NC HealthConnex
Powering Health Care Outcomes

NORTH CAROLINA HEALTH INFORMATION EXCHANGE AUTHORITY

Quarterly Teletown Hall Webinar
August 17, 2022

NC Medicaid
NC Health Information Exchange Authority

NCDIT NORTH CAROLINA DEPARTMENT OF INFORMATION TECHNOLOGY

North Carolina Health Information Exchange Authority

Overview of Topics

- Introductions
- What's New with NC HealthConnex
- Overview: Tailored Care Management
- How the Use of NC HealthConnex Can Support Tailored Care Management
- Recent Questions
- Value of NC HealthConnex
- Questions

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Introductions

North Carolina Medicaid

- Kelly Crosbie, MSW, LCSW – Chief Quality Officer
- Loul Alvarez, MPA – Associate Director, Population Health
- Sachin Chintawar – Data Science Manager

North Carolina Health Information Exchange Authority (NC HIEA)

- Kenya Servia, MPA – Business Development and Outreach Specialist
- Timothy Taylor, MHA – Application Systems Specialist (NC*Notify)
- Garrett Smith, MBA – Business Relations Manager
- Kim Webster, RN – Business Development and Outreach Specialist

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What's New with NC HealthConnex

- Check out the latest NC HIEA monthly update.

- The next NC HIEA Advisory Board Meeting will be Thursday September 15 from 2pm-5pm. Registration details.

- Important Legal Updates as of July 2022
  - The enforcement mechanism is temporarily suspended "until a bill designating a lead agency responsible for enforcement of the Statewide Health Information Exchange Act is enacted into law."

  - The connection deadline of January 1, 2023, remains unchanged.

  - In March 2023, the General Assembly will receive a report outlining the status of organizations that met – or failed to meet – the January 1, 2023, connection and submission deadline.

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Tailored Care Management:

Transitional Care Management and Using ADT Information

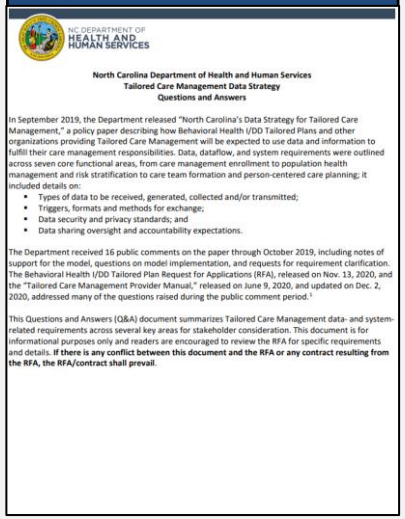
Kelly Crosbie, MSW, LCSW – Chief Quality Officer
NC Medicaid
August 2022

Tailored Care Management
Data Strategy Source Documents

Tailored Care Management Data Strategy Source Documents

The Tailored Care Management Provider Manual is the primary source for AMH+ practice and CMA data exchange and HIT requirements. The Tailored Care Management Data Strategy FAQ and Care Management Data System Guidance may also be helpful resources.

Tailored Care Management Data Strategy FAQ



NC DEPARTMENT OF HEALTH AND HUMAN SERVICES

North Carolina Department of Health and Human Services
Tailored Care Management Data Strategy
Questions and Answers

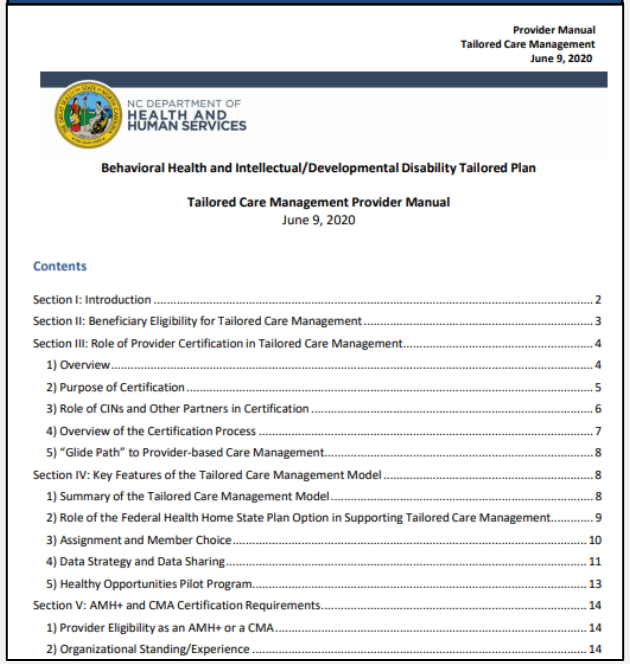
In September 2019, the Department released "North Carolina's Data Strategy for Tailored Care Management," a policy paper describing how Behavioral Health I/DD Tailored Plans and other organizations providing Tailored Care Management will be expected to use data and information to fulfill their care management responsibilities. Data, dataflow, and system requirements were outlined across seven core functional areas, from care management enrollment to population health management and risk stratification to care team formation and person-centered care planning; it included details on:

- Types of data to be received, generated, collected and/or transmitted;
- Triggers, formats and methods for exchange;
- Data security and privacy standards; and
- Data sharing oversight and accountability expectations.

The Department received 16 public comments on the paper through October 2019, including notes of support for the model, questions on model implementation, and requests for requirement clarification. The Behavioral Health I/DD Tailored Plan Request for Applications (RFA), released on Nov. 13, 2020, and the "Tailored Care Management Provider Manual," released on June 9, 2020, and updated on Dec. 2, 2020, addressed many of the questions raised during the public comment period.[1]

This Questions and Answers (Q&A) document summarizes Tailored Care Management data- and system-related requirements across several key areas for stakeholder consideration. This document is for informational purposes only and readers are encouraged to review the RFA for specific requirements and details. **If there is any conflict between this document and the RFA or any contract resulting from the RFA, the RFA/contract shall prevail.**

Tailored Care Management Provider Manual



Provider Manual
Tailored Care Management
June 9, 2020

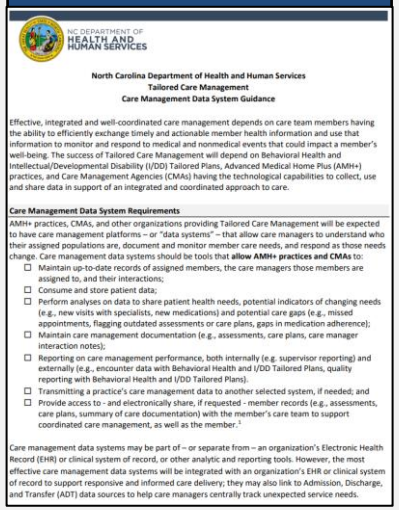
NC DEPARTMENT OF HEALTH AND HUMAN SERVICES

Behavioral Health and Intellectual/Developmental Disability Tailored Plan

Tailored Care Management Provider Manual
June 9, 2020

Contents

Care Management Data System Guidance



NC DEPARTMENT OF HEALTH AND HUMAN SERVICES

North Carolina Department of Health and Human Services
Tailored Care Management
Care Management Data System Guidance

Effective, integrated and well-coordinated care management depends on care team members having the ability to efficiently exchange timely and actionable member health information and use that information to monitor and respond to medical and nonmedical events that could impact a member's well-being. The success of Tailored Care Management will depend on Behavioral Health and Intellectual/Developmental Disability (I/DD) Tailored Plans, Advanced Medical Home Plus (AMH+) practices, and Care Management Agencies (CMAs) having the technological capabilities to collect, use and share data in support of an integrated and coordinated approach to care.

