Virtual Quality Forum

August 9, 2023
12:00pm – 1:00pm

NCDHHS
NC Medicaid
Division of Health Benefits

NC AHEC
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Closed Captioning is available for this webinar

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Logistics for Today's Webinar

Question during the live webinar

Technical assistance

technicalassistanceCOVID19@gmail.com

Agenda

Topic	Presenter
Welcome & Introductions 2 minutes	• Chris Weathington - NC AHEC
2023 AMH Measure Set 2 minutes	• Measure Set Overview – DHB – Sam Thompson
Performance Improvement Projects 5 minutes	• Chelsea Gailey - DHB
AMH Priority Measures 8 minutes	• CIS - Jennifer Frazer - AmeriHealth • PPC - Tina Bronson - United Health • HbA1c Control - Lauren Roberts - WellCare
Strategic Plan to Leverage the HIE 8 minutes	• Jess Kuhn - DHB
CAHPS 10 minutes	• Liz Senn - Carolina Complete Health
Provider Survey Results 10 minutes	• Hannah Fletcher - DHB
Administrative Simplification 2 minutes	• Dr. William Lawrence - Carolina Complete Health
Questions/Meeting Close 10 minutes	• Chris Weathington - NC AHEC
Appendix	• For Reference Only

2023 AMH Measure Set

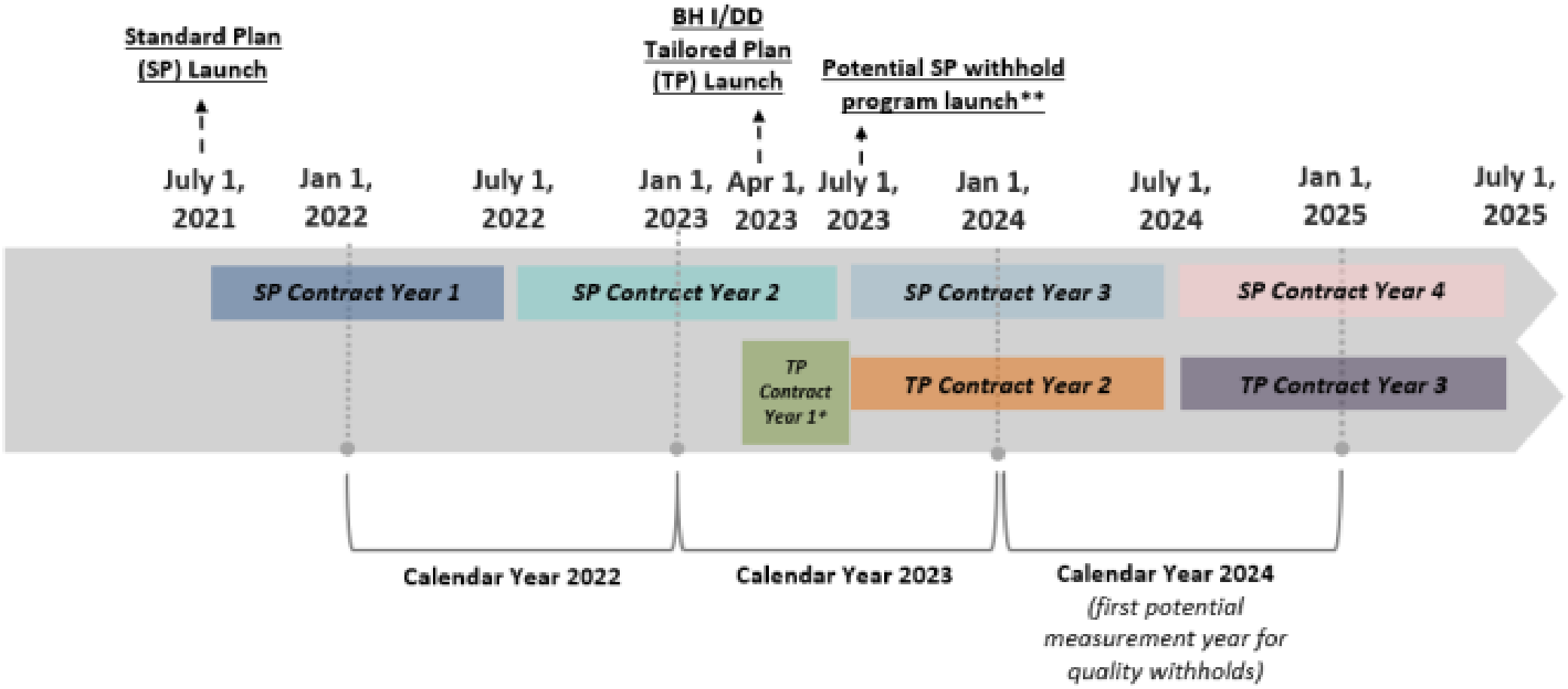
AMH Measure Set

NQF#	Measure Name	Steward	Frequency[20]
Pediatric Measures			
1516	Child and Adolescent Well-Care Visits (WCV)	NCQA	Annually
0038	Childhood Immunization Status (Combination 10) (CIS)	NCQA	Annually
0033	Chlamydia Screening in Women (CHL) – Ages 16 to 20	NCQA	Annually
1407	Immunizations for Adolescents (Combination 2) (IMA)	NCQA	Annually
0418/0418e	Screening for Depression and Follow-up Plan (CDF) – Ages 12 to 17	CMS	Annually
1392	Well-Child Visits in the First 30 Months of Life (W30)	NCQA	Annually
Adult Measures (Age 18 and Older Unless Otherwise Noted)			
0032	Cervical Cancer Screening (CCS) – Ages 21 to 64	NCQA	Annually
0033	Chlamydia Screening in Women (CHL) – Ages 21 to 24	NCQA	Annually
0018	Controlling High Blood Pressure (CBP)	NCQA	Annually
0059/0575	Hemoglobin A1c Control for Patients With Diabetes (HBD)	NCQA	Annually
1768	Plan All-Cause Readmissions (PCR) [Observed versus expected ratio]	NCQA	Annually
0418/ 0418e	Screening for Depression and Follow-up Plan (CDF)	CMS	Annually
N/A	Total Cost of Care	Health Partners	Annually
1517	**NEW:** Prenatal and Postpartum Care (PPC)[21]	NCQA	Annually

20 Monthly gap measure reports are also required.

Standard Plan Quality Measurement Timeline

Quality measure performance is assessed according to the calendar year.



Performance Improvement Projects

Performance Improvement Projects Background

States must require managed care plans to implement performance improvement projects (PIPs) as part of a comprehensive quality assessment and performance improvement (QAPI) program.

The purpose of these projects is to achieve significant improvement in measurement of quality performance with objective indicators, as well as to sustain this improvement over time (42 CFR 438.330).

States must require MCOs, PIHPs, and PAHPs to conduct clinical and nonclinical PIPs to examine access to and quality of care.

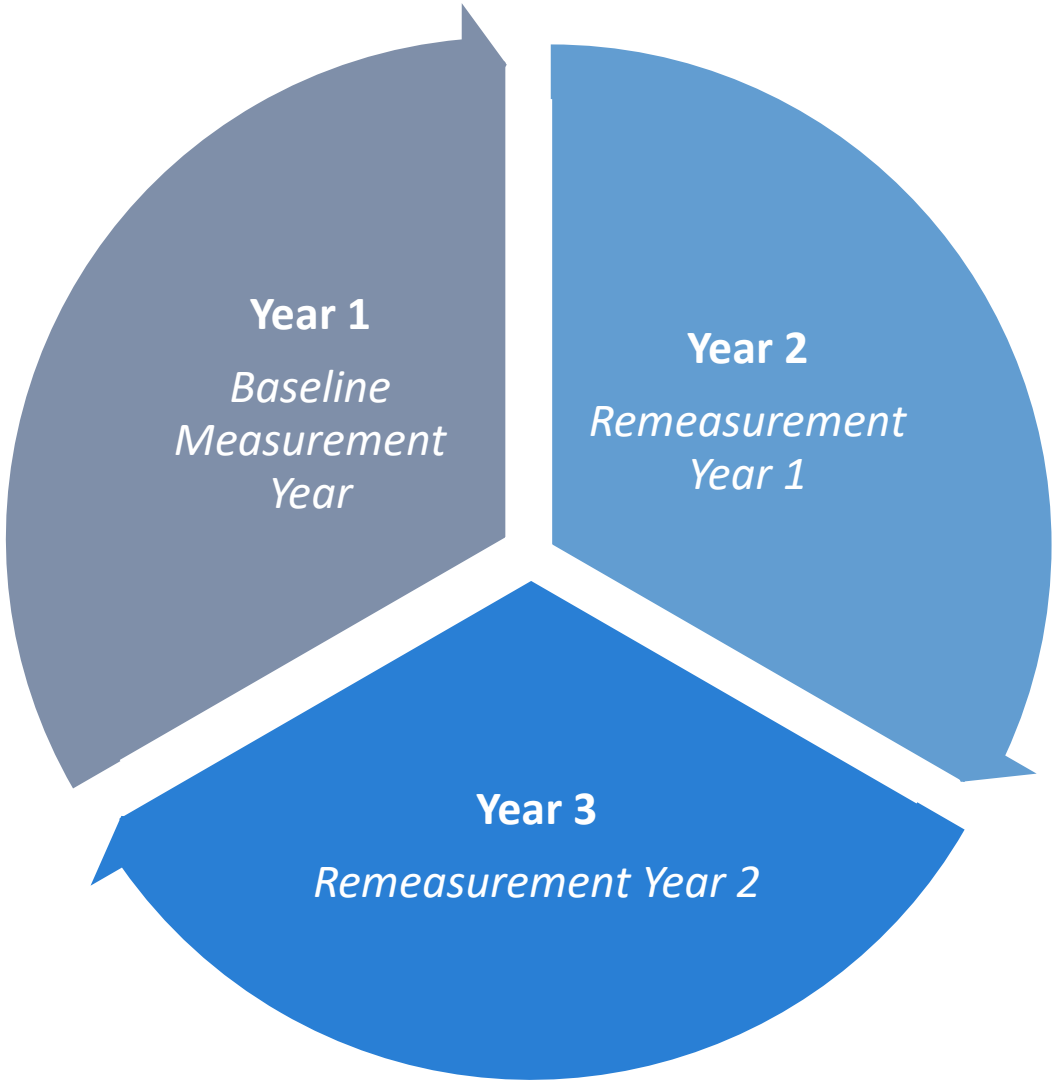
PIPs must include four key elements:

- performance measurement;
- implementation of interventions;
- evaluation of the interventions' impact using the performance measures; and
- activities to increase/sustain improvement (42 CFR 438.330(d)).

PIP Life Cycle

DHB has elected to do 3-year PIP Cycles.

1. **Year one establishes the PIP and its baseline data.** During year one, plans establish:
    1. PIP Topic
    2. AIM Statement
    3. PIP Eligible Population
    4. Sampling Methodology (If applicable)
    5. Performance Indicators
    6. Data collection Methodology
2. **Year two consists of "remeasurement" of data to assess impact of interventions.** During year two, plans establish:
    7. Indicator Results (initial rates from Baseline Measurement Year)
    8. Improvement Strategies
3. **Year three consists of a final "remeasurement" to establish impact of improvement strategies.**



Clinical and Non-Clinical PIP Definitions

The Standard Plans are responsible for <u>four total PIPs</u>: three *clinical* PIPs and one *nonclinical* PIP.

1. **A Clinical PIP** refers to the process of *managing the patient/ member*, most often relating or pertaining to the treatment or management of a condition or disease state.
   - For example, A1C control, or blood pressure control, relates to Diabetes and Hypertension and the effective management of each. Mostly relating to providers / clinicians / nurses measuring clinical issues.
2. **A Non-Clinical PIP** refers to the *"administrative" management of the patient/ member*, which measures the effectiveness of policies and procedures / workflows that surround the clinical management.
   - Examples may include scheduling, patient outreach or other internal organizational practices that help in coordinating care.

