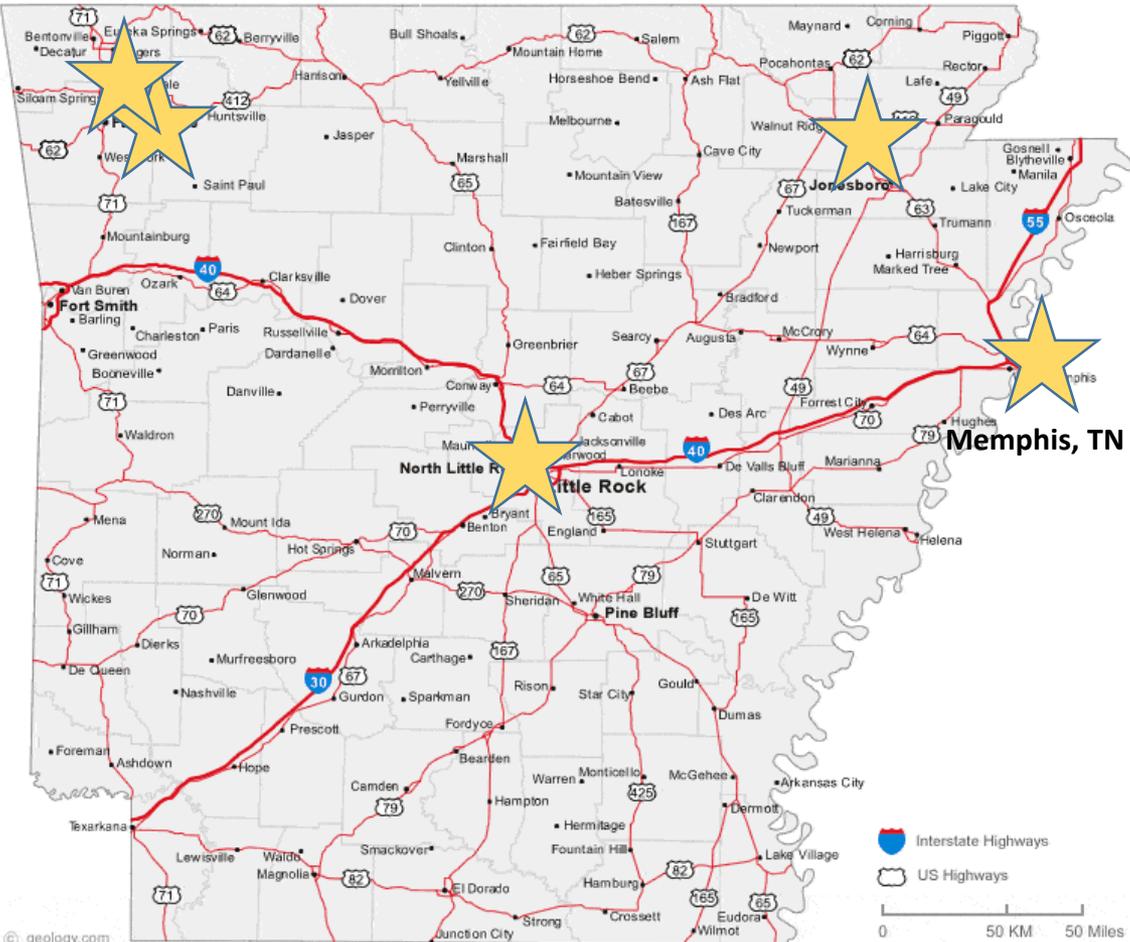
Nearby Bariatric Surgery Centers of Excellence as Designated by MBSAQIP



Springfield, MO



Tulsa, OK



Approximate regional surgery volume by patient residence, 2012-2016:

- Central: 310**
- Northwest: 300**
- Northeast: 85**
- Southwest: 50**
- Southeast: 30**

Shreveport, LA



Monroe, LA



Action Items from Previous Quality of Care Subcommittee Meeting

- **Health risk assessment analysis question:**
- **What is the self-reported obesity rate among EBD members, stratified by age?**
 - Updated analysis later in presentation addresses this question

Action Items from Previous Quality of Care Subcommittee Meeting

- **Low-back imaging analysis related question:**
- **What is the impact of provider outreach on wasteful imaging for low back pain?**
 - **Pending dissemination of provider letters; Impact will be assessed at a later date**

EBD HRA Analysis Background

Purpose of Health Risk Assessments:

- **Effort to engage membership in managing health**
- **Guides plan management/interventions with longitudinal data**
- **Provides member-specific reports outlining health risks**
 - **Can be used for disease/risk-behavior management referral**

EBD HRA Analysis Background

History of HRA Analysis in EBD Population:

- **ACHI designed and facilitated HRA for EBD population from 2004-2008**
- **Prior analysis of data was completed and presented to EBD in 2009**
- **Three risk behaviors assessed in analysis:**
 - Obesity
 - Physical Inactivity
 - Smoking Status

EBD HRA Analysis Background

- **Completion required by primary member and spouse to receive premium discount**
- **HRA developed and administered by vendor ComPsych (same survey administered in 2015 and 2016)**

- **HRA Question**: How many days per week do you do at least 20 to 30 minutes of physical activity?
- **HRA respondents overall physical inactivity rate (zero days of physical activity) = 8.4%**

- **Self-Reported Current Smoker Rate:**

–8.7%

- **Arkansas Current Smoker Statistics (2016):**

–23.6% of adults (18+) who are current smokers

Source: Centers for Disease and Control (CDC). Behavioral Risk Factor Surveillance System (BRFSS) Prevalence & Trends Data. Arkansas—Current Smoker Status. Accessed March 2, 2018.



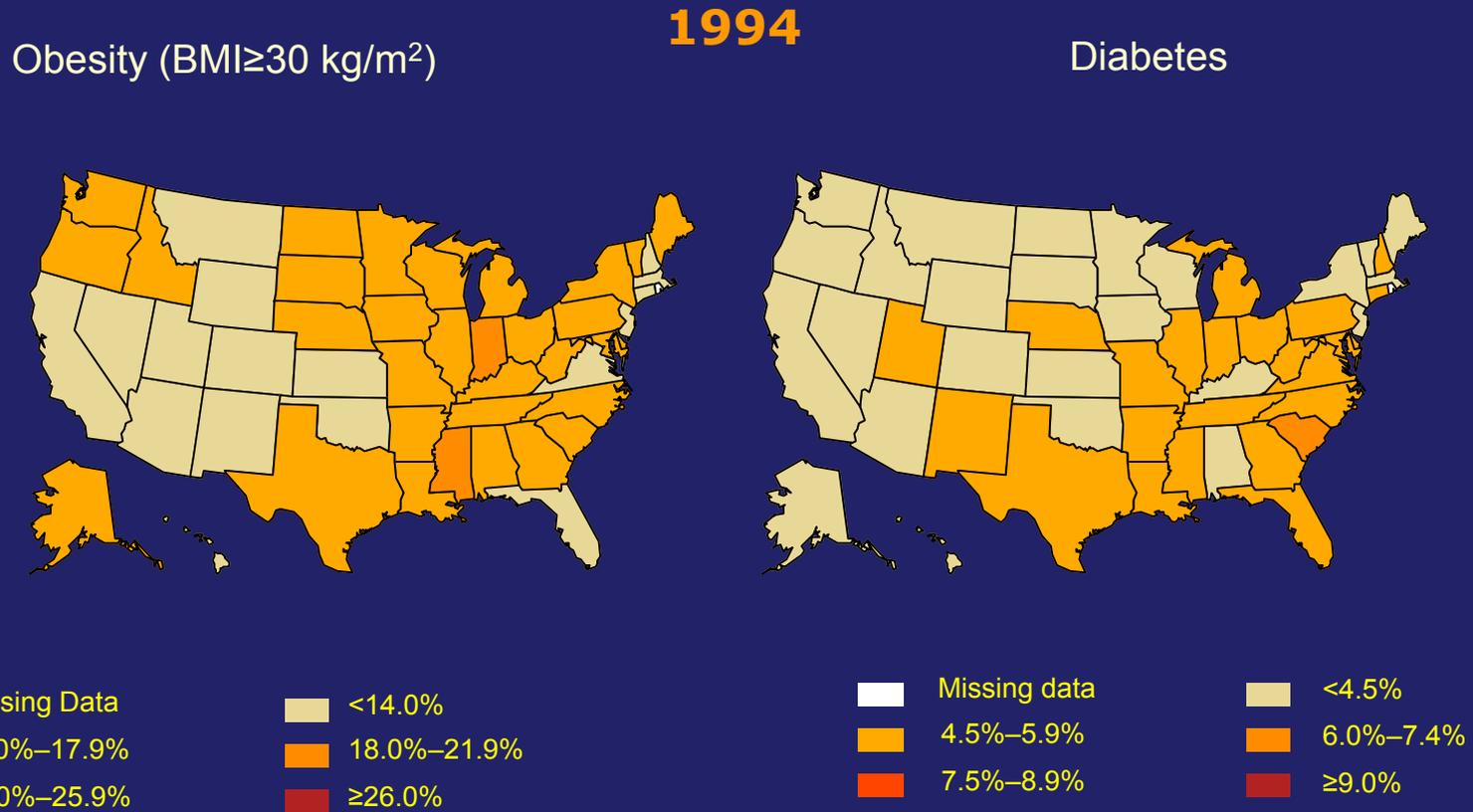
Obesity within the EBD Population (2017)

- HRA Question: What is your height and weight?
- Self-Reported Obesity Rate:
 - 43.7% reported as obese (BMI of 30 or higher)
- Arkansas Adult Obesity Statistics (CDC 2016 Behavioral Risk Factors and Surveillance Survey):
 - 35.7% adult obesity rate
 - 3rd highest adult obesity rate in the nation

Source: The State of Obesity, "Adult Obesity Rate by State, 2016." A project of the Trust for America's Health and Robert Wood Johnson Foundation. Accessed March 2, 2018.



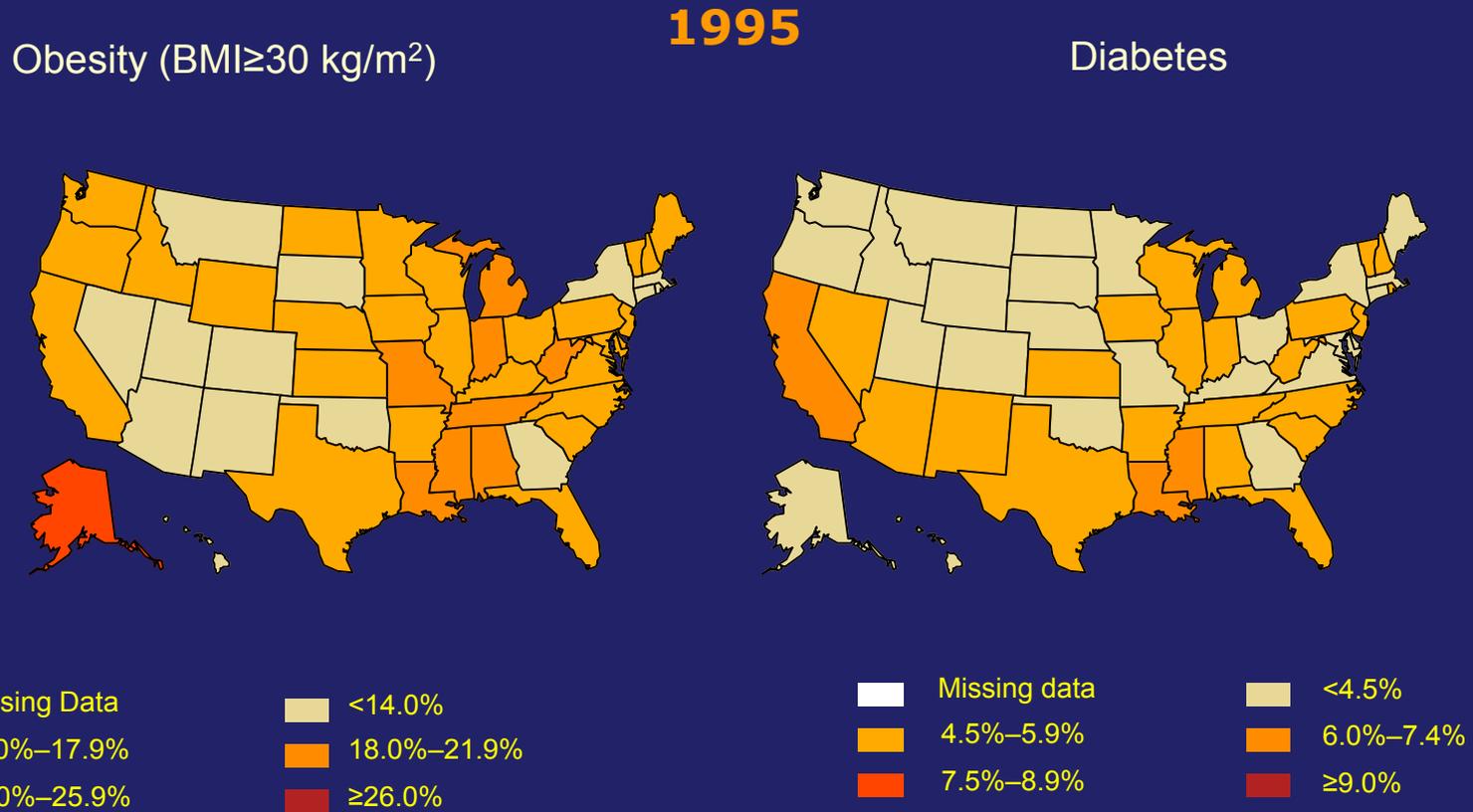
Age-Adjusted Prevalence of Obesity and Diagnosed Diabetes Among US Adults