Care Management Data System Requirements

AMH+ practices, CMAs, and other organizations providing Tailored Care Management will be expected to have care management platforms – or "data systems" – that allow care managers to understand who their assigned populations are, document and monitor member care needs, and respond as those needs change. Care management data systems should be tools that **allow AMH+ practices and CMAs** to:

- ☐ Maintain up-to-date records of assigned members, the care managers those members are assigned to, and their interactions;
- ☐ Consume and store patient data;
- ☐ Perform analyses on data to share patient health needs, potential indicators of changing needs (e.g., new visits with specialists, new medications) and potential care gaps (e.g., missed appointments, flagging outdated assessments or care plans, gaps in medication adherence);
- ☐ Maintain care management documentation (e.g., assessments, care plans, care manager interaction notes);
- ☐ Reporting on care management performance, both internally (e.g. supervisor reporting) and externally (e.g., encounter data with Behavioral Health and I/DD Tailored Plans, quality reporting with Behavioral Health and I/DD Tailored Plans).
- ☐ Transmitting a practice's care management data to another selected system, if needed; and
- ☐ Provide access to – and electronically share, if requested – member records (e.g., assessments, care plans, summary of care documentation) with the member's care team to support coordinated care management, as well as the member.[1]

Care management data systems may be part of – or separate from – an organization's Electronic Health Record (EHR) or clinical system of record, or other analytic and reporting tools. However, the most effective care management data systems will be integrated with an organization's EHR or clinical system of record to support responsive and informed care delivery; they may also link to Admission, Discharge, and Transfer (ADT) data sources to help care managers centrally track unexpected service needs.

1. North Carolina's "Tailored Care Management Provider Manual". December 2, 2020. https://files.nc.gov/ncdma/Tailored-Care-Management-Provider-Manual20201202.pdf
2. Tailored Care Management Care Management Data System Guidance. July 13, 2021. https://medicaid.ncdhhs.gov/tailored-care-management-data-system-guidance/
3. Tailored Care Management Data Strategy FAQ. July 2021. https://medicaid.ncdhhs.gov/documents/tailored-care-management-data-strategy-questions-and-answers/

Tailored Care Management HIT Systems Overview

AMH+ practices and CMAs must meet the following HIT requirements prior to Tailored Plan launch.

Use an electronic health record (EHR) or clinical system of record*

Use a care management data system

Use NCCARE360 (once operational)

AMH+ practices/CMAs may meet the HIT requirements by:

(1) Implementing or using their own systems;
(2) Partnering with a Clinically Integrated Network (CIN) or Other Data/Technology Partner; or
(3) Using the Tailored Plan's care management data system

Data Exchange Requirements Overview

Data Types from Tailored Plan to AMH+ Practices/CMAs[1]

1. Member assignment information[1]
2. Member claims/encounter data[1]
3. Acuity tiering and risk stratification data[1]
4. Quality measure performance information
5. OPTIONAL: Other data to support Tailored Care Management (e.g., previously established care plans, historical member clinical info)

Tailored Plan

AMH+ Practices/CMAs

Data Types from AMH+ Practices/CMAs to Tailored Plan[1]

1. Care management contacts[1]
2. Quality measure and reporting (possible in future)

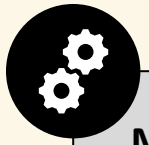
1. **These data types will be shared through consolidated standard data interfaces** https://medicaid.ncdhhs.gov/tailored-care-management/tailored-care-management-data-specifications-guidance.

2. DHHS is working on standardizing the sharing of care needs and assessment data.

AMH+ Practice/CMA Data Acquisition & Use

Data-Driven Tailored Care Management Functions

AMH+ practices and CMAs will be expected to consume, analyze, and apply the following types of data to support critical Tailored Care Management program functions:



Member clinical, claims, and encounter data will be used to guide care manager assignment, inform the care management comprehensive assessment, aid in developing actionable care plans or individual support plans (ISPs), and support ongoing care management (e.g., providing information on member diagnoses, medications, and active treatments).

Today's Focus with the NCHIEA

Admission, Discharge, and Transfer (ADT) information will be used to identify when members are transitioning into or out of the hospital and trigger systematic, clinically appropriate processes to support care transitions.

See the Tailored Care Management Provider Manual for additional detail on the HIT requirements for AMH+ Practices and CMAs.

WHY DOES ADT MATTER FOR TAILORED CARE MANAGEMENT?

TCM Providers are Responsible to Support Members During Transitions

AMH+ practices, CMAs, and Tailored Plans delivering Tailored Care Management must conduct *transitional care management* during the following transitions from a clinical or residential setting, as well as life transitions.

Clinical or Residential Transitions	Life Transitions
▪ **Transitioning out of hospital (inpatient or emergency department [ED] visit) to the community**	▪ Transitioning out of school-related services
▪ Transitioning out of residential setting to the community	▪ Life changes with employment, retirement, or other life events
▪ Transitioning between clinical and/or residential settings	▪ Loss of or change in primary caregiver
	▪ Transitioning out of foster care

Care managers are also responsible for care management when a person is hospitalized or in a residential setting (e.g., visiting the member, reviewing the discharge plan with the member) to prepare the member for successful transition.

Reassessments and Care Plan/ISP Updates

The following transitions or "triggering events" will prompt reassessments and/or care plan/ISP updates.