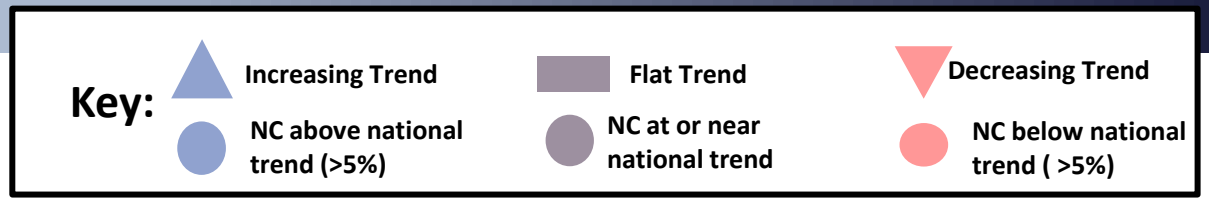
Standard Plan PIPs Additional Information

1. Performance Indicator goals are a 5% relative increase from baseline rate
2. PIP Topic / Indicator follows HEDIS Technical Specifications
3. Quarterly progress reports
4. Learning Collaboratives

   These are collaborative spaces where plan representatives' problem solve barriers to improve rates and implement change ideas with the support of DHB's QI Team. The following will be implemented in 2024:

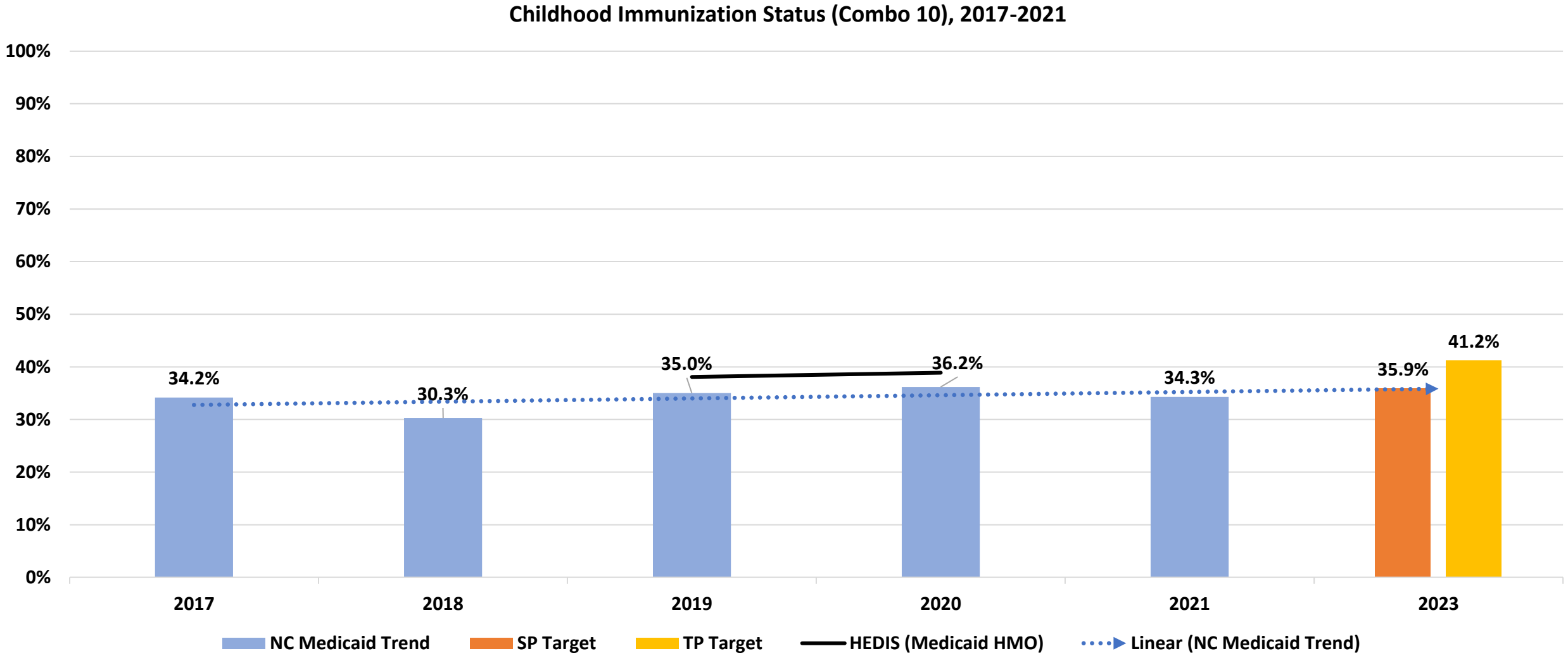
   a. Child Health Learning Collaborative
      - Began in 2023 as IWC W30 Submeasure 1 Collaborative
   b. Prenatal and Postpartum Care Learning Collaborative
   c. Care Needs Screening Learning Collaborative
   d. Diabetes Management Learning Collaborative

Childhood Immunization Status (CIS) (Combo 10) (NQF# 0038, NCQA, Process Measure)



	Review Area		
Core Fields	**Endorsement Status (e.g., Active, Retired, Pending)**	Active	
	Clinical Significance	Childhood vaccines protect children from a number of serious and potentially life-threatening diseases such as diphtheria, measles, meningitis, polio, tetanus and whooping cough, at a time in their lives when they are most vulnerable to disease.	
	Performance (e.g., National, State, Comparison to Prior Years)	**NC:** See Next Slide	**National Median:** 38.9% Medicaid HMO; 58%/51.4% Commercial HMO, Commercial PPO (HEDIS 2020)
	Measure Specifications Changes	No changes in 2022	
	Selected Equity Results/Considerations	Large disparities in 2021 performance for Black enrollees (>40%) (see slide 15).	
Optional Fields	**Data Collection/Reporting Considerations**	Administrative eCQM	
	Measure Alignment with CMS and Other State Medicaid Programs	CMS Child Core MA ACO/MCO Program measure Virginia Managed Care Plan Performance Withhold Program measure (Combo 3) Oregon 2023 Challenge Pool measure (Combo 3) NY Total Care for General Population VBP Quality Measure (Combo 3) (2022)	

Childhood Immunization Status (CIS) (Combo 10) (NQF# 0038, NCQA, Process Measure)



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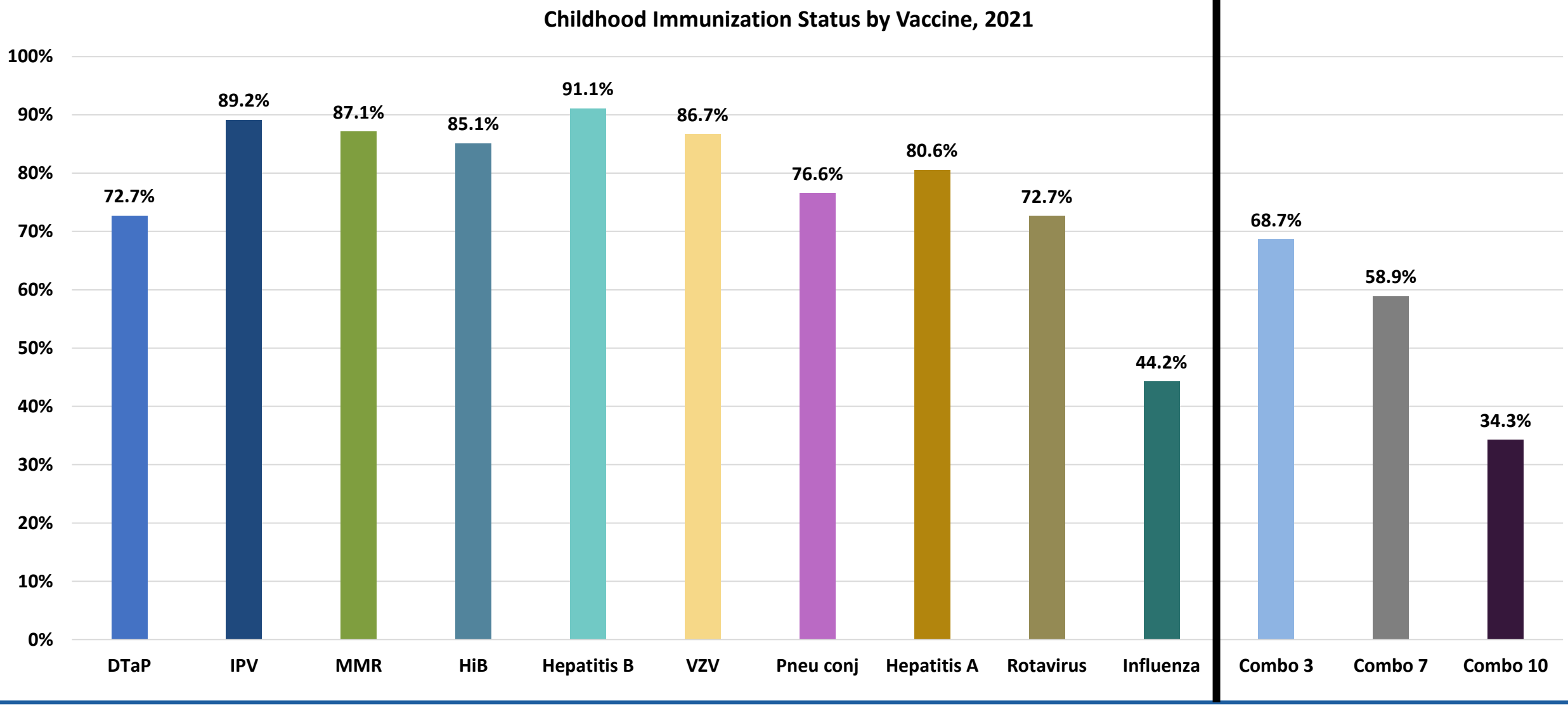

