SIXTH ANNUAL VIRTUAL

Quality Forum

Statewide quality priorities. Shared solutions. Better outcomes.

OCTOBER 14, 2026

11:00 a.m. – 1:00 p.m.

Presented in collaboration with NC Medicaid and the Standard Plans

Important Reminders

- This webinar is being recorded.
- The Q&A function is enabled throughout the webinar.
- We welcome your participation, please submit questions and/or comments through the Q&A function.
- Poll question results will be displayed.
- The presentation will be made available online following today's session.

Agenda

Topic	Time	Presenter
Welcome & Introductions	5 minutes	**Carolina Complete Health (**Melissa Fabrikant, Director Quality Improvement)
Why Quality Matters/ Leadership Team	10 minutes	**Carolina Complete Health** (Melissa Fabrikant, Director Quality Improvement)
Early and Periodic Screening, Diagnostic and Treatment (EPSDT) • Overview • DHB Child Health Learning Collaborative	15 Minutes	**NC Division of Health Benefits** (Amanda Tromblee, EPSDT & MCHIP Program Manager) (Rachel Baisden, Quality and Policy Specialist)
Navigating Women's Health and Continuum of Care		
Cervical Cancer Screening Overview	12 minutes	**AmeriHealth Caritas** (Lisa Tucker, Manager of Quality Management)
Maternal Health Overview: • Preconception and Prenatal Care	12 Minutes	**United Healthcare** (Allison Wood, Director of Quality) **United Healthcare** (Amanda Barker, Clinical Quality Consultant)
• Postpartum Care • Postpartum Depression Screening	12 minutes	**Healthy Blue NC (**Laura Day, Snr Director Quality Management)
DHB Maternal State Learning Collaborative	6 minutes	**NC Division of Health Benefits** (Kate Davis, Clinical Nurse Quality Manager)
Panel Discussion/ Multiple level panel discussion. Moderator: **Carolina Complete Health –** Melissa Fabrikant	30-35 minutes	Dr. Michele Benoit-Wilson, Medical Director - **Carolina Complete Health** Jennifer Rook, Nurse Admin Clinical Ops/ OBGYN **– East Carolina University** Carol Ellison, Nurse Manager Quality Dept/ OBGYN **– East Carolina University** Dr. Alicia Firestone - **Atrium Health Wake Forest. Wilkes OBGYN** Stacy Fackler, Dir, Patient , Medical Care, Perinatal - **Atrium Cabarrus**
Questions	10 minutes	**Carolina Complete Health** (Christina Nunemacher, Dir. Quality Improvement) **NC Division of Health Benefits** (Kate Davis, Clinical Nurse Quality Manager)
Meeting Close	3 minutes	**Carolina Complete Health (**Melissa Fabrikant, Director Quality Improvement)

Why Quality Matters

Quality is the shared agenda between managed care and our providers: equitable care, healthier populations, a better experience for members and clinicians, and smarter spending.

For providers, quality performance drives value-based payment, regulatory and accreditation ratings, and where we direct data, staffing and care-management support. We align with the NC Department of Health and Human Services (DHHS) Medicaid Managed Care Quality Strategy and focus together on the areas below.

- Quality of Care
- Quality of Service
- Population Health
- Patient Safety
- Coordination of Care
- Health Equity
- Member and Provider Satisfaction
- Access to and Availability of Care
- Performance Measurement
- Value-Based Care
- Regulatory Oversight

2025 NC Medicaid Managed Care Quality Strategy

Standard Plan Quality Leaders

Jennifer Frazer
Director of Quality Management



Allison Wood
Director of Quality



Laura Day
Senior Director of Quality Management



Michelle Minton
Vice President of Quality Management



NC Division of Health Benefits – Quality Department

Dr. Terris Moss – Chief Quality Officer

Nicholas Bailey – Deputy Director, Quality

Jekisha Elliott – Associate Director, Quality

David Reichert – Senior Quality Manager

Shawn Latta – Provider Support Manager, Quality



EPSDT

Early and Periodic Screening, Diagnostic, and Treatment

PRESENTED BY

Amanda Tromblee

EPSDT & MCHIP Program Manager

NC Division of Health Benefits

SIXTH ANNUAL VIRTUAL QUALITY FORUM

What is EPSDT?

- Federal Medicaid law at 42 U.S.C.§ 1396d(r) and 1396a(a)(10)(A), a(a)(43), and d(a)(4)(B) [1905(r) of the Social Security Act] requires state Medicaid programs to provide Early and Periodic Screening, Diagnostics, and Treatment (EPSDT) for recipients under 21 years of age.
- Within the scope of EPSDT benefits under the federal Medicaid law, states are required to cover any service that is medically necessary "to correct or ameliorate a defect, physical or mental illness, or a condition identified by screening," whether or not the service is covered under the North Carolina State Medicaid Plan.
- This includes any condition or illness identified through a child health screening service or encounter with a licensed practitioner
- Any qualified provider operating within the scope of his or her practice, as defined by state law, can provide a periodic or inter-periodic screening. The screening need not be conducted by a Medicaid provider in order to trigger EPSDT coverage for follow up diagnostic services and medically necessary treatment by a qualified Medicaid provider.
- The services covered under EPSDT are limited to those within the scope of the category of services listed in the federal law at 42 U.S.C. § 1396d(a) [1905(a) of the Social Security Act].

What is EPSDT? (continued)

Early and Periodic Screening

- Preventive Screenings at age-appropriate intervals for Medicaid enrolled children under the age of 21
- North Carolina Medicaid follows the American Academy of Pediatrics (AAP) Bright Futures Periodicity Schedule for preventive screenings under EPSDT
- The AAP Bright Futures Periodicity Schedule outlines which screening or risk assessment services should be performed for each child within that age group
- NC Medicaid does follow an enhanced schedule for developmental screenings recommending these screenings be performed for children at the 6-month, 12-month, 18- or 24-month, 36 months, 48 month and 60-month visits.
- If an indication is found to perform additional screening services for that child, those screenings should be performed, and the appropriate diagnosis code should be utilized to indicate an abnormal finding. The indication should also be documented appropriately within their medical records
- Health Check Program Guide | NC Medicaid

What is EPSDT (continued)

Diagnostic and Treatment Services

- If a defect, physical or mental illness, or a condition is identified during a preventive screening, that child should be referred for follow up care
- When a Medicaid beneficiary under the age of 21 is found to need services outside the scope of what is covered within NC Medicaid's clinical coverage policies or State Plan, that request can be submitted for that child as an EPSDT request
- It is important to include appropriate documentation to show medical necessity of this service for this child. This requires current information from the recipient's physician, other licensed clinicians, or the requesting qualified provider. If this information is not provided, this may delay the prior approval decision
- Reviews are conducted on a case-by-case basis, taking into account that child's condition, comorbidities, and the medical necessity of the requested service
- Services covered under EPSDT are provided in the most integrated setting appropriate for the child, which includes clinics, or in schools, and at home, and must avoid unnecessary placements in segregated treatment settings.
- NC Medicaid EPSDT Procedural Policy

Early and Periodic Screening

Per the Center for Medicare & Medicaid Services (CMS), the five required components of an Early and Periodic Screening encounter are:

- Comprehensive health and developmental history that assesses for both physical and mental health, as well as for substance use disorders;
- Comprehensive, unclothed physical examination;
- Appropriate immunizations, in accordance with the schedule for pediatric vaccines established by the Advisory Committee on Immunization Practices (ACIP);
- Laboratory testing (including blood lead screening appropriate for age and risk factors); and,
- Health education and anticipatory guidance for both the child and caregiver.
- North Carolina Medicaid also has an Oral Health Periodicity Schedule which can be found here: NC Medicaid: Health Check and EPSDT
- All children should be referred to a dentist by the age of 1 year old
- If screenings are missed, you should perform a “catch-up” screening for that child at their next appointment
- Prior approval is not required for preventive screenings. Please refer to our Health Check Program Guide for the most up to date billing guidance when submitting claims for preventive services
- Health Check Program Guide | NC Medicaid

Diagnosis & Treatment

- When a screening examination indicates the need for further evaluation of a child's health, the child should be appropriately referred for diagnosis without delay.
- These are the service requests for EPSDT services that include any medical or remedial care that is medically necessary to correct or ameliorate a defect, physical or mental illness, or condition [health problem].
- "Ameliorate" means to improve or maintain the recipient's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems. Even if the service will not cure the recipient's condition, it must be covered if the service is medically necessary to improve or maintain the recipient's overall health.
- This means that EPSDT covers most of the treatments a recipient under 21 years of age needs to stay as healthy as possible, and North Carolina Medicaid and all Managed Care Organizations (MCO's) must arrange and provide for (either directly or through referral to appropriate agencies, organizations or individuals) corrective treatment when the need for such treatment is identified through a child health screening service or encounter with a licensed practitioner.

Diagnosis and Treatment

- EPSDT services must be coverable services within the scope of those listed in the federal law at 42 U.S.C. § 1396d(a) [1905(a) of the Social Security Act]. For example, “rehabilitative services” are a covered EPSDT service, even if the particular rehabilitative service requested is not listed in Division of Health Benefits (DHB) clinical policies or service definitions.
- The service must be medically necessary to correct or ameliorate a defect, physical or mental illness, or a condition [health problem] diagnosed by the recipient’s physician, therapist, or other licensed practitioner. By requiring coverage of services needed to correct or ameliorate a defect, physical or mental illness, or a condition [health problem], EPSDT requires payment of services that are medically necessary to sustain or support rather than cure or eliminate health problems to the extent that the service is needed to correct or ameliorate a defect, physical or mental illness, or condition [health problem].
- The determination of whether a service is medically necessary for an individual child must be made on a case-by-case basis, taking into account the particular needs of the child.
- This means that services not listed in the N.C. Medicaid State Plan may be covered under EPSDT if those services are within the scope of those listed in the federal law at 42 U.S.C. § 1396d(a) [1905(a) of the Social Security Act] and they are determined to be medically necessary to correct or ameliorate the child’s health condition.
- It is important to note that the service can only be covered under EPSDT if all criteria specified below are met.
  - The requested service must be determined to be medically necessary.
  - The service must be safe.
  - The service must be effective.
  - The service must be generally recognized as an accepted method of medical practice or treatment.
  - The service must not be experimental/investigational

Vaccinations

- Ensuring access to vaccinations is an integral part of preventive screenings and maintaining children's health.
- Preventive screening is not only an integral part of maintaining children's health, it helps to ensure issues are addressed quickly, and provides access to additional services outside of the benefits offered to adults under Medicaid
- Educating beneficiaries about the importance of maintaining their vaccinations is an incredibly important part of maintaining their health
- You can always locate the ACIP recommended schedule for vaccinations here: Child Immunization Schedule Notes | Vaccines & Immunizations | CDC

Diagnosis & Treatment

- When a screening examination indicates the need for further evaluation of a child's health, the child should be appropriately referred for diagnosis without delay.
- These are the service requests for EPSDT services that include any medical or remedial care that is medically necessary to correct or ameliorate a defect, physical or mental illness, or condition [health problem].
- "Ameliorate" means to improve or maintain the recipient's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems. Even if the service will not cure the recipient's condition, it must be covered if the service is medically necessary to improve or maintain the recipient's overall health.
- This means that EPSDT covers most of the treatments a recipient under 21 years of age needs to stay as healthy as possible, and North Carolina Medicaid and all Managed Care Organizations (MCO's) must arrange and provide for (either directly or through referral to appropriate agencies, organizations or individuals) corrective treatment when the need for such treatment is identified through a child health screening service or encounter with a licensed practitioner.