- **Inpatient hospitalization**
- **Two ED visits since the last care management comprehensive assessment or reassessment**
- Involuntary treatment episode
- Other change in circumstances requiring increased or decreased need for care (e.g., transition into or out of an institution, loss of a family/friend caregiver)
- Becoming pregnant and/or giving birth
- Loss of housing
- Foster care involvement
- Use of behavioral health crisis services
- Arrest or other justice system involvement

Transitional Care Management Functions

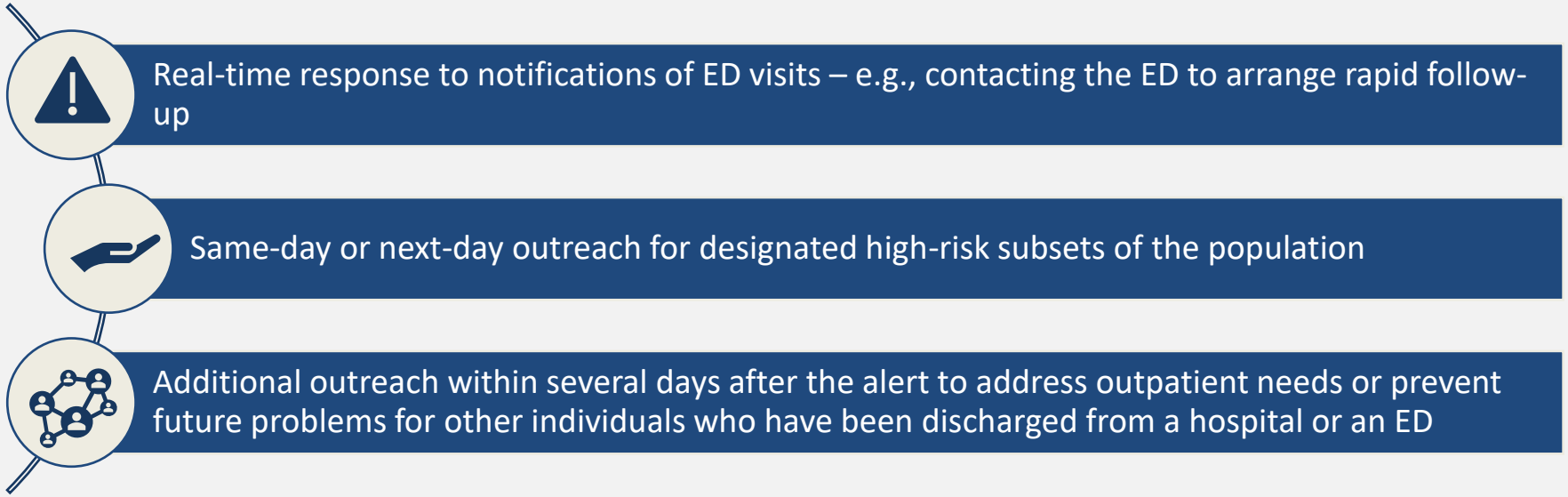
Organizations providing Tailored Care Management must manage care transitions for members by making best efforts to conduct the following activities.

- **Assign a care manager to manage the transition** and have care manager/care team member **visit the member** during institution stay and on discharge day
- **Conduct outreach to the member's providers**, **review discharge plan** with the member and facility staff, and **facilitate clinical handoffs**
- **Assist the member in obtaining medications** prior to discharge and with medication reconciliation/management and medication adherence
- **Create, communicate/educate** member and caregivers/providers about, and **implement a 90-day transition plan** outlining how the member will maintain/access needed services and supports, transition to the new care setting, and integrate into his or her community
- **Facilitate arrangements for transportation, in-home services, and follow-up outpatient visits** within seven days
- **Follow up with the member within 48 hours of discharge** and arrange to **visit the member** in the new care setting after discharge/transition
- **Conduct a care management comprehensive assessment within 30 days** of the discharge/transition, or update the current assessment
- **Update the member's care plan or ISP within 90 days** of the discharge/transition

Identifying Individuals in Transition

The care team must access admission, discharge, transfer (ADT) data that correctly identifies when members are admitted, discharged, or transferred to or from an ED or a hospital in real time or near-real time.

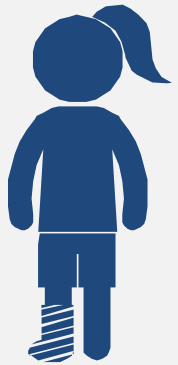
Organizations providing care management must implement a systematic, clinically appropriate process with designated staffing for responding to certain high-risk ADT alerts, including:



- Real-time response to notifications of ED visits – e.g., contacting the ED to arrange rapid follow-up
- Same-day or next-day outreach for designated high-risk subsets of the population
- Additional outreach within several days after the alert to address outpatient needs or prevent future problems for other individuals who have been discharged from a hospital or an ED

Example Scenario 1

Member is enrolled in a Tailored Plan and selects AMH+ practice as her care management provider.



Member

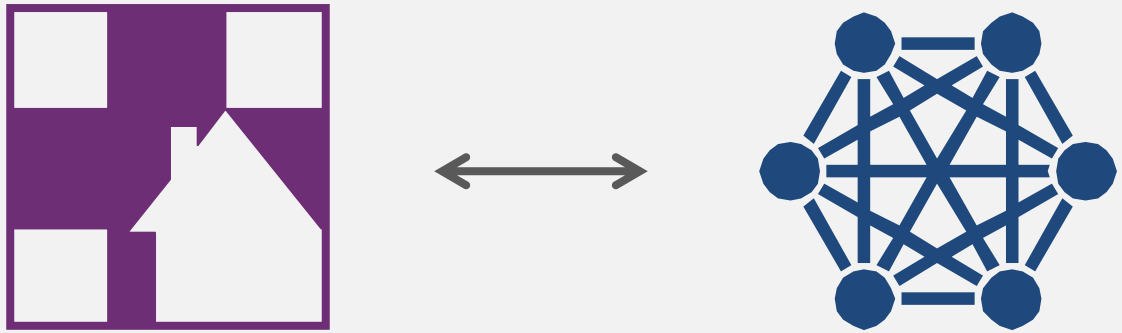
- Individual with very low income, eligible for Medicaid
- History of opioid use disorder, not on medication-assisted treatment
- Stable, now in outpatient SUD care after SAIOP, but at risk for relapse

Scenario

- Injured in car crash
- Discharged from ED with nonoperative fracture
- At risk of untreated pain or relapse due to self-medication

Example Scenario 1 – *continued*

AMH+ practice has partnered with a CIN/Other Partner to support care management for HIT requirements, including access to ADT alerts.



