State Health Policy in the Era of Big Data

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Professor, UAMS Colleges of Medicine & Public Health
Informing Health Policy - Link to Current Issue Briefs, Fact Sheets and Reports

Since its inception in 1998, the Arkansas Center for Health Improvement has become widely recognized as a reliable source for local and national health and industry information. This includes providing critical data, analyses and strategies that inform decisions and help shape public policy surrounding the health and productivity of Arkansans.

ACHI Features

Medicaid Eligibility Redetermination Fact Sheet

Recent news accounts have documented the challenges of the Medicaid information system and eligibility redetermination processes. This fact sheet provides an overview of the eligibility redetermination process for Health Care Independence Program beneficiaries, including key definitions and process flow diagrams.

New Brochure

The History of Arkansas's Traditional Medicaid Program (1970-2013) provides a timeline and overview of Medicaid in Arkansas prior to the 2014 implementation of the Health Care Independence Act. A map-folded print version of this brochure is available from ACHI.

ACHI Contact Information

ACHI was envisioned as an organization dedicated to change—change that leads to improved health for all Arkansans. While we have made positive strides in changing Arkansas’s health environment, our work is far from finished.

ACHI’s activities are centered in three Areas of Focus that influence the health of Arkansans—population health policy, access to quality care, and health care system transformation—with supporting infrastructure of health data and research.

Through development of policy positions and statements, the ACHI Health Policy Board helps establish strategic priorities that provide guidance for our work. More information on the Health Policy Board and their policy positions and statements is available here.

Sign Up for our e-mail alerts

The Arkansas Center for Health Improvement will periodically update our website to include informative links and issue briefs on subjects related to improving health and health care in Arkansas. Use the form below to sign up for e-mail updates.

Latest News

Join our Team! Career Opportunities Available at ACHI

Two positions now available. Applications Systems Analyst/Programmer/Integrator and Applications Systems Analyst/Programmer Tester. Applications will be taken through the UAMS job portal only. Read more for minimum qualifications and a link to job description.

External RSS Feeds

- Average Medicare Advantage premiums to decline in 2016 - 9/21/2015, via Modern Healthcare
- New Report Finds 23 of 25 States with Highest Rates of Obesity are in the South and Midwest - 9/21/2015, via Robert Wood Johnson Foundation
- Biden: 'no rush' on WH decision - 9/21/2015, via TheHill.com
Arkansas System Transformation Strategy

- Workforce
- Payment System
- Insurance Coverage
- Population Health
- Health IT
- Transparency
Arkansas Health Data Initiative

ACHI established the Health Data Initiative (HDI) with Act 1035 of 2003

The HDI provides health data and an analytic platform for research to support health policy

Act 1035:

- Gives authority to ACHI to access personally identifiable information collected by state agencies with state agency permission
- Enabled the development and maintenance of a robust, scalable analytic data warehouse for health policy research
# ACHI Health Data Initiative Sources

<table>
<thead>
<tr>
<th>Data Sources with Available Date Range</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>AR Department of Health Birth Records, 1989-2016</td>
<td>AR Medicaid Member data and Medical, Pharmacy, Nursing Home, and Dental Claims, 2007-2017</td>
</tr>
<tr>
<td>AR Department of Health Death Records, 1990-2016</td>
<td>AR Medicare Member data and Medical, Pharmacy, and Nursing Home Claims, 2005-2016</td>
</tr>
<tr>
<td>AR Hospital Discharge Data, 2000-2015</td>
<td>AR State and Public School Employee Member data and Medical and Pharmacy Claims</td>
</tr>
<tr>
<td>AR State Police Crash Data, 2004-2014</td>
<td>Arkansas Worker’s Compensation Claims, Payment, and Claim Approval Data, 2000-2016</td>
</tr>
</tbody>
</table>
Arkansas Health Data Initiative: Key Projects

- State Employee Health Risk Assessments & Wellness Strategy
- School Body Mass Index (BMI) Assessments
- Health Insurance/ Uninsured Impact Analyses
- Workforce Assessments / Scope of Practice Issues
- Accident and Fatality Analysis-Graduated Drivers License
- Interventions for Obesity Prevention Targeting Young Children in At-Risk Environments
- Racial Disparities in Quality of Care
- Statewide Diabetes Treatment
- Emergency Department Use Analysis
- Medicaid Beneficiary Work Status
Medicaid Expansion Decision by State

Percentage Uninsured by County, 2015

Competition Has Fallen

About 18 percent of people eligible for the Obamacare markets will live in counties with only one insurance carrier offering health plans next year.