Human Papilloma Virus (HPV) Vaccinations

- HPV vaccination routinely recommended at **age 11–12 years (can start at age 9 years)** and catch-up HPV vaccination recommended for all persons through age 18 years if not adequately vaccinated
- 2- or 3-dose series depending on age at initial vaccination:
  - **Age 9 –14 years at initial vaccination**: 2-dose series at 0, 6–12 months (minimum interval: 5 months; repeat dose if administered too soon)
  - **Age 15 years or older at initial vaccination:** 3-dose series at 0, 1–2 months, 6 months (minimum intervals: dose 1 to dose 2 = 4 weeks; dose 2 to dose 3 = 12 weeks; dose 1 to dose 3 = 5 months; repeat dose if administered too soon)
- Human papillomavirus, is spread by sexual activity. Some strains of HPV cause genital warts. Other HPV strains can cause cancers. It is important to encourage beneficiaries to get vaccinated before they become sexually active.
- Most of the time, the body can find and clear out HPV, but if the virus stays in the body for a long time, it can cause cancer. Getting vaccinated against HPV helps prevent cancer in men and women.
- This is also an integral part of maintaining women's reproductive health, and children's health as HPV can be associated with higher risks of preterm birth, low birth weight, or other complications

Caregiver Screenings

- It is also important to screen the caregivers of the child for mental health and depression
- The American Academy of Pediatrics Bright Futures Periodicity Schedule recommends four caregiver depression screenings, completed for the benefit of the caregiver and child, to be performed in the first year of the child's life
- The mother can also receive four Postpartum Depression screenings through her OBGYN or postpartum provider, during the first year after her delivery per clinical coverage policy 1E-5 Obstetrics (1E-5.pdf)
- These screenings are an integral part of maintaining both the mother and child's health after delivery

Pregnancy Management Program

- The Pregnancy Management Program (PMP) (formerly Pregnancy Medical Home - PMH) is a care program with a set of mandatory standards and clinical initiatives aimed at improving the quality of pregnancy care, improving maternal and infant outcomes, and reducing health care costs. The PMP encourages adoption of the best prenatal, pregnancy, and perinatal care for Medicaid beneficiaries. Unlike the PMH program, there is no enrollment requirement for the PMP. All providers eligible to bill NC Medicaid (Medicaid) for obstetric services are considered participating PMP providers.
- A key feature of the PMP is the continued use of the standardized screening form to identify and refer women at risk for an adverse birth outcome to the Care Management for High-Risk Pregnancies (CMHRP) program, a more intense set of care management services that is coordinated and provided by Local Health Departments (LHDs). Together, these two programs work to improve the overall health of women and newborns across the state.
- For Pregnancy Care Management services:
- Pregnancy care management services must begin with the initial assessment and continue as long as the need exists during the pregnancy. Pregnancy care management services shall end on the last day of the month in which the 60th postpartum day occurs.
- b. Pregnancy care management services may begin in the postpartum period if not identified during the antepartum period. Pregnancy care management services shall end on the last day of the month in which the 60th postpartum day occurs.
- c. If the beneficiary is receiving case management services at the time of the referral, the new pregnancy care manager and the current care manager shall determine who shall be the lead care manager with the beneficiary during the pregnancy.
- d. Pregnancy care managers shall work in partnership with PMP providers to ensure proper care of the beneficiary during the pregnancy.
- e. The pregnancy care manager shall refer a MPW beneficiary at the end of their postpartum Medicaid eligibility period to the Family Planning (FP) program.
- f. 23L12 For a beneficiary with full Medicaid benefits, the pregnancy care manager shall ensure that the beneficiary is referred to their original provider of care prior to the pregnancy. If the beneficiary does not have a health care provider, the pregnancy care manager shall assist in connecting the beneficiary to a primary care provider of her choice.
- g. The pregnancy care manager shall assist in connecting the beneficiary to a primary care provider of their choice for any future care management service's needs.

Care Management During Pregnancy

- The Pregnancy Management Program (PMP) (formerly Pregnancy Medical Home - PMH) is a care program with a set of mandatory standards and clinical initiatives aimed at improving the quality of pregnancy care, improving maternal and infant outcomes, and reducing health care costs.
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- All PMP providers shall be required to ensure appropriate coordination with LHD care managers for the sub-set of their practice population who receive CMHRP services. To allow the PMP to stay abreast of PMP beneficiary medical needs, LHD care managers shall provide the PMP alerts, including emergency department (ED) visits, visits to a specialist, and missed appointments.
- Pregnancy care management services must begin with the initial assessment and continue as long as the need exists during the pregnancy. Pregnancy care management services shall end on the last day of the month in which the 60th postpartum day occurs.
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- For a beneficiary with full Medicaid benefits, the pregnancy care manager shall ensure that the beneficiary is referred to their original provider of care prior to the pregnancy. If the beneficiary does not have a health care provider, the pregnancy care manager shall assist in connecting the beneficiary to a primary care provider of her choice.
- The pregnancy care manager shall assist in connecting the beneficiary to a primary care provider of their choice for any future care management service's needs.

Recap & Important Things to Know

- There are currently no copays for services related to pregnancy, childbirth, and postpartum care- including prenatal care
- There are currently no copays for beneficiaries under the age of 21 under North Carolina Medicaid
- Copays should not be a barrier to care
- The Early and Periodic Screening, Diagnosis and Treatment benefit available to children under the age of 21 is meant to help keep children as healthy as possible by keeping up with the most up to date clinical guidance and recommendations for preventive screenings as well as allowing for coverage of medically necessary services not typically covered for adults
- It is important to follow the American Academy of Pediatrics Bright Futures Periodicity Schedule guidance when providing preventive screenings to beneficiaries under the age of 21. This schedule recommends what screenings should be performed at what ages. By ensuring you provide all the appropriate screenings for each child, you are helping to maintain that child's health, and discover issues or concerns early so they can be addressed as early as possible
- The AAP Bright Futures Periodicity Schedule is the minimum of what should be performed for that child at that age. If there is an indication to provide additional screenings, those should be performed, and documented appropriately
- The goal is to help children maintain their health and be as healthy as possible

CHILD HEALTH

NC Medicaid Standard Plan Child Health Learning Collaborative

PRESENTED BY

Rachel Baisden, MPH, MDiv

Quality and Policy Specialist

NC Division of Health Benefits

SIXTH ANNUAL VIRTUAL QUALITY FORUM

Previous Child Health Learning Collaborative Topics

2023

- Initially started under the name "Infant Well-Child (IWC) Learning Collaborative"
- Part of an improvement project through the IWC Affinity Group as part of CMS' Maternal and Infant Health Initiative
- Focused on improving the use and quality of well-child visits

Measure Name	Description
Well-Child Visits in the First 30 Months of Life (W30)	The percentage of members who had the following number of well-child visits with a primary care provider (PCP) during the last 15 months. The following rates are reported:
Well-Child Visits in the First 15 Months	Children who turned 15 months old during the measurement year and had six or more well-child visits.
Well-Child Visits for Age 15-30 Months	Children who turned 30 months old during the measurement year and had two or more well-child visits.
Child and Adolescent Well-Care Visits (WCV)	The percentage of members 3–21 years of age who had at least one comprehensive well-care visit with a primary care provider (PCP) or an obstetrician/gynecologist (OB/GYN) practitioner during the measurement year.

NCQA, "State of Health Care Quality Report," Link.

Previous Child Health Learning Collaborative Topics

2024

- Focus shifted to improving measures related to immunization
- Primary focus on CIS Combo 10, secondary focus on IMA Combo 2

Measure Name	Description
Childhood Immunization Status (CIS) - Combination 10	The percentage of children 2 years of age who had four diphtheria, tetanus and acellular pertussis (DTaP); three polio (IPV); one measles, mumps and rubella (MMR); three haemophilus influenzae type B (HiB); three hepatitis B (HepB); one chicken pox (VZV); four pneumococcal conjugate (PCV); one hepatitis A (HepA); two or three rotavirus (RV); and two influenza (flu) vaccines by their second birthday.
Immunizations for Adolescents (IMA) - Combination 2	Percentage of adolescents 13 years of age who had one dose of meningococcal conjugate vaccine; had one tetanus, diphtheria toxoids and acellular pertussis (Tdap) vaccine; and completed the human papillomavirus (HPV) vaccine series by their 13th birthday.

2025

- Continued focus on immunizations
- CIS Combo 10
- In alignment with PIPs and Standard Plan Withhold Program

NCQA, "State of Health Care Quality Report," Link.

Work Previously Completed in the CHLC

<u>Use of Quality Improvement Tools</u>

Root Cause Analysis/Fishbone Diagram

Best Practices

Driver Diagram

PDSA Cycles

Standard Plans Sharing Interventions

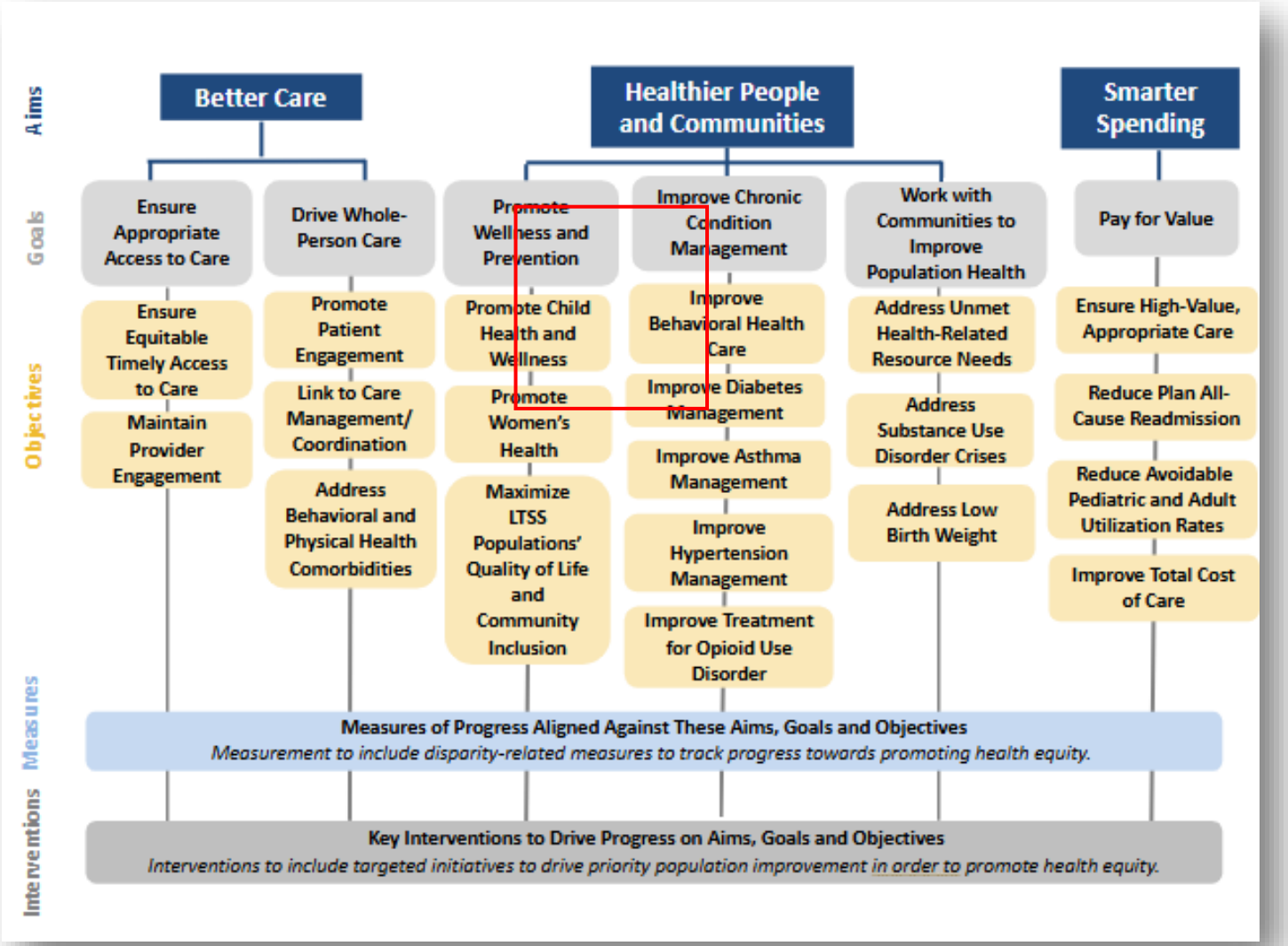
SMEs and Discussions on Special Topics

Topic Began in April 2026

Based on the Standard Plans' desire to focus on preventative care, Departmental priorities and room for quality improvement, the measure selected as the focus of the Child Health Learning Collaborative in April 2026 is:

Whole Care Wellness with a focus on EPSDT (Screening Ratio – Line 7)

This selection was also approved by the internal team who leads EPSDT service delivery.