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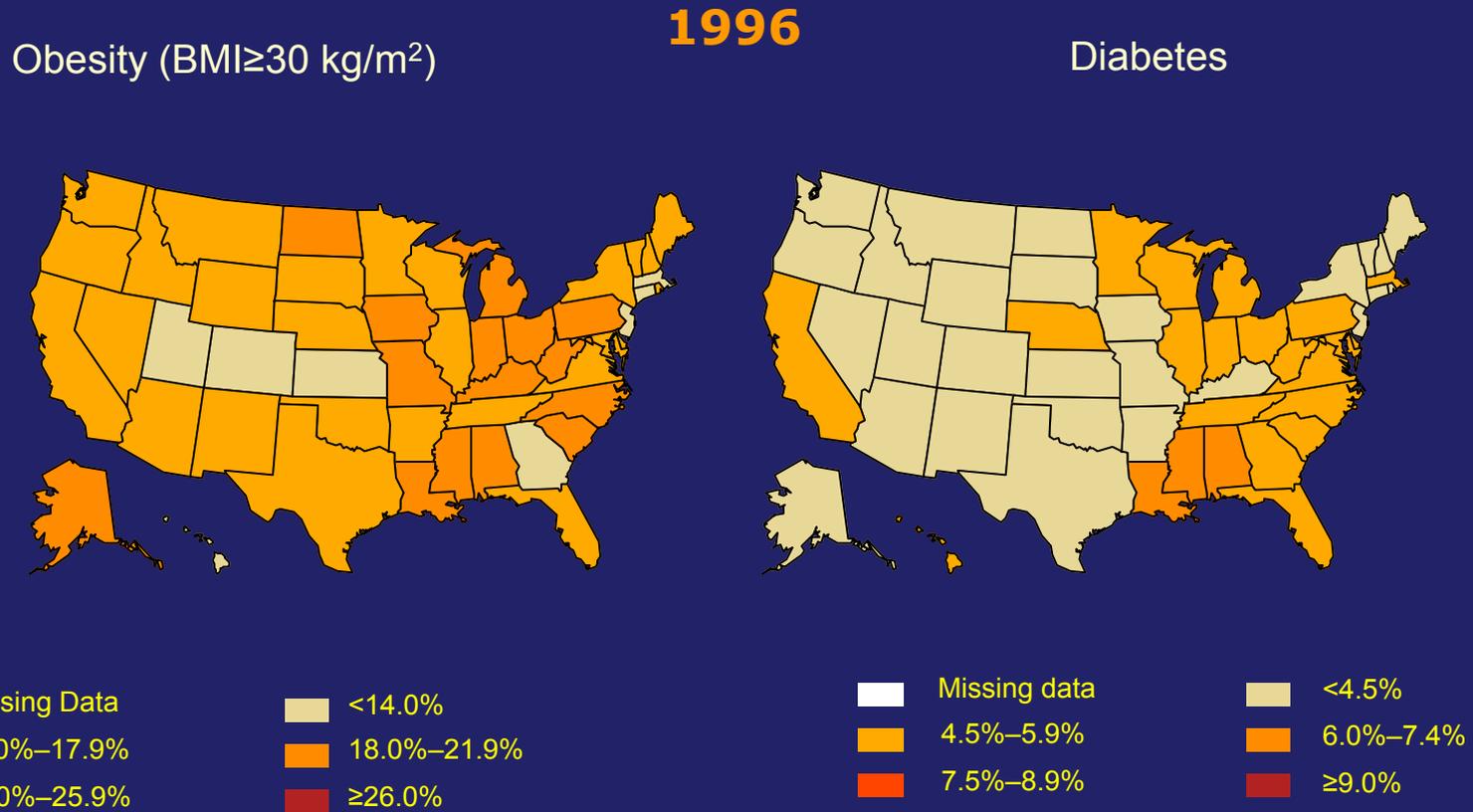
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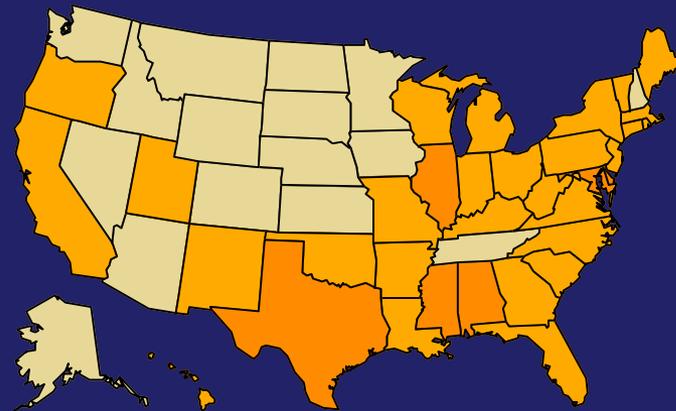
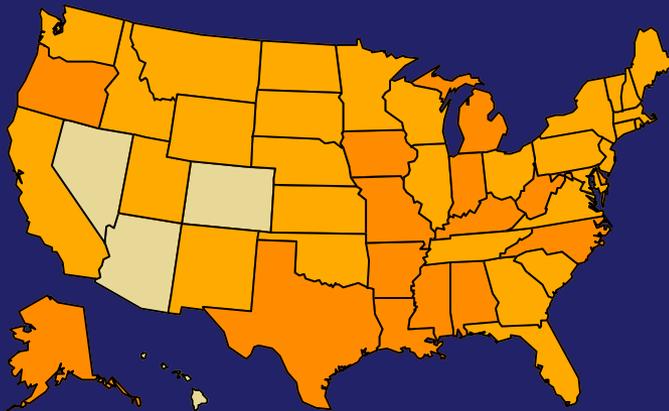


Age-Adjusted Prevalence of Obesity and Diagnosed Diabetes Among US Adults

Obesity (BMI \geq 30 kg/m²)

1997

Diabetes



CDC's Division of Diabetes Translation. National Diabetes Surveillance System
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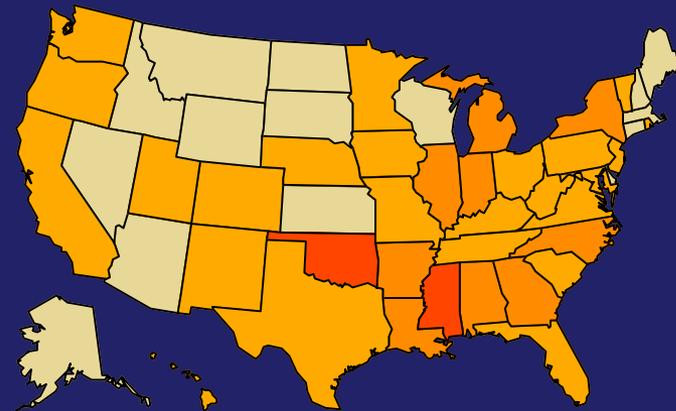
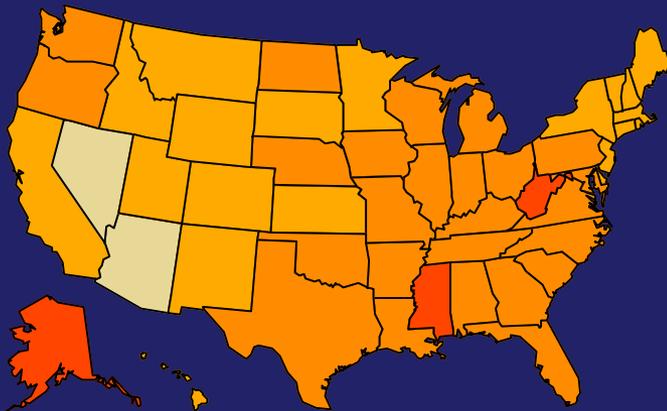


Age-Adjusted Prevalence of Obesity and Diagnosed Diabetes Among US Adults

Obesity (BMI \geq 30 kg/m²)

1998

Diabetes



Missing Data
14.0%–17.9%
22.0%–25.9%

<14.0%
18.0%–21.9%
≥26.0%

Missing data
4.5%–5.9%
7.5%–8.9%

<4.5%
6.0%–7.4%
≥9.0%



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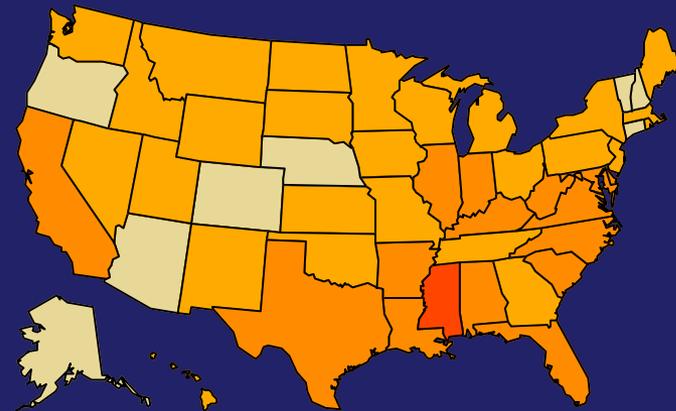
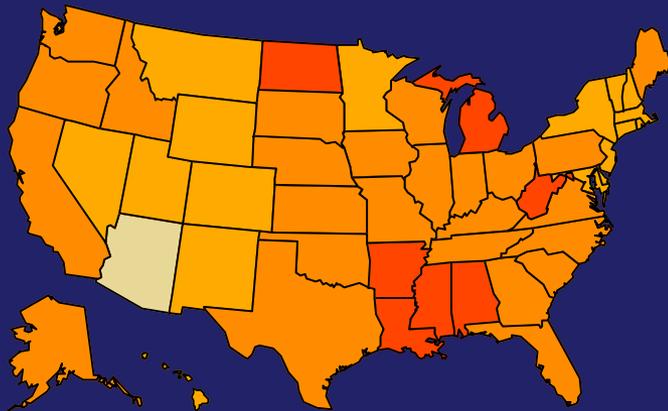


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Obesity (BMI \geq 30 kg/m²)

1999

Diabetes



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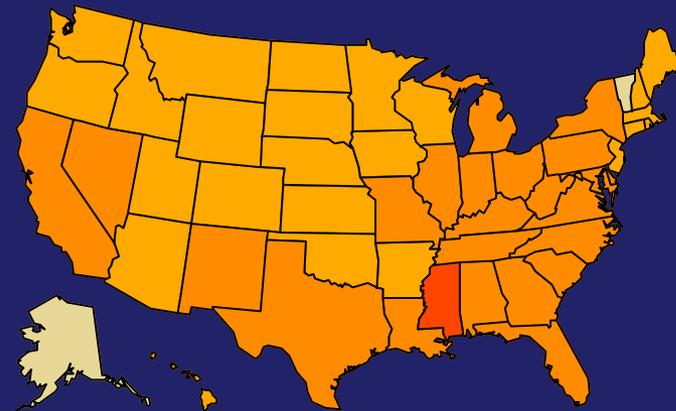
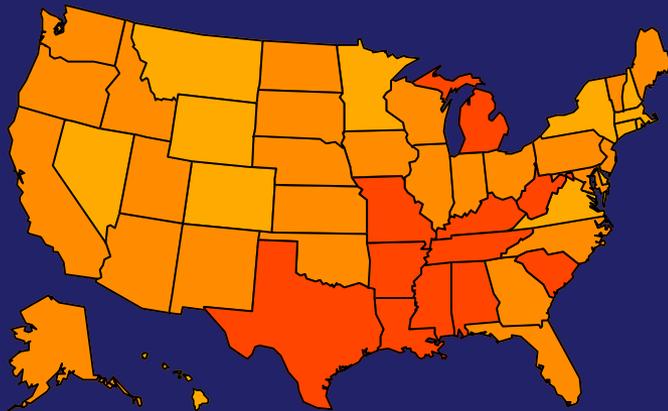


Age-Adjusted Prevalence of Obesity and Diagnosed Diabetes Among US Adults

Obesity (BMI \geq 30 kg/m²)

2000

Diabetes



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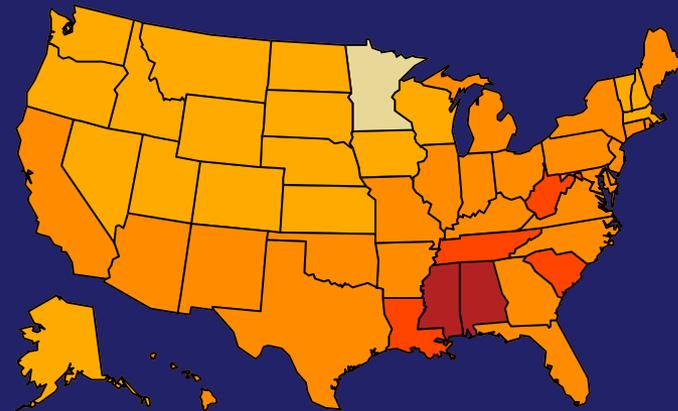
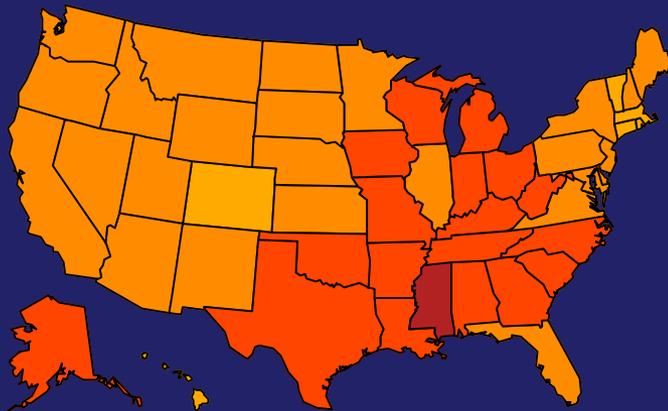


Age-Adjusted Prevalence of Obesity and Diagnosed Diabetes Among US Adults

Obesity (BMI \geq 30 kg/m²)

2001

Diabetes



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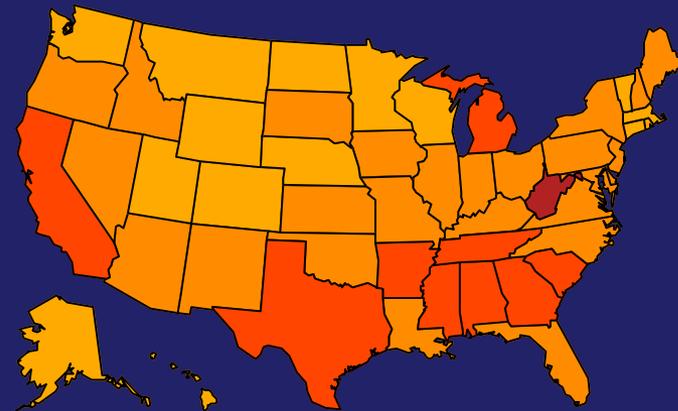
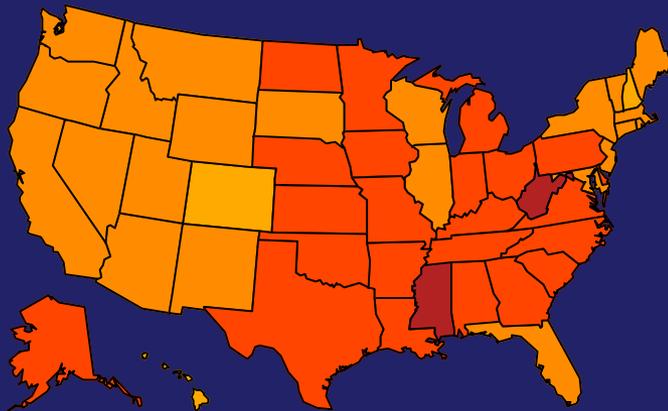


Age-Adjusted Prevalence of Obesity and Diagnosed Diabetes Among US Adults

Obesity (BMI \geq 30 kg/m²)