**Number of insurance carriers in the Obamacare markets**

Source: McKinsey Center for U.S. Health System Reform
Obamacare Rates Are Rising

But there’s a lot of variation. In some Arizona counties, prices for the most affordable midlevel plan are going up by 191 percent. In parts of Texas, premiums are going down by 30 percent.

2017 premium increase for lowest-cost silver plan

Note: There are two separate markets in Los Angeles County. We have shown rates for the market where more customers are enrolled.

Source: McKinsey Center for U.S. Health System Reform
Losses at Hospitals Caring for Low-income Arkansans Decreased by $149M

Uninsured Admissions - Down 48.7%

Uninsured ER Visits - Down 38.8%

Uninsured Outpatient Visits - Down 45.7%

Source: Arkansas Hospital Association, April 2015
Rural Hospital Closings, Surrounding States

Source: Adapted from the North Carolina Rural Health Research Program, “56 Rural Hospital Closures Map.” Accessed August 2015.
Arkansas Demonstration Waiver Evaluation Hypotheses

Compared with Medicaid fee-for-service, HCIP will provide equal or better:

- Access to health care
- Care and outcomes
- Continuity of care

Compared with a counterfactual Medicaid fee-for-service option, the HCIP will be cost effective
Evaluation Indicators

- **Access**
  - Geographic drive times between enrollees and provider(s)
  - Observed utilization
  - Self-reported experience

- **Clinical Care and Outcomes**
  - Consumer Assessment of Health Plans Survey (CAHPS)
  - Modified Healthcare Effectiveness Data and Information Set (HEDIS)
  - New York University Algorithm for Emergent/Non-Emergent ER use

- **Costs**
  - Paid premiums and cost-sharing reductions, paid claims, Medicaid supplemental payments
  - Budgetary impact analysis on total Medicaid program
# Medicaid and Commercial Payer Price Differences for Outpatient Procedures by Provider Type

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Weighted Medicaid Average Price</th>
<th>Weighted Commercial Average Price</th>
<th>Absolute Difference</th>
<th>Relative Difference (Percent)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary Care Physician</td>
<td>$53.07</td>
<td>$100.67</td>
<td>$47.60</td>
<td>89.69%</td>
</tr>
<tr>
<td>Advanced Practice Nurses (APN)</td>
<td>$41.90</td>
<td>$68.19</td>
<td>$26.29</td>
<td>62.75%</td>
</tr>
<tr>
<td>Cardiologists</td>
<td>$61.49</td>
<td>$126.36</td>
<td>$64.87</td>
<td>105.49%</td>
</tr>
<tr>
<td>General Surgery</td>
<td>$52.74</td>
<td>$109.72</td>
<td>$56.98</td>
<td>108.05%</td>
</tr>
<tr>
<td>Obstetrician / Gynecologist (OB/GYN)</td>
<td>$48.84</td>
<td>$92.72</td>
<td>$43.88</td>
<td>89.85%</td>
</tr>
<tr>
<td>Oncologist</td>
<td>$62.56</td>
<td>$120.35</td>
<td>$57.79</td>
<td>92.37%</td>
</tr>
<tr>
<td>Ophthalmologists</td>
<td>$44.47</td>
<td>$118.05</td>
<td>$73.58</td>
<td>165.46%</td>
</tr>
<tr>
<td>Orthopedists</td>
<td>$50.75</td>
<td>$98.23</td>
<td>$47.49</td>
<td>93.57%</td>
</tr>
<tr>
<td>Psychologists / Psychiatrists</td>
<td>$44.25</td>
<td>$91.92</td>
<td>$47.67</td>
<td>107.74%</td>
</tr>
</tbody>
</table>

Notes: Weighted Commercial and Medicaid Averages Prices were based on the most common CPT procedures billed for outpatient services. Only CPT procedures that were represented both in Commercial and Medicaid claims are included in the weighted averages. Relative difference percent calculated as \(\frac{\text{Commercial} - \text{Medicaid}}{\text{Medicaid}} \times 100\).
Interim Evaluation Summary of Key Findings

• Geographic access comparable

• Significant differences in reported and observed access in QHPs with improved:
  – Primary care availability
  – Specialty visits
  – Care when needed