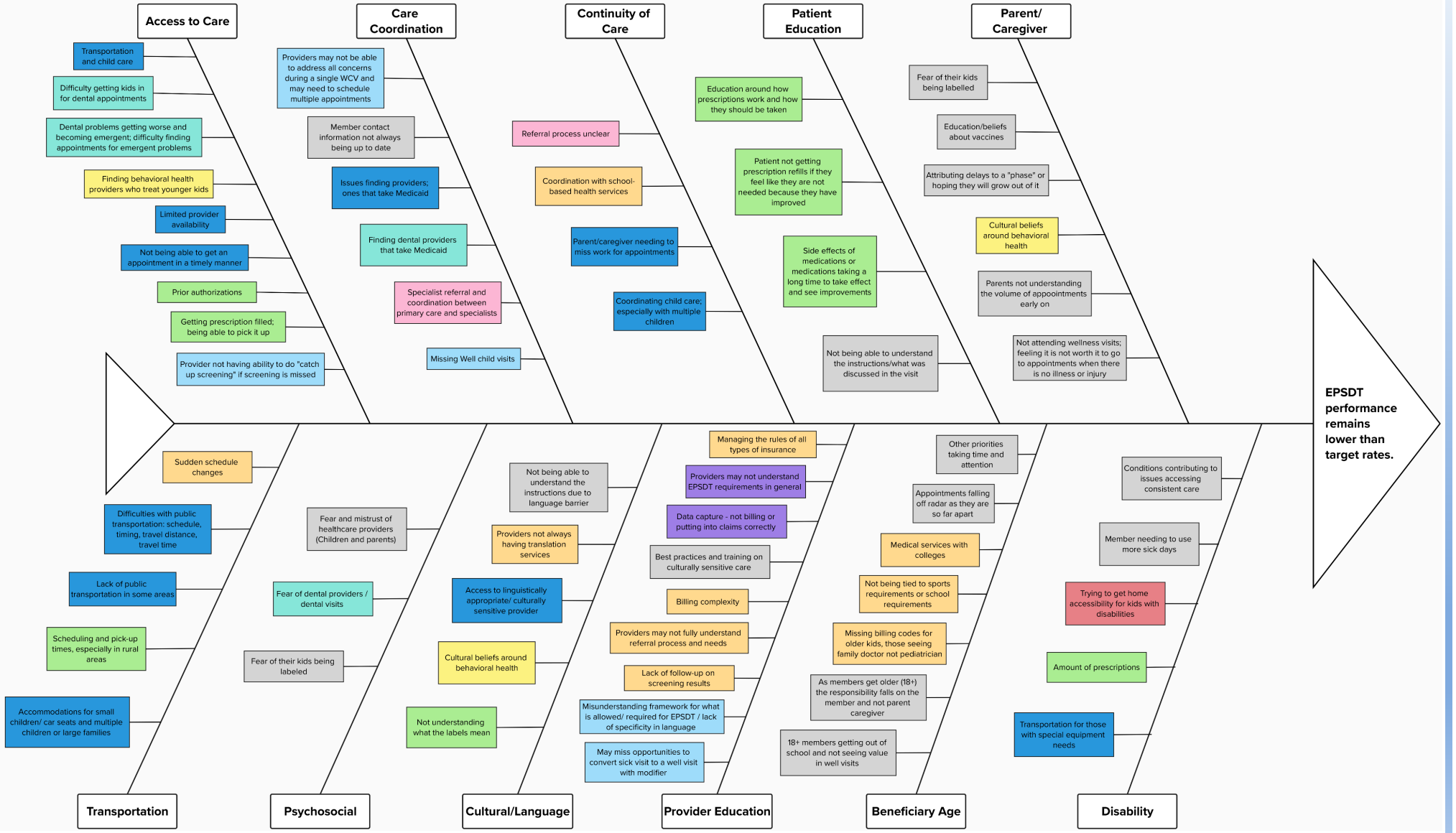
EPSDT Fishbone Diagram

EPSDT Fishbone Diagram/Root Cause Analysis

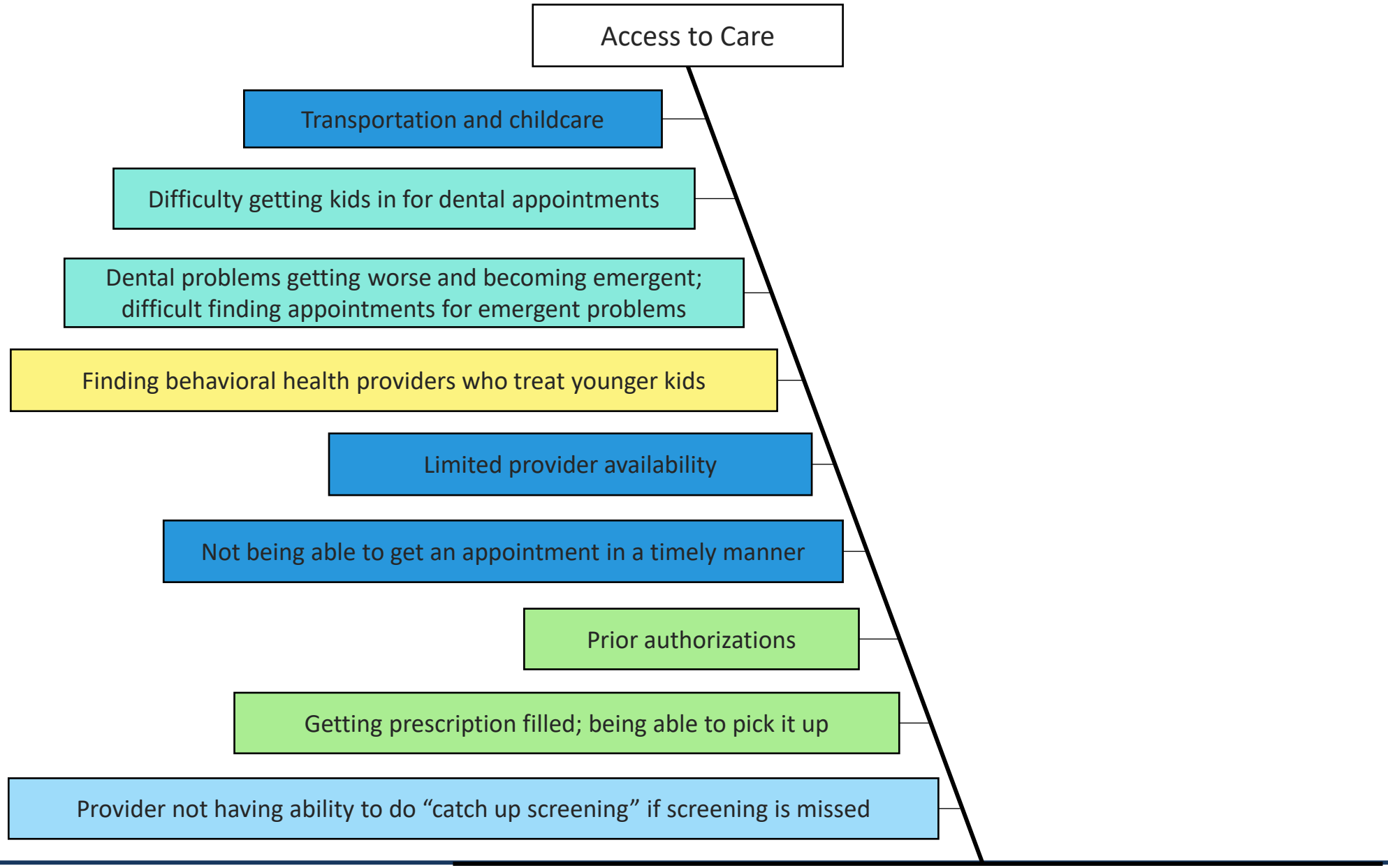
Categories:*

Preventive Care	Behavioral Health	Drugs
Home Health	Dental	Vision
Patient or parent/ caregiver related	Care Coordination/ Continuity of Care	Process-related
Access/ Availability	Other	

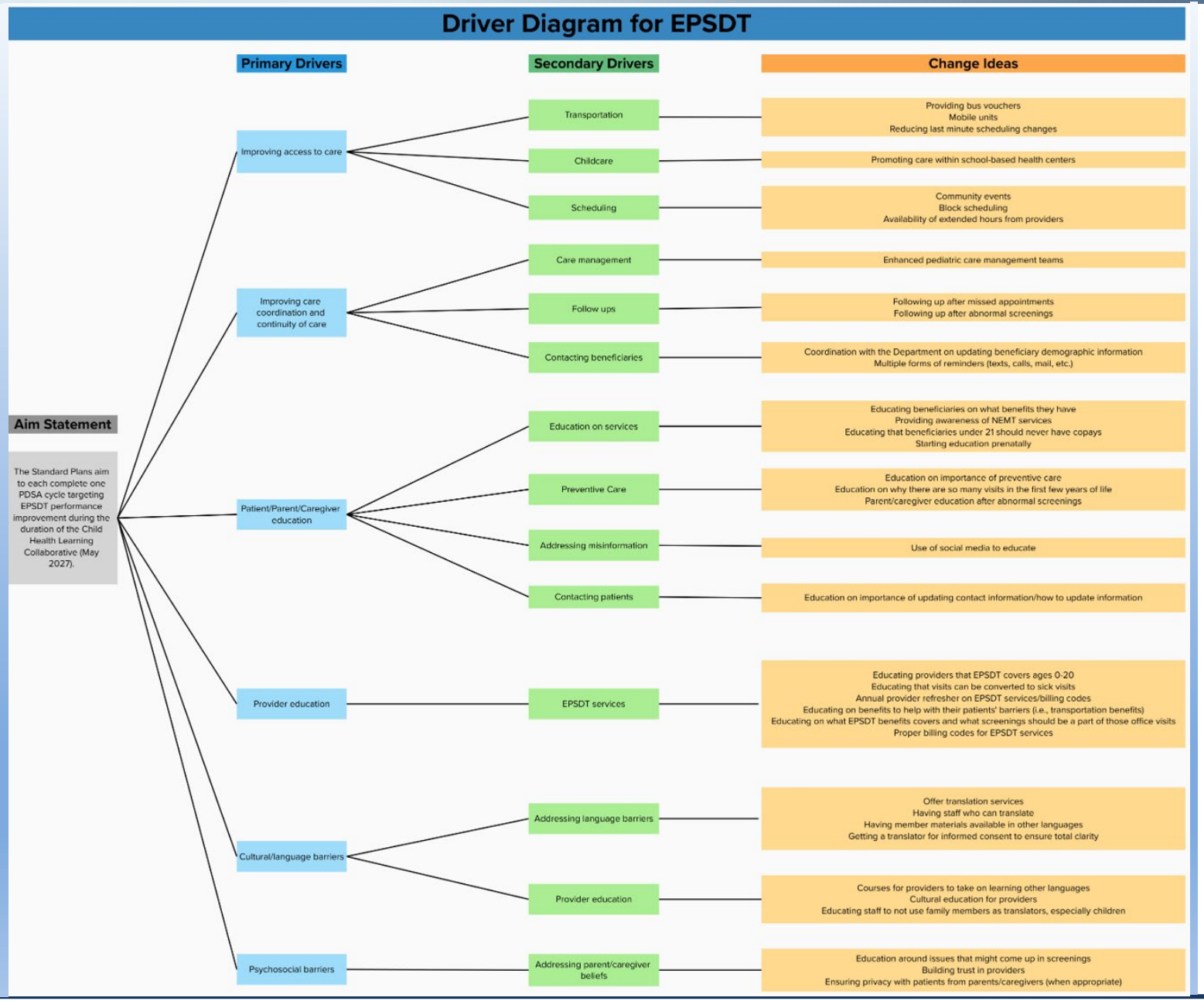
*This does not serve as a comprehensive list of services included under EPSDT services