AMH+ Practice

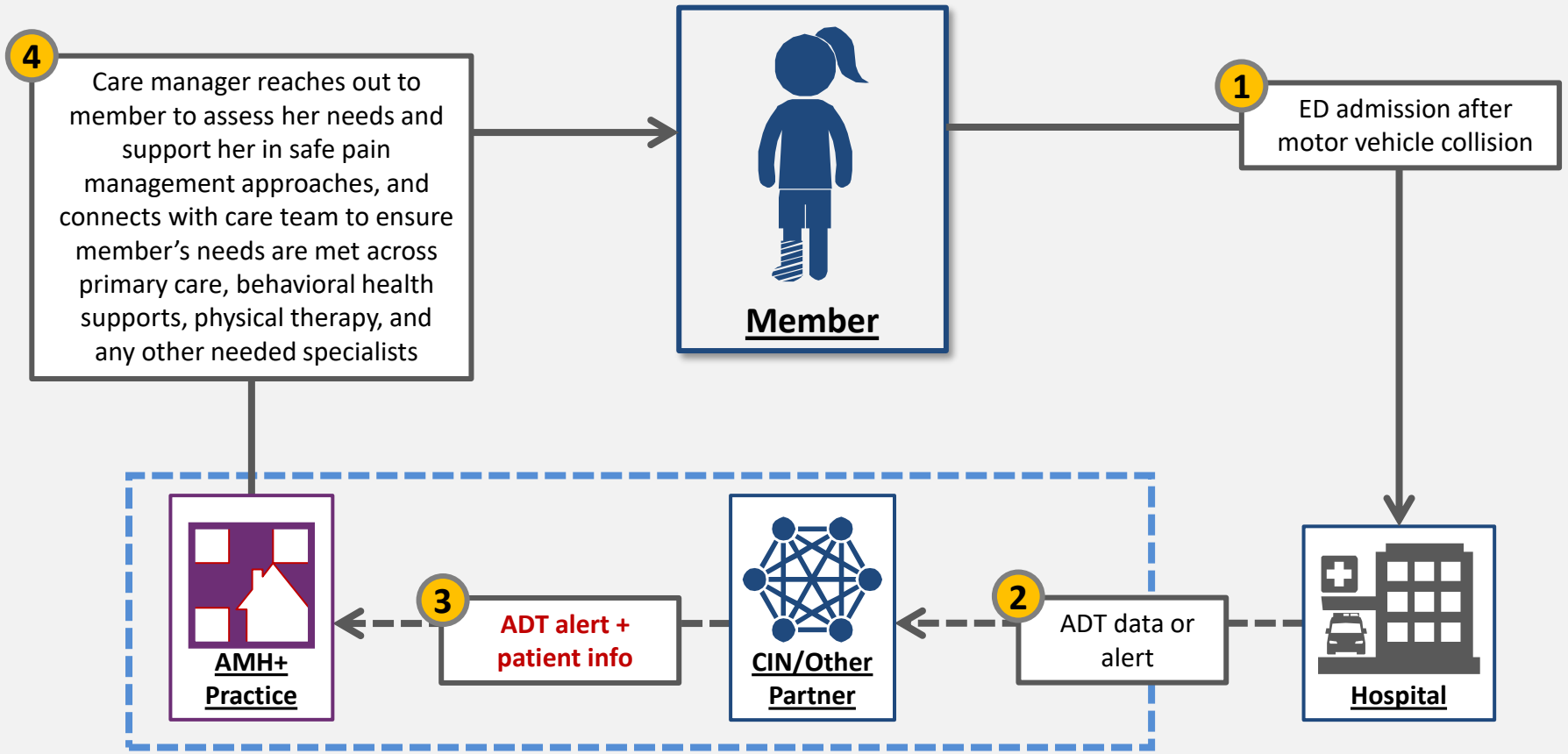
- Conducts care planning
- Has care management staff in-house
- Leads transitional care management with assistance from CIN/Other Partner

CIN/Other Partner

- Aggregates data from Tailored Plan
- **Receives high-risk ADT alerts**
- Delivers panel-specific information that may be incorporated into AMH+ practice workflows

Example Scenario 1 – *continued*

After ED discharge, AMH+ practice engages in transitional care management to ensure member has good pain relief and avoids relapse.



Example Scenario 2

Member is enrolled in a Tailored Plan and selects a CMA as his care management provider.

Member

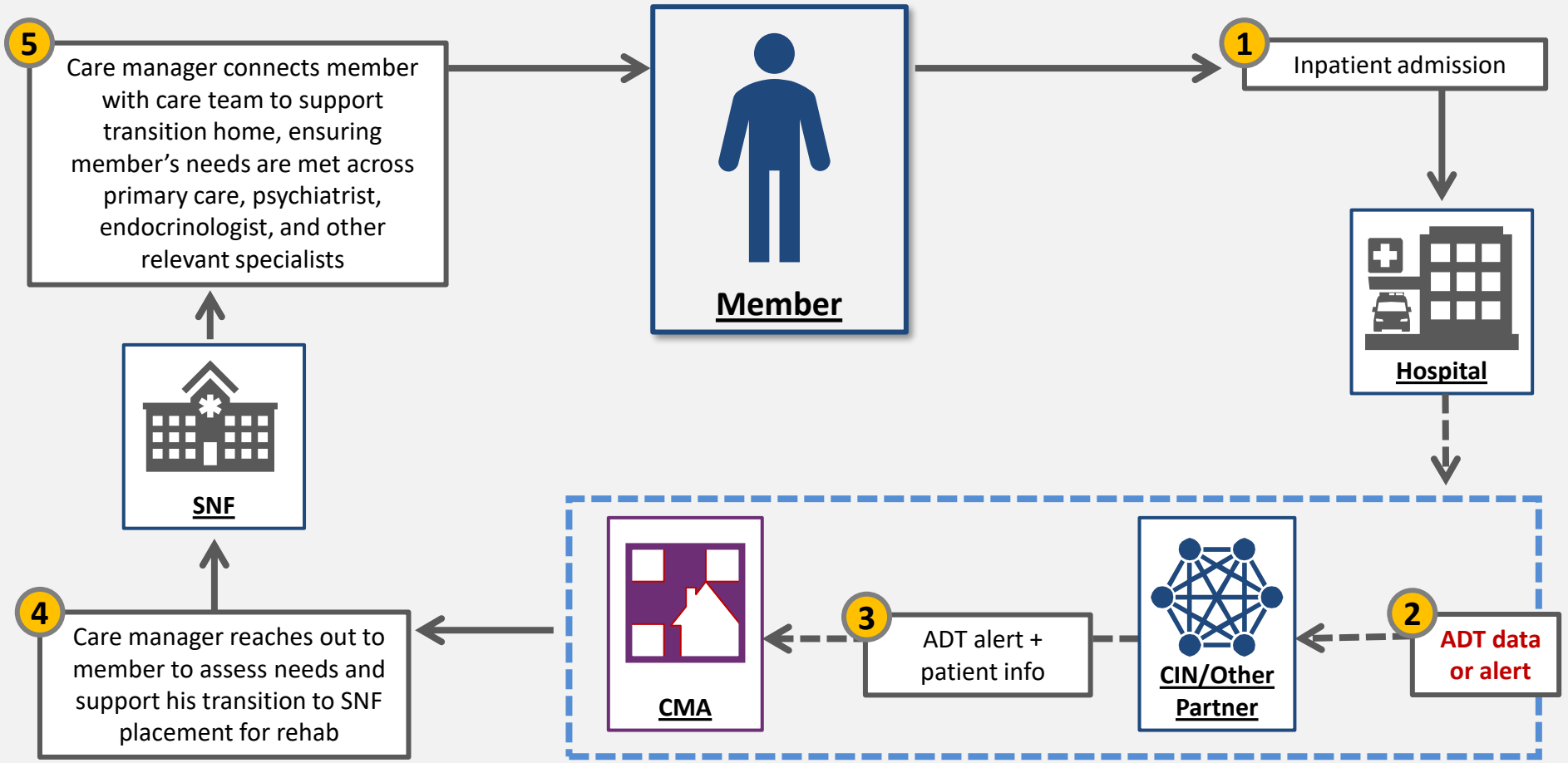
- Individual with bipolar disorder and long-term use of lithium medication, as well as kidney disease

