AGENDA

State and Public School Life and Health Insurance Board
Wellness Sub-Committee
Meeting

March 17, 2017

1:00 p.m.

EBD Board Room – 501 Building, Suite 500

I. *Call to Order .....Dr. John Vinson, Chair*

II. *Wellness Discussion ..... Chris Howlett, EBD Executive Director*

III. *New Topic Discussion ..... Dr. John Vinson, Chair*

Upcoming Meetings

To be determined.

NOTE: All material for this meeting will be available by electronic means only. Please contact ASEPSE-BOARD@dfa.arkansas.gov. Notice: Silence your cell phones. Keep your personal conversations to a minimum. Observe restrictions designating areas as "Members and Staff only"

State and Public School Life and Health Insurance Board
Wellness Discussion Committee
Minutes
March 17, 2017

The Wellness Discussion Committee of the State and Public School Life and Health Insurance Board (hereinafter called the Committee) met on March 17, 2017, at 1:00 p.m. in the EBD Board Room, 501 Woodlane, Suite 500, Little Rock, Arkansas.

Members Present	Members Absent
Janis Harrison	Carla Haugen
Dr. John Kirtley	
Dr. Joseph Thompson	
Dr. John Vinson	

Chris Howlett, Executive Director, Employee Benefits Division (EBD)

Others Present

Marla Wallace, Ethel Whittaker, Eric Gallo, Cecilia Walker, Drew Higginbotham, Amanda K Hood-Armstrong, Terri Freeman, Stella Greene, Shalada Toles; EBD; Jennifer Vaughn, Kristi Jackson, ComPsych; Sandra Wilson, AHM; Marc Watts, ASEA; Ronda Walthall, AHTD; Mike Motley, Elizabeth Whittington, ACHI; Karyn Langley, QualChoice; Heather Mercer, AIAC

CALL TO ORDER

The meeting was called to order by John Vinson, Chair

APPROVAL OF MINUTES: *by John Vinson, Chair*

Vinson asked for a motion to approve the March 3, 2017, minutes. Kirtley motioned to approve. Harrison seconded; all were in favor.

Motion approved.

WELLNESS DISCUSSION *by Elizabeth Whittington, Mike Motley, Dr. Arlo Kahn, ACHI; Chris Howlett, EBD Executive Director*

Howlett followed up on the previous March 10, 2017, meeting reiterating the recommendation by Harrison, Committee member, which is to focus on the primary functions to define or discuss what the qualifiers will be for the Wellness plan options.

Howlett reported the team at ComPysch provided valuable data regarding the wellness initiative.

Dr. Vinson recommended for the Wellness Committee to provide direction to the Board and Sub-committees, creating a Wellness Program that seeks to improve the well-being of the employees and families of the State and Public School life and Health Insurance Plan, as individuals to be successful in both their work and personal lives. Consistent with the definition outlined in last week's meeting, it is the desire of the Division for each employee, their family, and the retirees to achieve their full potential using the multi-dimensional approach, which would include baseline screening information. Also, give the members a program that seeks to mobilize the positive qualities' and strengths of the person to be successful with their goals.

Dr. Vinson reported Bob Boyd, Board member, and other Committee members expressed concerns with the value of the Health Risk Assessment as self-reported data.

Dr. Vinson stated in the past the Health Risk Assessment and online tools are a benefit, however, gathering objective measurement of real Biometrics is more accurate and captures real data. The committee agrees.

Dr. Vinson said the Wellness Plan needs to be a combination of community-based, work-place based, and patient family-centered.

Dr. Vinson reported phone assessments are not as desirable as face-to-face activity.

Harrison reported the phone assessments possibly serve as a backup resource for various services that are offered to the members. Members receive guidance for categories such as emergency room visits.

Harrison agrees assessments should be face-to-face as various data is essential to determine the individual's health condition and what areas to target to achieve better health.

Howlett would like the Board to consider the initiative level of the participants and their willingness to comply. It would be more beneficial to consider options

without a financial benefit with the desire to increase the number of employees who are serious about behavior modification.

Kirtley reported the Division is seeking wellness information. However, he would recommend developing a strategic plan regarding what to do with the findings. Will there be a decrease in premium for those who maintain better healthcare?

Dr. Vinson reported the following five recommendations for consideration:

- Employee's and families would be screened with the option to get the recommended United States Preventative Services Task Force (USPSTF) Services.
- Employee, Family, Adult and Child screenings and immunizations included.
- Weight/Obesity, Blood Pressure screening and Lipid panel screening.
- Obesity Management Program to assist with weight loss.
- Smoking Cessation Program to ensure there are measurable goals in regards to the quit ratios.