• Observed differences in ER use:
  – More appropriate ER use in QHPs
  – Higher utilization rates in Medicaid
  – More non-emergent care delivered in ER for Medicaid

• Clinical outcomes improved in QHPs
Political Observations: Need vs Reality

- Cost Sharing
- Premiums
- Benefit Incentives
- Lock-out periods
- Health Savings Accounts
- Work Requirements
- Retrospective eligibility restrictions
- Block grants – Global vs. Per-Capita
State Innovation Model

Center for Medicare and Medicaid Innovation providing up to $300 million to 25 states to support development and testing of multi-payer payment and delivery system models.
Arkansas Payment Improvement Initiative’s Integrated Model
Medical Home: Rollout Timeline

**Multi-payer PCMH Coverage Strategy**

- **Wave 1**: Comprehensive Primary Care Initiative (CPC), 69 Practices, Start of wave: October 2012
- **Wave 2**: 123 Practices, January 2014
- **Wave 3**: 135 Practices, January 2015
- **Wave 4**: 178 practices, January 2016
- **Wave 5**: 192 Practices with 182 enrolled in new CPC+ Initiative, January 2017
Of the $660.9M predicted total cost of care, $606.5M is the actual cost, $54.4M is the generated cost avoidance of the $54.4M in cost avoidance:
- $14.8M has been reinvested back into the provider community
- $39.6M represents total net cost avoidance
- $4.6M shared savings payments to providers for CY2015
PCMHs Receiving Shared Savings in 2017

- For Medicaid, 22 Provider Groups received Shared Savings
- Amounts from $35k to $1.54 million
Arkansas Payment Improvement Initiative’s Integrated Model
## Wave 1 Episodes

<table>
<thead>
<tr>
<th>Episode</th>
<th>Description</th>
<th>Principal Accountable Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Total Hip/ Knee replacement</strong></td>
<td>• Surgical procedure plus related claims 30 days prior to 90 days after</td>
<td>Orthopedic surgeon</td>
</tr>
<tr>
<td><strong>Perinatal (non-NICU)</strong></td>
<td>• Pregnancy-related claims for mother 40 wks before to 60 days after delivery</td>
<td>Delivering provider</td>
</tr>
<tr>
<td><strong>Ambulatory URI</strong></td>
<td>• 21-day window beginning with initial consultation</td>
<td>First provider to diagnose patient in-person</td>
</tr>
<tr>
<td><strong>Congestive Heart Failure Admission</strong></td>
<td>• Hospital admission and care within 30 days of discharge</td>
<td>Admitting hospital</td>
</tr>
<tr>
<td><strong>ADHD</strong></td>
<td>• 12-month episode including all ADHD services plus pharmacy costs</td>
<td>Physician or licensed mental health provider</td>
</tr>
</tbody>
</table>
How the Episode Payment Model Works

Year 1 results

Shared Savings
Savings/Cost Neutral
Shared Cost

* Quality of care protected by limits on gain sharing and required quality metrics

Average cost per episode for each provider

High

Low

Individual providers, in order from highest to lowest average cost

Acceptable
Commendable
Gain sharing limit

Regional individual average cost by episode, in order from highest to lowest average cost
<table>
<thead>
<tr>
<th>Patient-Centered Medical Home</th>
<th>Multi-Payer Participation</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Episodes</strong></td>
<td></td>
</tr>
<tr>
<td>Upper Respiratory Infection</td>
<td>[ARMedicaid]</td>
</tr>
<tr>
<td>Attention Deficit Hyperactivity Disorder</td>
<td>[ARMedicaid]</td>
</tr>
<tr>
<td>Perinatal</td>
<td></td>
</tr>
<tr>
<td>Congestive Heart Failure</td>
<td>[ARMedicaid]</td>
</tr>
<tr>
<td>Total Joint Replacement (Hip &amp; Knee)</td>
<td>[ARMedicaid][QualChoice]</td>
</tr>
<tr>
<td>Colonoscopy</td>
<td>[ARMedicaid][QualChoice]</td>
</tr>
<tr>
<td>Cholecystectomy (Gallbladder Removal)</td>
<td>[ARMedicaid][QualChoice]</td>
</tr>
<tr>
<td>Tonsillectomy</td>
<td>[ARMedicaid][QualChoice]</td>
</tr>
<tr>
<td>Oppositional Defiance Disorder</td>
<td>[ARMedicaid]</td>
</tr>
<tr>
<td>Coronary Artery Bypass Grafting</td>
<td>[ARMedicaid][QualChoice]</td>
</tr>
<tr>
<td>Asthma</td>
<td>[ARMedicaid][QualChoice]</td>
</tr>
<tr>
<td>Percutaneous Coronary Intervention</td>
<td>[ARMedicaid][QualChoice]</td>
</tr>
<tr>
<td>Chronic Obstructive Pulmonary Disease</td>
<td>[ARMedicaid][QualChoice]</td>
</tr>
<tr>
<td>Neonatal</td>
<td>[ARMedicaid]</td>
</tr>
<tr>
<td>ADHD/ODD Comorbidity</td>
<td>[ARMedicaid]</td>
</tr>
</tbody>
</table>
Arkansas Episodes of Care Highlights