Scenario

- **Hospitalized** due to uremia (caused by kidney dysfunction), low blood pressure, and mental status changes
- Requires transition to short-term skilled nursing facility (SNF) for rehab and transition back home with dialysis

Example Scenario 2 – *continued*

After hospital discharge, CMA engages in transitional care management to ensure member's care is coordinated across transitions to the SNF and back home.



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AN OVERVIEW OF THE NC HEALTH INFORMATION EXCHANGE AUTHORITY

Kenya Servia, MPA
Business Development and Outreach Specialist
NC Health Information Exchange Authority

NCDIT
NORTH CAROLINA DEPARTMENT OF INFORMATION TECHNOLOGY

The Vision for Integrated Care, Whole Person Care

Effective, integrated and well-coordinated care management depends on care team members having the ability to efficiently exchange member/patient health information and use that information to monitor and respond to medical and nonmedical issues that could impact beneficiaries.

How Can Use of an HIE Support This Vision?

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What Is a Health Information Exchange (HIE)?

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.

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Who We Are

STATE DESIGNATED

SECURE

PARTNERSHIP

- The North Carolina General Assembly created the North Carolina Health Information Exchange Authority (NC HIEA) in 2015 to facilitate the creation of a modernized HIE to better serve North Carolina's health care providers and their patients. *(NCGS 90-414.7)*
- NC HIEA is housed within the N.C. Department of Information Technology's (NCDIT) Government Data Analytics Center (GDAC).
- Our technology partner is SAS Institute.
- A 12-member Advisory Board is made of health care representatives, including the N.C. Department of Health and Human Services secretary, NCDIT secretary and GDAC director.

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NC HealthConnex by the Numbers

We connect 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
- 3,000+ behavioral health participants
- 8,000+ health care facilities live submitting data, including 140 hospitals
- 5,000+ health care facilities in onboarding
- 150 million+ continuity of care documents (CCDs)
- 11 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 Patient Centered Data Home, including the U.S. Veterans Affairs and Department of Defense

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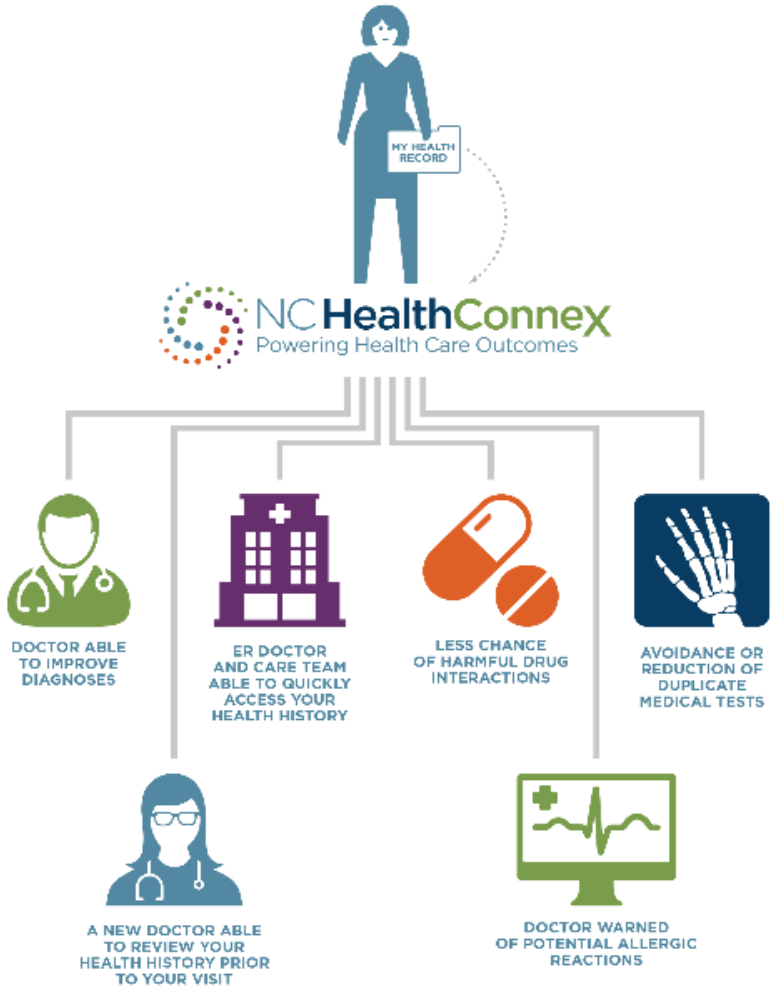
Health Information Exchange

Benefits



- A full “picture” of a person’s health, including ambulatory visits, hospitalizations and medications
- Reduction in valuable staff time spent phoning and faxing other providers involved in a patient’s care to track down health information
- Timely access to important health events as they happen to patients (near, real-time notifications)
- Improved, more accurate and timely medication reconciliation that reduces errors and avoids unnecessary tests
- Access to test results, reducing costly duplicative tests and gaps in treatment

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Exchange

How HIE Works

Uni-directional Connection

Electronic Health Record

Clinicians enter data into EHR, and that data is automatically sent to HIE.