Dr. Vinson reported on Nabholz Wellness Program, which was featured on HBO. HBO featured The Weight of the Nation Program regarding Nabholz' successful wellness plan. The Nabholz representative who developed Mayo Wellness will be available April 6-7 to speak with the Committee regarding the program.

Dr. Thompson agrees that Nabholz would be valuable to the planning stages as well as the Healthy Active Arkansas Initiative, a U.A.M.S. Program, and the plan's third-party administrator in regards to a recommendation, operationally to justify the wellness incentive, which could potentially be easier to implement.

Dr. Vinson requested flu shot data on the previous year, and current influenza vaccine claims to include; August 1, 2015 -April 30, 2016, and August 1, 2016 – April 30, 2017.

Kirtley reported when the plan excluded the flu nasal spray, the message received by the members resulted in those not engaging in a flu shot, and those with concerns that flu shots are not good.

Howlett reported his responsibility would be to provide the requested data from BlueCross, the Healthy Active Arkansas Initiative, and the Arkansas Department of Health as well as coordinate a presentation from Nabholz. Also, Howlett will provide the flu shot claim data.

Howlett reported the Wellness Program might need to extend the deadline of October 31, 2017, to December 31, 2017.

Kirtley said he would like to analyze the flu shot data and listen to any presentations that would be helpful in developing a strategy that is successful but also educate the committee in regards to the development phases, research, and the groundwork involved from the foundation to the finished product; including the results thus far.

OTHER BUSINESS: *by Dr. John Vinson, Chair*

Harrison reported viewing the recent segment on Channel 7 regarding bariatric surgery for the Arkansas State employees. The interview targeted the cost to taxpayers.

Motley reported data regarding Employee Benefits Division (EBD) population compared to the commercial population. Employee Benefits Division attributed to 57% of the bariatric procedures from 2013 – 2015 and 43% were assigned to the commercial population, EBD Member Population was 15%, and 85% attributed to the remaining commercial payers.

Howlett reported the interview published was intended for State and Public School employees. Also, the tax amount consists of state and district contributions as well as member submitted funding.

Dr. Vinson asked for a motion to adjourn. Dr. Kirtley motioned to adjourn. Haugen seconded; all were in favor.

Meeting adjourned

Bariatric Surgery Overview

BACKGROUND

Bariatric surgery is one of the fastest growing operative procedures performed worldwide, with approximately >340,000 operations performed in 2011. However, the number of procedures performed in the United States appears to have plateaued at approximately 200,000 operations per year. This may be a result of several factors, including multidisciplinary team identification of patients who can be effectively managed with behavior modification or a comprehensive evaluation which may identify patients who are not ideal surgical candidates.[1]

Legislation was passed in 2011 which charged the Employee Benefits Division (EBD) to establish a bariatric surgery pilot program as a covered benefit for qualifying members. The first surgeries began in 2012, and Table 1 shows the number of procedures per year through 2016.

Table 1. Number of Bariatric Procedures Performed on Eligible ASE/PSE Members

Year	2012	2013	2014	2015	2016	Overall
Number of Procedures	189	298	181	48	59	**775**

EFFECTIVENESS

- **Weight Loss**—Evidence demonstrates that bariatric surgery is an effective method of achieving weight-loss in obese individuals. However, expected weight loss varies based on the type of surgery: [2]
    - **Gastric bypass**—"Gastric bypass has a high success rate, and people lose an average of 70 to 75 percent of their excess body weight in the first year. For a person who is 120 pounds overweight, an average of 85 to 90 pounds of weight loss would be expected. Weight loss typically levels off after one to two years, with an overall excess weight loss between 60 and 70 percent after five years."
    - **Gastric sleeve**—"The gastric sleeve has a good success rate, and people lose an average of 60 to 65 percent of their excess body weight at two years after their procedure. For a person who is 120 pounds overweight, this would mean losing about 72 to 78 pounds. Like the lap band and gastric bypass, it is important to follow an appropriate diet after surgery."
    - **Lap banding**—"Weight loss after two years ranges from 50 to 60 percent of excess weight. As an example, a person who is 120 pounds overweight could expect to lose approximately 60 to 72 pounds in the two years after lap banding."