2002

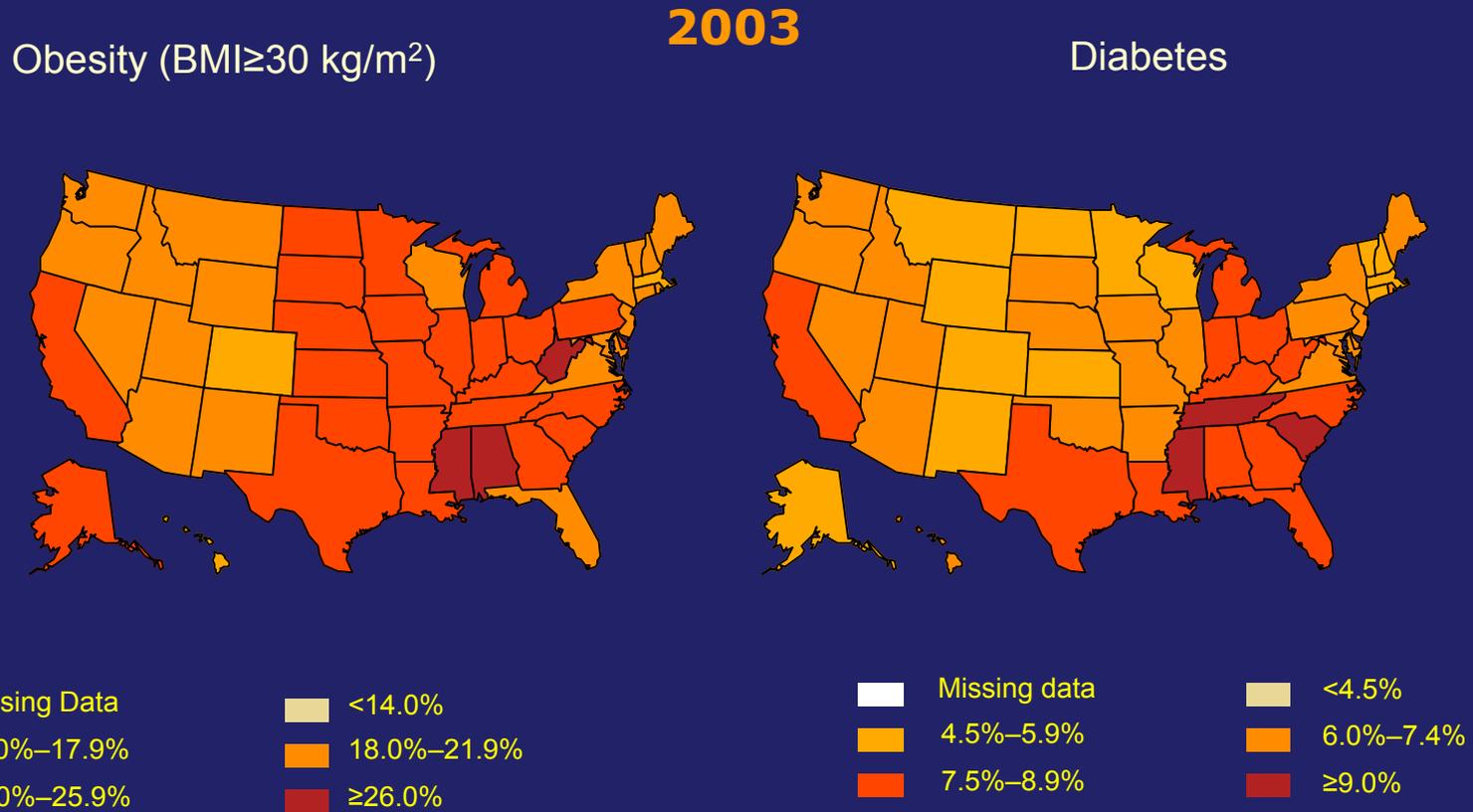
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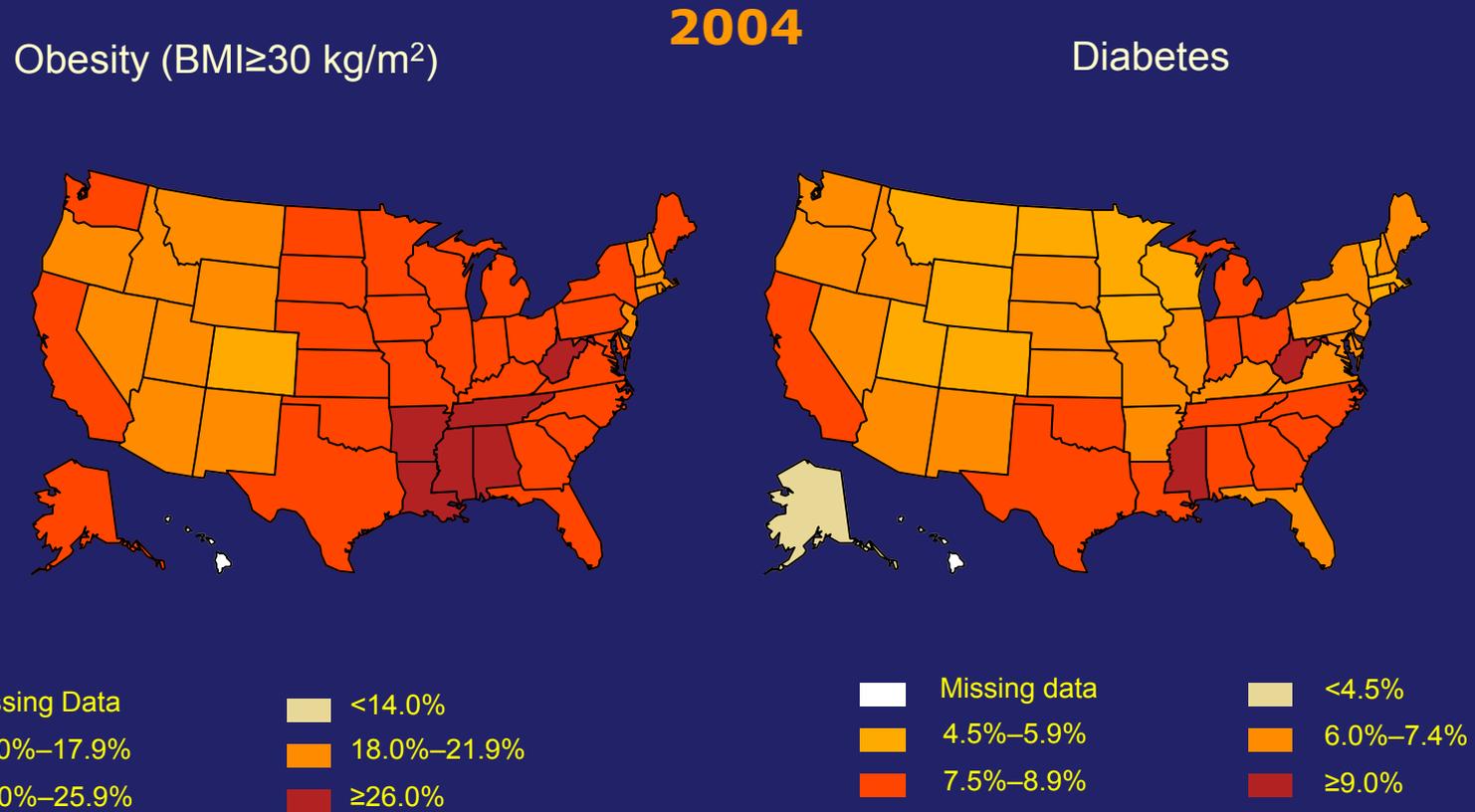
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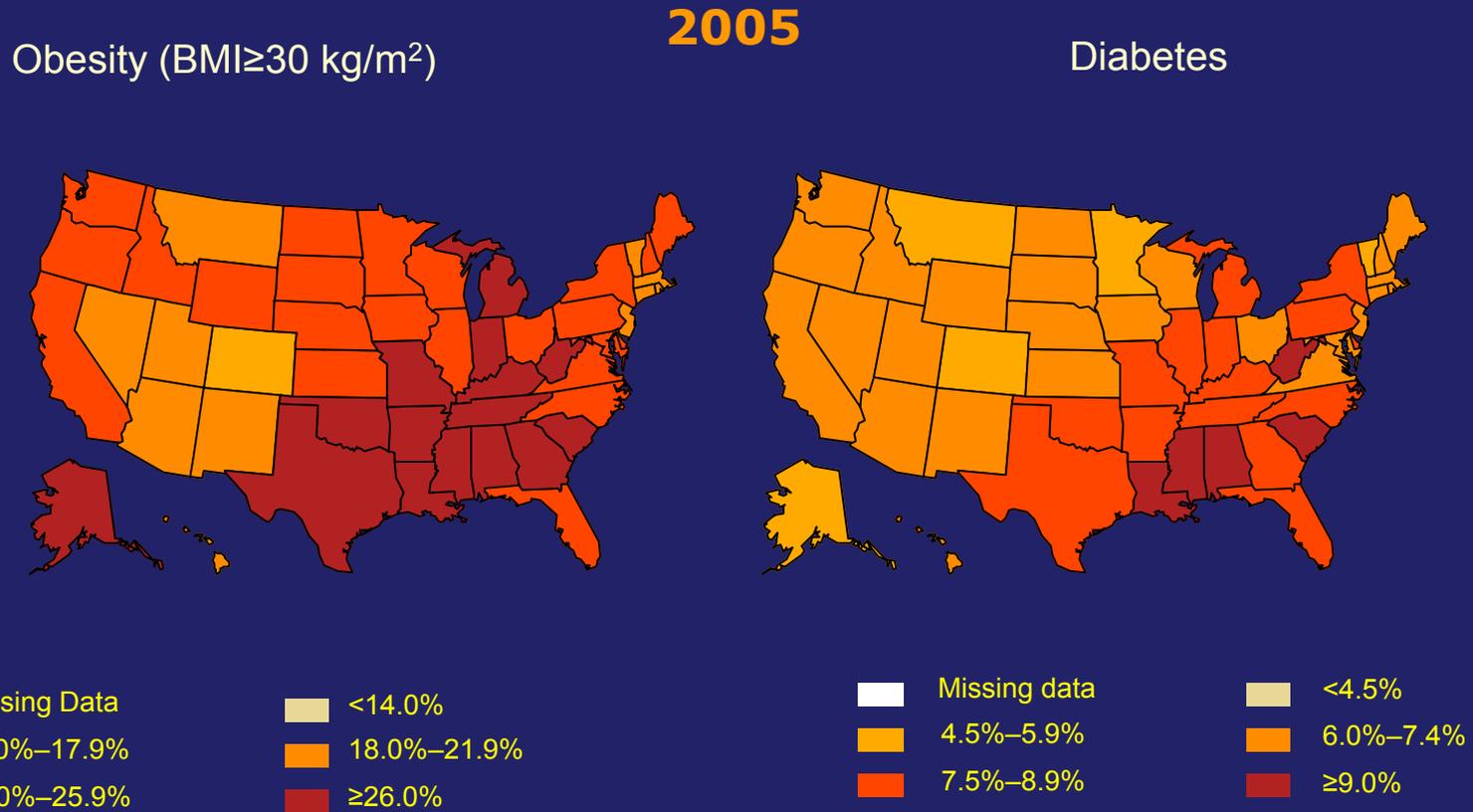
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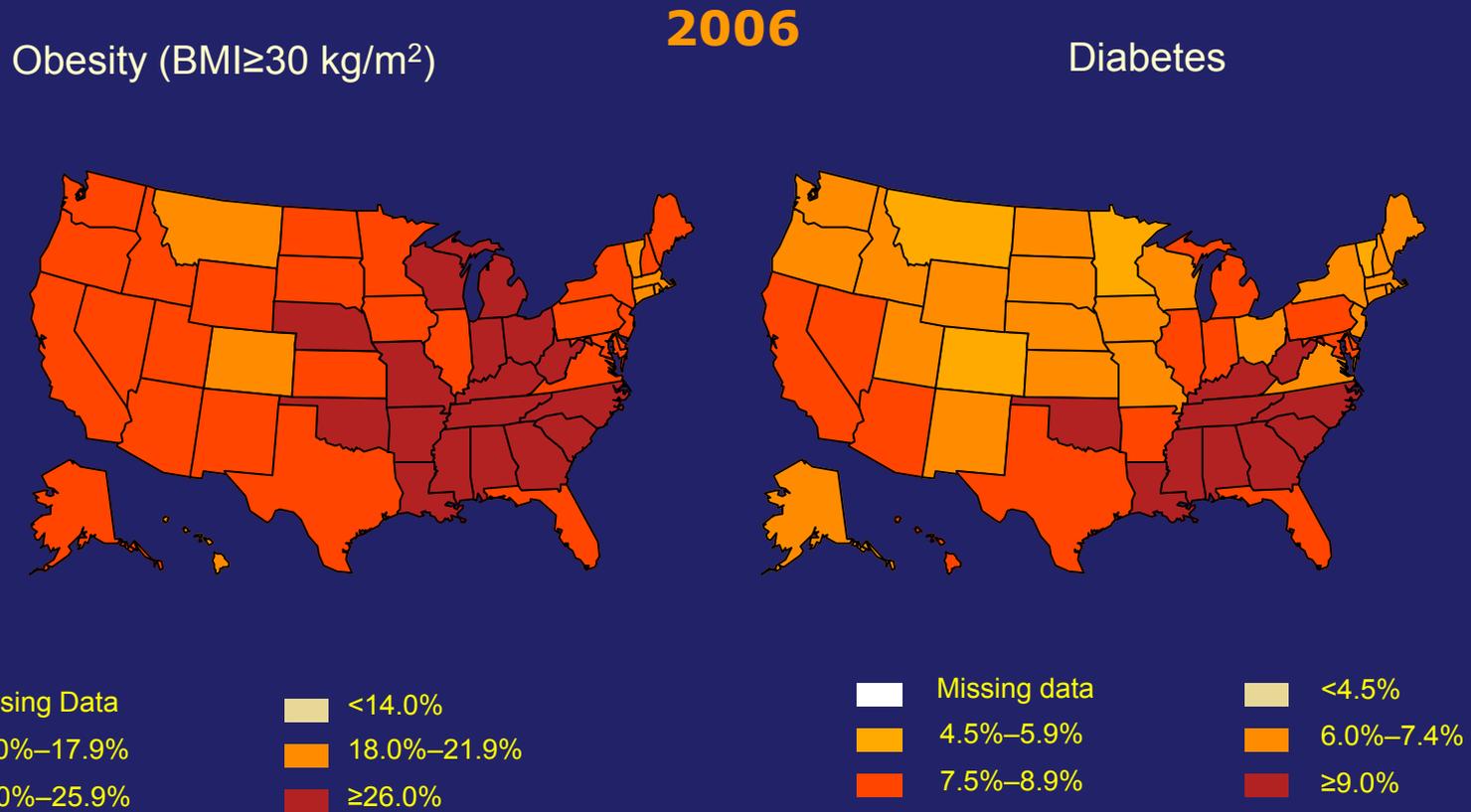
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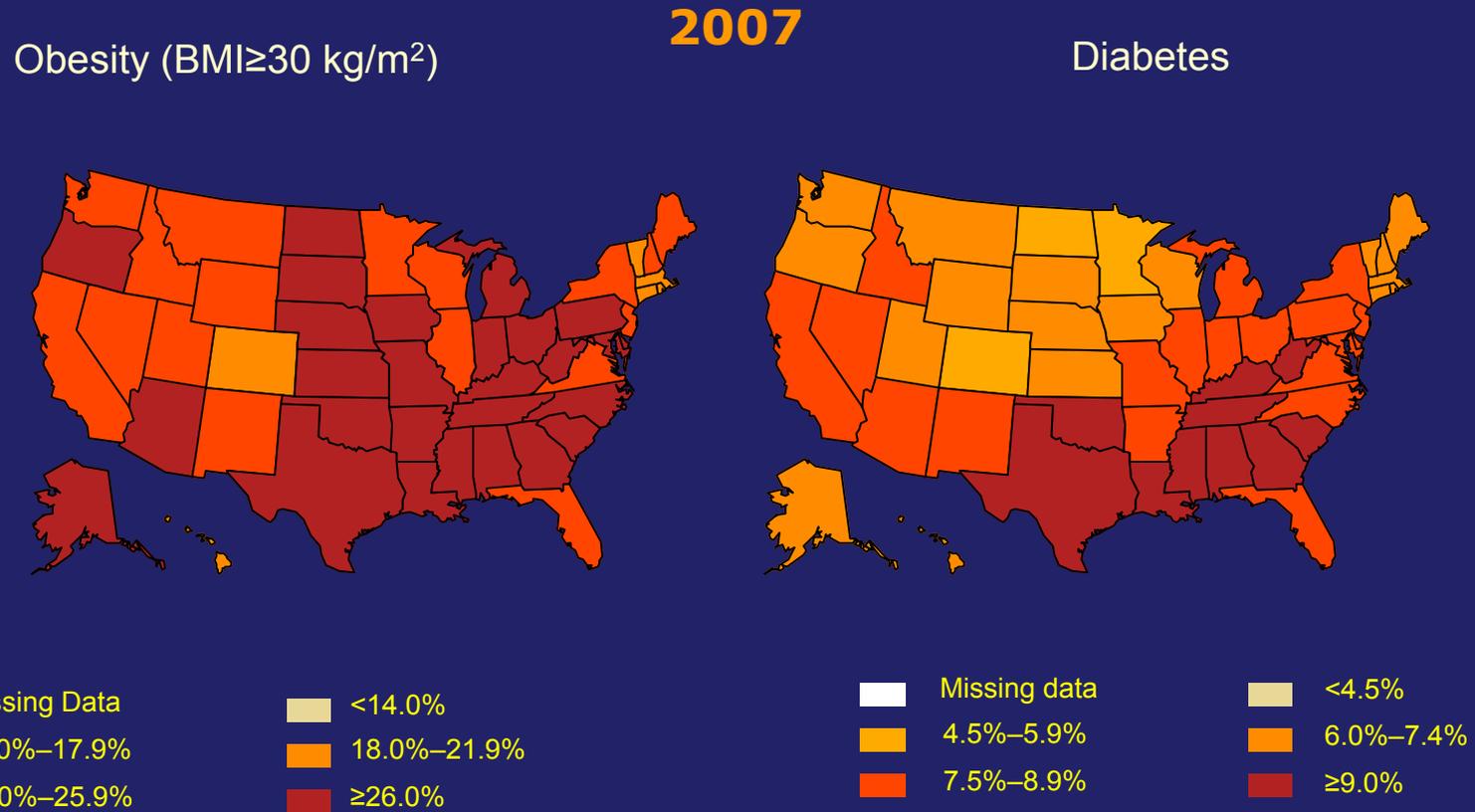
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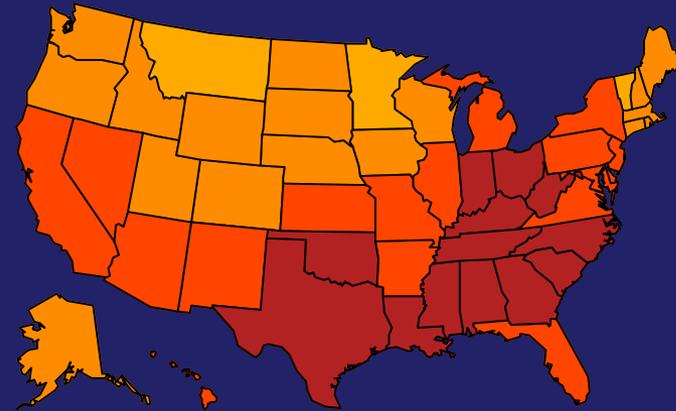
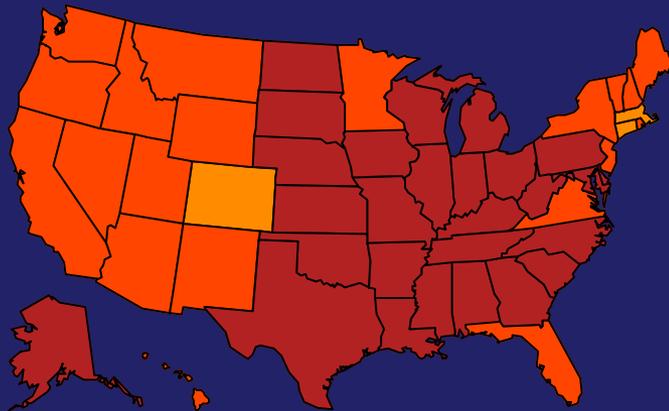