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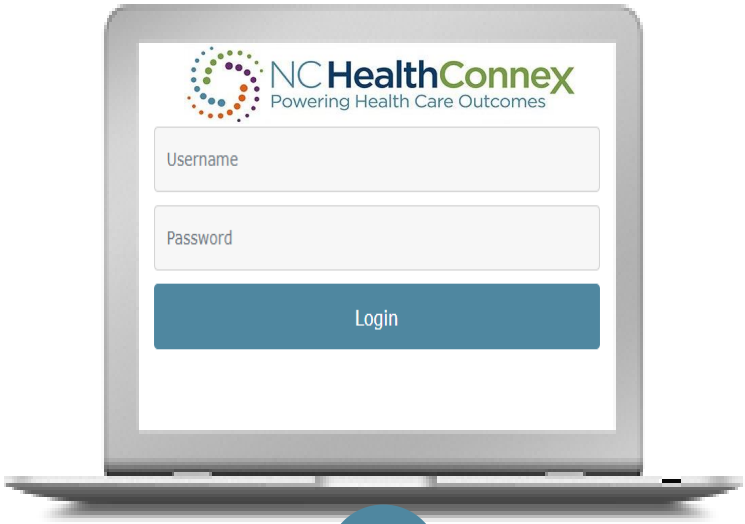

Data Provided

Clinicians who have care relationships with their patients are readily able to access that data.

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Exchange

How HIE Works

Bi-directional Connection

Electronic Health Record

Clinicians enter data into EHR, and that data is automatically sent to the HIE.

Data Sent into EHR

Clinicians who have care relationships with their patients are able readily access that data via their EHR.

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Exchange

Expanding Exchange Reach & Capabilities

Access a patient's clinical record

- Web-based portal (uni-directional connection)
- EMR integration (bi-directional connection)
- Information in the portal parsed from the patients' CCDs for easy viewing in a longitudinal record

Communicate PHI securely

- DIRECT Secure Messaging (DSM), which is HIPAA compliant and convenient

Additional integrations

- Controlled Substance Reporting System (CSRS)
- eHealth Exchange
- Patient Centered Data Home (PCDH)
- Carequality *(coming soon)*

Access NC*Notify ADT notifications via a clinical portal

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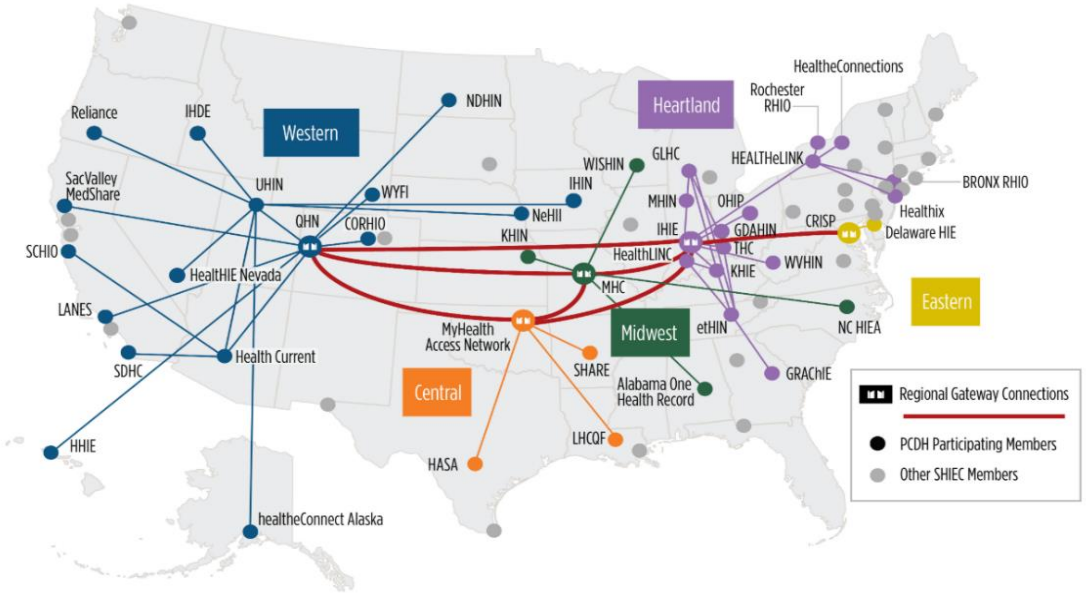
Exchange

Neighboring Connections via National Networks

eHealth Exchange

- Atrium Health CareConnect HIE (Charlotte, NC)
- Carolina eHealth Network (SC)
- Coastal Connect HIE (NC)
- Cone Health (Greensboro, NC)
- DaVita (national)
- eTHIN (East Tennessee)
- Florida HIE Services
- GaHIN (Atlanta, GA)
- GRAChIE (Augusta, GA)
- healthconnect Alaska
- MedVirginia (Richmond, VA)
- OCHIN (Portland, OR)
- PULSE (Patient Unified Lookup System for Emergencies)
- SCHIEx (SC)
- Sentara Health (Northern VA)
- VA HIE (Veterans Administration), DMIX (U.S. Department of Defense)
- Vidant Health (Greenville, NC)

Patient Centered Data Home (PCDH)



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NC*NOTIFY CAN SUPPORT TAILORED CARE MANAGEMENT AND WHOLE PERSON CARE

Timothy Taylor, MHA – Application Systems Specialist – NC*Notify
NC Health Information Exchange Authority