- **Medical Conditions**—Bariatric surgery can also improve health issues that are related to obesity, including diabetes, high blood pressure, and sleep apnea. In some cases, the patient may no longer need to take medication used to treat these and other related conditions. Surgery may also help to reduce the patient's risk of developing other conditions related to obesity, such as heart disease.[3]

COMPLICATION AND REOPERATION RATES

A 2014 national systemic review and meta-analysis spanning 2003-2012 concluded the following with respect to both the complication rates and reoperation rates for individuals who had undergone various types of bariatric procedures: [4]

- Of the 164 studies assessed, the complication rate from bariatric surgery was 17 percent.
- Reoperation rate was 7 percent.
- Gastric bypass, a more invasive surgery but considered more effective in weight loss, was associated with more complications.
- Adjustable gastric banding had lower complication rates but was more likely to have higher reoperation rates than both gastric bypass and sleeve gastrostomy procedures.

TYPES OF BARIATRIC SURGERY

Bariatric surgery includes a group of procedures that cause weight-loss by restricting the amount of food an individual's stomach can hold and the calories/nutrients the body absorbs. The most common bariatric surgery procedures in the U.S. include the following: [2]

- **Gastric bypass**—Roux-en-Y gastric bypass, also called gastric bypass, reduces the amount of food that can be eaten and reduces the number of calories and nutrients that can be absorbed food. The surgeon creates a small stomach pouch by dividing the stomach and attaching it to the small intestine.
- **Gastric sleeve**—Gastric sleeve, also known as sleeve gastrectomy, is a surgery that reduces the size of the stomach and makes it into a narrow tube. The new stomach is much smaller, it does not stretch when eating, and it produces less of the hormone (ghrelin) that causes hunger, helping the patient feel satisfied with less food.
- **Lap banding**—Laparoscopic adjustable gastric banding (LAGB), or lap banding, is a surgery that uses an adjustable band around the opening to the stomach. This reduces the amount of food that the patient can eat at one time.

(Other procedures are available, but are rarely performed in Arkansas.)

ELIGIBILITY

Patients meeting the following criteria *may* be eligible for surgery:[1]

- Adults with a body-mass-index (BMI) greater than 40
- Adults with a BMI between 35 and 39.5 with at least one serious coexisting condition, including but not limited to:
  - Type 2 diabetes
  - Sleep apnea
  - Hypertension
  - Hyperlipidemia
  - Asthma
- Adults with a BMI between 30 and 34.9 with uncontrollable Type 2 diabetes or metabolic syndrome, although there is no long-term evidence of benefit to support routinely performing bariatric surgery on these individuals

PRE- AND POST-SURGERY COMPONENTS

Pre-Surgery Components

U.S. Preventive Services Task Force (USPSTF) Recommendation on Obesity—Clinicians should offer or refer patients with a BMI of 30 or higher to intensive, multicomponent behavioral interventions. These interventions can lead to an average weight loss of 8.8 to15.4 pounds and improve glucose tolerance and other physiologic risk factors for cardiovascular disease."[3] While bariatric surgery is often a last-resort for individuals who have exhausted other avenues in weight-loss, both the compiled academic findings and USPSTF recommendations emphasize the key role of intensive behavioral therapy in the treatment of obesity.

Preoperative Assessment—Bariatric surgery should be performed along with a comprehensive preoperative assessment. A multidisciplinary team that includes a nutritionist, medical bariatric specialist, psychologist/psychiatrist, nurse specialist, and skilled surgeons offer well-rounded assessments and support for the obese patient considering a bariatric surgical procedure.[2]

Post-Surgery Components

After a patient has undergone bariatric surgery, there are two components to post-surgery care—postoperative care (both in the hospital immediately following surgery and follow-up visits within the first few months of surgery) and long-term care/management. The type of bariatric procedure can also determine the level of post-surgery care required.[5]

For long-term management, individuals who have undergone bariatric surgery require ongoing routine visits with their physicians, which should include weight monitoring and discussion of compliance with required dietary modifications and other behavior changes. As with pre-surgery requirements, post-surgery care should include a multidisciplinary team approach including a nursing team to address patient concerns, registered dieticians to assist with dietary needs, and opportunities for group-support. For individuals with coexisting conditions such as hypertension and diabetes, monitoring changes in these conditions must also be tracked.[4]

CONCLUSION

Evidence-based information on bariatric surgery should be considered as EBD makes decisions regarding the continuation of its bariatric surgery program. Candidates for surgery should include individuals with BMIs greater than 40 or with BMIs 35 and greater with a coexisting condition present. Both the pre- and post-operative care of individuals undergoing surgery should include a multidisciplinary-team approach, including intensive behavioral therapy. Effectiveness, complications, and reoperation rates for procedures must also be considered.

REFERENCES

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