Age-Adjusted Prevalence of Obesity and Diagnosed Diabetes Among US Adults

Obesity (BMI \geq 30 kg/m²)

2008

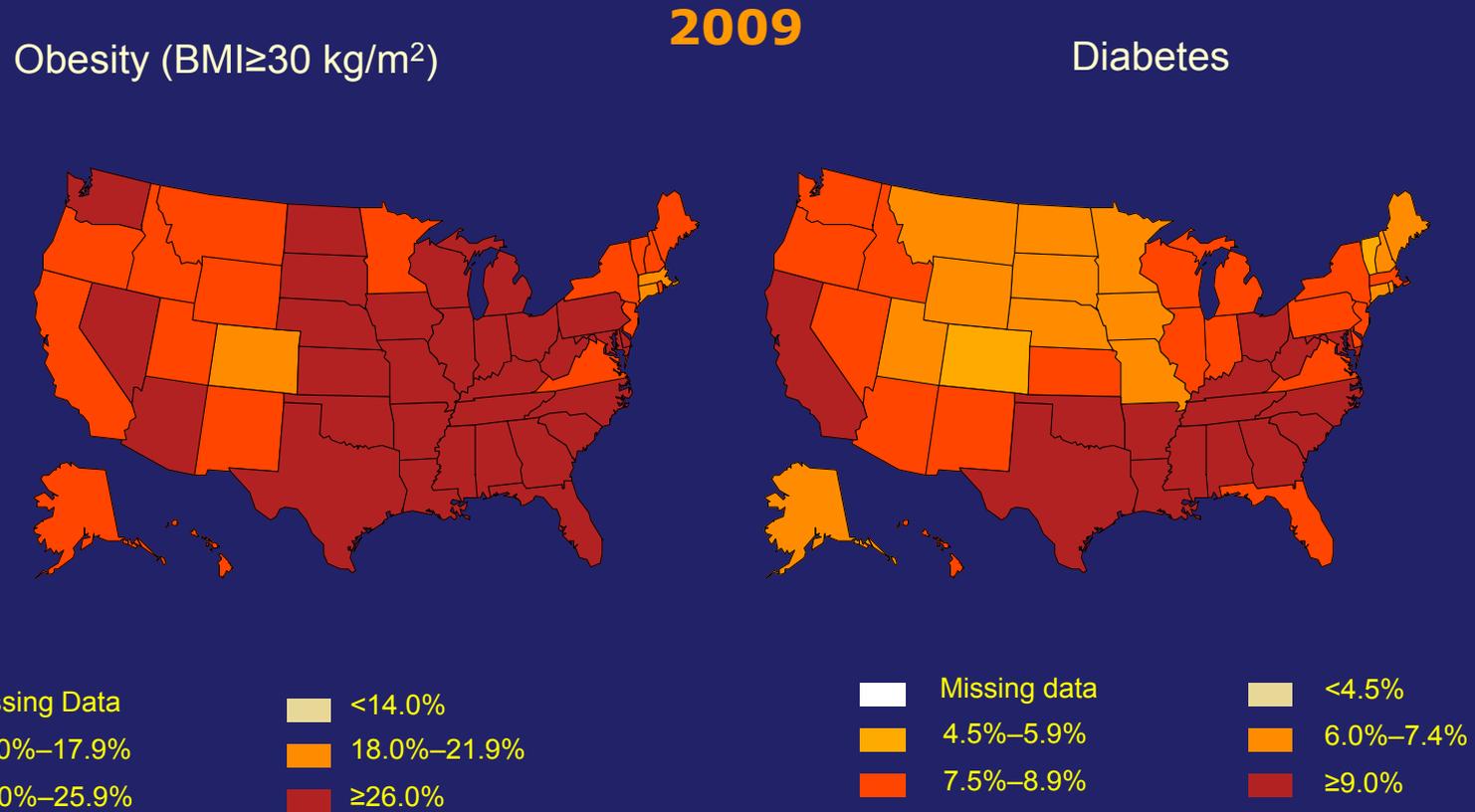
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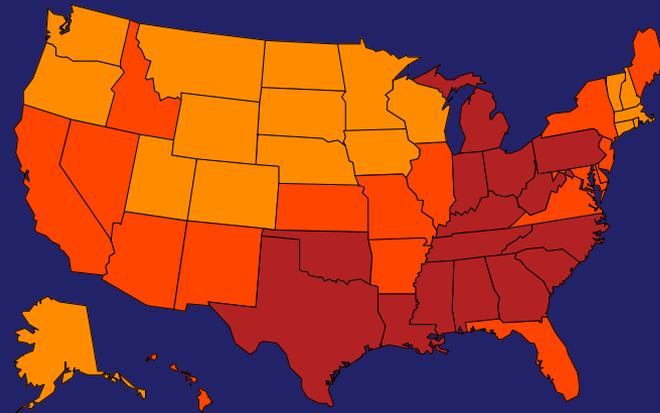
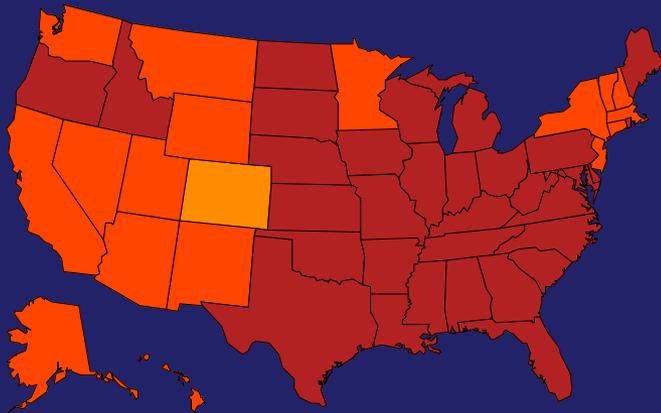


Age-Adjusted Prevalence of Obesity and Diagnosed Diabetes Among US Adults

Obesity (BMI \geq 30 kg/m²)

2010

Diabetes



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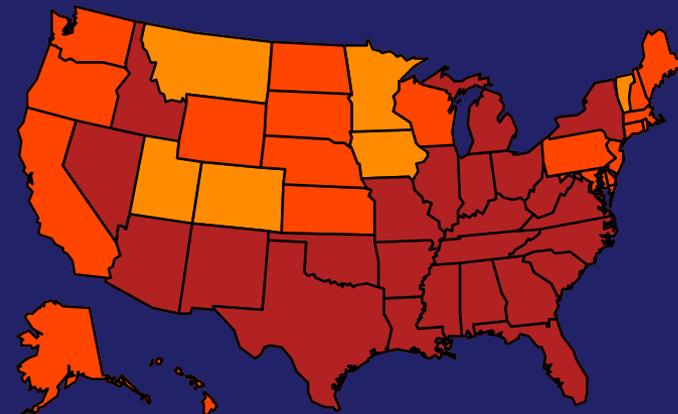
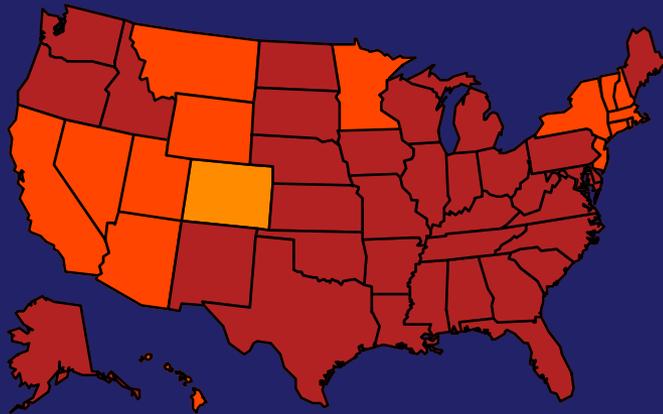


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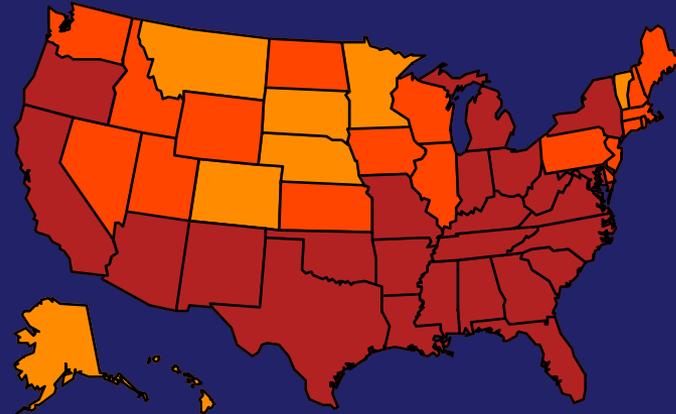
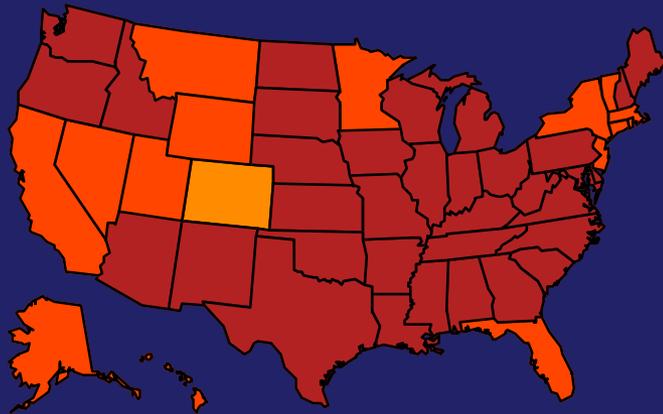


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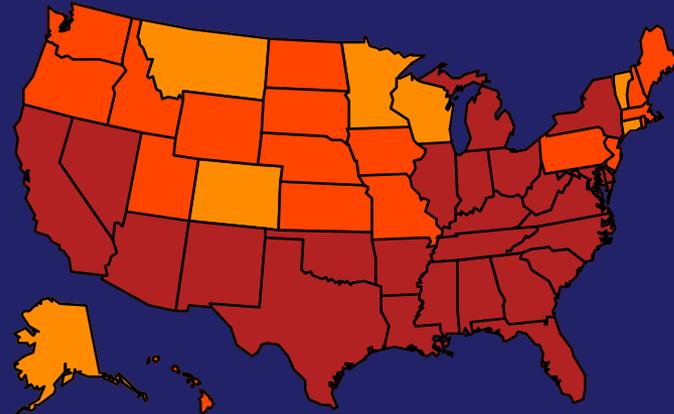
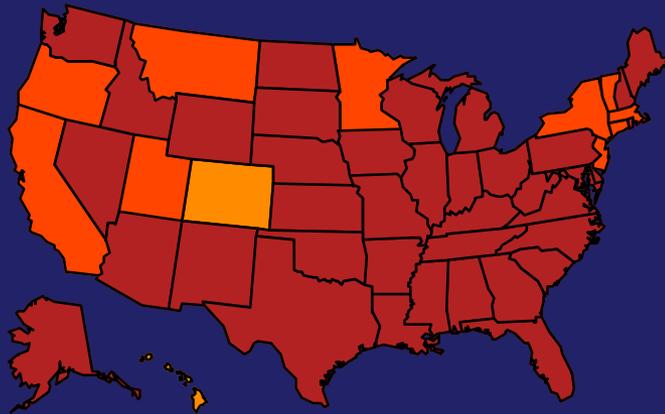


Age-Adjusted Prevalence of Obesity and Diagnosed Diabetes Among US Adults

Obesity (BMI \geq 30 kg/m²)