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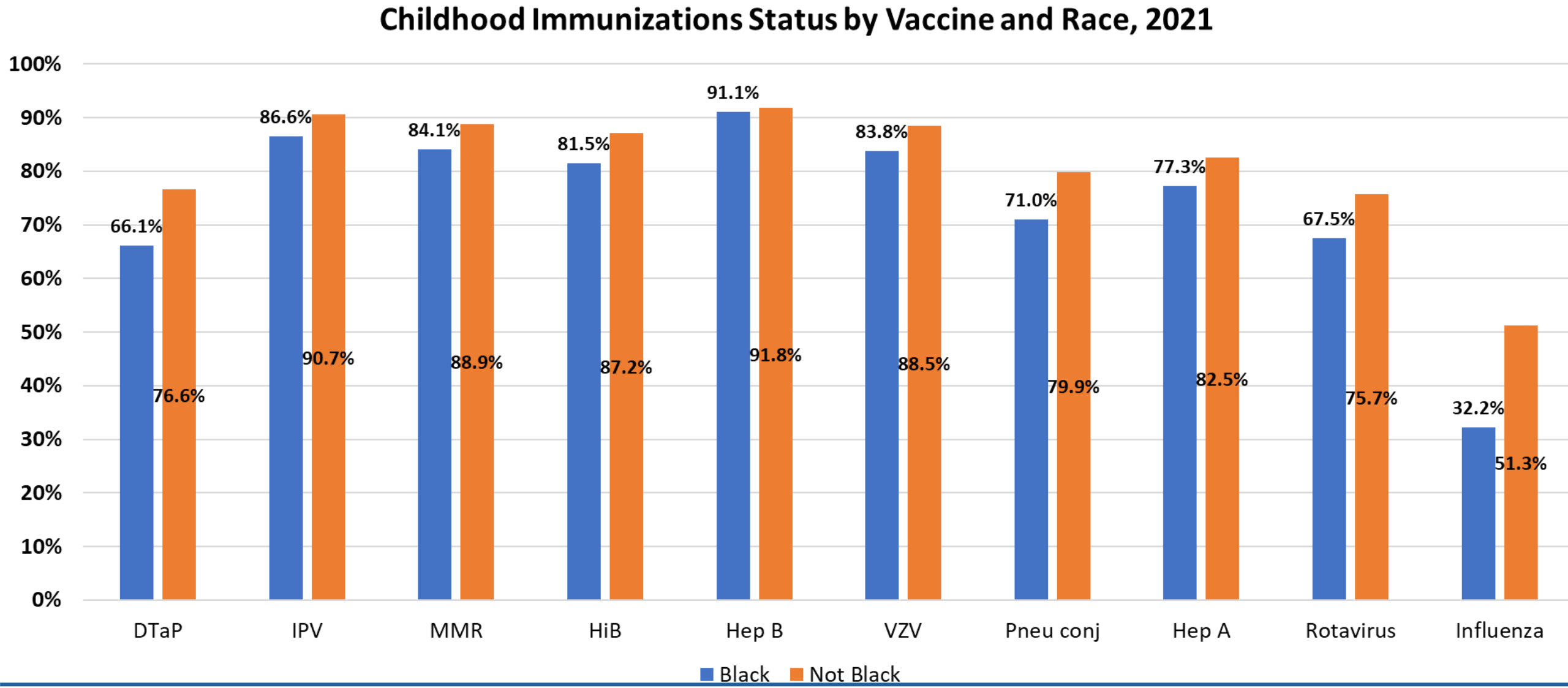
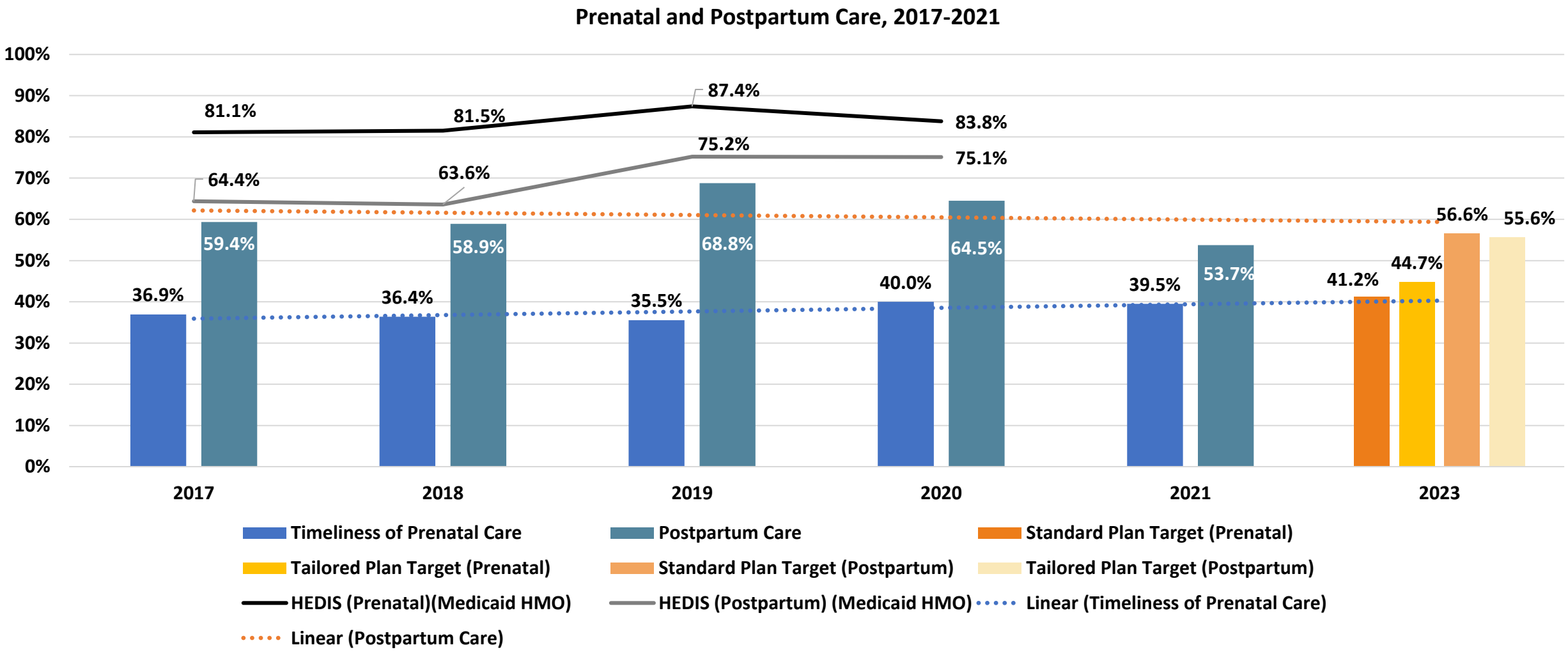


Prenatal and Postpartum Care (1517, NCQA, Process Measure)

Key: Increasing Trend | Flat Trend | Decreasing Trend | NC above national trend (>5%) | NC at or near national trend | NC below national trend (>5%)

	Review Area		
Core Fields	**Endorsement Status (e.g., Active, Retired, Pending)**	NQF Endorsement Removed in 2021	
	Clinical Significance	Each year, about four million women in the U.S. give birth, with one million women having one or more **complications** during pregnancy, labor and delivery or the postpartum period. Studies indicate that as many as **60% of all pregnancy-related deaths could be prevented** if women had better access to health care, received better quality of care and made changes in their health and lifestyle habits. Timely and adequate prenatal and postpartum care can **set the stage for the long-term health and well-being** of new mothers and their infants	
	Performance (e.g., National, State, Comparison to Prior Years)	**NC:** See Next Slide	**National Rates (HEDIS, 2020):** See Next Slide
	Measure Specifications Changes	None	
	Selected Equity Results/Considerations	NCQA introduced race and ethnicity stratifications to this measure in 2022. Small disparities for Black Standard Plan enrollees for both rates and Black Tailored Plan-eligible enrollees (Postpartum rate only) (<5%).	
Optional Fields	**Data Collection/Reporting Considerations**	Administrative	
	Measure Alignment with CMS and Other State Medicaid Programs	Medicaid Child Core Measure Georgia Performance Improvement Project (Timeliness of Prenatal Care Visits) NY Total Care for General Population VBP Quality Measure (2022) Virginia Managed Care Plan Performance Withhold Program measure	

Prenatal and Postpartum Care (1517, NCQA, Process Measure)

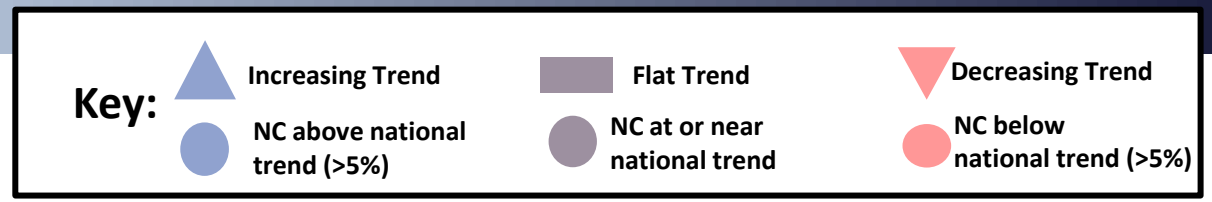


Rates artificially low due to global billing.

Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) (HPC) (0059, NCQA, Outcome Measure)

Measure Summary	The percentage of patients 18-75 years of age with diabetes (type 1 and type 2) whose most recent HbA1c level during the measurement year was greater than 9.0% (poor control) or was missing a result, or if an HbA1c test was not done during the measurement year.
Public Health and Clinical Considerations	Diabetes is a complex group of diseases marked by high blood glucose (blood sugar) due to the body's inability to make or use insulin. Left unmanaged, diabetes can lead to serious complications, including heart disease, stroke, hypertension, blindness, kidney disease, diseases of the nervous system, amputations and premature death. Proper diabetes management is essential to control blood glucose, reduce risks for complications and prolong life. With support from health care providers, patients can manage their diabetes with self-care, taking medications as instructed, eating a healthy diet, being physically active and quitting smoking.

Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)(HPC)(0059, NCQA, Outcome Measure)



	Review Area		
Core Fields	**Endorsement Status (e.g., Active, Retired, Pending)**	Active	
	Performance (e.g., National, State, Comparison to Prior Years)	**NC:** N/A, see "Data Collection" below	**National Rates (HEDIS, 2020):** 45.4% (Medicaid HMO); 54.5%/49% (Commercial HMO/PPO); 39% (CMS Scorecard,2020)
	Measure Specifications Changes	In 2022, NCQA modified the Comprehensive Diabetes Care measure (CDC) to create three standalone measures. Hemoglobin A1c Control for Patients With Diabetes (HBD) includes HbA1c Poor Control (>9.0%) and HbA1c control (<8.0%).	
	Selected Equity Results/Considerations	Disparities sensitive measure as indicated by HHS; NCQA introduced race and ethnicity stratifications in 2022; No disparities for Black or Hispanic enrollees in NC.	
Optional Fields	**Data Collection/Reporting Considerations**	DHB does not get A1c values via claims and encounters. Consequently, **our results are to be interpreted with caution**. We are working to get accurate A1c data via the Health Information Exchange but that process is under development.	
	Measure Alignment with CMS and Other State Medicaid Programs	Medicaid Adult Core Measure New York: 2020 Quality Improvement Incentive Program Oregon: CCO Incentive Measure (2022/2023) Virginia Managed Care Plan Performance Withhold Program measure MA ACO/MCO Program measure	

AMH Priority Measures

Childhood Immunization Status Combo 10 (CIS)

Description:
The percentage of children 2 years of age who are up to date on recommended routine Combination 10 vaccines

Lookback Period:
Birth to 2 years of age for members who meet eligibility criteria for the CIS measure

Lines of Business:
Commercial, Medicaid, Medicare (report each product line separately)

Required Exclusions:
- Members who died anytime during measurement year
- Members in hospice or using hospice services
- Members who had any of the following on or before 2nd birthday:
  - Severe combined immunodeficiency
  - Immunodeficiency
  - HIV
  - Lymphoreticular cancer, multiple myeloma, or leukemia
  - Intussusception

Description	Codes*
DTaP	**CPT:** 90697, 90698, 90700, 90723
HiB	**CPT:** 90644, 90647, 90648, 90697, 90698, 90748
HepA	**CPT:** 90633
HepB	**CPT:** 90723, 90740, 90744, 90747, 90748
IPV	**CPT:** 90697, 90698, 90713, 90723
Influenza	**CPT:** 90655, 90657, 90661, 90673, 90685, 90686, 90687, 90688, 90689, 90660, 90672
MMR	**CPT:** 90707, 90710
PCV	**CPT:** 90670
RV	**CPT:** 90680 (3 dose), 90681 (2 dose)
VZV	**CPT:** 90710, 90716
Hospice Care	**CPT:** 99377-99378 **HCPCS:** G0182, G9473-G9479, Q5003-Q5010, S9126, T2042-T2046

- Disparity noted for Black children in CY2021 NC Medicaid Childhood Immunization Status data
- Influenza, pneumococcal, and rotavirus adherence are drivers in Combo 10 performance

MCD Quality Compass 2022 (MY 2021) 50th percentile	MCD Quality Compass 2022 (MY 2021) 75th Percentile	NC DHHS 2021 Target	NC DHHS 2023 Target
34.79%	42.09%	34.15%	35.85%

Source: NCQA Quality Compass, 2022 and NC DHHS 2021 Standard Plan Quality Measures and 2023 Targets document, 12/8/2022

*Codes subject to change

CIS: Tips for Providers

Friendly Reminders for Our Providers	When talking to members

• Target disparate populations by generating a list from Electronic Health Record (EHR) systems (Ex: families in rural areas and/or those with transportation issues)
• Utilize opportunities at visits outside of well visits to administer vaccines
• Document in the EHR and NC Immunization Registry if immunizations were received elsewhere
• Develop a workflow document to determine if immunizations were received elsewhere
• Use standing orders to empower nurses or other qualified health care professionals to administer vaccines (see www.immunize.org/catg.d/p3067.pdf)
• Partner with local Health Departments and PHPs to ensure communication/coordination flow
• Partner with school systems to advertise immunization clinics/dates being provided
• Run kid-friendly videos in well child clinics on importance of vaccinations
	• Remind members of open care gaps for preventive health during care management calls and other encounters
	• Use already developed handouts for parents related to importance of vaccines (www.immunize.org/catg.d/p4314.pdf)
	• Offer drive-through vaccination clinics, focus on flu vaccination
	• Mail post card reminders to families
	• Implement a well child/immunization promotion monthly with gift card drawing
	• Partner with PHPs and NC DHHS to
	  • Promote preventive care in conjunction with childcare centers and faith-based groups
	  • Public service announcements and state agency funded events
	  • PHP initiated care alerts via text messaging, emails, live outbound calls or Integrated Voice Response (IVR) messaging
	  • Offer member incentives for care gap closure

Additional CIS resources in Appendix

Prenatal & Postpartum Care (PPC)

Prenatal and Postpartum Care (PPC)

Description:

The percentage of deliveries of live births on or between October 8 of the year prior to the measurement year (MY) and October 7 of the measurement year (MY). For these members, the measure assesses the following facets of prenatal and postpartum care:

- **Timeliness of Prenatal Care:** The percentage of deliveries that received a prenatal care visit in the first trimester, on or before the enrollment start date or within 42 days of enrollment in the organizations
- **Postpartum Care:** The percentage of deliveries that had a postpartum visit on or between 7 and 84 days after delivery

Lookback Period:

October 8 of the year prior to the measurement year and October 7 of the measurement year

First Trimester is defined as 280-170 days prior to delivery OR expected date of confinement/expected due date (EDC/EDD)

Lines of Business:

Commercial, Medicaid (report each product line separately)

Required Exclusions:

- Members who died anytime during the measurement year.
- Members in hospice or using hospice services anytime during the measurement year.
- Member was not pregnant, or pregnancy did not result in live birth.