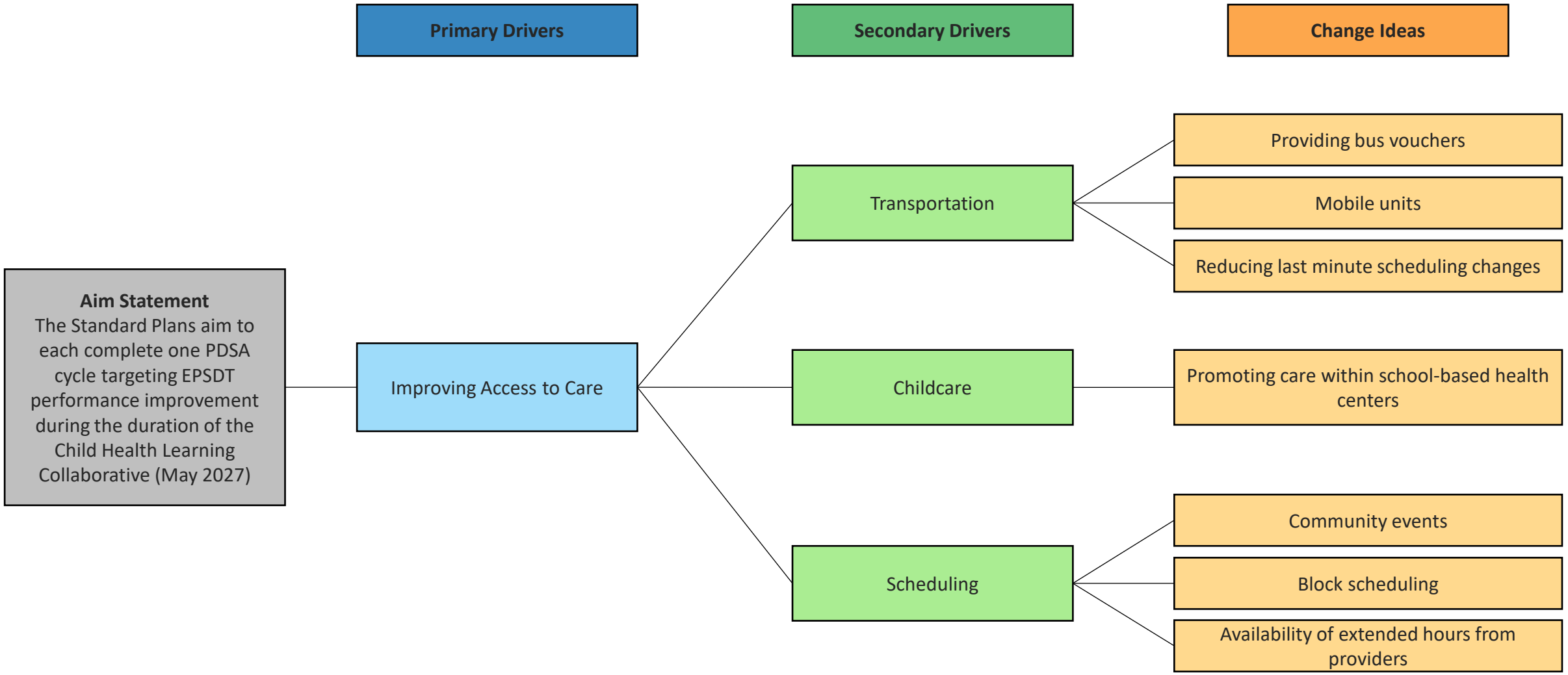
Fishbone Diagram



EPSDT Driver Diagram



EPSDT Driver Diagram





WOMEN'S HEALTH

Navigating Women's Health and Continuum of Care



SECTION OVERVIEW

Women's Health and Continuum of Care

A statewide discussion focused on coordinated, person-centered care.

SIXTH ANNUAL VIRTUAL QUALITY FORUM

Cervical Cancer Screening Overview

PRESENTED BY

Lisa Tucker, BSN, RN, CCM, CPHQ

Manager of Quality Improvement

AmeriHealth Caritas North Carolina

SIXTH ANNUAL VIRTUAL QUALITY FORUM

Cervical Cancer Screening

AUDIENCE ENGAGEMENT

POLL QUESTIONS

Please respond using the webinar polling feature.

Cervical Cancer Screening (CCS-E)

Description:

The percentage of individuals, 21-64 years of age who were screened for cervical cancer using any of the following criteria:

- 21-64 years of age who had a cervical cytology (Pap Test) performed within the last 3 years
- 30-64 years old who had cervical high-risk human papillomavirus (hrHPV) testing within the last 5 years
- 30-64 years old who had cervical cytology/high-risk human papillomavirus (hrHPV) co-testing within the last 5 years

Lookback Period:

3 years for Pap Test for members 21-64 years of age
5 years for hrHPV for members 30-60 years of age

Required Exclusions:

Members who died anytime during the measurement year.
Members in hospice, using hospice services, receiving palliative care services, or who had a palliative care encounter anytime during the measurement year.
Members with hysterectomy with no residual cervix, cervical agenesis or acquired absence of cervix at any time during the member's history through the end of the measurement year.
Members with sex assigned at birth as male at any time during the member's history

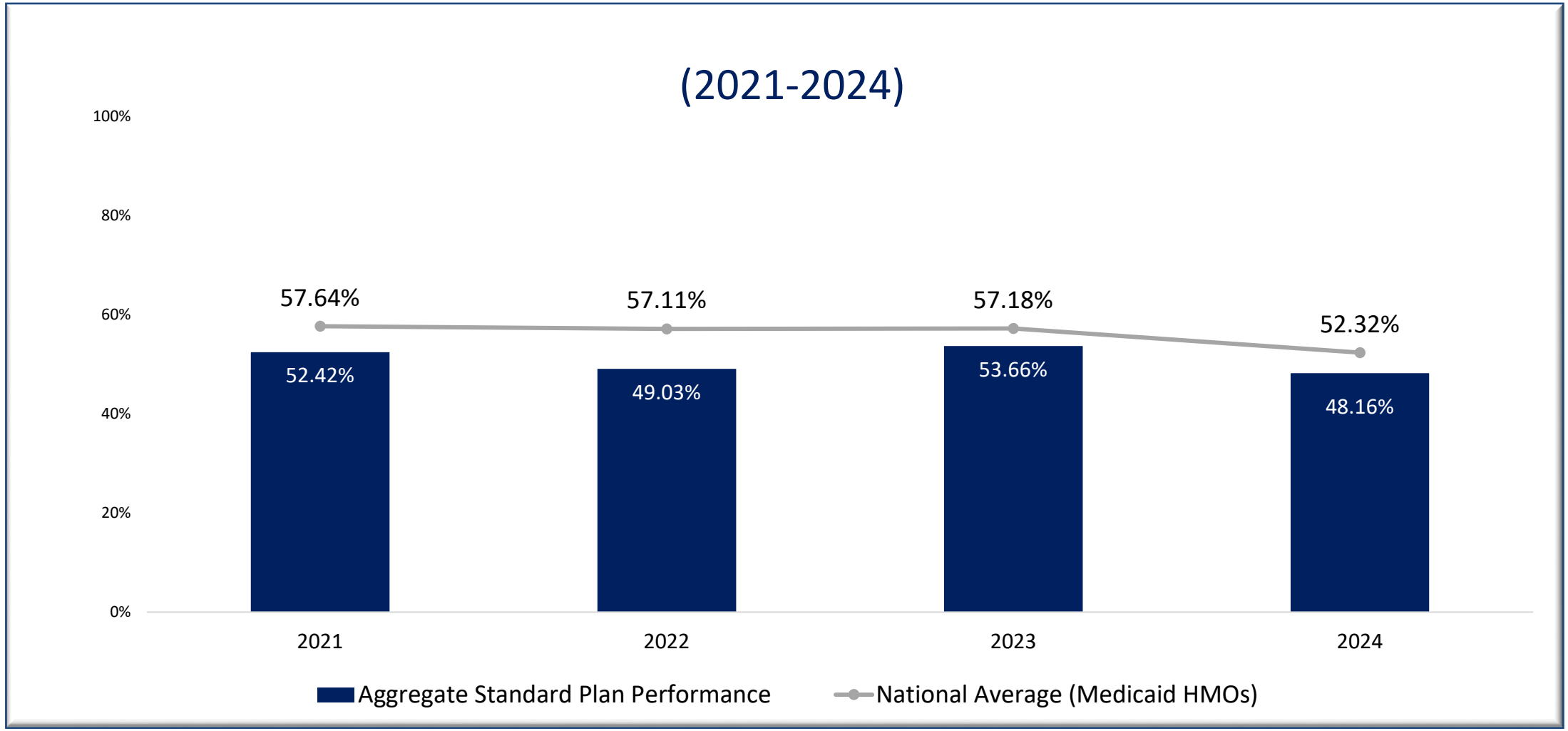
Description	Codes*
Cervical Cytology Lab Test	**CPT:** 88141-88143, 88147-88148, 88150, 88152, 88153-88154, 88164-88167, 88174-88175 **HCPCS**: G0123- G0124, G0141, G0143-G0145, G0147, G0148, P3000, P3001
High Risk HPV Testing	**CPT:** 87624, 87625, 87626, 0502U **HCPCS:** G0476
Exclusion: Absence of Cervix Diagnosis	**ICD-10:** Q51.5, Z90.710, Z90.712
Exclusion: Hysterectomy with No Residual Cervix	**CPT:** 57530, 57531, 57540, 57545, 57550, 57555, 57556, 58150, 58152, 58200, 58210, 58240, 58260, 58262, 58263, 58267, 58270, 58275, 58280, 58285, 58290-58294, 58548, 58550, 58552-58554, 58570-58573, 58575, 58951, 58953, 58954, 59856, 59135

*** In measure year 2025, the HEDIS® Cervical Cancer Screening measure (CCS) became an Electronic Clinical Data Systems (ECDS) measure and was renamed CCS-E. ECDS is a HEDIS reporting method for health plans collecting and submitting quality measures to NCQA.**

*Codes subject to change

**Source: NCQA Quality Compass, 2024 and NC Medicaid Quality Measure Performance and Targets for the AMH Measure Set document, January 2026*

Total NC Medicaid CCS-E, Cervical Cancer Screening Performance



Standard Plan Aggregate Target – 49.16%

CCS-E: Strategies for Practice Improvement

- Develop a reminder system or flag patient files to identify which patients are due for a cervical cancer screening test
- If screening is due or overdue, incorporate discussions about screening into every appointment to avoid missed opportunities
- Complete screenings during well woman OB/GYN visit, sick visits, urine pregnancy tests, UTI or screening for STDs
- Always include dates of service, specific test names, and results in the medical record
- If your patient has had a total hysterectomy with no residual cervix, please ensure to include applicable codes in billing and document in the medical record
- Offer HPV self-collection tests when clinically appropriate

CCS-E: Strategies for Practice Improvement

- Proactively raise the topic of cervical cancer screening and emphasize its success In preventing cervical cancer.
- Explain that anyone who has ever been sexually active can get HPV and could develop cervical cancer—even if they have had only one sexual partner.
- Explain that the goal of screening for cervical cancer is to find precancerous cervical cell changes, when treatment can prevent cervical cancer from developing.
- 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.
- For patients with lower health literacy or English as a second language, utilize visual aids along with simple explanations.
- Some patients may have experienced trauma that impacts their comfort being examined. Ask about a patient's comfort without requiring them to disclose trauma and offer alternatives to improve their comfort.