2013

Diabetes

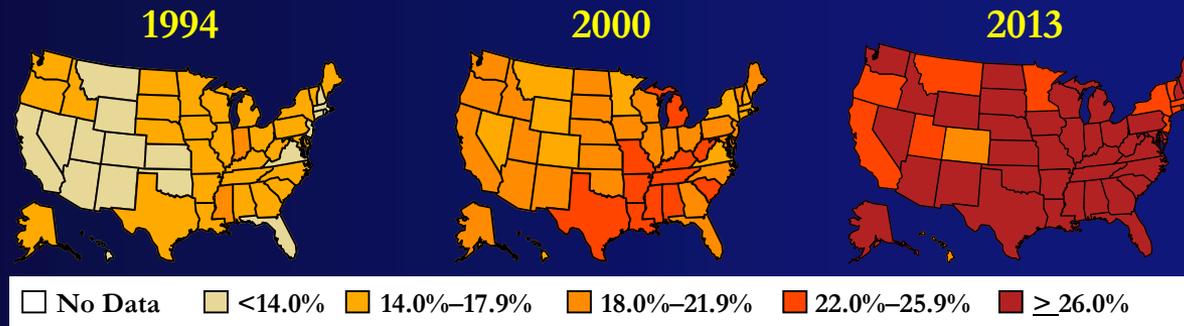


CDC's Division of Diabetes Translation. National Diabetes Surveillance System
available at <http://www.cdc.gov/diabetes/statistics>

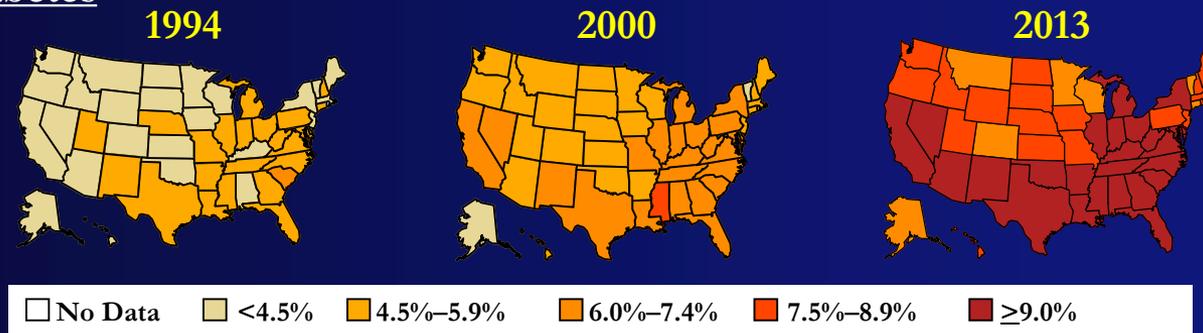


Age-adjusted Prevalence of Obesity and Diagnosed Diabetes Among US Adults

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Diabetes



CDC's Division of Diabetes Translation. National Diabetes Surveillance System available at <http://www.cdc.gov/diabetes/statistics>



Diabetes Pathway

Obesity and Physical inactivity

Glucose elevations

Insulin insufficiency

Metabolic abnormalities

Diabetes

Arteriolar damage

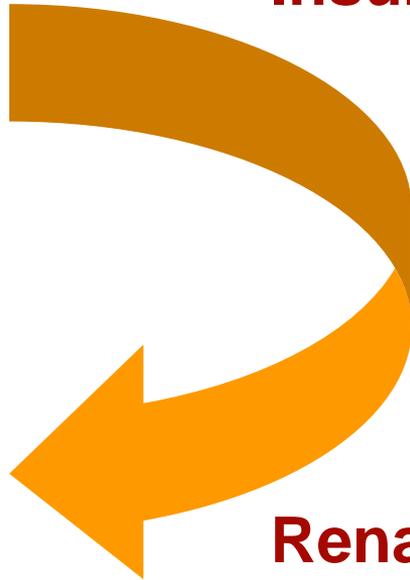
Retinal disease

Amputations

**Renal failure
leading to
dialysis or
transplant**

Heart Attack

Cardiac death



Top 20 ASE/PSE Diagnoses in 2016

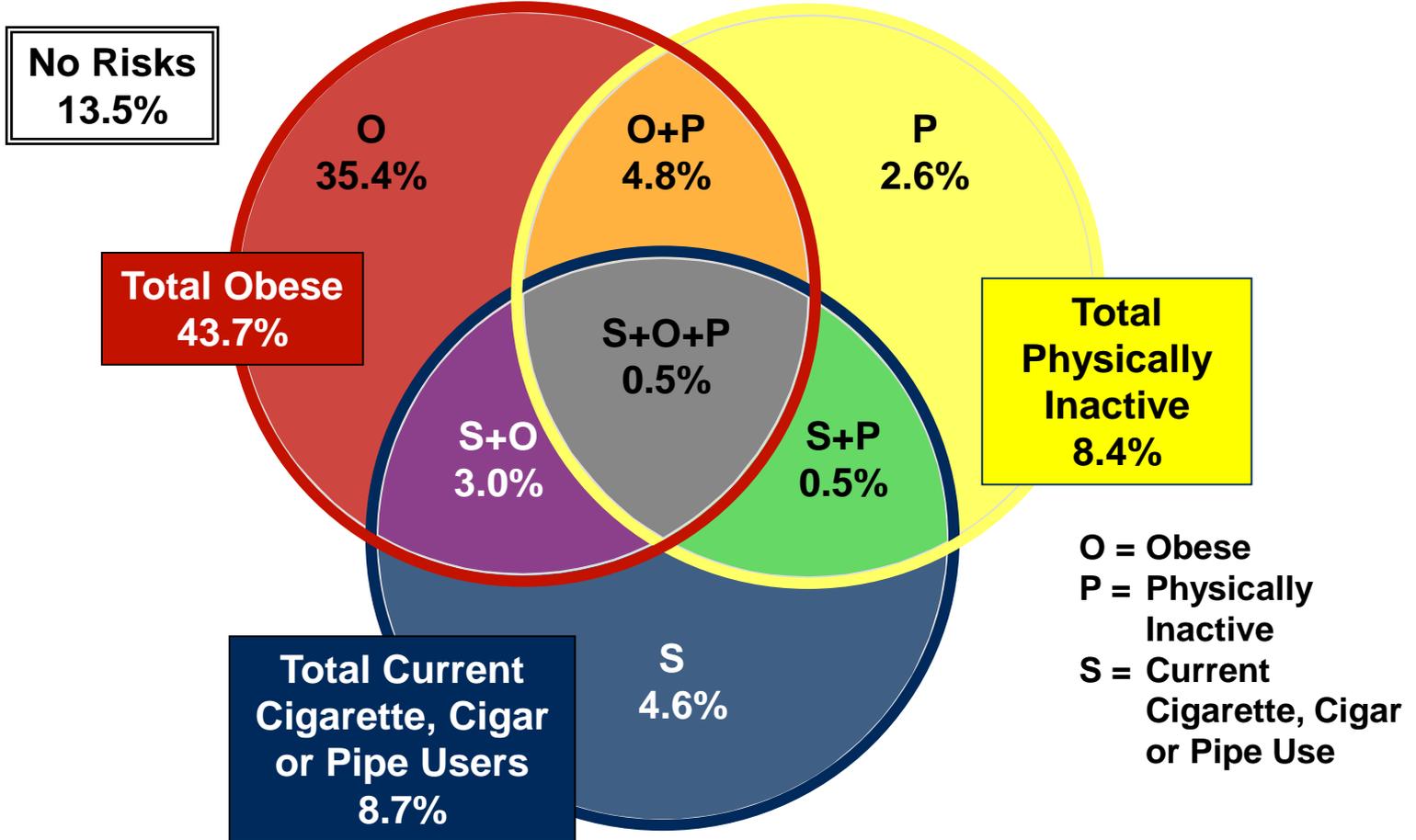
Clinical Classification Category	Total Plan Paid	Unique Patients
Spondylosis; intervertebral disc disorders; other back problems	\$14,694,262	16,614
Medical examination/evaluation	\$14,383,565	75,200
Maintenance chemotherapy; radiotherapy	\$12,005,758	731
Osteoarthritis	\$9,859,450	7,026
Other screening for suspected conditions (not mental disorders or infectious disease)	\$8,581,436	40,557
Coronary atherosclerosis and other heart disease	\$8,278,458	6,724
Cancer of breast	\$8,137,618	2,156
Other connective tissue disease	\$5,624,911	16,647
Cardiac dysrhythmias	\$5,590,183	6,877
Chronic kidney disease	\$5,550,786	1,758
Residual codes; unclassified	\$5,539,904	13,476
Septicemia (except in labor)	\$5,486,604	656
Leukemia	\$5,312,409	257
Immunizations and screening for infectious disease	\$5,275,877	39,770
Complication of device; implant or graft	\$5,208,682	1,268
Nonspecific chest pain	\$5,148,580	8,580
Other nervous system disorders	\$4,746,518	7,712
Diabetes mellitus with complications	\$4,176,209	5,912
Other ear and sense organ disorders	\$4,130,922	6,037



State Health Plan Self-Reported Risks 2017

HRA Respondents Eligible to Incur Claims (N=65,805)

No Risk =
 - Non-obese
 - Have never smoked
 - Physically active 5 or more days (moderate) or 3 or more days (vigorous)

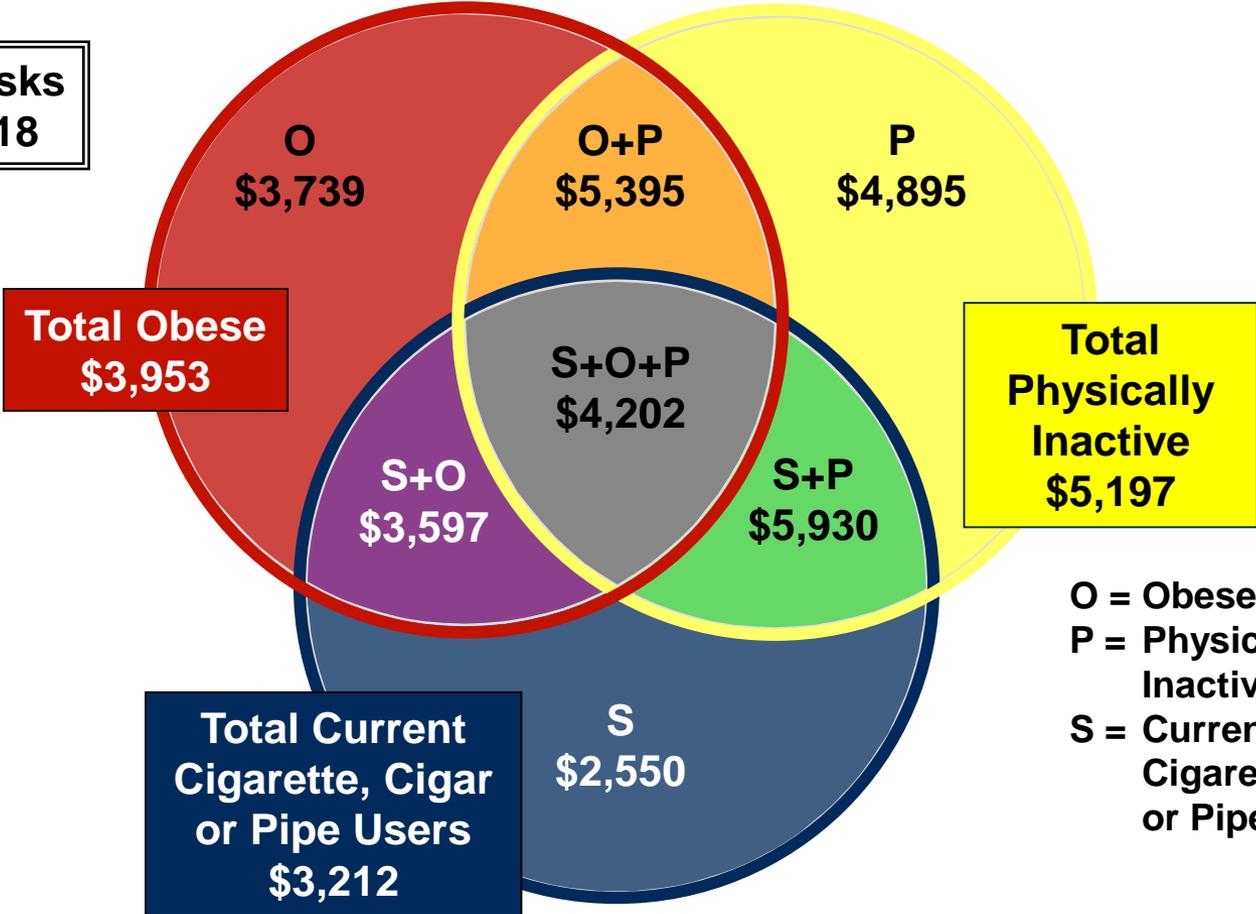


State Health Plan Self-Reported Risks 2017

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No Risks
\$2,518



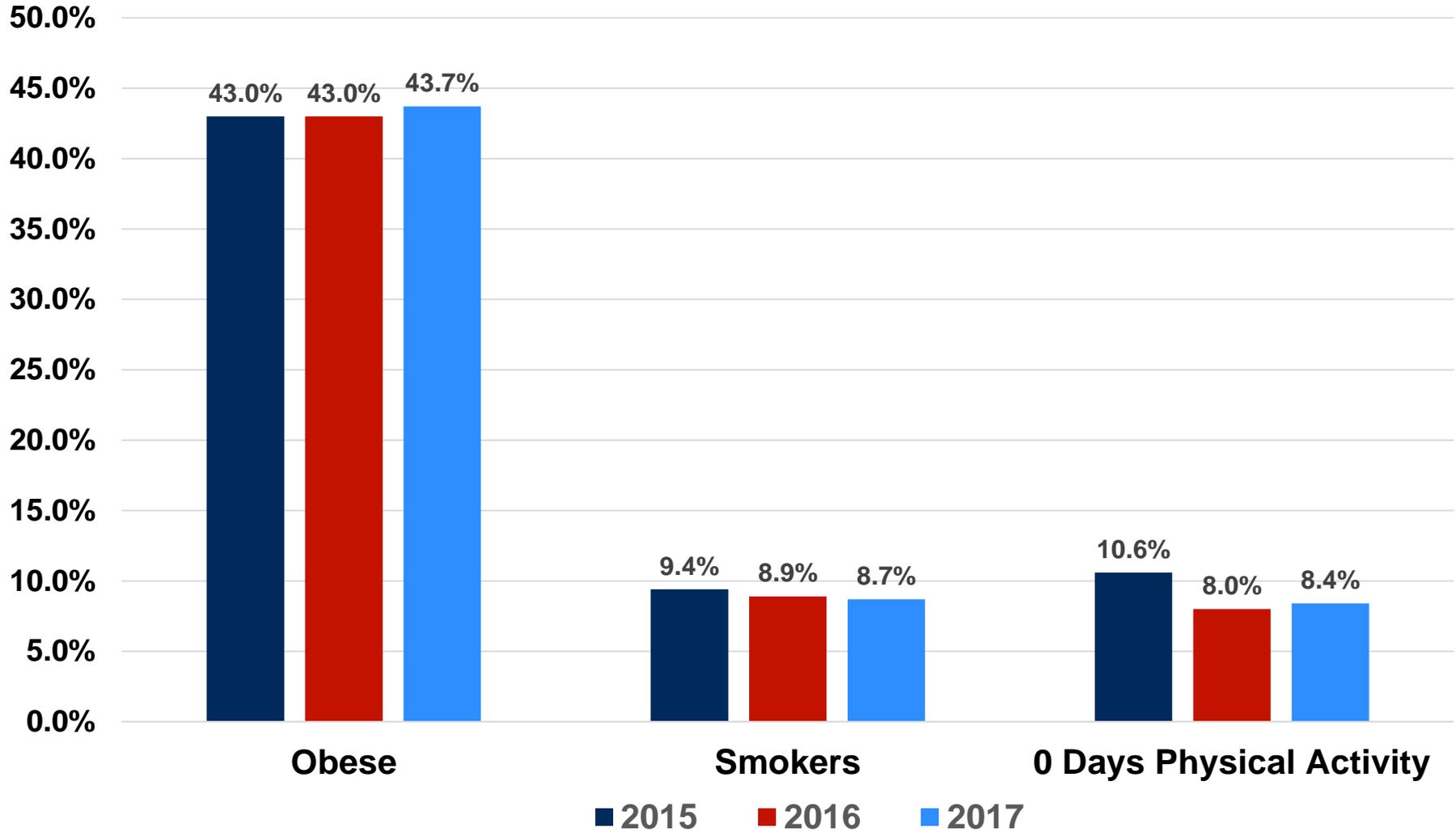
O = Obese
 P = Physically Inactive
 S = Current Cigarette, Cigar or Pipe Use