Description	Codes*
Prenatal Bundled Services	**CPT/CPT II:** 59400, 59425, 59426, 59510, 59610, 59618 **HCPCS:** H1005
Stand-Alone Prenatal Visits	**CPT/CPT II:** 99500, 0500F, 0501F, 0502F **HCPCS:** H1000, H1001, H1002, H1003, H1004
Prenatal Office Visits with Diagnosis of Pregnancy	**CPT/CPT II:** 99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245, 99483 **HCPCS:** G0463, T1015
Pregnancy Diagnosis	**ICD -10 Diagnosis:** Z34.90, Encounter for supervision of normal pregnancy, unspecified, unspecified trimester
Telephone Visit, E-visit or Online Assessment with a Diagnosis of Pregnancy Telephone Visit	**CPT-CAT-II:** 98966, 98967, 98968, 99441, 99442, 99443
Postpartum Bundled Services	**CPT/CPT II:** 59400, 59410, 59510, 59515, 59610, 59614, 59618, 59622
Postpartum Visits	**CPT/CPT II:** 57170, 58300, 59430, 99501, 0503F **HCPCS:** G0101 **ICD -10 Diagnosis:** Z01.411, Z01.419, Z01.42, Z30.430, Z39.1, Z39.2

Prenatal				Postpartum			
MCD Quality Compass 2022 (MY 2021) (50th Percentile)	MCD Quality Compass 2022 (MY 2021) (75th Percentile)	NC DHHS 2021 Target	NC DHHS 2023 Target	MCD Quality Compass 2022 (MY 2021) (50th Percentile)	MCD Quality Compass 2022 (MY 2021) (75th Percentile)	NC DHHS 2021 Target	NC DHHS 2023 Target
85.40%	88.86%	39.21%	41.17%	77.37%	81.27%	53.84%	56.53%

*Codes subject to change

Prenatal and Postpartum Care (PPC): Tips for Providers

Friendly Reminders for Our Providers	When talking to members
• Offer comprehensive prenatal care to expectant mothers, including regular check-ups, appropriate screening tests, nutritional guidance, and emotional support throughout pregnancy. • Identify high-risk pregnancies, such as those involving maternal age, pre-existing medical conditions, or previous complications because early identification allows for proactive management and appropriate referrals to specialists. • Screen for perinatal mood disorders and offer appropriate counseling, therapy, or referral services. • Establish breastfeeding-friendly environments, offer lactation support, and connect new mothers with lactation consultants if needed. • Develop individualized postpartum care plans for each woman, considering her specific needs and circumstances, including information on physical recovery, contraception options, newborn care, and available community resources. • Provide culturally competent care and ensure awareness of the diverse backgrounds and beliefs of patients. by respecting cultural preferences and providing tailored care that aligns with individual values, traditions, and practices. • Establish mechanisms for continuous quality improvement, such as regular audits, feedback loops, and performance evaluations. • Stay updated with evidence-based guidelines and participate in relevant professional development opportunities.	• Providers should prioritize educating pregnant women about the importance of prenatal care, healthy lifestyle choices, and potential risks. Inform them about proper nutrition, exercise, and self-care practices during pregnancy. • Promote the importance of continuity of care throughout the entire pregnancy and postpartum period and maintain consistent communication and collaboration, ensuring a seamless transition between prenatal, intrapartum, and postpartum care. • Address the mental health needs of pregnant and postpartum women and encourage the establishment of support groups to foster a sense of community and reduce feelings of isolation. • Emphasize the benefits of breastfeeding and provide support and education to promote successful breastfeeding. • Promote family-centered care by involving partners and family members in prenatal and postpartum care decisions. • Encourage open communication, shared decision-making, and the involvement of support persons during childbirth and postpartum recovery.

Additional PPC resources in Appendix

Hemoglobin A1c Control for Patients With Diabetes

Hemoglobin A1c Control For Patients with Diabetes (HBD)

Description:

Percentage of members 18-75 years of age with diabetes (types 1 and 2) whose hemoglobin A1c (HbA1c) was at the following levels during the measurement year:

- HbA1c Control (<8.0%)
- HbA1c Poor Control (>9.0%)
  *This is an inverse measure; the goal is to be less than or equal to 9.0%.

Lookback Period:

January 1, MY-December 31, MY

Lines of Business:

Commercial, Medicaid, Medicare (report each product line separately)

Required Exclusions:

- Members receiving palliative care
- Members in hospice or using hospice services
- Members who do not have a diagnosis of diabetes in any setting, and who had a diagnosis of polycystic ovarian syndrome, gestational diabetes, or steroid-induced diabetes, in any setting

Description	Codes*
HbA1c screening	**CPT:** 83036, 83037
HbA1c level **less than 7%**	**CPT-CAT-II:** 3044F
HbA1c level **greater than or equal to 7%** and **less than 8%**	**CPT-CAT-II:** 3051F
HbA1c level **greater than or equal to 8%** and **less than or equal to 9%**	**CPT-CAT-II:** 3052F
HbA1c **greater than 9.0%**	**CPT-CAT-II:** 3046F
Hospice Care	**CPT:** 99377-99378 **HCPCS:** G0182, G9473-G9479, Q5003-Q5010, S9126, T2042-T2046
Palliative Care	**HCPCS:** G9054, M1017

MCD Quality Compass 2022 (MY 2021) (50th Percentile)	MCD Quality Compass 2022 (MY 2021) (75th Percentile)	NC DHHS 2021 Target	NC DHHS 2023 Target
39.9%	35.52%	95.76% (Inverse)	90.97% (Inverse)

Source: Quality Compass Percentiles-National All LOBs-CY2022-MCD; 2021 Standard Plan Quality Measures and 2023 Targets

*Codes subject to change

Hemoglobin A1c Control For Patients with Diabetes (HBD): Tips for Providers

Friendly Reminders for Our Providers	When Talking to Members
• Ensure patient facing medical staff are aware of the HbA1c monitoring requirements for diabetics. It's important they're aware of the role they can play in assisting these members receive their HbA1c checks timely. Ex. Having staff complete POC A1c testing on the member before they see the provider. • Remember to document all A1c lab values with dates for all diabetic members. No matter the value. • Frequency of visits can depend on level of HbA1c control. Members with elevated A1c levels should be seen more often. • For point-of-care HbA1c testing, document the date of the in-office test with the result. The office MUST submit the CPT code for the test performed in addition to CPT-II codes to report A1c result value.	• Provide education to members regarding the need to monitor and manage their blood sugars (HbA1c). • Provide a visual representation of a normal, prediabetic and diabetic A1c reading/range. Ex. Stoplight report. • Stress the importance of how uncontrolled blood sugars can negatively affect the member's body/health. • Assist members if needed to schedule lab visits for regular A1c testing to include transportation assistance. • Remind members of open care gaps during care management calls, for the best management of their diabetes.

Additional HBD resources in Appendix

Strategic Plan to Leverage the HIE

The Challenge

1. Some key data elements used for NC Medicaid programs are currently incomplete, non-standardized, and duplicative across multiple sources
2. Exchange of data between PHPs and providers is often decentralized and requires many different interfaces
3. Practices face increasing administrative burden related to paperwork, documentation, and data sharing

How can we provide actionable data to support care management and quality improvement, while also reducing provider burden related to data exchange?

What is a Health Information Exchange?

A health information exchange (HIE) is a secure, electronic network that gives authorized health care providers the ability to access and share health-related information across a statewide information highway.

Leveraging the HIE will…

1. Reduce administrative burden and improve processes
2. Align with federal interoperability and quality objectives
3. Support DHHS's goals and priorities

Slide provided by the Health Information Exchange Authority (HIEA)

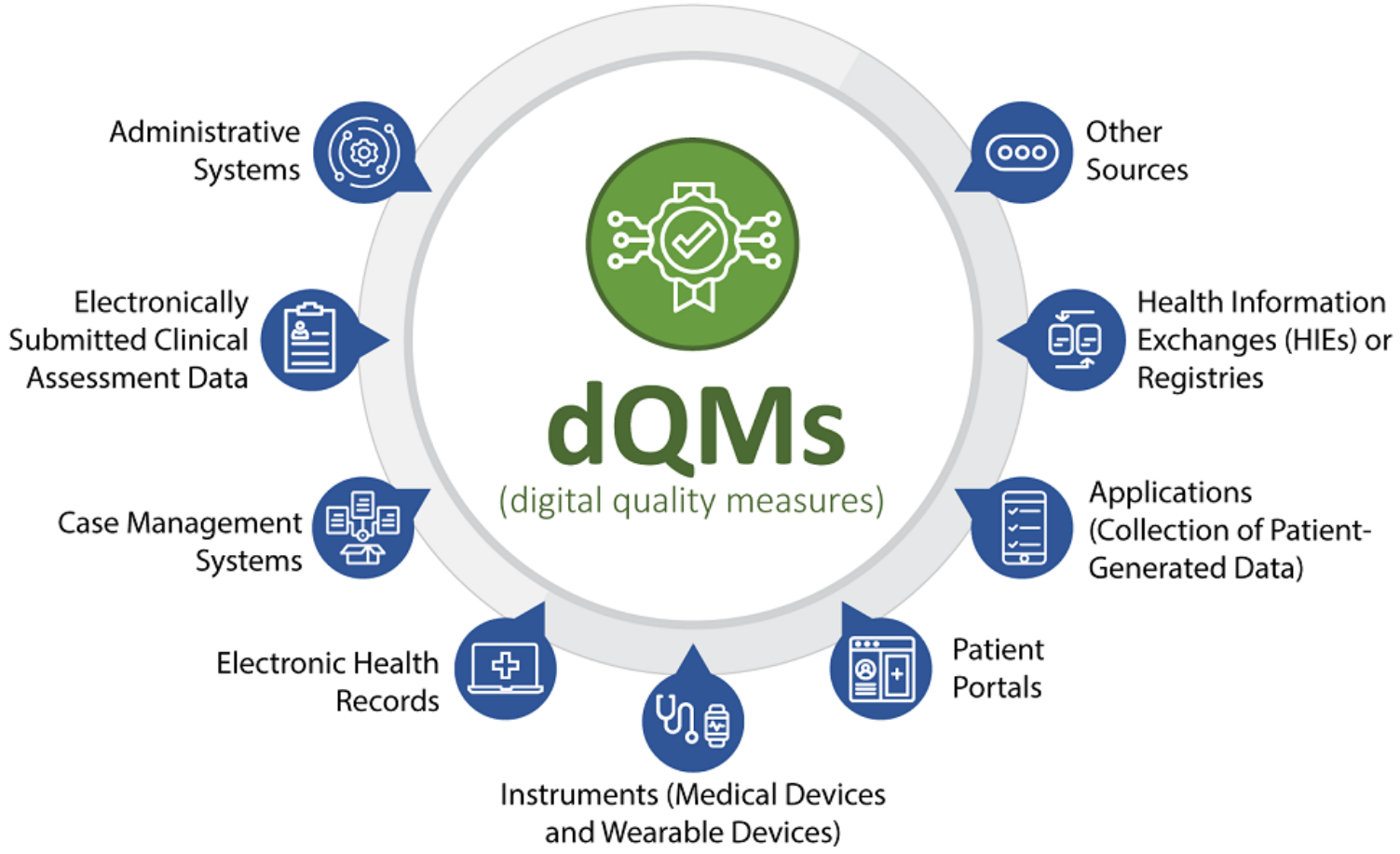
1 Reduced Administrative Burden and Improved Processes

Challenges with Our Current Process	Potential Future Using the HIE
1. Administrative burden	1. Reduces burden associated with sending data and reporting to multiple sources
2. Siloed patient health information	2. Real-time access to patient health information from multiple sources at the point of care
3. Lag in data availability and variability in care gap reports	3. Near-real-time care management and quality measure data, decreased variability in care gap reports
4. Operational complexity and lack of cross-system communication	4. Standardized, accurate, and timely data pulled in from multiple sources with minimal human interaction

2 Alignment with CMS Objectives

The CMS draft definition of Digital Quality Measures (dQMs) are:

"Quality measures, organized as self-contained measure specifications and code packages, that use one or more sources of health information that is captured and can be transmitted electronically via interoperable systems"



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Support for DHHS's Priorities

1. **Workforce**: Reduces provider administrative burden, reduces operational complexity, and incentivizes tech improvements and accurate coding
2. **Behavioral Health:** Supports care managers and practices in identifying, addressing, and sharing information on behavioral health needs and outcomes (such as depression screening data)
3. **Child and Family Well-Being:** Supports care managers and practices in identifying, addressing, and sharing information on needs and outcomes (such as data on unmet resource needs)

Health Equity: *By supporting improved data exchange, this vision can help DHB, care managers, and practices identify and address disparities across different services and outcomes.*

NC HealthConnex by the Numbers

NC HealthConnex is North Carolina's HIE. It allows health care providers to safely and securely share health information through a trusted network to improve health care quality and outcomes for North Carolinians.