Maternal Health:
Prenatal Care Overview

PRESENTED BY

Allison Wood, BSN, RN, CCM
Director of Quality
UnitedHealthcare Community Plan of North Carolina

Amanda Barker, CPC, CRC
Senior Clinical Quality Consultant
UnitedHealthcare Community Plan of North Carolina

SIXTH ANNUAL VIRTUAL QUALITY FORUM

Prenatal & Postpartum Care

AUDIENCE ENGAGEMENT

POLL QUESTION

Please respond using the webinar polling feature.

State of Maternal Health in North Carolina

Maternal Health Challenges

- North Carolina faces higher rates of preterm births, infant and maternal mortality compared to national averages.

Medicaid's Role

- Medicaid finances over half of births in North Carolina, playing a key role in determining health outcomes statewide.

  Medicaid populations face chronic diseases, limited prenatal care, and social barriers like transportation and housing instability.

Disparities and Populations Affected

- Rural areas and racial minorities, especially Black and American Indian populations, face reduced care access and worse outcomes.

Strategic Interventions Needed

- Improving maternal health requires early intervention, better care coordination, and targeted regional approaches.

NC Medicaid Maternal Health Quality Report

Medicaid Performance Drivers

Prenatal Care Access Gap

- Medicaid beneficiaries are less likely to receive adequate prenatal care during the critical first trimester.
- Limited maternity providers and facilities in rural areas create significant access challenges for maternal health care.

Clinical and Social Risks

- Higher rates of smoking, obesity, and substance use among Medicaid beneficiaries contribute to increased risk of complications in pregnancy.
- Mental health conditions, including depression and anxiety, are leading causes of maternal mortality and often go untreated.
- Food insecurity, housing instability, and economic hardship disproportionately affect Medicaid beneficiaries.

Adverse Birth Outcomes

- Medicaid beneficiaries experience increased incidence of preterm birth, low birth weight, and infant mortality.

Opportunity for Improvement

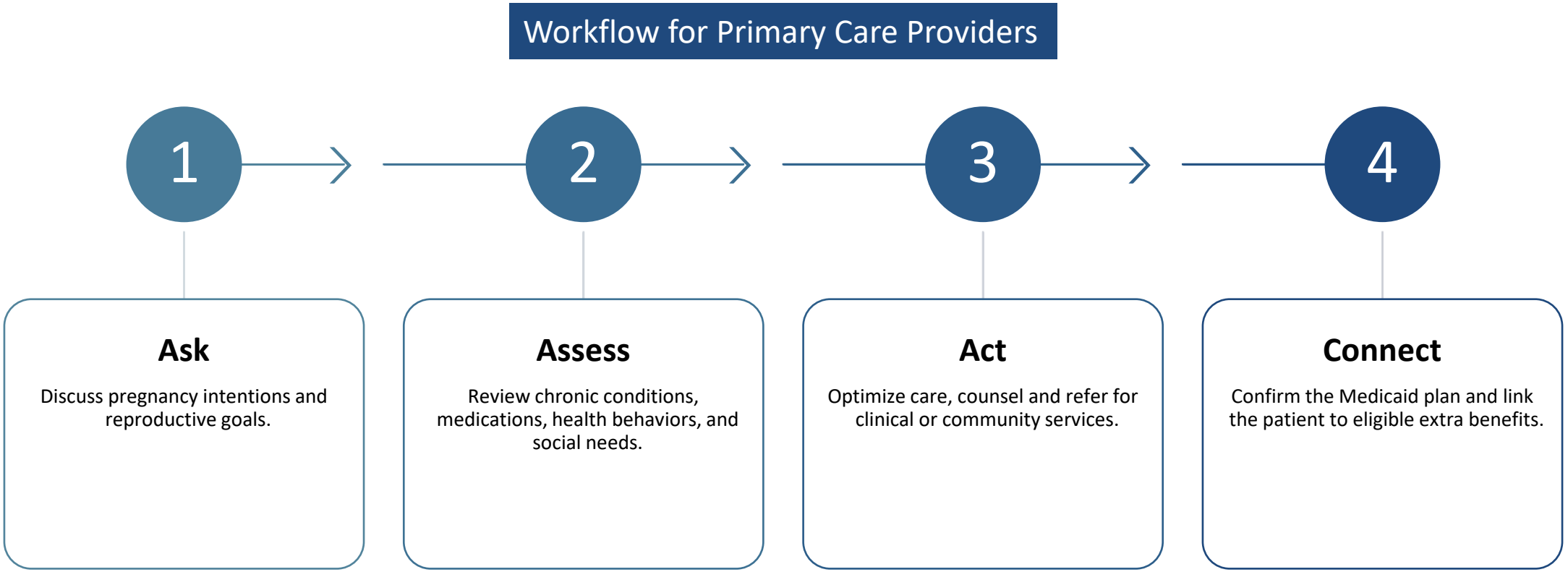
- Coordinated care and targeted interventions can close gaps and improve maternal health outcomes for Medicaid beneficiaries.
- Inaccurate reporting from billing practices reduces visibility of prenatal and postpartum care quality.

Addressing these drivers requires a holistic approach that goes beyond traditional healthcare delivery. Investments in community-based programs, enhanced data infrastructure, and partnerships with local organizations will be essential to overcoming these barriers. Targeting both clinical and non-clinical drivers, is essential to improve maternal health outcomes and reduce disparities.

NC Medicaid Maternal Health Quality Report

Preconception Health Starts in Primary Care

Primary care providers (PCPs) play a central role in improving preconception health by identifying and addressing risk factors before pregnancy, promoting healthy reproductive life planning and connecting patients to resources.



Perinatal Health Strategic Plan 2022-2026

Benefits That Build Preconception Health

Value-Added Standard Plan Benefits

Use the patient's need to guide the referral. Many supports improve health before pregnancy.

Social Needs	Risk Reduction	Chronic Condition Management	Access
Healthy Foods & Grocery Allowances	Tobacco Cessation	Weight Management	Transportation Services
Housing Support	Opioid Misuse Prevention	Fitness Memberships	Education & GED Assistance
Utility Assistance	Behavioral Health Supports	Healthy Foods & Grocery Allowance	Doula Services
Transportation Assistance	Life-Skills Classes	Cooking Classes	Community-Resource Navigation

Benefits vary by health plan, eligibility, geography, and program requirements and may change. Confirm current benefits directly with the patient's health plan.

- NC Medicaid Managed Care, Health Plan Comparison Chart

Maternal Immunizations

- The American College of Obstetrics and Gynecology recommends the following guidelines for immunizations during pregnancy:
- Routinely assess pregnant patients' vaccination status
- Recommend and when possible, administer needed vaccines to pregnant patients
- Individuals who are or will be pregnant during the fall/winter respiratory illness season should receive annual influenza and coronavirus disease 2019 (COVD-19) vaccines
- All pregnant individuals should receive a Tdap (tetanus toxoid, reduced diphtheria toxoid, and acellular pertussis) vaccine during each pregnancy, as early in the 27-36 gestational-week window as possible
- All eligible pregnant individuals who meet criteria should receive the respiratory syncytial virus (RSV) vaccine
- Other vaccines may be recommended during pregnancy depending on the patient's age, prior immunizations, comorbidities, or disease risk factors

  - Maternal Immunizations | ACOG

Every Mother, Every Baby, Every Time



Present Vaccinations as Standard of Care

- Provide each patient with information and resources
- Ensure staff deliver consistent messages
- Normalize vaccination



Provide a Strong Recommendation

- State clearly that you would like your patient to get vaccinated
- Research indicates that some patients did not feel their provider strongly recommended vaccines



Start the Conversation – Remember to *SHARE*

- **S**hare why the vaccine is right for the patient
- **H**ighlight positive experiences with vaccines
- **A**ddress questions and concerns
- **R**emind your patient that vaccines offer protection
- **E**xplain the potential cost of getting the diseases

ObGyn-Vaccines-Tip-Sheet-NCDHHS-Jan-2025.pdf

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Timeliness of Prenatal Care (PPC)

Description:

Percentage of deliveries of live births on or between Oct. 8 of the year prior to the measurement year and Oct. 7 of the measurement year. The measure includes the following 2 indicators:

- Timeliness of prenatal care
- Postpartum care

Lookback Period:

Timeliness of prenatal care – Percentage of women who had a live birth, who received a prenatal care visit in the first trimester on or before the enrollment start date or within 42 days of enrollment in a standard health plan

Required Exclusions:

Members in hospice or using hospice services
Members who died
Pregnancy didn't result in a live birth (Oct 8 prior year → Oct 7 current year)
Member wasn't pregnant (Oct 8 prior year → Oct 7 current year)
Delivery wasn't in date parameters (Oct 8 prior year → Oct 7 current year)

Description	Codes*
Prenatal Bundled Services**	**CPT/CPTII :** 59400, 59425, 59426, 59510, 59610, 59618 **HCPCS**: H1005
Stand-alone Prenatal Visits	**CPT/CPTII :** 99500, 0500F, 0501F, 0502F **HCPCS:** H1000, H1001, H1002, H1003, H1004
Prenatal Visits with Diagnosis of Pregnancy	**CPT/CPTII :** 98000, 98001, 98002, 98003, 98004, 98005, 98006, 98007, 98008, 98009, 98010, 98011, 98012, 98013, 98014, 98015, 98016, 98966, 98967, 98968, 98970, 98971, 98972, 98980, 98981, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99242, 99243, 99244, 99245, 99421, 99422, 99423, 99441, 99442, 99443, 99457, 99458, 99483, 98979, 99470 **HCPCS:** G0463, T1015, G0071, G2010, G2012, G2250, G2251, G2252, G0544