• **URI:** 28% drop in unnecessary antibiotic prescribing for non-specific URI from 2012-2015

• **Perinatal:** Sustained improvements in perinatal screening rates; reduced C-Section rates; 3-4% overall cost reduction compared to neighbor states

• **Tonsillectomy:** Path lab use down 48% for Medicaid; costs reduced by 5% for ARBCBS

• **Congestive Heart Failure:** Medicaid CHF costs reduced by 14% from 2014-2015

• **For 2015 Medicaid performance:** $519k in gain-share payments and $257k in risk-share

January 2017
Reports provide performance information for PAP’s episode(s):

- Overview of **quality** across a PAP’s episodes
- Overview of **cost effectiveness** (how a PAP is doing relative to cost thresholds and relative to other providers)
- Overview of **utilization** and drivers of a PAP’s average episode cost
AR Healthcare Transparency Initiative

• Mandatory All-payer Claims Database (following failed voluntary effort)
  – All commercial carriers with >2000 covered lives
  – Medicaid and Medicare
  – Self-insured plans receiving state dollars
  – Private self-insured: voluntary or as legally required

• Types of data
  – Enrollment data with standardized hashed identifier
  – Medical and pharmaceutical claims
  – Dental claims
  – Workers compensation claims
Medicare Type II Diabetes Rate by County

Type II Diabetes Rate for Medicare Beneficiaries 2013

ADMINISTERED BY APCD

ACHI
Medicare HbA1c Testing Rate by County

HbA1C Annual Test Rate for Medicare Type II Diabetics 2013

ADMINISTERED BY
Arkansas APCD Website Reports

**Arkansas APCD**

**EpiPen Cost Trends in Arkansas**

**Commercial Health Insurance**
- 2013: $216
- 2014: $321
- 2015: $433
- 2013: $53
- 2014: $37
- 2015: $21

**Arkansas Medicaid**
- 2013: $251
- 2014: $340
- 2015: $445

The graphic uses Arkansas All-Payer Claims Database (APCD) data to analyze the amounts paid for EpiPens (2-pack) over time. Amounts paid do not reflect any available rebates to patients or payers.

ACHI is a nonpartisan, independent, health policy center that serves as a catalyst to improve the health of Arkansans.

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(501) 526-2244 - www.achi.net

Administered by: ACHI

With support from the Arkansas Insurance Department, Health Insurance Rate Review Division.
## Dental Provider Procedure/Price Variation