NC HealthConnex, By the Numbers:

- 60,000+ providers with contributed records
- 9,000+ health care facilities live submitting data, including 145 hospitals
- 6,000+ health care facilities in onboarding
- 150 million+ continuity of care documents (CCDs)
- 14 million+ unique patient records with clinical documents
- 80 Electronic Health Record (EHR) vendors live
- 22+ border and interstate HIEs connected via the eHealth Exchange and the Patient Centered Data Home, including connections to the VA and DoD

*See appendix for information on how to get connected.

How do we get there?

1. Better understand current gaps, priorities, and actionable sources of variation in how entities submit and exchange data
2. Work closely with providers, payors, and the Health Information Exchange Authority (HIEA) to identify solutions that improve the standardization, completeness, and accuracy of data submitted by entities
3. Implement these solutions through new policy guidance, provider incentives, technology updates, and practice coaching

Medicaid CAHPS Survey Provider Overview

Medicaid CAHPS Survey – Purpose

CAHPS = Consumer Assessment of Healthcare Providers and Systems

- Developed as collaboration among CMS, AHRQ, and NCQA to improve safety and quality of health care in America.
- Every year, a random sample of patients are surveyed about their experiences with their healthcare providers and Medicaid plans.
- It is an important component of ensuring that patients are satisfied, not only with their health outcomes, but also with their healthcare experience.
- CAHPS surveys allow patients to rate the aspects of care delivery that matter the most to them.
- Results represent two populations:
  - Adult Medicaid Respondents (self-report data)
  - Child Medicaid Respondents (data reported by a parent, guardian, or similar figure)

As a provider, <u>you</u> are the most critical component of that experience.

Medicaid CAHPS Survey – Uses and Importance

PUBLIC REPORTING

ACCREDITATION

NCQA HEALTH PLAN RATING SYSTEM (HPRS)

QUALITY IMPROVEMENT

CAHPS evaluates patients' perceptions as well as overall satisfaction to improve patient experience.

CAHPS allows health plans to receive candid, anonymous feedback from patients.

CAHPS supports consumers in assessing health plans' performance and choosing the best plan for their needs.

CAHPS identifies the strengths and weaknesses of health plans and targets areas for improvement.

Medicaid CAHPS Survey – How It Works

Timeline

- Typically, CAHPS Surveys follow the standard NCQA timeline.
- NC is currently off that timeline but will follow NCQA timeline in 2024.

2024 TIMELINE	MONTH
Prenotification Letter	February
Mailed Surveys	February - March
Telephone Collection	April
Initial CAHPS Results	July
Final CAHPS Results	November

Blackout Period

- Late February through June, health plans are prohibited from asking members any CAHPS-related question that could influence survey responses.
- Physicians, however, may discuss CAHPS with patients during this period.

New Web Option

- NC has retired the telephone modality; new web option added to take the survey online.
- Web option provided to the member via a mailed letter with instructions on how to take the survey online.

Medicaid CAHPS Survey – Questions

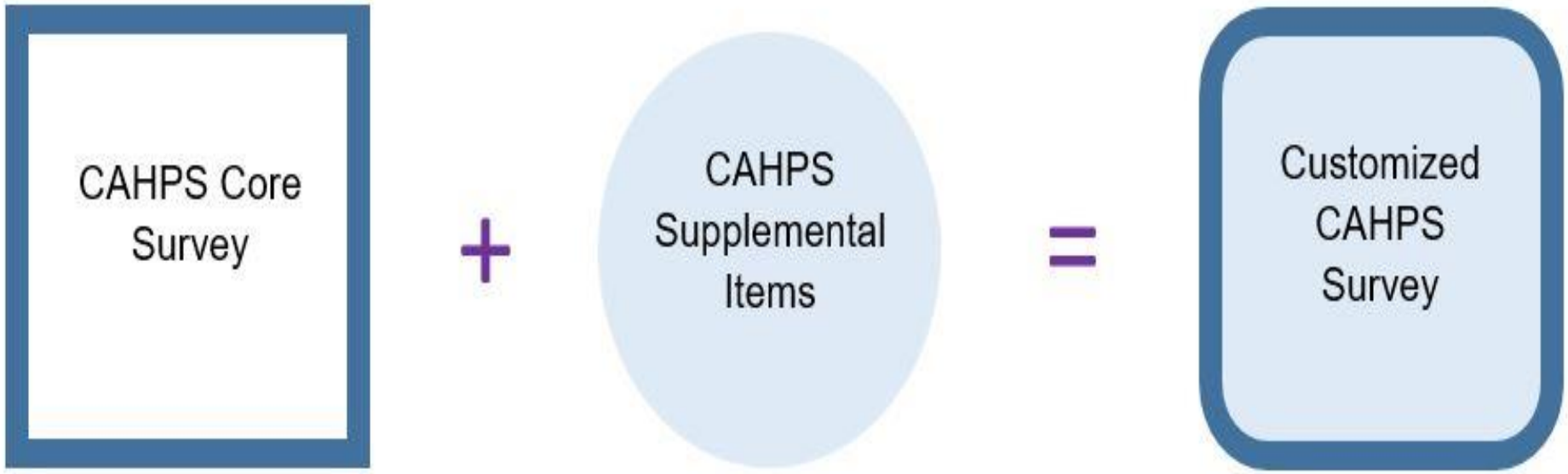
Getting care quickly	Rating of health plan
Getting needed care	Rating of personal doctor
Access to information	Rating of specialist
Customer Service	Flu vaccinations (ages 18-64)
Care Coordination	Smoking/tobacco cessation
Rating of all health care	Overall satisfaction

Medicaid CAHPS Survey – Composite and Rating Measures

Composites	Composite Measures
• Getting Needed Care • Quick Access to Care • Physician Communication • Customer Service	• Combine results for closely related items grouped together. • Four answers (Always, Usually, Sometimes, Never).

Rating	Rating Measures
• Rating of all health care • Rating of personal doctor • Rating of specialist • Rating of health plan	• Based on scale of 0 to 10 • Measures respondents' assessment of health plan and quality of care over a specific time period.

Medicaid CAHPS Survey – Supplemental Questions



Medicaid CAHPS Survey – Survey Sample

NC DEPARTMENT OF HEALTH AND HUMAN SERVICES
Division of Health Benefits

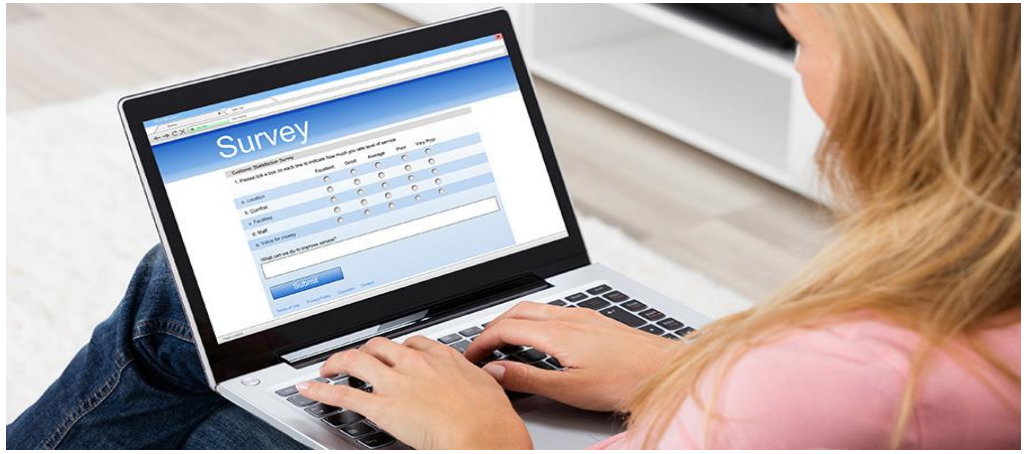
DataStat

Your privacy is protected. The research staff will not share your personal information with anyone without your OK. Personally identifiable information will not be made public and will only be released in accordance with federal laws and regulations.

You may choose to answer this survey or not. If you choose not to, this will not affect the benefits you get. You may notice a number on the cover of this survey. This number is ONLY used to let us know if you returned your survey so we don't have to send you reminders.

If you want to know more about this study, please call 1-800-842-1627.

SURVEY INSTRUCTIONS



YOUR HEALTH CARE IN THE LAST 6 MONTHS

These questions ask about your own health care from a clinic, emergency room, or doctor's office. This includes care you got in person, by phone, or by video. Do not include care you got when you stayed overnight in a hospital. Do not include the times you went for dental care visits.

3. In the last 6 months, did you have an illness, injury, or condition that needed care right away?

   - O Yes
   - O No → *Go to Question 5*

4. In the last 6 months, when you needed care right away, how often did you get care as soon as you needed?

   - O Never
   - O Sometimes
   - O Usually
   - O Always

5. In the last 6 months, did you make any in person, phone, or video appointments for a check-up or routine care?

   - O Yes
   - O No → *Go to Question 7*

7. In the last 6 months, not counting the times you went to an emergency room, how many times did you get health care for yourself in person, by phone, or by video?

   - O None → *Go to Question 9a*
   - O 1 time
   - O 2
   - O 3
   - O 4
   - O 5 to 9
   - O 10 or more times

8. Using any number from 0 to 10, where 0 is the worst health care possible and 10 is the best health care possible, what number would you use to rate all your health care in the last 6 months?

   O O O O O O O O O O O
   0 1 2 3 4 5 6 7 8 9 10
   Worst Health Care Possible — Best Health Care Possible

9. In the last 6 months, how often was it easy to get the care, tests, or treatment you needed?

   - O Never
   - O Sometimes
   - O Usually
   - O Always

Medicaid CAHPS Survey – Everyone Owns It

- Delivering high quality care to EVERY patient is EVERYONE's responsibility.
- Take EVERY opportunity to improve patient care and health outcomes.
- Look for EVERY chance to introduce CAHPS language so patients become familiar with the survey and terminology.
- Encourage EVERY patient to complete the CAHPS survey.

Provider Survey Results

Survey Overview

- Partnered with the Sheps Center for Health Services Research at UNC Chapel Hill
- Administered among organizations providing primary care and/or Ob/Gyn services to Medicaid patients in North Carolina.
- Part of a larger multi-year evaluation effort of NC's Medicaid managed care transformation.
- Provides a snapshot of organizational experiences, contracting, and satisfaction with Prepaid Health Plans (PHPs) in the transition to Medicaid managed care.
- Findings will serve as a leading indicator for quality improvement for PHPs.