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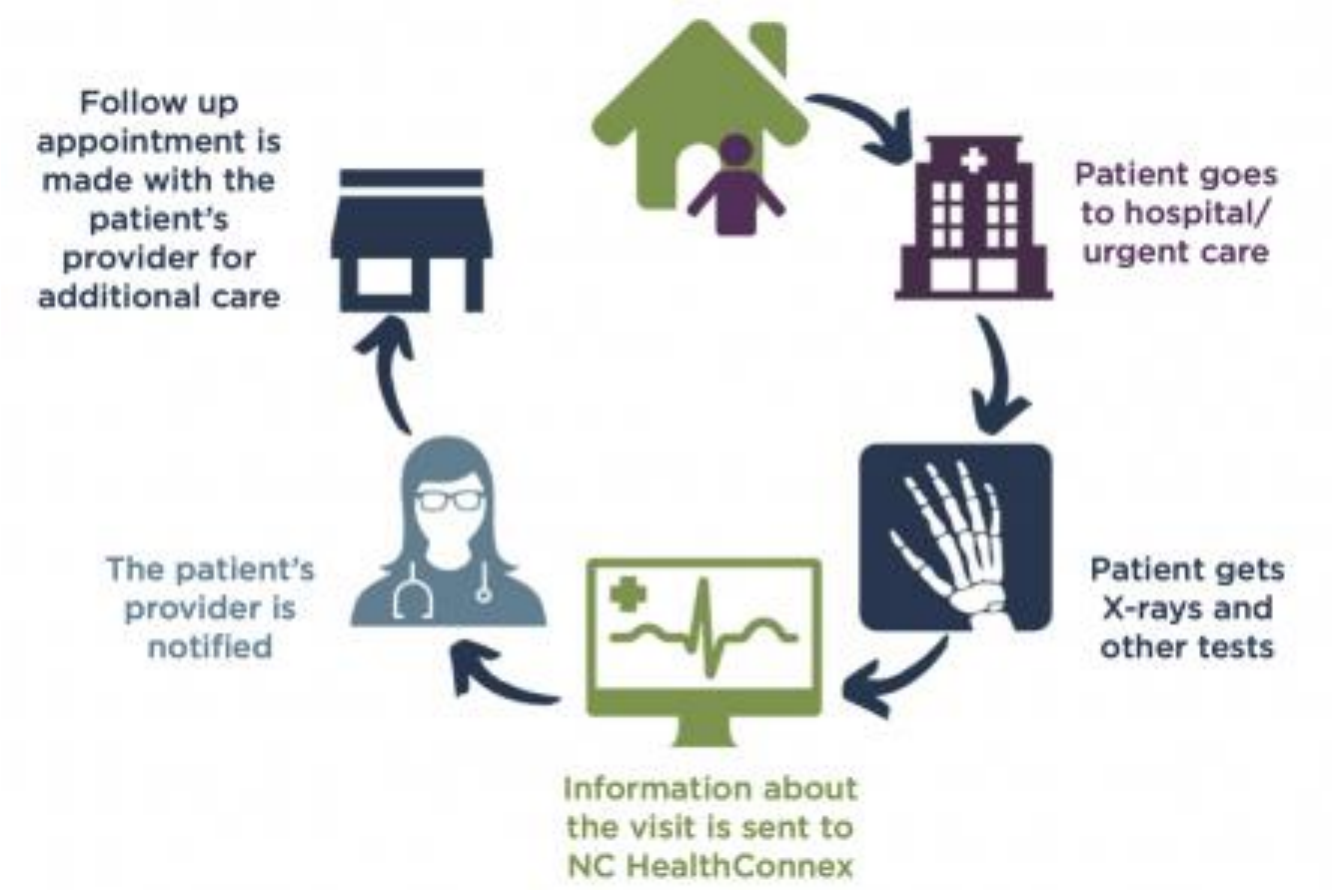
What is NC*Notify?

A subscription-based service based on admit and discharge (ADT) messages that notifies providers as their patients receive services across the NC HealthConnex participant base – spanning geography, health care systems, acute and ambulatory care settings



Statewide Impacts

- 667 participants live, including LME/MCOs and BH organizations
- 8.3 million patients monitored
- 1.8 million average alerts sent per month

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Care Coordination & NC*Notify

Tailored Care Management Focus

- Community based
- Provider driven
- Whole person care

Bridging the Gap

- Enhance care coordination
- New alerts and place of service enhancements
- Referral confirmation

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How Does It Work?

Subscriptions

Subscribers establish their cohort of patients for whom they want to receive alerts.

Monitoring Feeds

All clinical data feeds coming into the HIE are monitored for a matching event or clinical data of interest to the subscribers. These events can then be pushed directly to the subscriber or made available on the web portal.

Receiving Notifications

Subscribers can receive notifications for events or data that match their patients via their preferred method.

- ❑Batched notification files in delimited or HL7 format
- ❑Near real-time notifications via HL7 messages
- ❑Web-based NC*Notify dashboard via the NC HealthConnex portal

NC*Notify Use Cases

"With services like NC*Notify, the entire care team can have much-needed information to keep patients safe during the riskiest times: when they **transition between one care entity and another**."
– FQHC Participant

"The emergency ADT feed from NC*Notify I reviewed yesterday was timely, and when I went into HealthConnex to pull the CCD, I was able to get some valuable information regarding the physical condition of the client, which could then be shared with the direct care staff in the program as the **guardian failed to let us know when she dropped the child off for treatment**."
– Behavioral Health Agency

"Patient care has largely been what I call synchronous, as in in-sync with a scheduled appointment. Our **real-time data gathering from the HIE has allowed us to prepare for a remodel of our system to asynchronous real-time knowledge-based care**, where our providers' workflows are disrupted 24/7, giving them immediate, actionable knowledge to make their care plans living documents as our patients navigate the healthcare ecosystem around us."
– Behavioral Health Services Agency

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What Notifications Are Available?

Admission, Discharge, or Transfer – Notification of any visit in the NC HealthConnex network. (Base and Plus Tiers)

COVID-19 alerts – Notifications of a COVID-19 test and the result. (Plus)

High utilizer alert – Notification of at least 2 ED visits in 90 days or at least 4 inpatient admissions in 12 months. (Plus)

Dental alerts – Providers are alerted when patients visit the emergency department for dental care. (Plus)

Care team change alert – Providers are informed when a new organization has subscribed to their patient. (Plus)

Diabetes diagnosis alert – Providers are alerted upon a new diabetes and/or pre-diabetes diagnosis for patients they are monitoring. (Plus)

Chronic care management alert – Providers receive an alert when a patient meets the Centers for Medicare and Medicaid Services' chronic care management services criteria. (Plus)