Potential Savings from Risk Behavior Mitigation

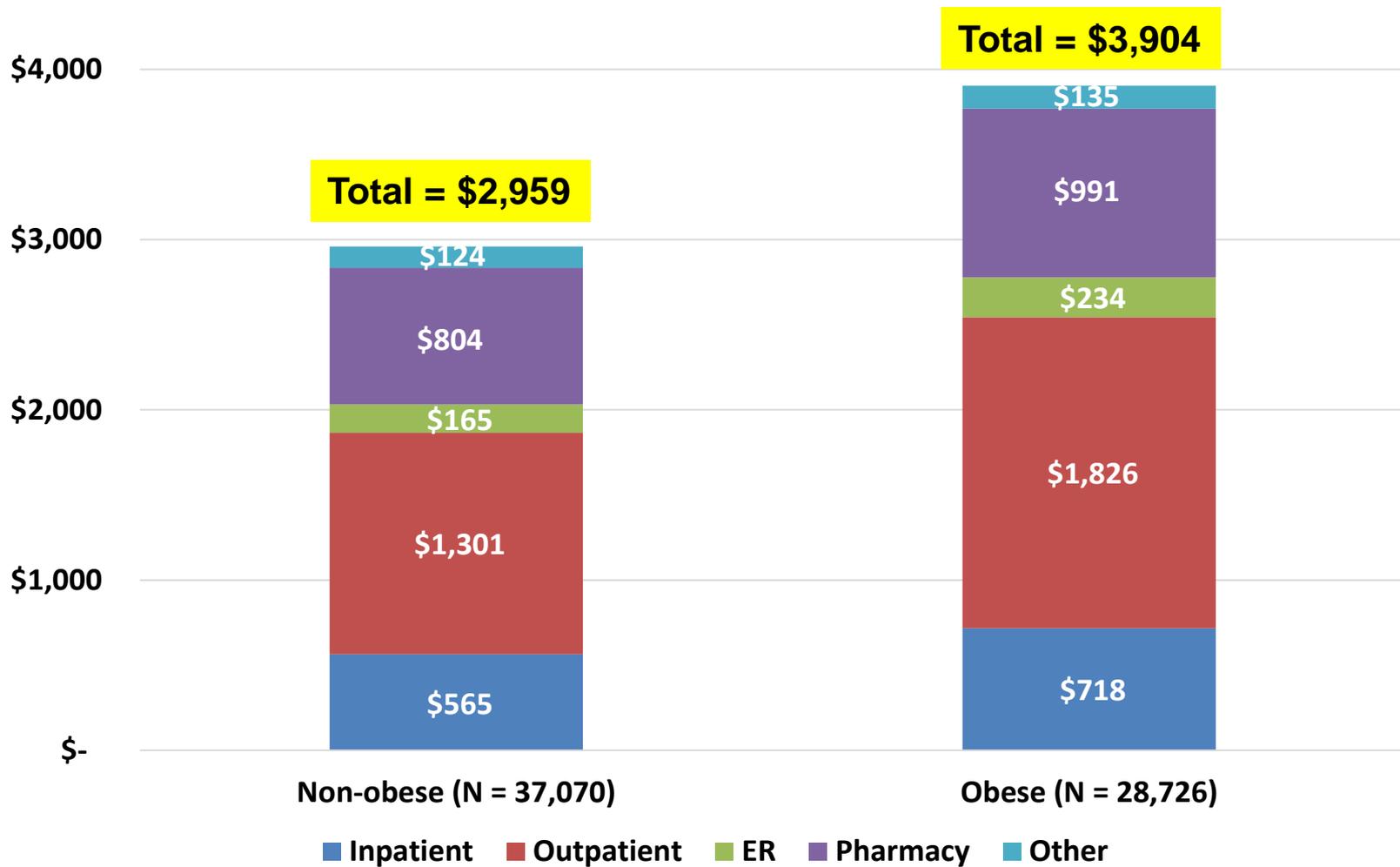
- **Cost per member with “no risk”: \$2,518**
- **However, approximately 50% of members have at least one risk (e.g. obesity, smoking, physically inactive)**
- **Potential savings to plan if at-risk patients become no risk = ~\$55 million annually**



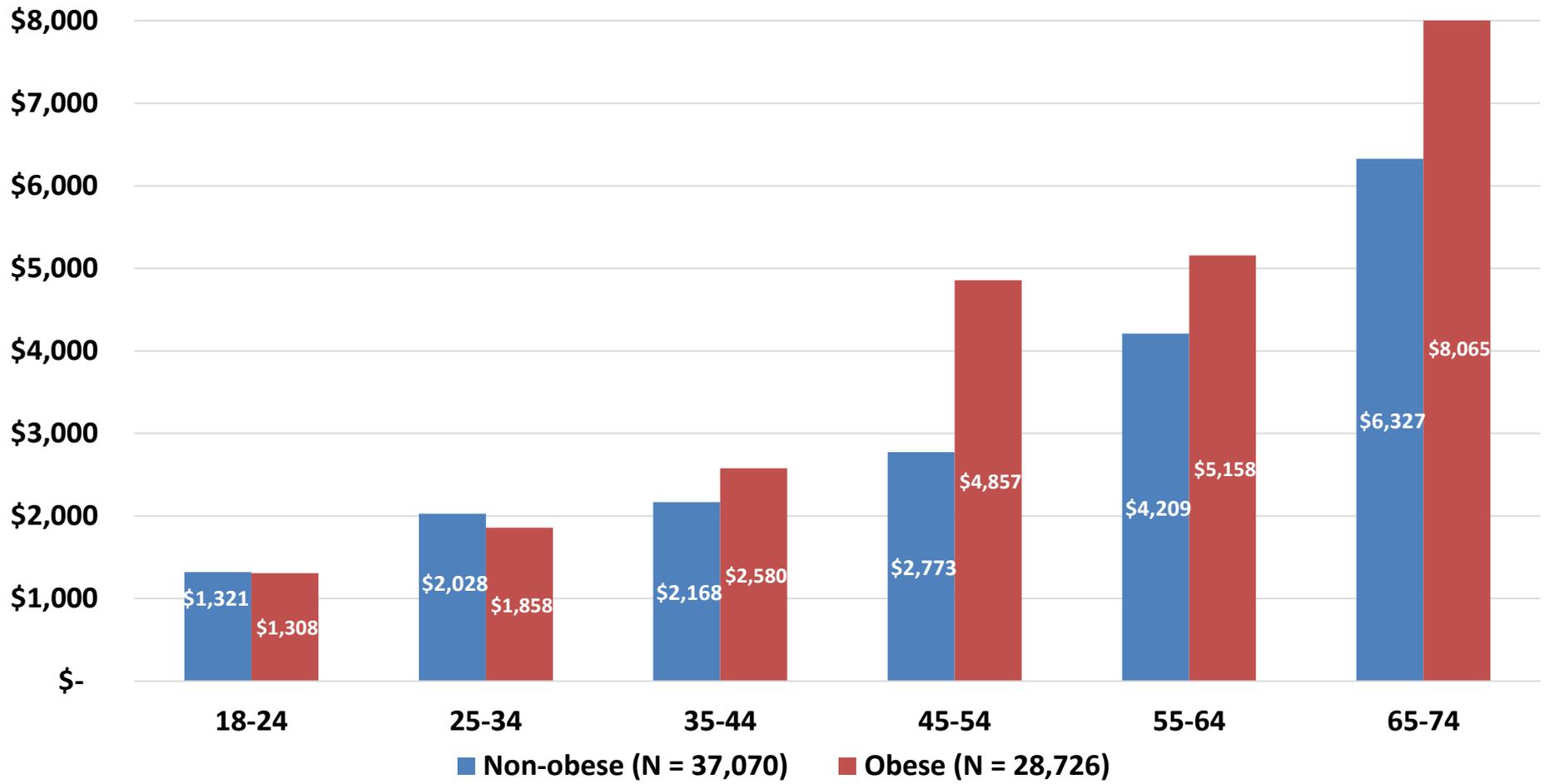
Risk Factor Trend Information 2015–2017



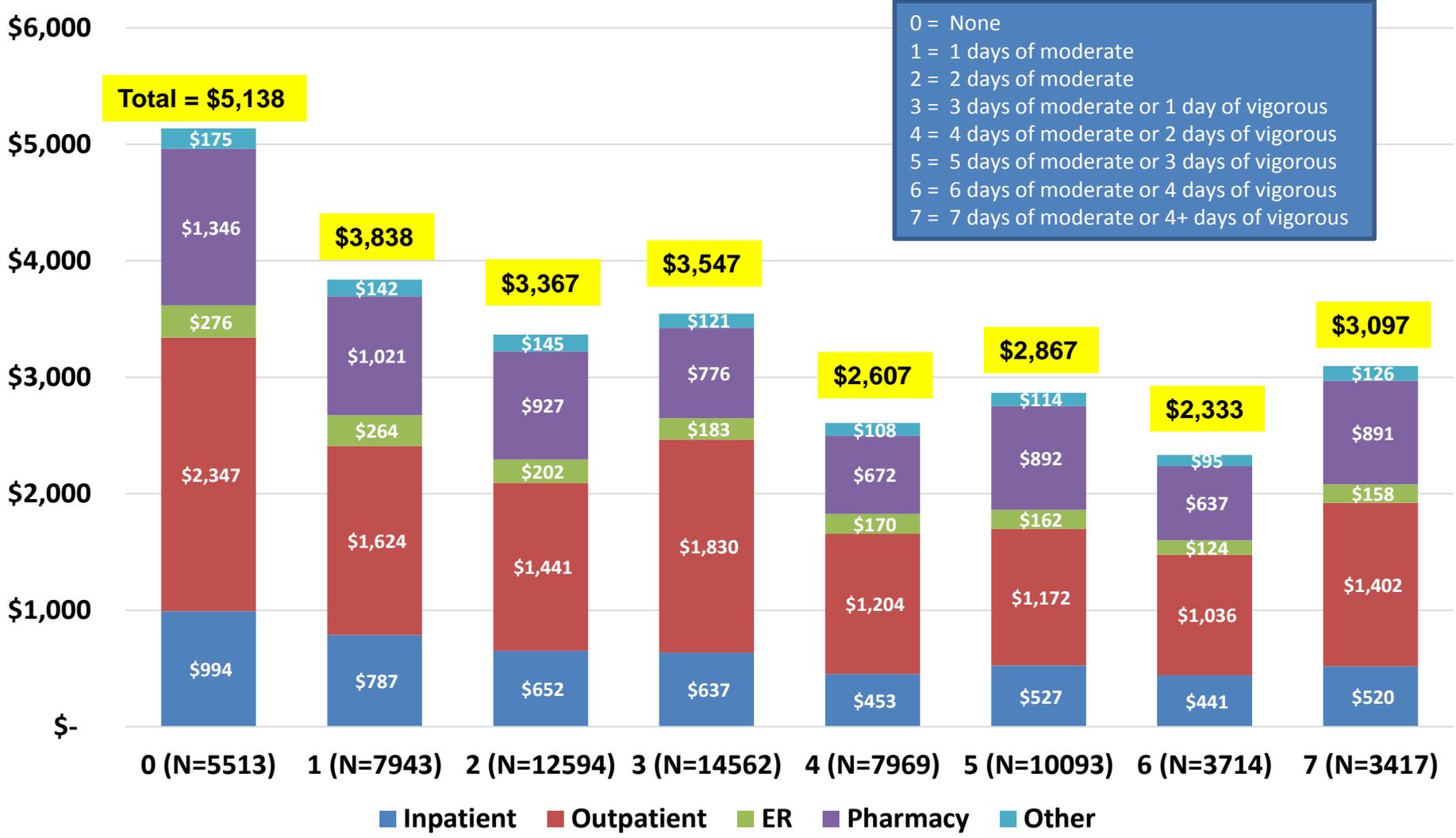
Annual Avg. EBD Costs Linked to Obesity (2017)



Annual Avg. EBD Costs Linked to Obesity by Age Group (2017)



Annual Avg. EBD Costs Linked to Days of Physical Activity (2017) 43



Takeaways from Analysis

- **Analysis provides longitudinal data to assess change in risk factors and associated costs within population**
 - **Tobacco use likely underreported**
 - **Obesity & physical inactivity responses are more likely to be accurate**
- **Self-reported obesity rates are higher than the statewide average within the EBD population**
- **If we were able to reduce risks within the EBD population, the plan could appreciate significant cost savings and better health outcomes for members**



Next Analysis: Diabetic Population Profile

- **Analysis will include key impact variables:**
 - **Volume/ rate of diabetes**
 - **EBD subgroups comparison to statewide rates (Type II, w/ complications, retiree vs. non retiree, etc.)**
 - **Cost Impact: Average total costs of diabetic vs. non-diabetic**
 - **Quality measures: Rate of testing (Hemoglobin A1c, nephropathy, eye exam, urinalysis, etc.)**
 - **Related diagnosis and medical, pharmacy utilization**
 - **Develop recommendations for EBD Subcommittees**

natura)(yslim[®]

offered by **acap**health.

Measurable results. *Guaranteed.*



natura)(ySlim[®]

Nation's leading digital program for weight management and metabolic syndrome reversal

10+
Years

Evidenced-based
MINDFUL EATING
and skill-building program



Flexibility to
**TAILOR
& DESIGN**
a best
practice
no-risk
pilot

Powerful
Testimonials



Emotional
Connections



Simple, scalable
technology platform

 **ZERO**
Implementation fees

VIRAL MOVEMENT



PREVENTIVE CLAIM

In network benefit with majority
of carriers and TPAs



America is struggling.



Traditional diet and exercise approaches have failed Americans.



EDUCATION AND MOTIVATION AREN'T SUFFICIENT

Despite best intentions and support from devices, health coaches and social groups, willpower is in limited supply.



WE LIVE IN A WORLD DESIGNED TO MAKE US OVEREAT

Cheap calories are everywhere and increased screen time both at work and at home has our society more sedentary.



OBESITY ISN'T JUST ABOUT PHYSICAL HEALTH

Deprivation-based programs ignore issues like stress and depression that lead to emotional and mindless eating.



America's Diabetes Escalator™.