Survey Development

- 2022 survey built on the initial baseline instrument developed in fall 2020.
  - Developed in consultation with clinicians, health system/practice leaders, and stakeholders from NC Department of Health and Human Services.
- Sampled and fielded the survey at the organizational level.
  - Most interactions with PHPs occur at the organizational (rather than individual clinician) level.

Survey Administration

- IQVIA OneKey data identified 1,243 unique organizations providing primary care and Ob/Gyn services in NC.
  - Medicaid provider data used to confirm the sample.
- Survey responses were collected between April and July of 2022.
- Phone call, mailing, and email recruitment process determined approximately 62.9% of the organizations in the sample were eligible to receive the survey.

Survey Respondents

- Total Response Rate: **50.2%**
- Represented diverse organizations, from large integrated delivery systems to solo practice physicians

Organizational Respondent Overview	Total (n = 394)
Ownership (self-reported)	
Health Systems	14 (4%)
Independent Practices/Medical Groups	380 (96%)
Size	
Small (1 – 2 physicians)	261 (66%)
Medium (3 – 9 physicians)	96 (24%)
Large (10+ physicians)	37 (12%)
Services (inclusive)	
Primary Care	385 (98%)
Prenatal/Postnatal Care	42 (11%)
Inpatient obstetrics care	26 (6%)
Geography	
No Rural Practice Sites (NCRC)	194 (49%)
Any Rural Practice Sites (NCRC)	200 (51%)

Survey Results

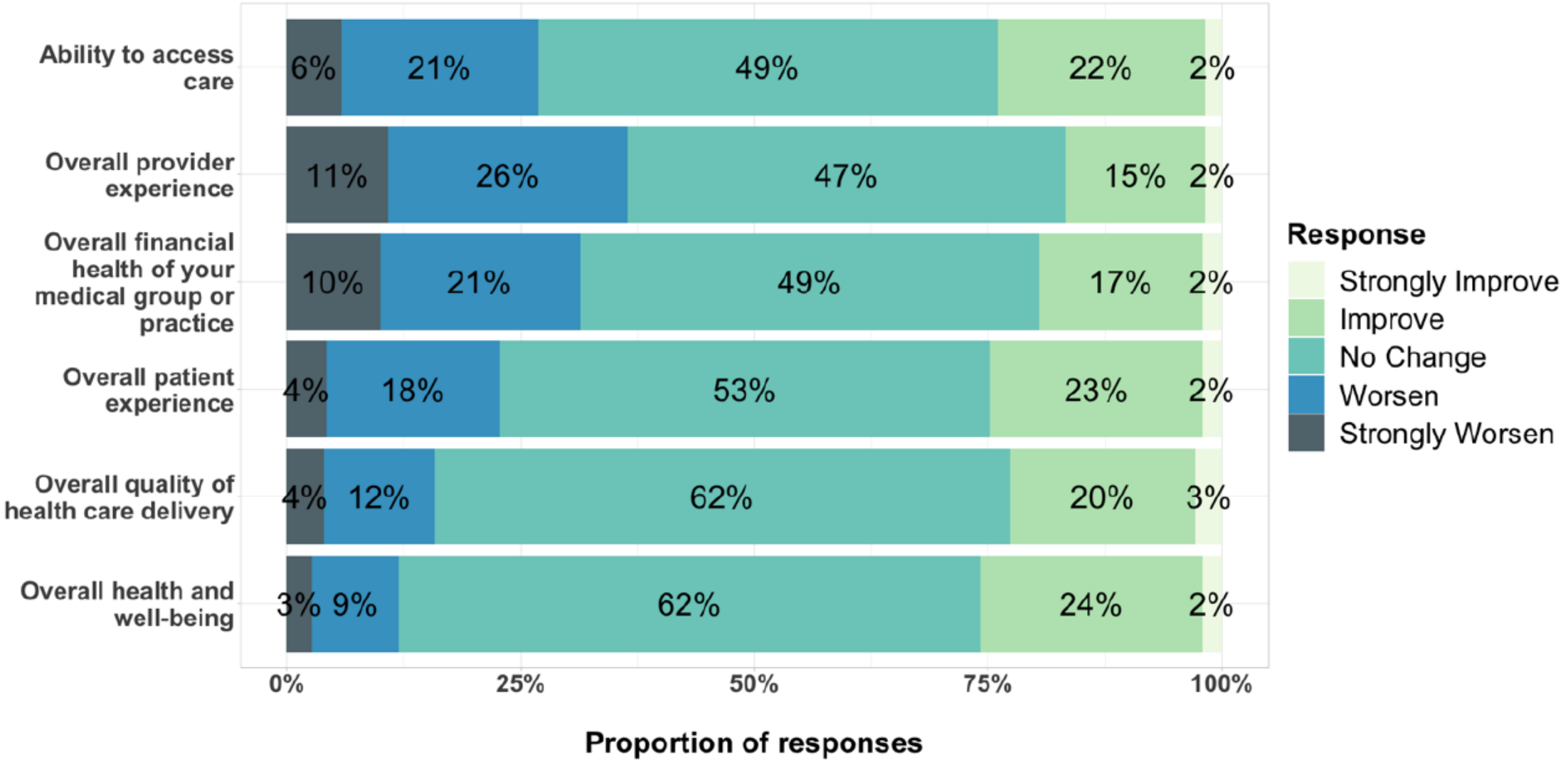
Contracting with PHPs

- Rates of contracting with each of the five available PHPs ranged from 73.3% to 94.5%
  - The respondent organizations contracted with an average of 4.3 plans out of the 5 PHPs available.
- 85.3% of provider organizations that had not contracted with all standard PHPs did not anticipate adding any PHP contracts in the coming year

Contracting with PHPs

- Mean overall ratings for the five PHPs (on a scale of 1 to 4, with 1 being “poor” and 4 being “excellent”) ranged from 2.56 to 2.69.
- 89.0% of provider organizations did not anticipate dropping any standard plan PHP contracts in the coming year
- One of the largest reported obstacles in contracting with PHPs was communication difficulties

Overall Perceived Effects of PHPs on Care Delivery



Experience with Clinical and Administrative Factors

Domain	PHPs		Clinical vs Administrative
	Opportunities for Improvement	Performed Well	
Access to medical specialists for Medicaid patients		✓	Clinical
Access to behavioral health prescribers for Medicaid patients		✓	Clinical
Access to behavioral health therapists for Medicaid patients		✓	Clinical
Access to needed drugs for Medicaid patients (formulary)		✓	Clinical
Provider relations overall	✓		Administrative
Timeliness to answer questions and/or resolve problems	✓		Administrative
Timeliness of claims processing	✓		Administrative
Care/case management for patients	✓		Clinical

Key Findings

- Open-ended comments reveal notable administrative burden in sustaining multiple PHP relationships, which providers say has ultimately harmed patient access to care
- Large provider organizations rated their experience with the health plans lower than smaller provider organizations
- Access to behavioral health prescribers and therapists were rated substantially worse than all other domains
- PHPs had opportunities for improvement on:
  - Provider relations,
  - Timeliness to answer questions, resolve problems, and process claims
  - Engaging in care/case management.

Please email Hannah.Fletcher@dhhs.nc.gov with any additional questions or comments. Thank you!

PHP Administrative Simplification Workgroup

Administrative Simplification – Projects Completed

Completed Initiatives	Description
Orientation	PHPs streamlined orientation for Medicaid providers, resulting in saving an estimated 1.75 hours per provider
Training	PHPs collaborated to identify one unified training for providers for Culturally and Linguistically Appropriate Services
Quick Reference Guide	Developed one shared template for all PHPs to use for critical information regularly referenced by provider offices
Primary Care Provider Change Form	Developed a single form for providers to easily facilitate changes to the assigned PCP when desired by beneficiaries
Prior Authorization	Identified and implemented changes to the Prior Authorization form, eliminating several time-consuming fields with limited operational value
Survey	Conducted a survey through key professional organizations to seek administrative simplification priorities, with insights shared across PHPs
Quality Forums	Convened joint quality forums to reduce the complexity of meeting separately with multiple PHPs in each region
COVID-19 Vaccination Incentive Guide	Created a simple quick reference guide for providers to easily access member incentives available from each PHP

Administrative Simplification – Projects In Flight

- Member Reassignment Guide (recently approved and now being implemented)
- Tip sheet for Behavioral Health Crisis Services (review pending)
- Provider Training Attestation Process (review pending)
- Provider Redetermination Guide (review pending)

Questions & Answers

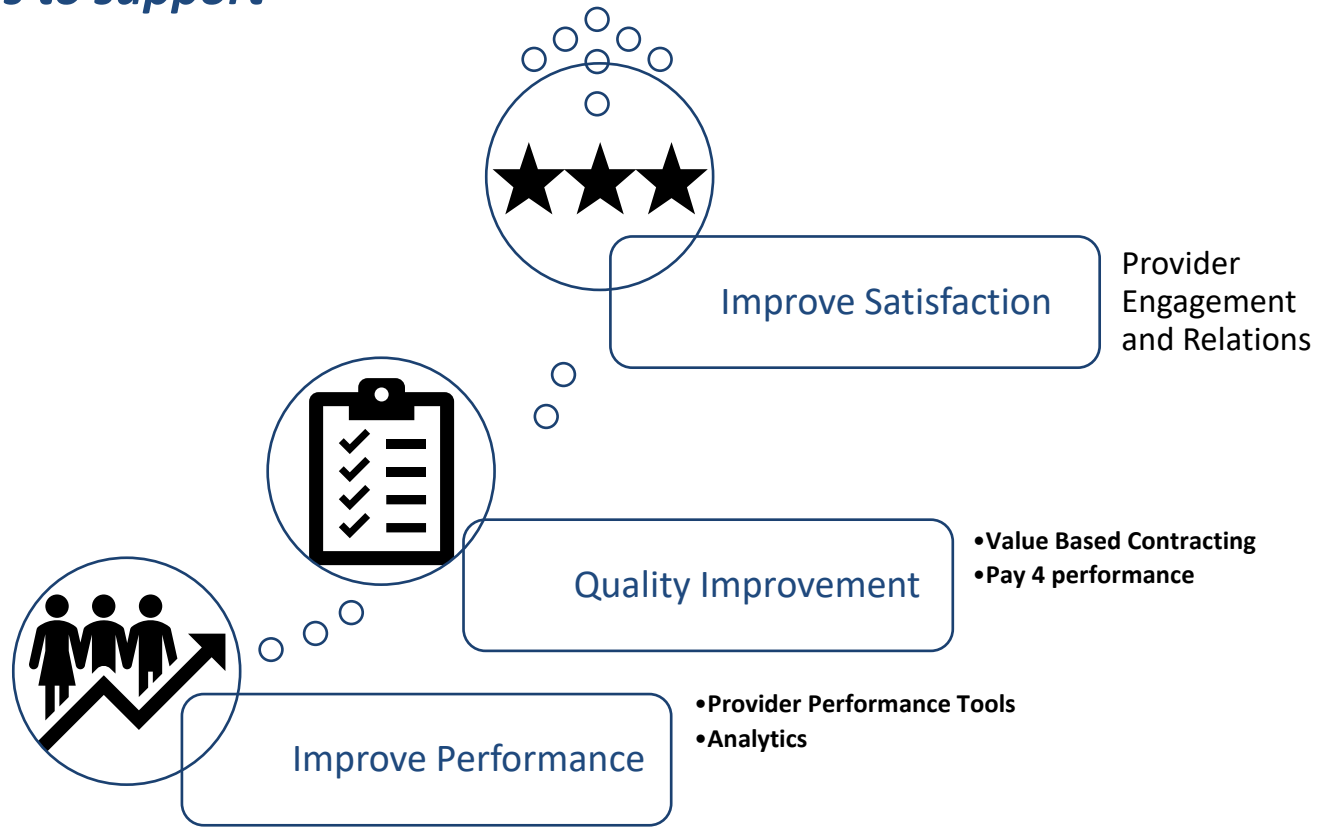
Appendix

AMH Support-
NC AHEC & Standard Plans

Health Plan and AHEC Practice Support

A common goal to provide quality care and services to support your success in Medicaid Transformation!

- PHP Known Issues Tracker
- Timely education and training
- Customized engagement strategies based upon the needs and preferences of the practice
- Local boots-on-the-ground support with onsite or virtual visit
- Cross-collaboration with providers, PHPs, Health Systems, CINs/ACOs, and AHEC.
- Support with Medicaid quality measures and Performance Improvement Projects (PIPs)
    - NC AHEC developed helpful PIP Tip Sheets in collaboration with AHEC coaches and NC DHHS. Access them via NC AHEC's website devoted to Medicaid Quality Improvement
- Genuine interest in your input and feedback!