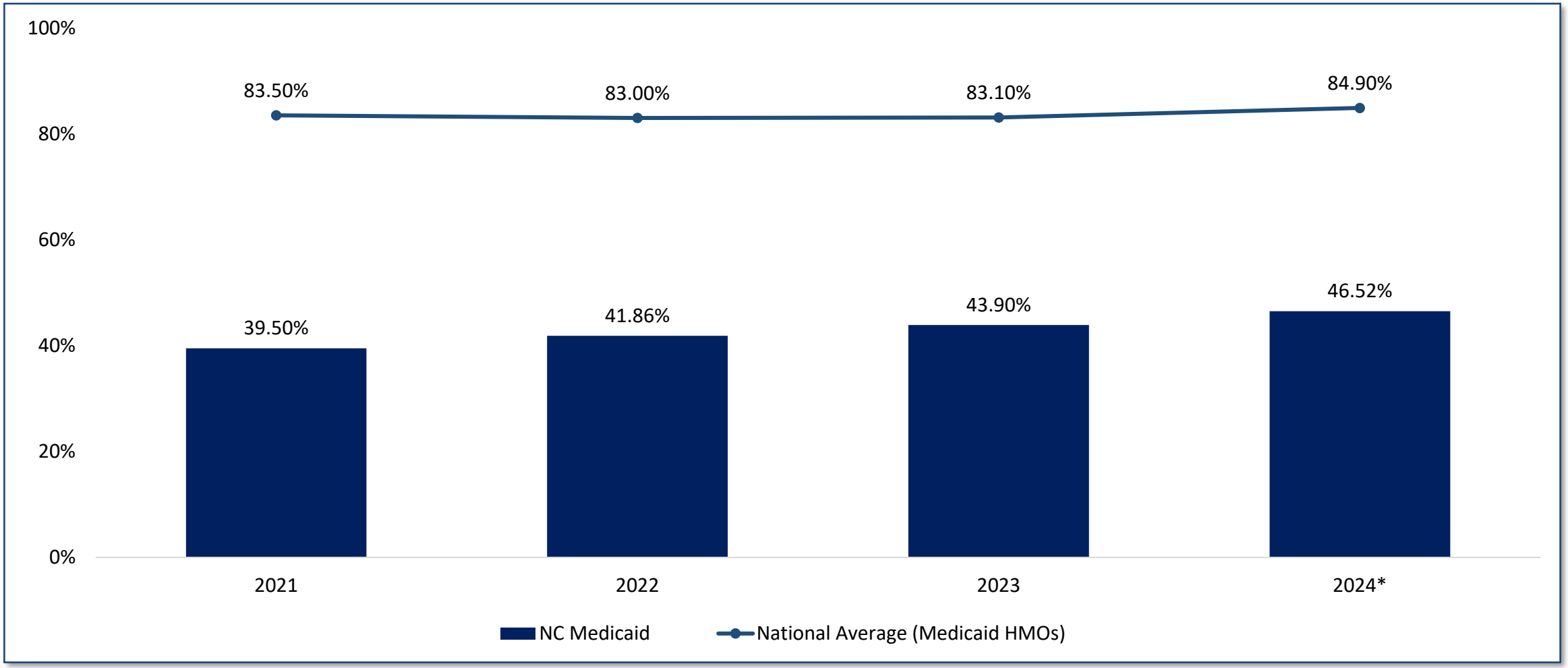
**These codes are being retired beginning January 1, 2027. Additional Information can be found using the following links:

- CPT Maternity Care Services Codes and Guidelines | AMA
- Payment for Obstetric Services | ACOG

**Source: NCQA Quality Compass, 2024 and NC Medicaid Quality Measure Performance and Targets for the AMH Measure Set document, January 2026*

Total NC Medicaid PPC, Timeliness of Prenatal Care Performance

(2021-2024)



*The Department released updated clinical policy and began encouraging practices/providers to practice using the F codes in April 2024.

PPC/Prenatal: Strategies for Practice Improvement

- For bundled maternity services, submit separate claims for the pregnancy diagnosis and postpartum visits, including 0500F (prenatal) and 0503F (postpartum) as no-charge line items—and use Electronic Medical Record (EMR) templates to auto-add 0500F when applicable.
    - Begin preparing for prenatal care coding changes that go into effect January 1, 2027.
- Ultrasound and lab results must be linked to an office visit with an appropriate practitioner to count for this measure. The ultrasound and lab result alone will not meet compliance.
- Services provided during a telephone visit or online assessment (e-visit/virtual check-in) will meet the criteria for compliance.
- When the prenatal care visit is with a PCP, the claim must include the prenatal visit, and a diagnosis of pregnancy.
- A Pap test alone doesn't count as a prenatal care visit but will count toward postpartum care as a pelvic exam.
- A visit with a registered nurse will not meet compliance.

Prenatal Care: Strategies for Patient Engagement

- Identify members with Emergency Room visits who have a diagnosis of pregnancy and initiate timely follow-up.
- Encourage early prenatal care (by 12 weeks) to support healthy outcomes for both mom and baby and identify any concerns early.
- Highlight flexible care options, including telehealth (video or phone), to ensure moms can connect with care even if in-person visits are difficult.
- Implement multi-modal engagement opportunities on importance of prenatal care and needed services.
- Reward members for completion of prenatal care visits.
- Assess and address barriers to regular screening (SDOH, access, transportation, cost, fear/anxiety).

Maternal Health:
Postpartum Care Overview

PRESENTED BY

Laura Day, RN, BSN
Senior Director of Quality Management
Healthy Blue North Carolina

Postpartum Care (PPC)

Description:
The percentage of deliveries of live births on or between October 8 of the year prior to the measurement period and October 7 of the measurement period that had a postpartum visit.

Lookback Period:
Postpartum care – Percentage of women who had a live birth who had a postpartum visit on or between 7–84 days after delivery

Required Exclusions:
- Must be continuously enrolled 43 days prior to delivery through 60 days after delivery with no gaps
- Non-live births
- If a person has more than one delivery in a 180-day period, include only the first eligible delivery. Then, if applicable, include the next delivery that occurs after the 180-day period. Identify deliveries chronologically, including only one per 180-day period.
- Date of death in the measurement period
- Persons who use hospice services or elect to use a hospice benefit any time during the measurement period

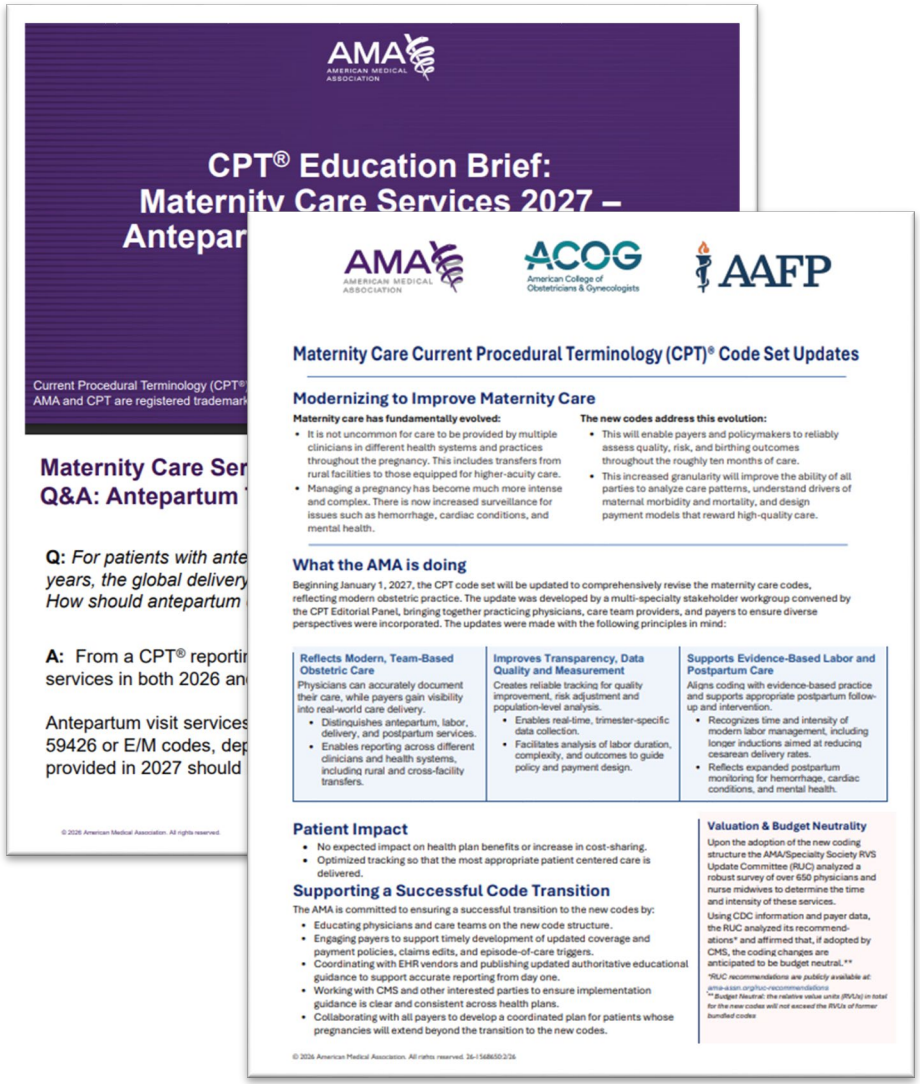
Description	Codes*
Deliveries	**CPT:** 59400, 59409, 59410, 59510, 59514, 59515, 59610, 59612, 59614, 59618, 59620, 59622 ICD10PCS: 10D00Z0-10D00Z2, 10D07Z3-10D07Z8, 10E0XZZ
Postpartum Bundled Services	59400, 59410, 59510, 59515, 59610, 59614, 59618, 59622 **(These codes will be retired 1/1/2027)**
Stand Alone Postpartum Care	**CPT-CAT II** 0503F: Postpartum care visit **(NC Medicaid providers must submit this code)** **CPT:** 57170, 58300, 59430, 99501 **HCPCS:** G0101: Cervical or vaginal cancer screening; pelvic and clinical breast examination **Encounters ICD10:** Z01.411, Z01.419, Z01.42, Z30.430, Z39.1, Z39.2
Encounter for Postpartum Care	**ICD10CM:** Z01.411, Z01.419, Z01.42, Z30.430, Z39.1, Z39.2

*Codes subject to change

**Source: NCQA Quality Compass, 2024 and NC Medicaid Quality Measure Performance and Targets for the AMH Measure Set document, January 2026*