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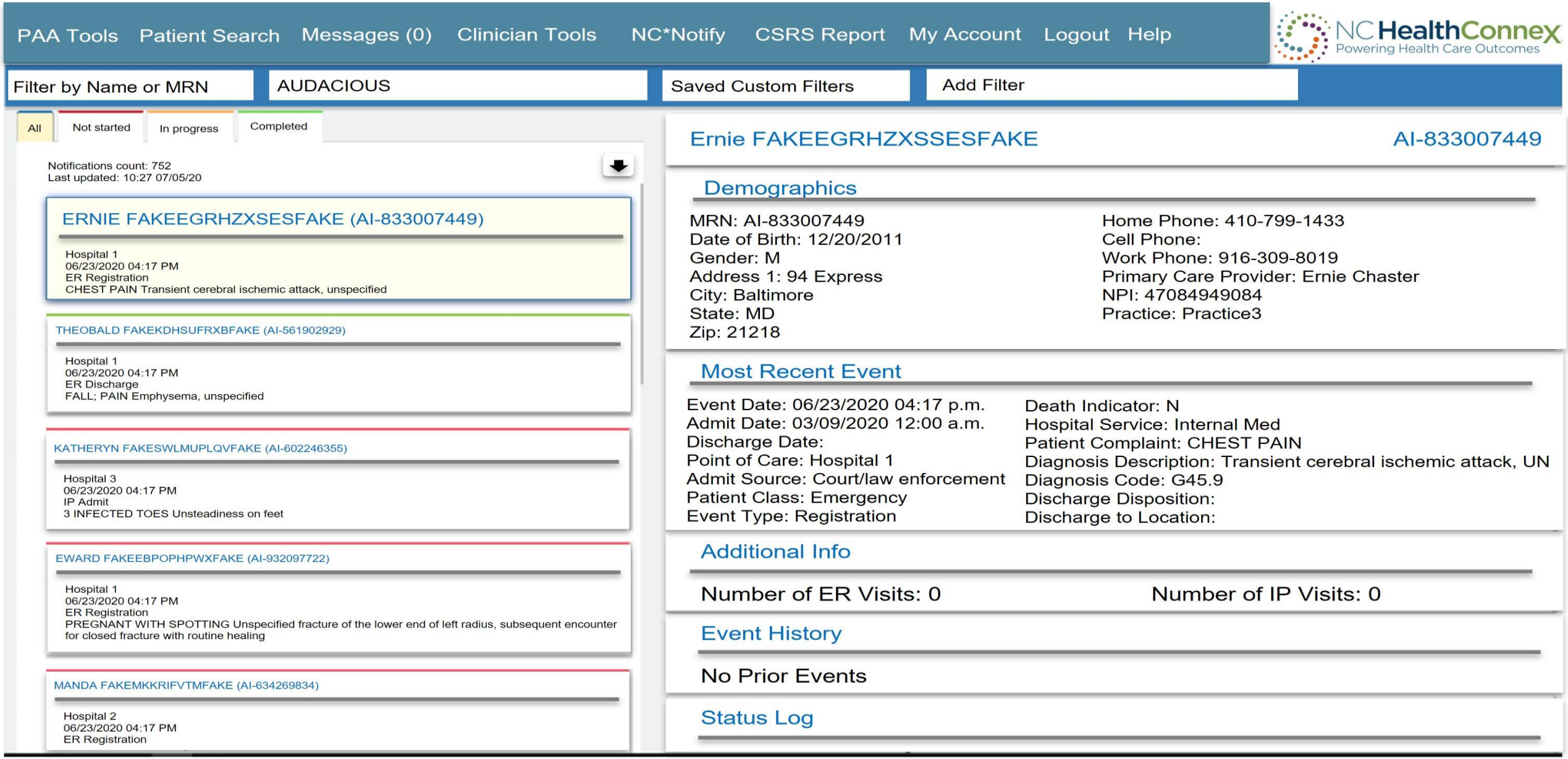
PAA Tools
Patient Search
Messages (0)
Clinician Tools
NC*Notify
CSRS Report
My Account
Logout
Help
NC HealthConnex
Powering Health Care Outcomes
Filter by Name or MRN
AUDACIOUS
Saved Custom Filters
Add Filter
All
Not started
In progress
Completed
Notifications count: 752
Last updated: 10:27 07/05/20
ERNIE FAKEEGRHZXSESFAKE (AI-833007449)
Hospital 1
06/23/2020 04:17 PM
ER Registration
CHEST PAIN Transient cerebral ischemic attack, unspecified
THEOBALD FAKEKDHSUFRXBFAKE (AI-561902929)
Hospital 1
06/23/2020 04:17 PM
ER Discharge
FALL; PAIN Emphysema, unspecified
KATHERYN FAKESWLMUPLQVFAKE (AI-602246355)
Hospital 3
06/23/2020 04:17 PM
IP Admit
3 INFECTED TOES Unsteadiness on feet
EWARD FAKEEBPOPHPWXFAKE (AI-932097722)
Hospital 1
06/23/2020 04:17 PM
ER Registration
PREGNANT WITH SPOTTING Unspecified fracture of the lower end of left radius, subsequent encounter for closed fracture with routine healing
MANDA FAKEMKKRIFVTMFAKE (AI-634269834)
Hospital 2
06/23/2020 04:17 PM
ER Registration
Ernie FAKEEGRHZXSSESFAKE
AI-833007449
Demographics
MRN: AI-833007449
Date of Birth: 12/20/2011
Gender: M
Address 1: 94 Express
City: Baltimore
State: MD
Zip: 21218
Home Phone: 410-799-1433
Cell Phone:
Work Phone: 916-309-8019
Primary Care Provider: Ernie Chaster
NPI: 47084949084
Practice: Practice3
Most Recent Event
Event Date: 06/23/2020 04:17 p.m.
Admit Date: 03/09/2020 12:00 a.m.
Discharge Date:
Point of Care: Hospital 1
Admit Source: Court/law enforcement
Patient Class: Emergency
Event Type: Registration
Death Indicator: N
Hospital Service: Internal Med
Patient Complaint: CHEST PAIN
Diagnosis Description: Transient cerebral ischemic attack, UN
Diagnosis Code: G45.9
Discharge Disposition:
Discharge to Location:
Additional Info
Number of ER Visits: 0
Number of IP Visits: 0
Event History
No Prior Events
Status Log

Web-Based Enrollment Form

NC*Notify Online Enrollment

*Indicates required field

Organization Information

Organization Name*

Organization Address*

Address 2

City*

Services

- NC HealthConnex Exchange
- NC*Notify
  - Frequently Asked Questions
  - Online Enrollment Form
  - Specifications & Release Notes
  - Conditions of Participation for Hospital eNotifications
  - How NC*Notify Works
  - Benefits
  - New Features & Enhancements
- Controlled Substance Reporting System

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NC*Notify – Important Links

NC*Notify landing page

Web-based enrollment form

NC*Notify specifications & release notes

Frequently asked questions

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RECENT QUESTIONS AND WRAPPING THINGS UP….

Garrett Smith – Business Relations Manager
NC Health Information Exchange Authority

NCDIT NORTH CAROLINA DEPARTMENT OF INFORMATION TECHNOLOGY

Recent Questions

If I am an I-DD Provider, am I still required to connect to the NC HIE?

Per G.S. 90-414.4, “Intellectual and developmental disability services and support providers, such as day supports and supported living providers” are considered voluntary and are not required to connect to the NC HIE.

Can a participant enroll and utilize NC*Notify without completing a connection project with their EHR?

Yes, a participant with a full participation agreement can enroll and utilize NC*Notify without an EHR connection.

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Recent Questions (cont.)

If my organization has a full participation agreement with the NC HIEA, what do I need to do to enroll and start using NC*Notify?

With a full participation agreement in place, a participant can enroll in NC*Notify by completing our online enrollment form.

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Value of NC HealthConnex to Providers

- **Increase** operational efficiencies
- **Reduce** duplicative tests/procedures
- **Improve** care coordination
- **Integrate** with public health registries

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Questions?

For more information Tailored Care Management, visit:

medicaid.ncdhhs.gov/tailored-care-management

888-245-0179

medicaid.tailoredcaremgmt@dhhs.nc.gov

For more information on NC HealthConnex and NC*Notify, visit:

nchealthconnex.gov

919-754-6912

hiea@nc.gov

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