AHEC Practice Support Resources

- Quality & Health Equity Improvement (Medicaid, Medicare, All Payors)
- Medicaid managed care education & issue resolution
- Clinical workflow redesign & process improvement
- Behavioral health integration (including Collaborative Care Model)
- COVID19 vaccine & clinical workflow assistance
- Practice operational assessments
- EHR optimization, telehealth integration
- HIE training and optimization
- Revenue cycle management
- Billing & coding guidance
- Advanced Medical Home (AMH) tier education and support
- Tailored Care Management (AMH+/CMA) support
- Community Health Worker integration and training
- Social Determinants of Health Workflow Optimization
- Virtual Collaborative Educational Programming

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Health Plan Practice Support: Quality

Each health plan focuses on driving performance through actionable data

- Secure PHP Provider Portal with various analytic & performance tools
- Customized reports and dashboards that are timely, actionable and available via provider portal
- P4P and Quality Incentive Data
- Assistance with reviewing and interpreting performance data
- Education & support around panel management and care-gap closure

Health Plan Practice Support Contacts

NC Medicaid Division of Health Benefits

Phone: **1-833-870-5500**

(TTY: 1-833-870-5588)

Monday – Saturday 7am-8pm

AmeriHealth Caritas:
amerihealthcaritasnc.com

Phone: **1-888-738-0004**

(TTY: 1-866-209-6421)

24 hours a day, 7 days a week

Carolina Complete Health:
carolinacompletehealth.com

NetworkRelations@CCH-Network.com

Phone: **1-833-552-3876, # 7**

(TTY: 711)

Monday – Saturday 7am-6pm

HealthyBlue of NC:

HealthyBlueNC.com

AMH@healthybluenc.com

United Healthcare Community Plan:
uhccommunityplan.com/NC

Phone: **1-800-349-1855**

(TTY: 711)

Monday – Saturday 7am-6pm

WellCare:

wellcare.com/NC

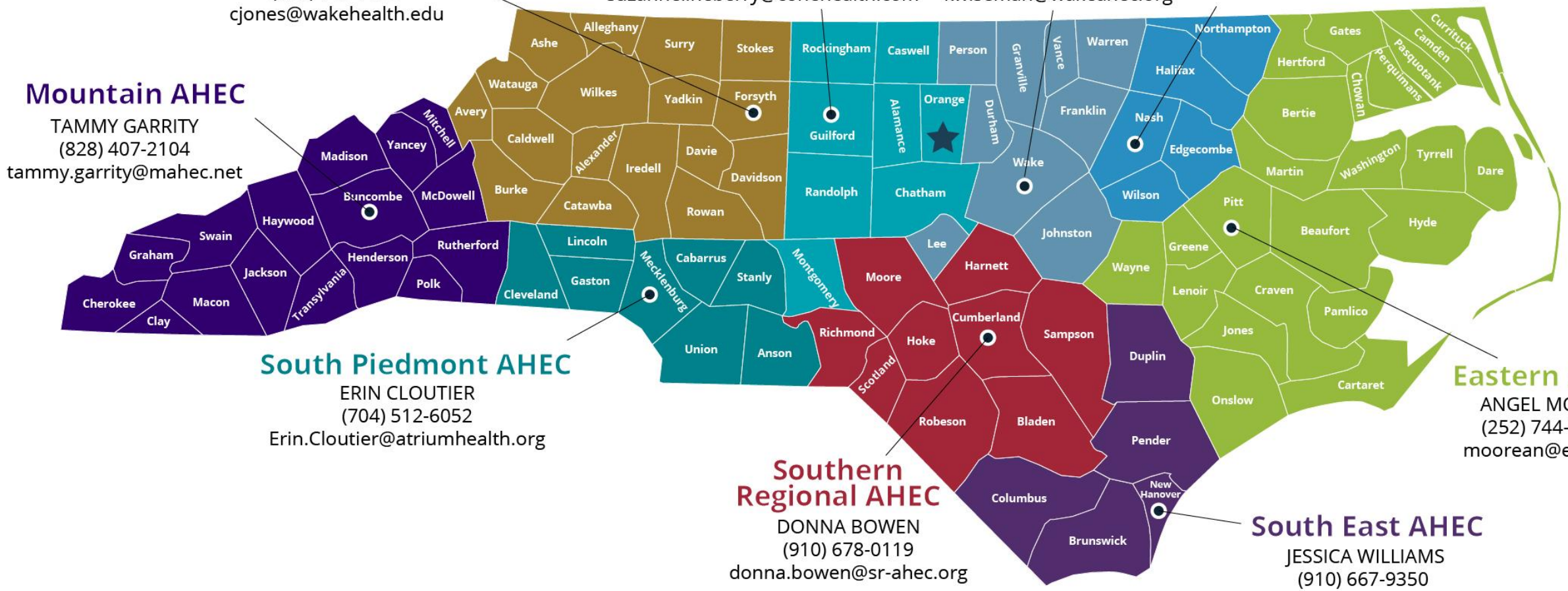
WellcareNC_Provider_Quality@wellcare.com

NCProviderRelations@Wellcare.com

Phone: **1-984-867-8637**

(TTY: 711)

NORTH CAROLINA AHEC REGIONAL PRACTICE SUPPORT CONTACTS



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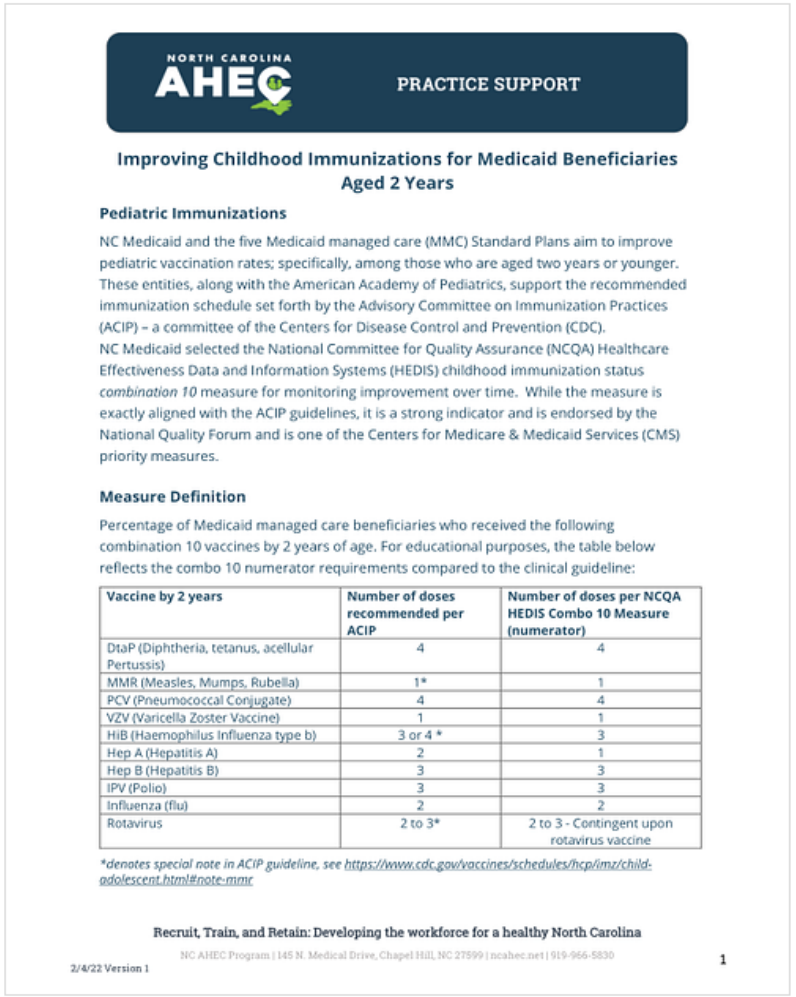
AHEC Practice Support Contacts

- You may also contact us at practicesupport@ncahec.net.
- More information is listed at Practice Support | NC AHEC.

NC AHEC | RECRUIT TRAIN RETAIN

Measure Resources

AHEC Practice Support Tip Sheets



NORTH CAROLINA AHEC PRACTICE SUPPORT

Improving Childhood Immunizations for Medicaid Beneficiaries Aged 2 Years

Pediatric Immunizations

NC Medicaid and the five Medicaid managed care (MMC) Standard Plans aim to improve pediatric vaccination rates; specifically, among those who are aged two years or younger. These entities, along with the American Academy of Pediatrics, support the recommended immunization schedule set forth by the Advisory Committee on Immunization Practices (ACIP) – a committee of the Centers for Disease Control and Prevention (CDC).
NC Medicaid selected the National Committee for Quality Assurance (NCQA) Healthcare Effectiveness Data and Information Systems (HEDIS) childhood immunization status *combination 10* measure for monitoring improvement over time. While the measure is exactly aligned with the ACIP guidelines, it is a strong indicator and is endorsed by the National Quality Forum and is one of the Centers for Medicare & Medicaid Services (CMS) priority measures.

Measure Definition

Percentage of Medicaid managed care beneficiaries who received the following combination 10 vaccines by 2 years of age. For educational purposes, the table below reflects the combo 10 numerator requirements compared to the clinical guideline:

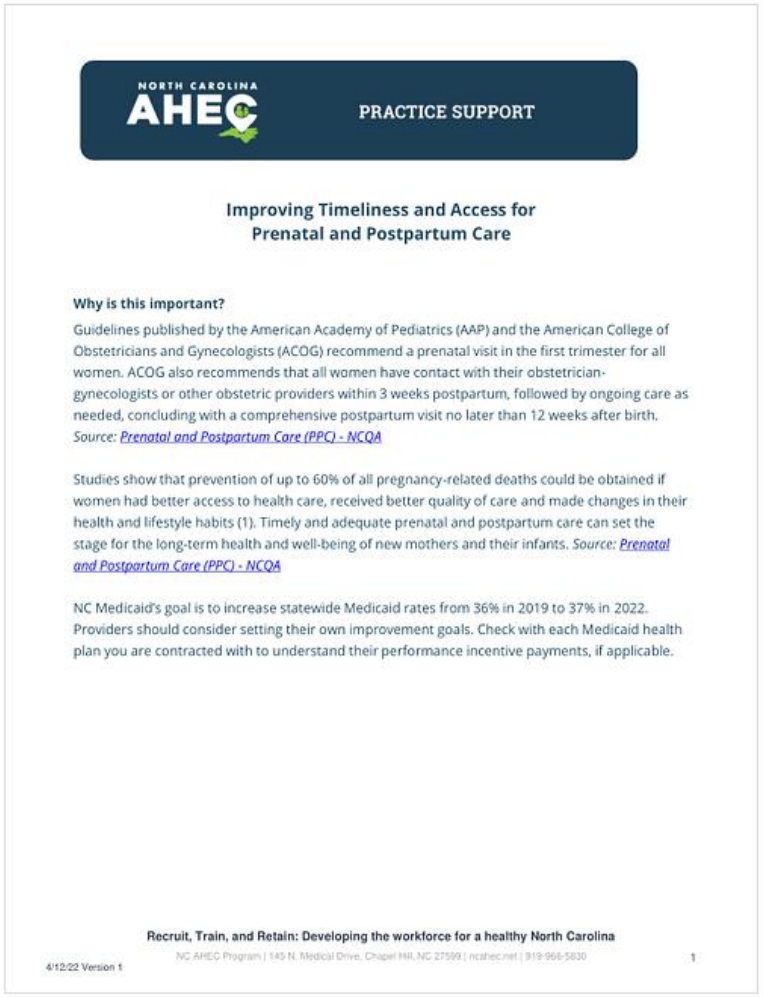
Vaccine by 2 years	Number of doses recommended per ACIP	Number of doses per NCQA HEDIS Combo 10 Measure (numerator)
DtaP (Diphtheria, tetanus, acellular Pertussis)	4	4
MMR (Measles, Mumps, Rubella)	1*	1
PCV (Pneumococcal Conjugate)	4	4
VZV (Varicella Zoster Vaccine)	1	1
HiB (Haemophilus Influenza type b)	3 or 4 *	3
Hep A (Hepatitis A)	2	1
Hep B (Hepatitis B)	3	3
IPV (Polio)	3	3
Influenza (flu)	2	2
Rotavirus	2 to 3*	2 to 3 - Contingent upon rotavirus vaccine

**denotes special note in ACIP guideline, see https://www.cdc.gov/vaccines/schedules/hcp/imz/child-adolescent.html#note-mmr*

Recruit, Train, and Retain: Developing the workforce for a healthy North Carolina

NC AHEC Program | 145 N. Medical Drive, Chapel Hill, NC 27599 | ncahec.net | 919-966-5830

2/4/22 Version 1 1



NORTH CAROLINA AHEC PRACTICE SUPPORT

Improving Timeliness and Access for Prenatal and Postpartum Care

Why is this important?