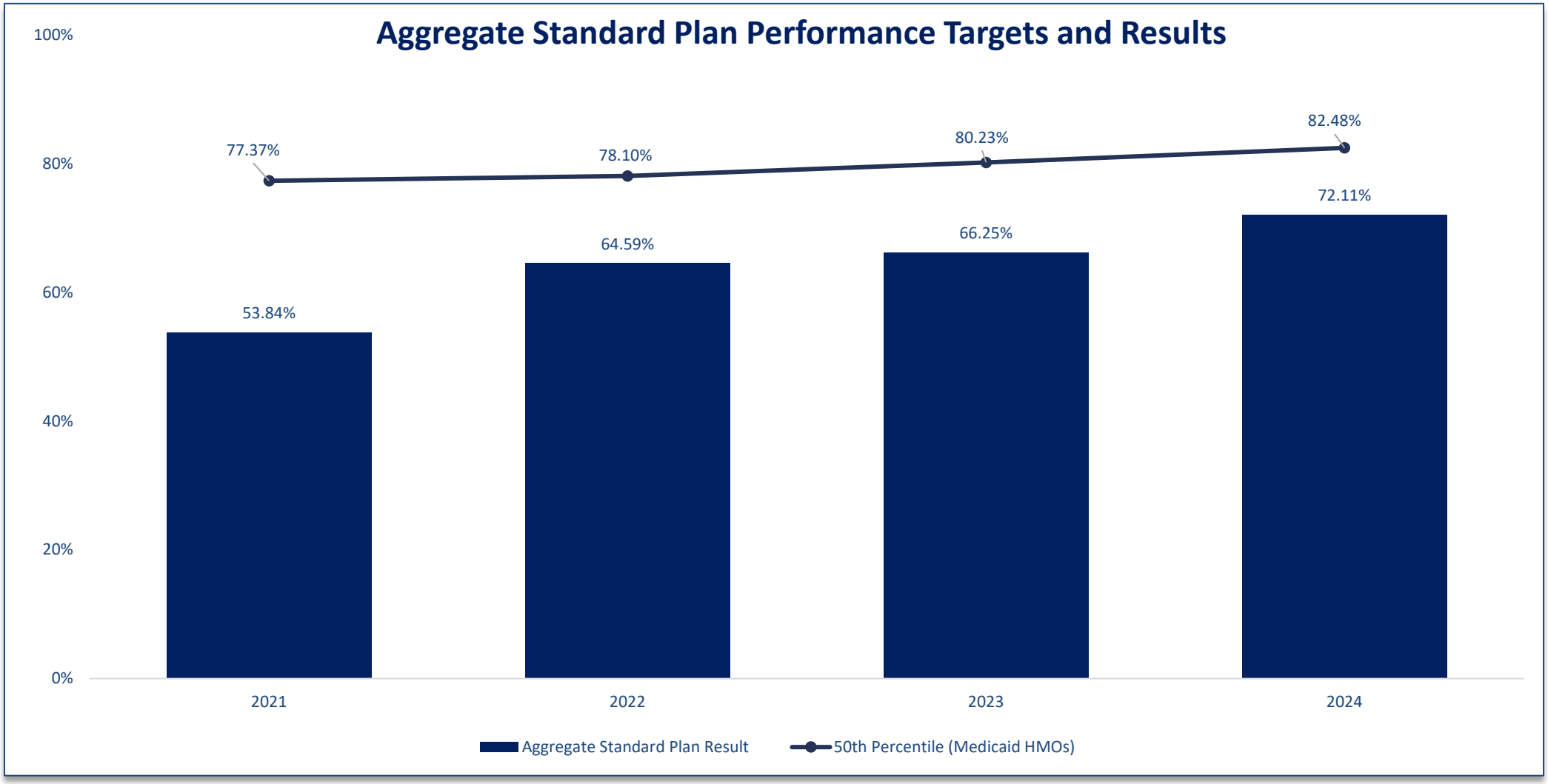
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Changes to Global Billing



- **January 1st, 2027, global billing codes for maternity services will be retired**
  - Delivery of maternity care has changed significantly over the past three decades and global billing doesn't accurately reflect modern care delivery. New CPT codes will more accurately reflect the how, when, where and by whom care is delivered to capture more granular data across the pregnancy continuum.
- **It is recommended these changes be implemented now to avoid administrative burden and denied claims**
- **The Department's policy on F codes remains unchanged**
  - 0500F will continue to be *required* for delivery reimbursement
  - 0503F will continue to be *highly encouraged*

Postpartum Care: Performance Rates



**The Aggregate Standard Plan 2026 Target is 73.55%*

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Postpartum Care: Postpartum Depression Screening

- Access hospital post-delivery depression screen; if positive at hospital schedule an earlier OB follow-up appointment.
- Screening helps ensure postpartum depression is addressed to improve quality of care and long-term outcomes for both beneficiary and child.
- Use scientifically validated maternal depression screening tools
  - **Edinburgh Postnatal Depression Scale (EPDS)**: A 10-item questionnaire validated for use during pregnancy and postpartum to detect depressive symptoms.
  - **Patient Health Questionnaire (PHQ-9)**: A 9-item tool commonly used to assess depression severity, also validated for perinatal populations.
- If screening is positive refer beneficiary to the appropriate resources for support and treatment (primary care provider or other appropriate providers).
- Educate patients on signs and symptoms of depression including who and when to call.
- Conduct a follow-up call with beneficiary who screens positive. A nurse could make this call.

Postpartum Care: Postpartum Depression Screening Billing

- NC Medicaid will reimburse providers for up to 4 maternal depression risk screens administered to mothers during the infant's first year postpartum.
- May be screened not only by obstetric provider at postpartum appointments, but also at family planning or primary care provider appointments.
- Maternal depression screening during the well-child visit is considered a pediatric best practice. AAP recommends at 1-, 2-, 4-, & 6-month visits.
- CMS directs use of CPT code 96161), one (1) unit per administration, with EP modifier when billing for this service.
- When conducted as part of a comprehensive Health Check Early Periodic Screening visit, it may be billed to the infant's Medicaid coverage.

Postpartum Care: Strategies for Practice Improvement

- CPT code 0503F required by NC Medicaid Clinical Coverage Policy 1E-5. Report this code at the comprehensive postpartum visit in addition to appropriate visit coding.
- Postpartum package services are covered when the attending provider: performed the delivery and provided the postpartum care; or performed postpartum care only.
- Postpartum visit can be to an obstetrical provider or other postpartum care practitioner, or primary care provider (PCP).
- Ensure coordination of medically necessary primary or specialty care for chronic medical conditions or pregnancy-related complications.
- Schedule postpartum visit appointment at discharge.
- Consider allowing children during visits.
- Consider flexible hours.
- Provide appointment reminders.

Postpartum Care: Strategies for Patient Engagement

- Emphasize importance of the postpartum visit (check physical recovery, emotional well-being, and address any questions).
- Reinforce that caring for mom is just as important as caring for baby.
- Highlight flexible care options, including telehealth (video or phone).
- Physicians, nurse practitioners, physician assistants and certified nurse midwives may conduct postpartum care via a telehealth visit, with a supporting home visit by an appropriately trained, delegated staff person.
- Assist with barriers like transportation to make care easier to access (leverage NEMT).
- Provide culturally competent care - awareness of diverse backgrounds and respect for cultural preferences.
- For patients with lower health literacy or English as a second language, use translation services and simple explanations.

MATERNAL HEALTH

NC Medicaid Standard Plan Maternal Health Learning Collaborative

PRESENTED BY

Kate Davis, RN, BSN

Clinical Nurse Quality Manager

NC Division of Health Benefits

SIXTH ANNUAL VIRTUAL QUALITY FORUM

NC Medicaid Standard Plan Maternal Health Learning Collaborative

The NC Medicaid Maternal Health Learning Collaborative brings together the Standard Plans to foster open discussion, shared problem-solving, and alignment around evidence-based strategies that support better maternal health outcomes for NC Medicaid members. Through collaborative sessions, participants use quality improvement tools, conduct root-cause analyses, and brainstorm actionable interventions to inform PDSA cycles, with the goal of piloting new and innovative interventions.

Currently, the Collaborative is focusing on the National Committee for Quality Assurance (NCQA) Healthcare Effectiveness Data and Information Set (HEDIS®) Prenatal and Postpartum Care (PPC) quality measure.



NC Medicaid Standard Plan Maternal Health Learning Collaborative

The NCQA HEDIS® Prenatal and Postpartum Care (PPC) quality measure assesses **utilization of** prenatal and postpartum care using two sub-measures:

- **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 organization.

- **Postpartum Care:** The percentage of deliveries that had a postpartum visit between seven and 84 days after delivery.

Timeline of the NC Medicaid Standard Plan Maternal Health Learning Collaborative

Initial Maternal Health Learning Collaborative

Review PPC data, including racial and ethnic disparities and regional differences.

March 2025

Root Cause Analysis

Completed a fishbone diagram to identify root cause barriers to timely delivery of prenatal and postpartum care.

May & July 2025

Provider Panel

Providers and practice managers from three health systems presented barriers and strategies for improving member adherence to prenatal and postpartum care appointments.

September 2025

Driver Diagram

Identified actionable interventions and approaches to target barriers identified during the root cause analysis.

November 2025

Subject Matter Expert Presentations

Presentations from Dr. Laurelle Bookhart and Dr. Ebony Carter regarding prenatal and postpartum care delivery and resources.

January & March 2026

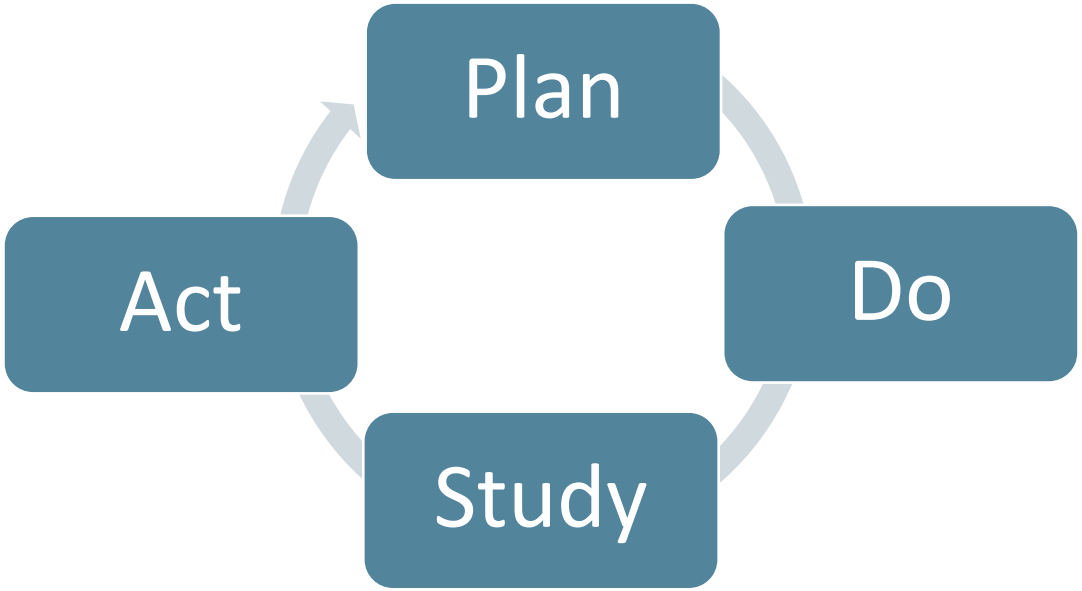
Presentation of PDSA Cycles

Presented the designs for pilot initiatives and plans for Plan, Do, Study, Act (PDSA) cycles.

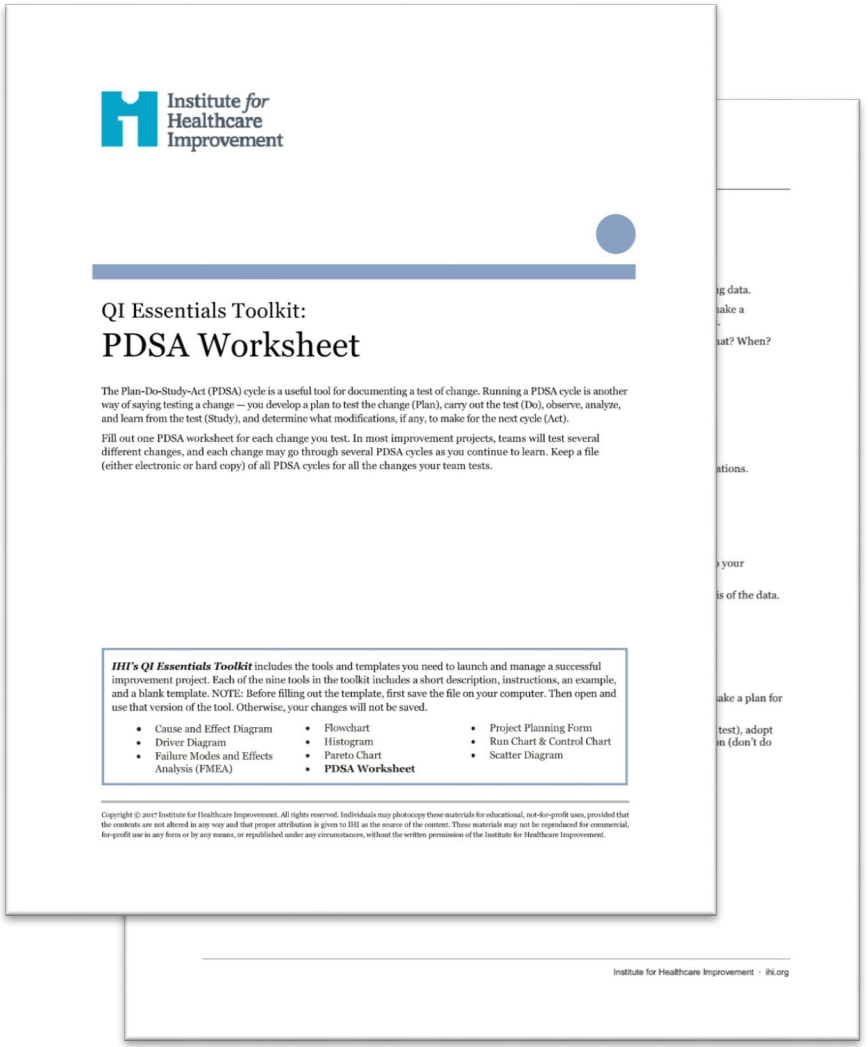
May 2026



Maternal Health Learning Collaborative: PDSA Cycles



A PDSA cycle is a brief, iterative, process that allow the plans to pilot interventions on a small scale, assess the results and adjust or adapt the intervention according to findings.