 **50%**

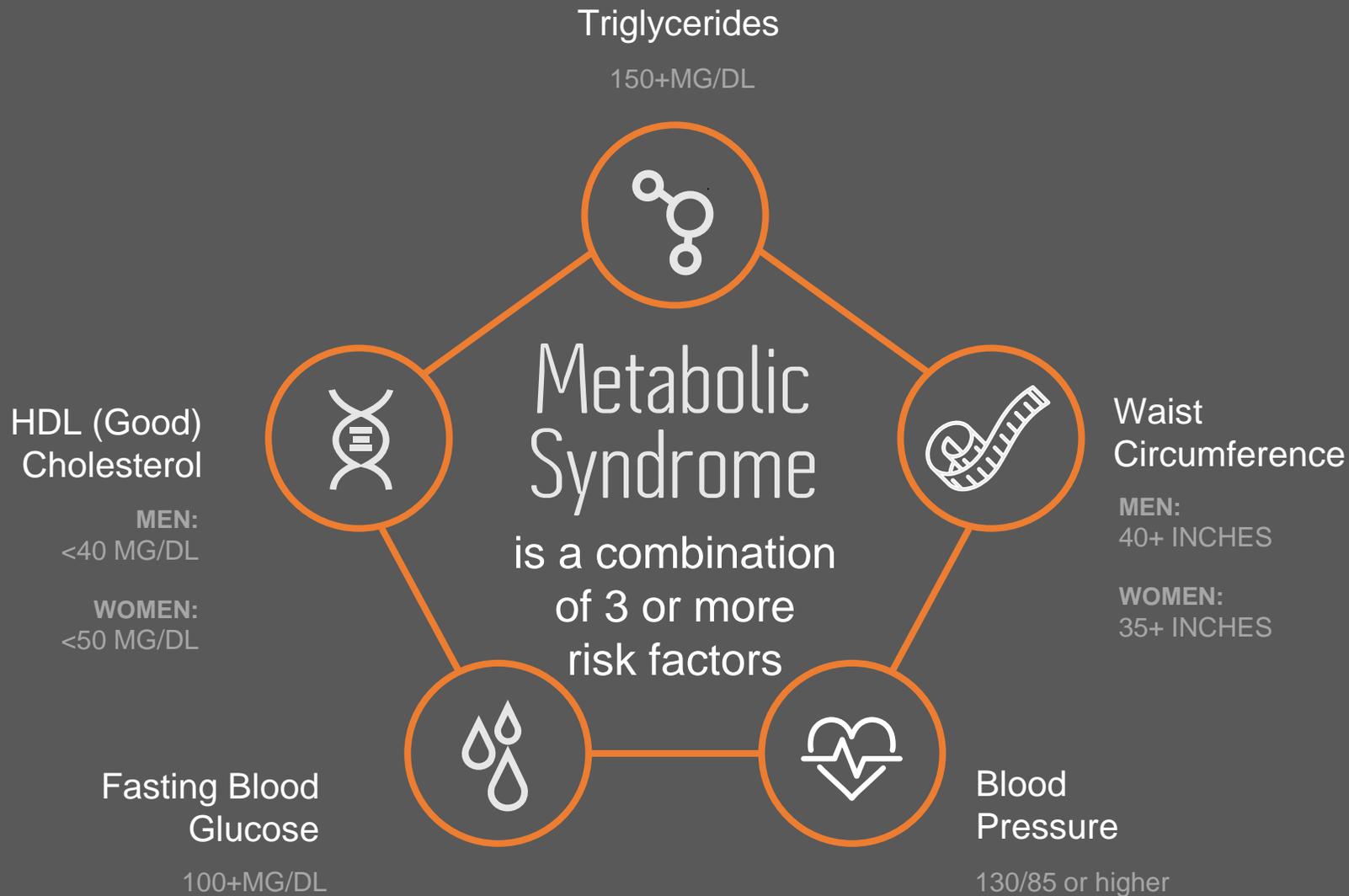
of Americans living
with pre-diabetes
or diabetes

 **70%**

of American adults
overweight
or obese



Predicting future claims risk.



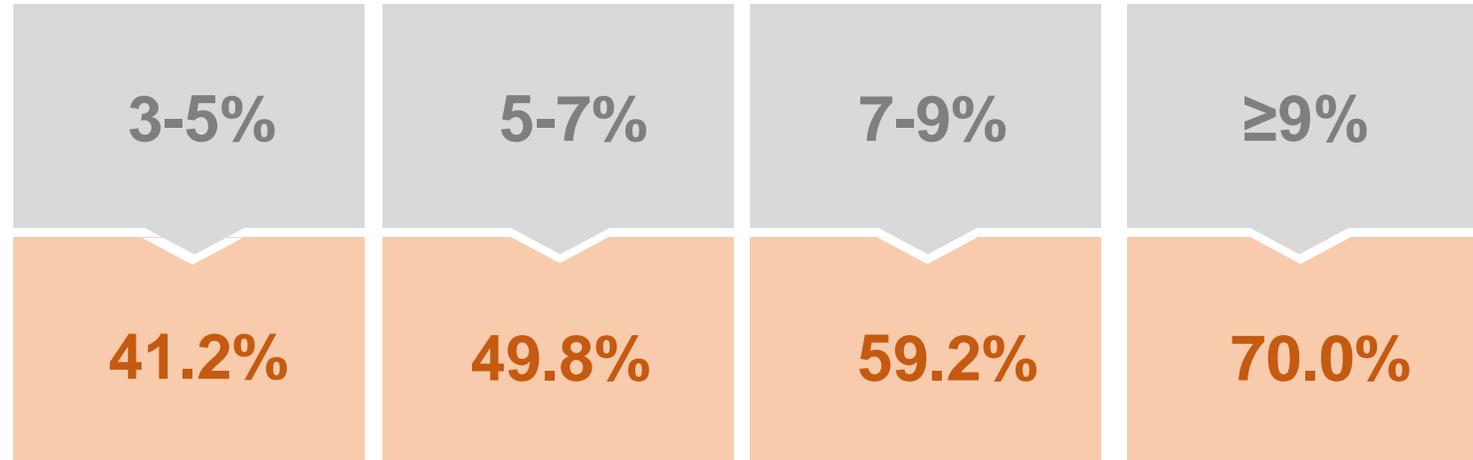
Change is Possible.



“ ... weight loss of as little as 3% to 5% is likely to result in clinically meaningful reductions in [metabolic disease risk]...¹



Percentage of body weight loss



Metabolic syndrome reversal rate



New understandings
of behaviors slim
people do

naturally.

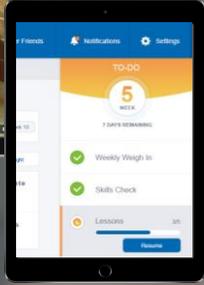




Skills

that change our relationship with food.





DIGITAL LEARNING



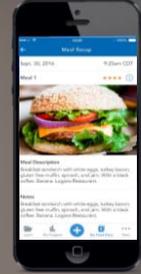
WORKBOOK

WELCOME KIT

SKILLS DEVELOPMENT



WEIGHT MAINTENANCE



FOOD DIARY

10-5-10 TIMER

SUPPORT



HEALTH COACH

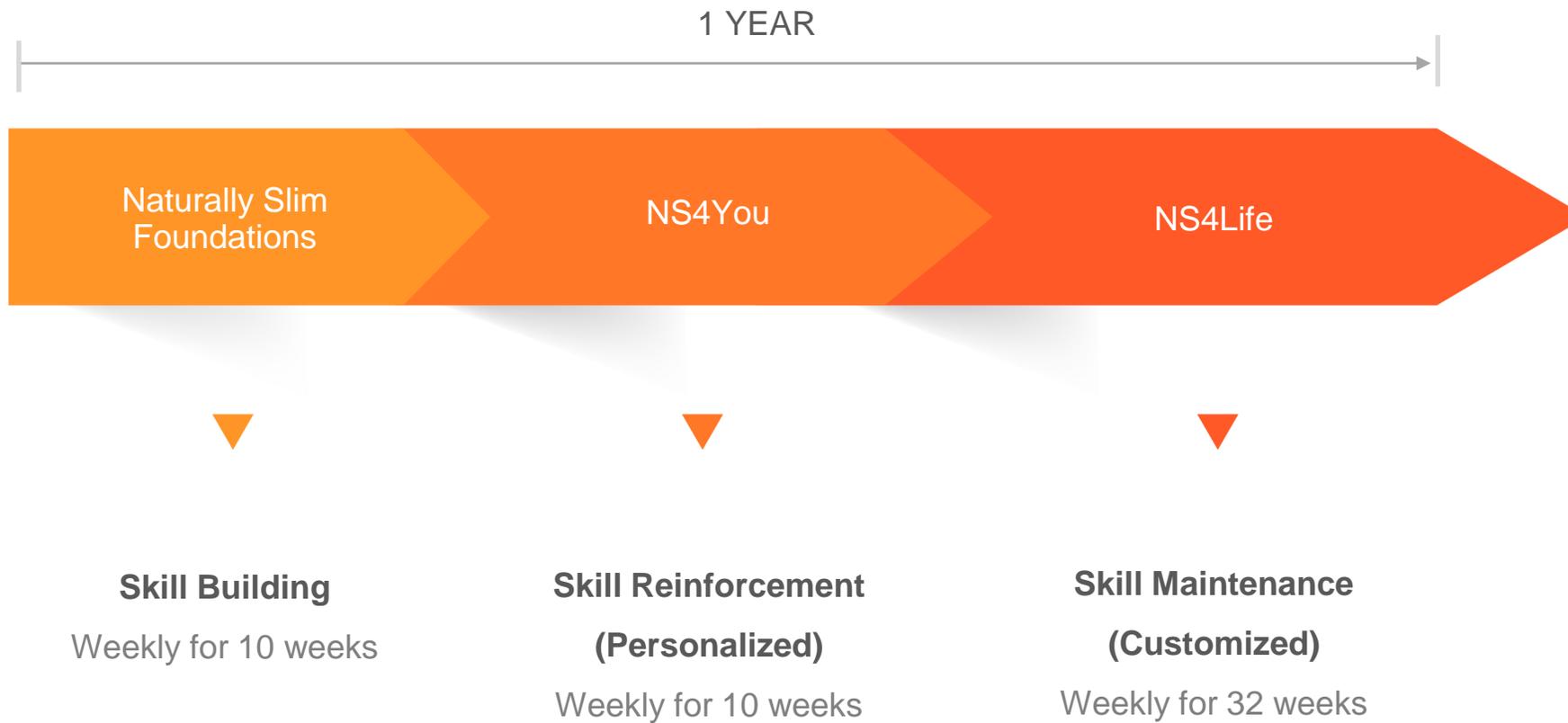
ONLINE COMMUNITY

ENJOY THE FOODS YOU LOVE. WE'LL TEACH YOU HOW.



Evidence-based treatment schedule.

10-week foundational skill-building program followed by skill reinforcement & maintenance for **sustainable behavior change**



Behavior change delivered by experts.



**MARCIA
UPSON**

*RN, MS, FNP-C
Founder, Lead Educator*



**DR. TIM
CHURCH**

*MD, PhD, MPH
300+ published studies*



**TODD
WHITTHORNE**

*Physical Activity Expert
Emmy® Award Winner*



**DR. DANA
LABAT**

*PhD
Clinical Psychologist*



**MERIDAN
ZERNER**

*MS, RDN, CSSD, LD
Diet & Nutrition Expert*



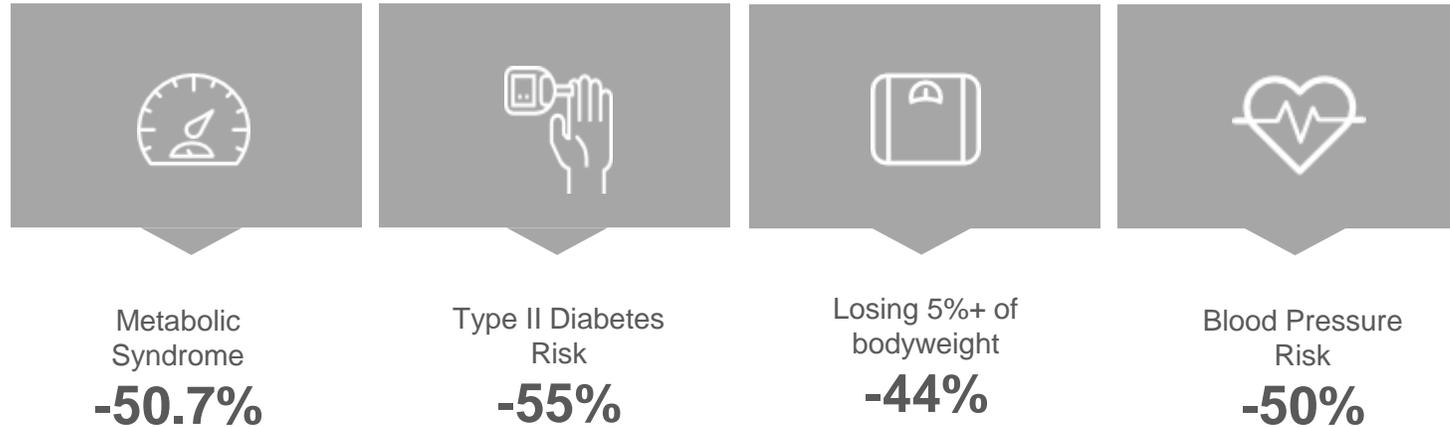
Sustainable, proven results.



What we now know is possible in employer populations.

JOURNAL OF METABOLIC
SYNDROME AND RELATED
DISORDERS
N = 3880

JOURNAL OF OCCUPATIONAL AND
ENVIRONMENTAL
MEDICINE
N = 5988



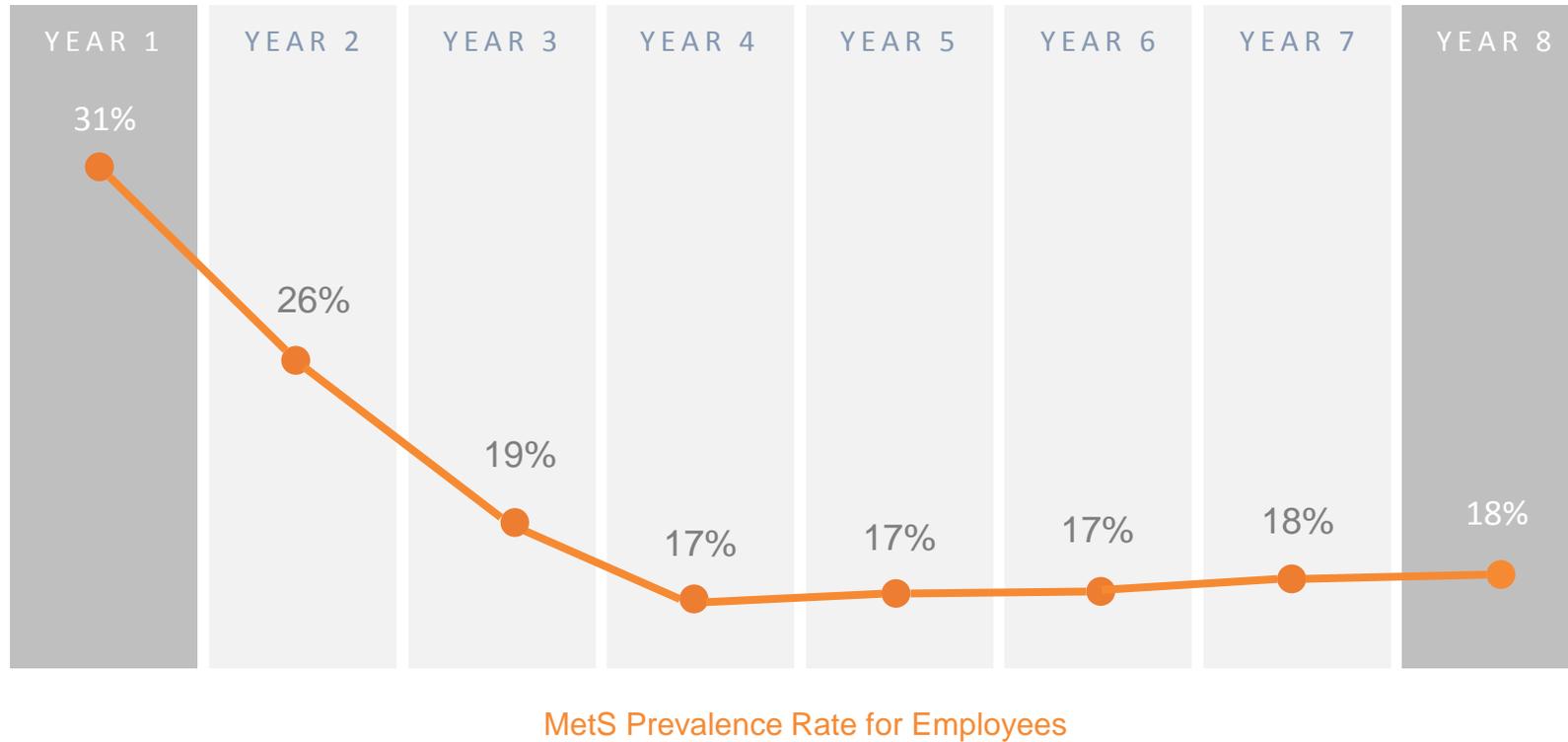
Men lose an average of
11.6 Pounds at 20 weeks
(6% of bodyweight).