### Single Molar Root Canal (does not include any other procedures, e.g. Xrays, exams, etc.)

<table>
<thead>
<tr>
<th>Provider</th>
<th>Specialty</th>
<th>Number of Encounters in 2014</th>
<th>25th Percentile</th>
<th>50th Percentile</th>
<th>75th Percentile</th>
</tr>
</thead>
<tbody>
<tr>
<td>Daniel Miles, DMD</td>
<td>Oral Maxillofacial Surgery</td>
<td>163</td>
<td>$736</td>
<td>$898</td>
<td>$898</td>
</tr>
<tr>
<td>Danny Bitner, DDS</td>
<td>Oral Maxillofacial Surgery</td>
<td>59</td>
<td>$802</td>
<td>$964</td>
<td>$964</td>
</tr>
<tr>
<td>Diane Park, DDS</td>
<td>Endodontist</td>
<td>46</td>
<td>$736</td>
<td>$898</td>
<td>$898</td>
</tr>
<tr>
<td>Brian Thompson, DMD</td>
<td>Endodontist</td>
<td>40</td>
<td>$842</td>
<td>$898</td>
<td>$978</td>
</tr>
<tr>
<td>Shannon Rocker, DDS PA</td>
<td>Endodontist</td>
<td>39</td>
<td>$737</td>
<td>$898</td>
<td>$964</td>
</tr>
<tr>
<td>Daniel Chan, DDS PA</td>
<td>Endodontist</td>
<td>36</td>
<td>$1,560</td>
<td>$1,700</td>
<td>$1,750</td>
</tr>
<tr>
<td>Peter Hill, DDS PA</td>
<td>General Practice</td>
<td>36</td>
<td>$572</td>
<td>$682</td>
<td>$682</td>
</tr>
<tr>
<td>Eric Rhee, DDS PA</td>
<td>Endodontist</td>
<td>33</td>
<td>$895</td>
<td>$895</td>
<td>$898</td>
</tr>
<tr>
<td>Sarah Lovell, DDS PLLC</td>
<td>General Practice</td>
<td>30</td>
<td>$571</td>
<td>$702</td>
<td>$702</td>
</tr>
<tr>
<td>Stephen Surat, DDS</td>
<td>General Practice</td>
<td>30</td>
<td>$737</td>
<td>$898</td>
<td>$964</td>
</tr>
</tbody>
</table>
ARKANSAS MEDICAL MARIJUANA: POTENTIAL QUALIFYING PATIENTS

Top Five Qualifying Conditions Statewide

Percent of Population with Condition

<table>
<thead>
<tr>
<th>Condition</th>
<th>Low</th>
<th>Med</th>
<th>High</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cancer</td>
<td>6%</td>
<td>9%</td>
<td>12%</td>
</tr>
<tr>
<td>Peripheral neuropathy</td>
<td>5%</td>
<td>8.5%</td>
<td>12%</td>
</tr>
<tr>
<td>Glaucoma</td>
<td>2%</td>
<td>7.5%</td>
<td>13%</td>
</tr>
<tr>
<td>Epilepsy</td>
<td>2%</td>
<td>3.5%</td>
<td>5%</td>
</tr>
<tr>
<td>Alzheimer’s</td>
<td>1%</td>
<td>2.5%</td>
<td>4%</td>
</tr>
</tbody>
</table>

STATE MAP KEY:
Number of Qualifying Patients by County

Total Number of Qualifying Patients Statewide: 541,673*

*Does not include patients with certain conditions; see text box at left of graphic for details.
AR Healthcare Transparency Initiative

- Mandatory All-payer Claims Database (following failed voluntary effort)
  - All commercial carriers with >2000 covered lives
  - Medicaid and Medicare
  - Self-insured plans receiving state dollars
  - Private self-insured: voluntary or as legally required

- Additional data elements legislatively authorized
  - Birth and death records
  - Cancer registry
  - Prescription drug monitoring program
  - Self-insured Hospital and ER data
  - Medical marijuana “user” flag
Age-Adjusted Prevalence of Obesity and Diagnosed Diabetes Among US Adults

1994

Obesity (BMI ≥ 30 kg/m²)

Diabetes

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

1995

**Obesity (BMI ≥ 30 kg/m²)**
- Missing Data
- 14.0%–17.9%
- 18.0%–21.9%
- 22.0%–25.9%
- ≥26.0%

**Diabetes**
- Missing data
- 4.5%–5.9%
- 6.0%–7.4%
- 7.5%–8.9%
- ≥9.0%

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

1996

**Obesity (BMI≥30 kg/m²)**

- **Missing Data**
- 14.0%–17.9%
- 18.0%–21.9%
- 22.0%–25.9%
- ≥26.0%

**Diabetes**

- **Missing data**
- 4.5%–5.9%
- 6.0%–7.4%
- 7.5%–8.9%
- ≥9.0%

CDC’s Division of Diabetes Translation.


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

1997

Obesity (BMI ≥30 kg/m²)

*Missing Data*
- 14.0%–17.9%
- 18.0%–21.9%
- 22.0%–25.9%
- ≥26.0%

Diabetes

*Missing data*
- <4.5%
- 4.5%–5.9%
- 6.0%–7.4%
- 7.5%–8.9%
- ≥9.0%
Age-Adjusted Prevalence of Obesity and Diagnosed Diabetes Among US Adults

1998

**Obesity (BMI≥30 kg/m²)**

- Missing Data
- 14.0%–17.9%
- 18.0%–21.9%
- 22.0%–25.9%
- ≥26.0%

**Diabetes**

- Missing data
- 4.5%–5.9%
- 6.0%–7.4%
- 7.5%–8.9%
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Age-Adjusted Prevalence of Obesity and Diagnosed Diabetes Among US Adults