Guidelines published by the American Academy of Pediatrics (AAP) and the American College of Obstetricians and Gynecologists (ACOG) recommend a prenatal visit in the first trimester for all women. ACOG also recommends that all women have contact with their obstetrician-gynecologists or other obstetric providers within 3 weeks postpartum, followed by ongoing care as needed, concluding with a comprehensive postpartum visit no later than 12 weeks after birth. *Source: Prenatal and Postpartum Care (PPC) - NCQA*

Studies show that prevention of up to 60% of all pregnancy-related deaths could be obtained if women had better access to health care, received better quality of care and made changes in their health and lifestyle habits (1). Timely and adequate prenatal and postpartum care can set the stage for the long-term health and well-being of new mothers and their infants. *Source: Prenatal and Postpartum Care (PPC) - NCQA*

NC Medicaid's goal is to increase statewide Medicaid rates from 36% in 2019 to 37% in 2022. Providers should consider setting their own improvement goals. Check with each Medicaid health plan you are contracted with to understand their performance incentive payments, if applicable.

Recruit, Train, and Retain: Developing the workforce for a healthy North Carolina

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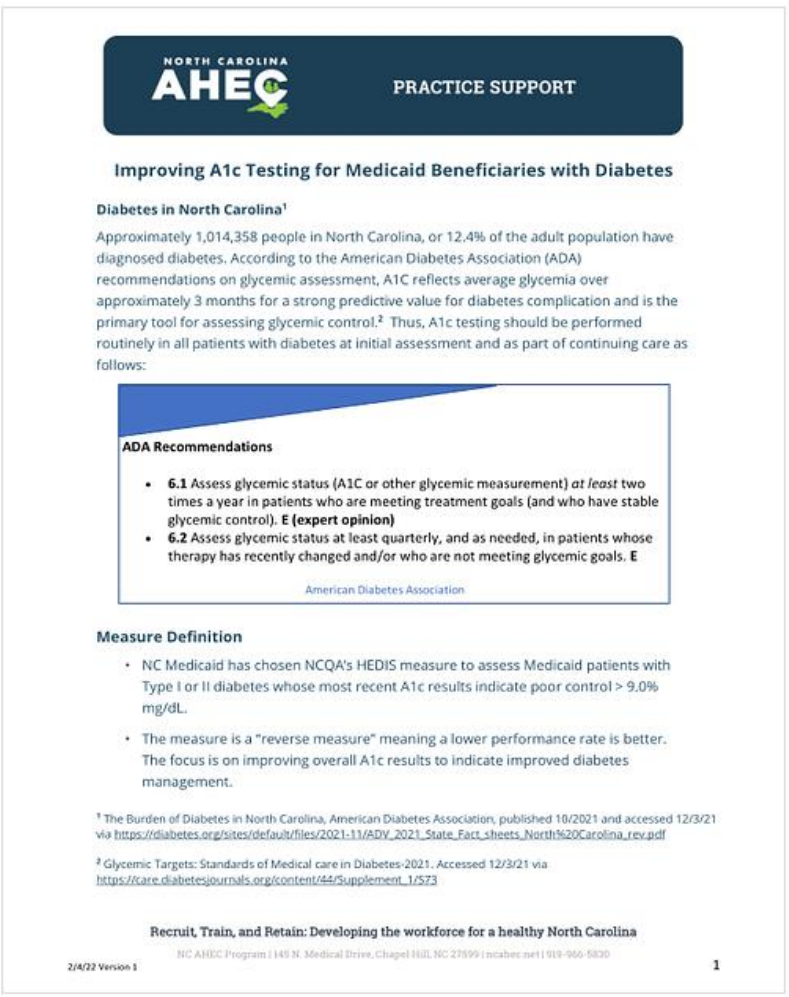

NORTH CAROLINA AHEC PRACTICE SUPPORT

Improving A1c Testing for Medicaid Beneficiaries with Diabetes

Diabetes in North Carolina[1]

Approximately 1,014,358 people in North Carolina, or 12.4% of the adult population have diagnosed diabetes. According to the American Diabetes Association (ADA) recommendations on glycemic assessment, A1C reflects average glycemia over approximately 3 months for a strong predictive value for diabetes complication and is the primary tool for assessing glycemic control.[2] Thus, A1c testing should be performed routinely in all patients with diabetes at initial assessment and as part of continuing care as follows:

ADA Recommendations

- **6.1** Assess glycemic status (A1C or other glycemic measurement) *at least* two times a year in patients who are meeting treatment goals (and who have stable glycemic control). **E (expert opinion)**
- **6.2** Assess glycemic status at least quarterly, and as needed, in patients whose therapy has recently changed and/or who are not meeting glycemic goals. **E**

American Diabetes Association

Measure Definition

- NC Medicaid has chosen NCQA's HEDIS measure to assess Medicaid patients with Type I or II diabetes whose most recent A1c results indicate poor control > 9.0% mg/dL.
- The measure is a "reverse measure" meaning a lower performance rate is better. The focus is on improving overall A1c results to indicate improved diabetes management.

[1] The Burden of Diabetes in North Carolina, American Diabetes Association, published 10/2021 and accessed 12/3/21 via https://diabetes.org/sites/default/files/2021-11/ADV_2021_State_Fact_sheets_North%20Carolina_rev.pdf

[2] Glycemic Targets: Standards of Medical care in Diabetes-2021. Accessed 12/3/21 via https://care.diabetesjournals.org/content/44/Supplement_1/S73

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Click on each sheet above to access the full tip sheet or click here to access all AHEC Practice Support Tip Sheets.

Childhood Immunization Status: Documentation Best Practices

Acceptable Documentation	Common Documentation Gaps
The following notations are examples of **acceptable** documentation for CIS: • A note indicating the name of the specific antigen and the date of the immunization. • A certificate of immunization prepared by an authorized health care provider or agency including the specific dates and types of immunizations administered. • Initial HepB given “at birth” or “nursery/hospital” should be documented in the medical record or indicated on the immunization record as appropriate. • Immunizations documented using a generic header (e.g., polio vaccine) or “IPV/OPV” can be counted as evidence of IPV. ****Use of correct billing codes or documentation in NCIR are critical to data capture. Remember to include correct codes when billing for administration of vaccines from federal Vaccines for Children (VFC) immunization stock.**	The following notations are examples of common documentation gaps for CIS: • Immunizations administered after the 2nd birthday. • PCP charts do not contain immunization records if vaccine(s) received elsewhere such as those given in health departments or those given in the hospital at birth. • No documentation of Contraindications/Allergies. • FluMist® only meets criteria when administered on the 2nd birthday. • A note that “member is up to date” with all immunizations does not constitute compliance due to insufficient data. • Parental refusal does not meet compliance. • Rotavirus documentation does not specify if 2 dose or 3 dose.

Prenatal and Postpartum Care (PPC) Documentation Best Practices

Acceptable Documentation (Compliant Record)	Unacceptable Documentation (Non-Compliant Record)
Prenatal care visit to an OB/GYN or other prenatal care practitioner, or PCP. For visits to a PCP, a diagnosis of pregnancy must be present. Documentation in the medical record must include a note indicating the date when the prenatal care visit occurred and evidence of ***one*** of the following: • Documentation indicating pregnancy (LMP, EDD, gestational age, or OB history) • A basic physical obstetrical examination that includes FHR or fundal Postpartum visit to an OB/GYN or other prenatal care practitioner, or PCP on or between 7 and 84 days after delivery. Do not include postpartum care provided in an acute inpatient setting. Documentation in the medical record must include a note indicating the date when a postpartum visit occurred and ***one*** of the following: • Notation of postpartum care • Screening for depression • Evaluation of breastfeeding • Documentation of infant care • Documentation of intercourse • Documentation of resumption of physical activity.	The following notations are examples of documentation that is **not acceptable** for HBD: • Progress notes that are unclear if the breast/breastfeeding was assessed • Progress notes that are unclear if the abdomen or incision was assessed • Documentation of "All 10 systems reviewed" is not specific and would not meet criteria • A negative finding of breastfeeding • Progress notes that are documented outside the parameters for a prenatal visit (First Trimester is defined as 280-170 days prior to delivery ***OR*** expected date of confinement/expected due date (EDC/EDD) • Progress notes that are documented outside the parameters for a postpartum visit (postpartum visits should occur on or between 7 and 84 days after delivery) • Progress notes that are documented outside the lookback period (October 8 of the year prior to the measurement year and October 7 of the measurement year)

Hemoglobin A1c Control For Patients with Diabetes (HBD): Documentation Best Practices

Acceptable Documentation (Compliant Chart)	Unacceptable Documentation (Non-compliant Chart)
• HbA1c test with the appropriate lab date can be taken from ANY section of the medical record including inpatient, ER / ED documentation, and Urgent Care. • Most recent HbA1c level during the measurement year regardless of compliancy (On or closest to December 31, MY) • Documentation of an A1c that is done in the doctor's office (POC: Point of Care testing) with a date of service and value (e.g., 83038 Glycated hemoglobin test, 83037 Hemoglobin glycosylated test, etc.) • Member-reported results in a medical history portion / HPI (History of Present Illness) of the progress note from a PCP or appropriate specialist (e.g., "HPI: Member reports A1c level was 5.5 on 3/28/20MY") • Diabetic flowsheets can be used. Be sure to abstract the most recent date and result in the MY. • Notation of words such as Yesterday, 2 weeks ago, 4 months ago, etc. related to an A1c being completed **with** results are specific enough to determine the event occurred. • Telehealth visits with a definitive date and result	• Home tests are NOT acceptable • Documentation of serum estimated average glucose, blood sugar via finger sticks for blood glucose, or serum samples not completed would not meet criteria. • Documentation outside the MY • Progress notes which are unclear or do NOT document the exact date of when a test was done (e.g., "A1c was 7.3 last visit", "most recent A1c was 7.2", etc.) • The date a provider **reviewed** a lab result cannot be used since it may not be the date of the actual test. • Coversheet with handwritten results • Thresholds or ranges are not acceptable, such as < 6.9 or 5.6-7.2%. A distinct numeric result is required for numerator compliance. • CCD (Continuity of Care Documents) and CCDA (Consolidated Clinical Document Architecture) forms

Hemoglobin A1c Control For Patients with Diabetes (HBD): Resources

- Lifestyle Change Programs | ADA - American Diabetes AssociationHealthy Living | ADA - American Diabetes Association
- Understanding A1C | ADA - American Diabetes Association
- Diabetes Symptoms, Causes, & Treatment | ADA
- Living With Diabetes | CDC
- Information for Diabetes Professionals | Diabetes | CDCMedical
- Practitioners | ADA - American Diabetes Association

Additional Information for Members

The American Diabetes Association Healthy Living Information

*Click a bubble to learn more on a specific topic.

Source: NCQA HEDIS MY2023 Technical Specifications

Additional Diabetes Resources

- A Snapshot: Diabetes In The United States
- North Carolina Diabetes Profile
- Vision and Eye Health Surveillance System (VEHSS)-Then drill down to Diabetic Retinopathy (DR) by state, county, etc.
- Diabetes Guide 2020-Screen  Diabetes Guide 2020
- Taking Control of Your Diabetes
- NC Division of Public Health
  - Diabetes NC
  - Diabetes Free NC-Diabetes Prevention Program
  - Diabetes Management NC

NC HealthConnex

NC HealthConnex-Connection Information

Click here for general information.

FAQs?
Click here.

Click here for information on how to connect.

For more information:
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