Women lose an average of
9.8 Pounds at 20 weeks
(5% of bodyweight).

8+ years of demonstrated population health outcomes.

Metabolic syndrome prevalence of blue collar and white collar companies.



Naturally Slim clients consistently demonstrate sustainable MetS rates almost **HALF** the national average (18% VS. 34%)

8 years of sustainable results to employees and spouses.

Annual biometric results years after implementing naturally slim.

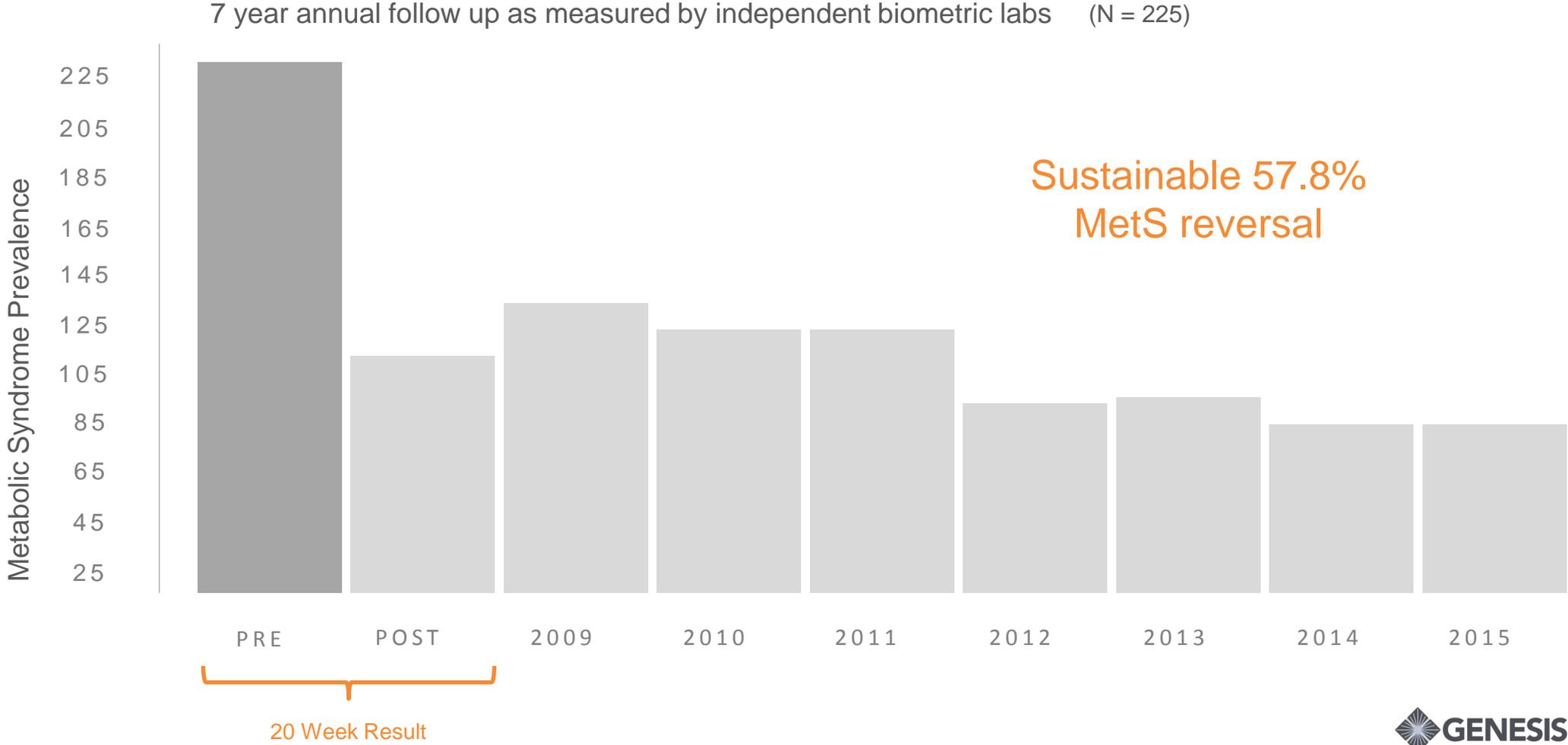


Sustainable **45%** reduction in metabolic syndrome prevalence

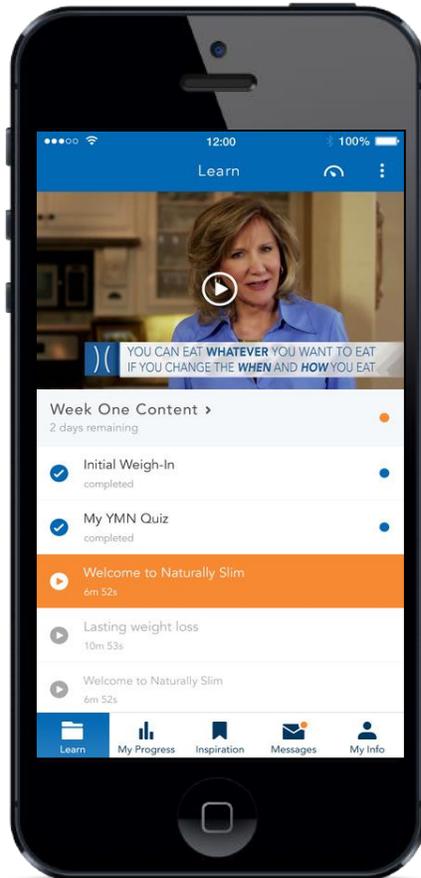
MetS Prevalence Rate for Employees and Spouses



We're in it for the long haul.



Success in Government.



5,980 Government Members Enrolled in 2016 Pilot

Total pounds lost

And counting with many continuing to lose weight

50,000+

MetS reversal

Total reversal rate of enrolled members no longer with Metabolic Syndrome

35%

Fasting glucose risk reversal

Total reduction in members no longer at risk for Diabetes/Pre-diabetes

29%

Blood pressure risk reversal

Total reduction in enrolled members no longer with Hypertension or Pre-hypertension risk

21%



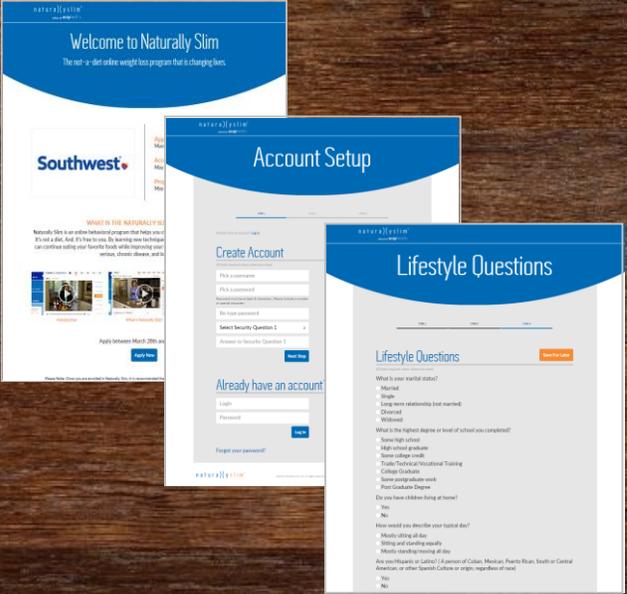
Getting started.



Just five weeks from kickoff call to program launch.



Announcement



Qualification



Begin



Marketing 101 + Behavioral Science

Focus on the participant's goal - **weight loss**

Communicate something different – **no scales & apples**

Use **loss aversion** with finite enrollment periods and cohort class model

Leverage **scarcity** by citing limited availability

FLYERS



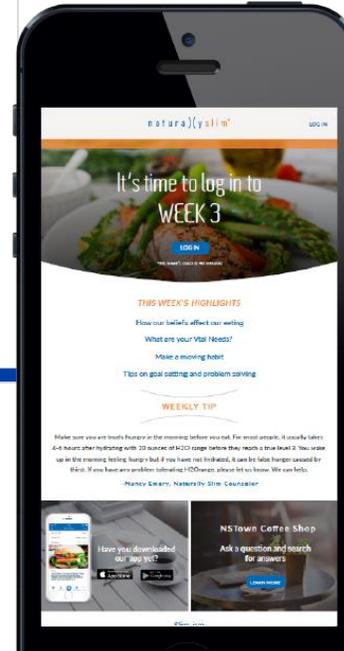
E-ANNOUNCEMENTS



TABLE TENTS



WEEKLY EMAILS



POSTCARDS



DIGITAL



AND MORE ...





Piece, love and happiness

Learn how to lose weight and
improve your health while
eating the foods you love.



Eat your way to an easy “A”



Learn how to lose weight and improve your health while eating the foods you love.

The Naturally Slim program has the secret to lasting weight loss and it doesn't include starving, counting calories or eating diet food. [Company] is now offering you the chance to learn how to eat to reduce your chances of getting a serious disease, like diabetes or heart disease, and increase your chance at living a longer, healthier life.

put dieting in detention



Learn how to lose weight and improve your health while eating the foods you love.

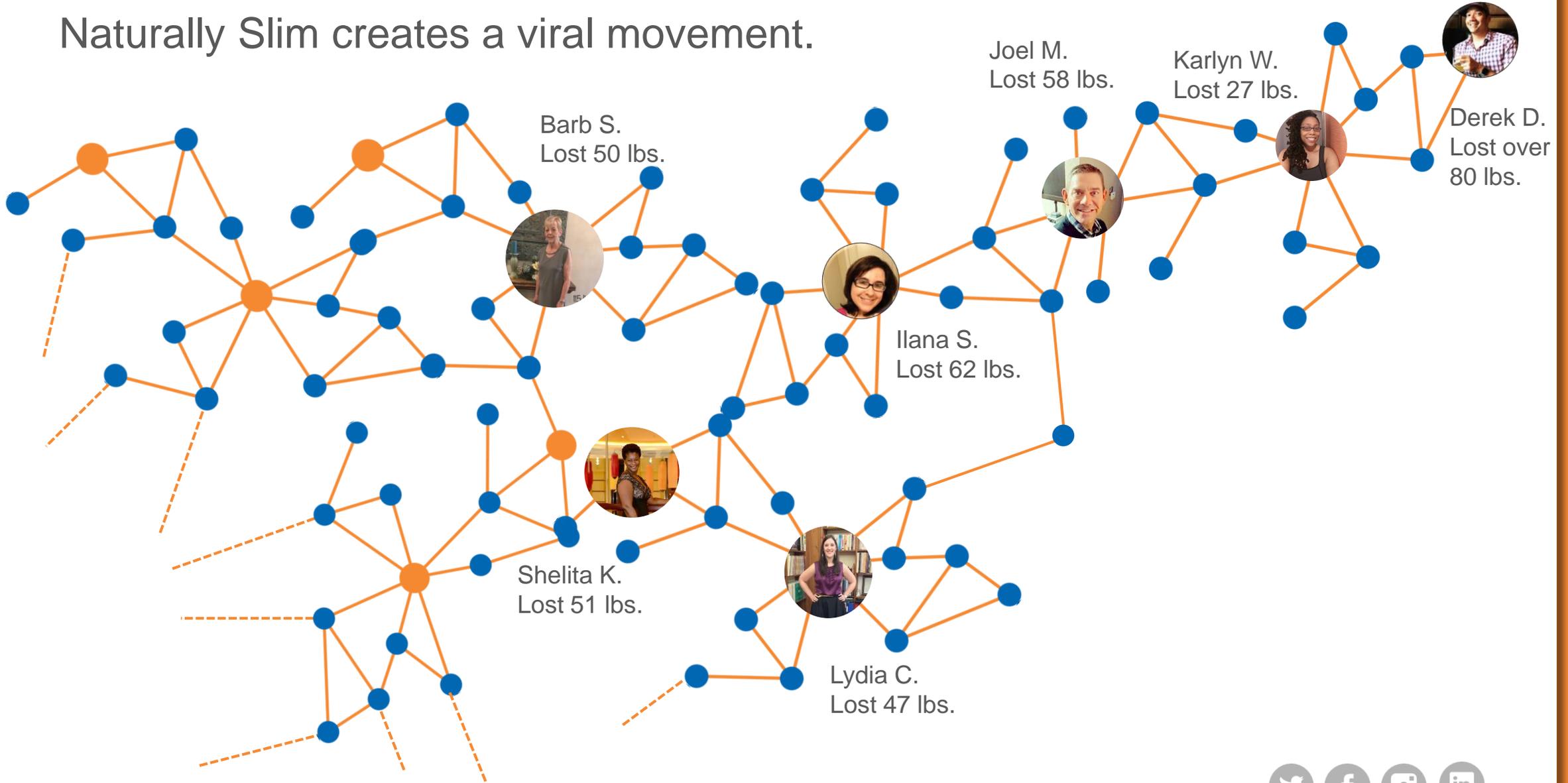




Yep, a welcome kit with Pringles and peanuts. Intrigued yet? Stick with us, we'll explain.



Naturally Slim creates a viral movement.



Success at State of Kansas.



8,587

Pilot participants exceeded expectation of 6,000



14,247+

Statewide buzz led Kansas to rollout 2nd class within a couple of weeks of Phase 1, enrolling an additional 5,660



29,000+

After enrolling more than 19,000 participants in 2017, more than 10,000 enrolled in the first class of 2018



natura)(ySlim®

Nation's leading digital program for weight management and metabolic syndrome reversal

10+
Years

Evidenced-based
MINDFUL EATING
and skill-building program



Flexibility to
**TAILOR
& DESIGN**
a best
practice
no-risk
pilot

Powerful
Testimonials



Emotional
Connections



Simple, scalable
technology platform

 **ZERO**
Implementation fees

VIRAL MOVEMENT



PREVENTIVE CLAIM

In network benefit with majority
of carriers and TPAs