1999

Obesity (BMI≥30 kg/m²)

Diabetes

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

2000

Obesity (BMI≥30 kg/m²)

Diabetes

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

2001

Obesity (BMI≥30 kg/m²)

- Missing Data
- 14.0%–17.9%
- 18.0%–21.9%
- 22.0%–25.9%
- ≥26.0%

Diabetes

- Missing data
- 4.5%–5.9%
- 6.0%–7.4%
- 7.5%–8.9%
- ≥9.0%

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

2002

Obesity (BMI≥30 kg/m²)

- Missing Data
- 14.0%–17.9%
- 18.0%–21.9%
- 22.0%–25.9%
- ≥26.0%

Diabetes

- Missing data
- 4.5%–5.9%
- 6.0%–7.4%
- 7.5%–8.9%
- ≥9.0%

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

2003

Obesity (BMI≥30 kg/m²)

- Missing Data
- 14.0%–17.9%
- 18.0%–21.9%
- 22.0%–25.9%
- ≥26.0%

Diabetes

- Missing data
- 4.5%–5.9%
- 6.0%–7.4%
- 7.5%–8.9%
- ≥9.0%

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

2004

Obesity (BMI≥30 kg/m²)

Diabetes

CDC’s Division of Diabetes Translation.


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

2005

Obesity (BMI≥30 kg/m²)

Diabetes

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

2006

Obesity (BMI≥30 kg/m²)

- Missing Data
- 14.0%–17.9%
- 18.0%–21.9%
- 22.0%–25.9%
- ≥26.0%

Diabetes

- Missing data
- 4.5%–5.9%
- 6.0%–7.4%
- 7.5%–8.9%
- ≥9.0%

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

2009

Obesity (BMI ≥30 kg/m²)

Diabetes

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

2010

Obesity (BMI≥30 kg/m²)

Diabetes

Missing Data

14.0%–17.9%

<14.0%

18.0%–21.9%

≥14.0%

22.0%–25.9%

≥14.0%

≥26.0%

Missing data

4.5%–5.9%

<4.5%

6.0%–7.4%

≥4.5%

7.5%–8.9%

≥9.0%

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

2011

Obesity (BMI ≥30 kg/m²)

- Missing Data
- <14.0%
- 14.0%–17.9%
- 18.0%–21.9%
- 22.0%–25.9%
- ≥26.0%

Diabetes

- Missing data
- <4.5%
- 4.5%–5.9%
- 6.0%–7.4%
- 7.5%–8.9%
- ≥9.0%

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

2012

Obesity (BMI≥30 kg/m²)

Diabetes

Age-Adjusted Prevalence of Obesity and Diagnosed Diabetes Among US Adults 2013

Obesity (BMI≥30 kg/m²)

- Missing Data
- 14.0%–17.9%
- 18.0%–21.9%
- 22.0%–25.9%
- ≥26.0%

Diabetes

- Missing data
- 4.5%–5.9%
- 6.0%–7.4%
- 7.5%–8.9%
- ≥9.0%

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

2014

Obesity (BMI≥30 kg/m²)

Diabetes

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

2015

Obesity (BMI≥30 kg/m²)

- Missing Data
- 14.0%–17.9%
- 18.0%–21.9%
- 22.0%–25.9%
- ≥26.0%

Diabetes

- Missing data
- 4.5%–5.9%
- 6.0%–7.4%
- 7.5%–8.9%
- ≥9.0%

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

**Obesity (BMI ≥30 kg/m²)**

- **1994**
- **2000**
- **2015**

**Diabetes**

- **1994**
- **2000**
- **2015**

CDC's Division of Diabetes Translation. United States Surveillance System available at http://www.cdc.gov/diabetes/data
HEALTHY ACTIVE
ARKANSAS
A 10-year Plan for Arkansas
Future of Healthcare: 2017 and beyond

- Best outcome for the patient still the goal
  - Technical quality and skill will be required
  - Health outcomes, patient engagement, clinical efficiencies will be rewarded

- Payment strategies will transition
  - ACA repeal, replace, repackage, revise?
  - MACRA with bipartisan support and in place

- Providers and health care systems must reach beyond institutional walls

- Medical, nursing, pharmaceutical education will evolve to support new system
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