Institute for Healthcare Improvement

QI Essentials Toolkit:

PDSA Worksheet

The Plan-Do-Study-Act (PDSA) cycle is a useful tool for documenting a test of change. Running a PDSA cycle is another way of saying testing a change — you develop a plan to test the change (Plan), carry out the test (Do), observe, analyze, and learn from the test (Study), and determine what modifications, if any, to make for the next cycle (Act).

Fill out one PDSA worksheet for each change you test. In most improvement projects, teams will test several different changes, and each change may go through several PDSA cycles as you continue to learn. Keep a file (either electronic or hard copy) of all PDSA cycles for all the changes your team tests.

IHI's QI Essentials Toolkit includes the tools and templates you need to launch and manage a successful improvement project. Each of the nine tools in the toolkit includes a short description, instructions, an example, and a blank template. NOTE: Before filling out the template, first save the file on your computer. Then open and use that version of the tool. Otherwise, your changes will not be saved.

- Cause and Effect Diagram
- Driver Diagram
- Failure Modes and Effects Analysis (FMEA)
- Flowchart
- Histogram
- Pareto Chart
- **PDSA Worksheet**
- Project Planning Form
- Run Chart & Control Chart
- Scatter Diagram

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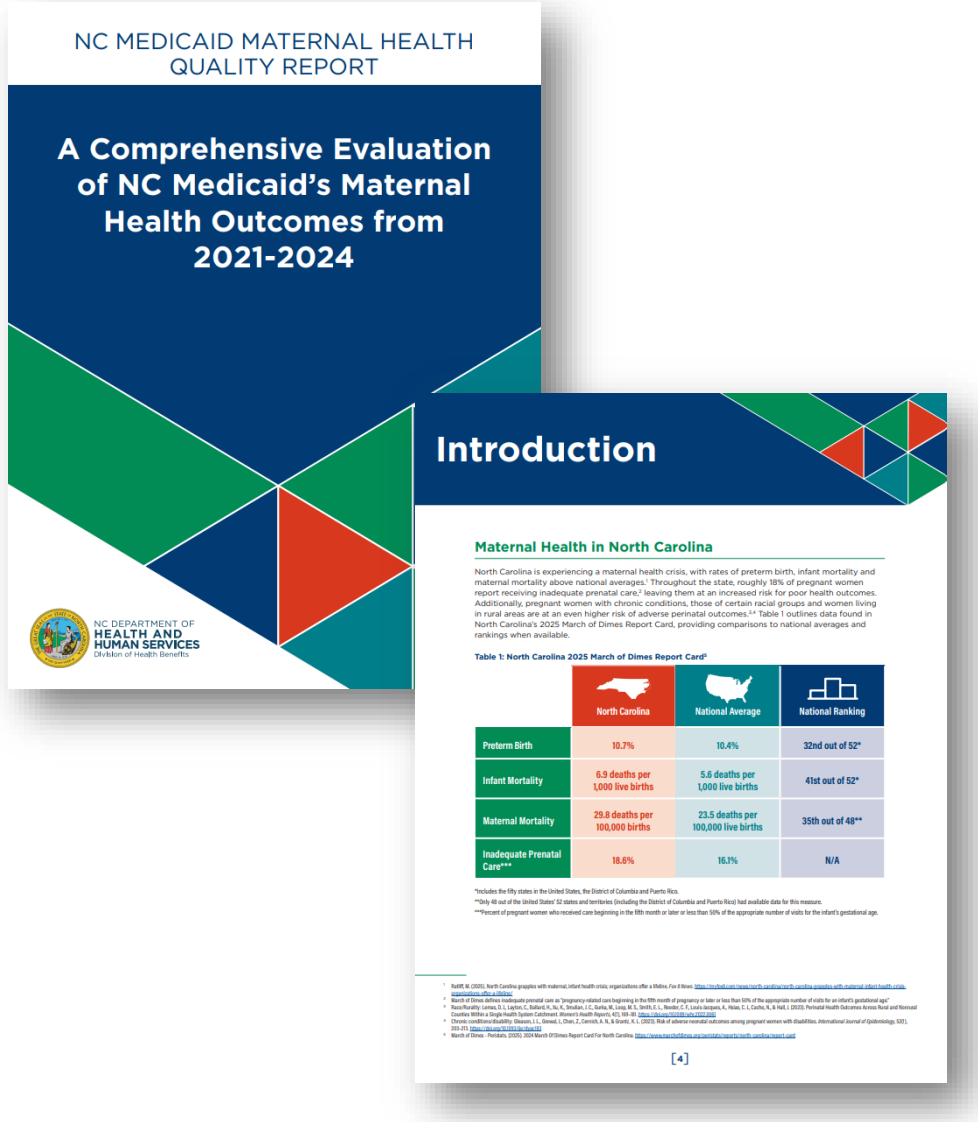
Maternal Health Quality Report

A first of its kind, the NC Medicaid Maternal Health Quality Report provides a comprehensive landscape of maternal health among NC Medicaid beneficiaries.

While traditional quality measures focus on care delivery and quality, this report showcases health outcome data that have not yet been analyzed at this level for the NC Medicaid population.

The report also features over 25 programs, organizations, interventions and initiatives from throughout North Carolina that are working to improve maternal health.

Click here to view the report!



Navigating Women's Healthcare:
Panel Discussion

Moderated BY

Melissa Fabrikant, MSW, LCSW
Director of Quality Improvement
Carolina Complete Health

Panelist



Dr. Michele Benoit-Wilson
Board-Certified Obstetrician/Gynecologist
Medical Director
Carolina Complete Health



Dr. Alicia Firestone
Family Medicine, Obstetrics
Atrium Health Wake Forest Baptist
Wilkes OBGYN/ Rock Creek Family



Stacy Fackler, DNP, RN, NEA-BC
Director, Patient Care Services
Perinatal Division
Atrium Health Cabarrus

Panelist



Carol Ellison, BSN, RN
Nurse Manager
Department of OBGYN | ECU Health
Physicians - Academic Practice



Jennifer Rook, MSN, RN
Nurse Administrator Clinical Ops
Department of OBGYN | ECU Health
Physicians - Academic Practice

Panel Questions

Cervical Cancer Screening – Primary Care & Women's Health

- What workflows have been most effective in your practice for improving Cervical Cancer Screening rates?
- How do you tailor CCS outreach for women who primarily engage with the healthcare system during maternity care rather than routine primary care?
- How do providers address members new to cervical cancer screening (young adults)?
- What role do care coordinators, standing orders, or in-office screening options play in driving Cervical Cancer Screening in your practice?

Panel Questions

Prenatal Care – Primary Care to Maternal Transition

- For pregnant members, how do primary care and OB teams collaborate to ensure timely prenatal care while avoiding duplication or missed opportunities for preventive services?
- How do you address immunization/vaccine hesitancy with pregnant members?
- What strategies have worked best in your practice to ensure women successfully reconnect with primary care?

Panel Questions

Postpartum Care – Maternal to Primary Care Transition

- How do you operationalize and ensure completion of postpartum depression screening within your practice? How are follow-ups handled, and who owns that transition?
- What are some alternatives to the traditional postpartum care models?
- What opportunities does the state and hospitals/health systems have to better support patients after discharge?

Panel Questions

Continuum of Women's Health Care

- Where are the most common breakdowns in care coordination between OB/GYN, maternal care teams, and primary care, particularly during the transition back to PCP postpartum?
- How do you define successful handoff from maternal care to primary care?
- What information must be exchanged to ensure continuity for the patient?

Panel Questions

Closing Question

If you could recommend one change at the practice or system level to improve coordination between maternal and primary care for women, what would it be?

DISCUSSION

Q & A

FACILITATED BY

Kate Davis, RN, BSN
Clinical Nurse Quality Manager
NC Division of Health Benefits

Christina Nunemacher, PharmD, BCGP, MBA-HM
Director of Quality Improvement
Carolina Complete Health

SIXTH ANNUAL VIRTUAL QUALITY FORUM

Appendix

Presented by

Melissa Fabrikant, MSW, LCSW
Director of Quality Improvement
Carolina Complete Health

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

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

Carolina Complete Health:

carolinacompletehealth.com

NetworkRelations@CCH-Network.com

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

(TTY: 711)

Monday – Saturday 7am-6pm

Resources

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT)

- NC Medicaid: Health Check and EPSDT
- EPSDT Fact Sheet
- Quality Management and Improvement | NC Medicaid
- NC Medicaid Managed Care Quality Measurement Technical Specifications Manual
- Primary Care Children Fact Sheet

Cervical Cancer Screening

- NC Medicaid Quality Fact Sheets: Cancer Screening
- NC DHHS Changes to the Clinical Coverage Policy: 1E-7: Family Planning Services effective 5/1/2025
- Improving Cervical Cancer Prevention, Screening, and Management: A Toolkit to Build Provider Capacity
- Human Resources & Service Administration (HRSA): New Cervical Cancer Screening Guidelines Strengthen Women's Preventative Health
- Adverse Childhood Experiences and Preventive Cervical Cancer Screening Behavior
- Preparing for Self-collection: Clinician Communication Guide (2026)
- National Coalition for Sexual Health: Clinician Guide for Trauma Informed Care

Resources

Maternal Care-

- NC Medicaid Maternal Health Quality Report
- NC Perinatal Health Strategic Plan 2022-2026
- NC DHHS Obstetrics and Gynecology Clinical Coverage Policies
- American College of Obstetricians & Gynecologists - Pregnancy and Childbirth
- National Institute of Child Health and Human Development - Pregnancy Resources
- Maternal Immunizations | ACOG
- ObGyn-Vaccines-Tip-Sheet-NCDHHS-Jan-2025.pdf

CPT code updates (Changes to Global Billing)

- AMA: Maternity Care Services
- AMA: Maternity Care CPT Code Set Updates
- AMA: CPT Education Brief - Maternity Care Services 2027
- AMA: Health Plan Primer - Previewing the CPT 2027 Restructure for Maternity Care Service
- ACOG: Payment for Obstetric Services

Miscellaneous

- From Data to Impact: How NC HealthConnex Supports NC Medicaid and Providers Follow Up , For your reference, the presentation for the webinar linked above can be found HERE
- 2025 NC Medicaid Managed Care Quality Strategy



Thank You

Satisfaction Survey

Statewide Quality Forum