



North Carolina Diabetes Advisory Council

Welcome

Friday, May 5, 2023

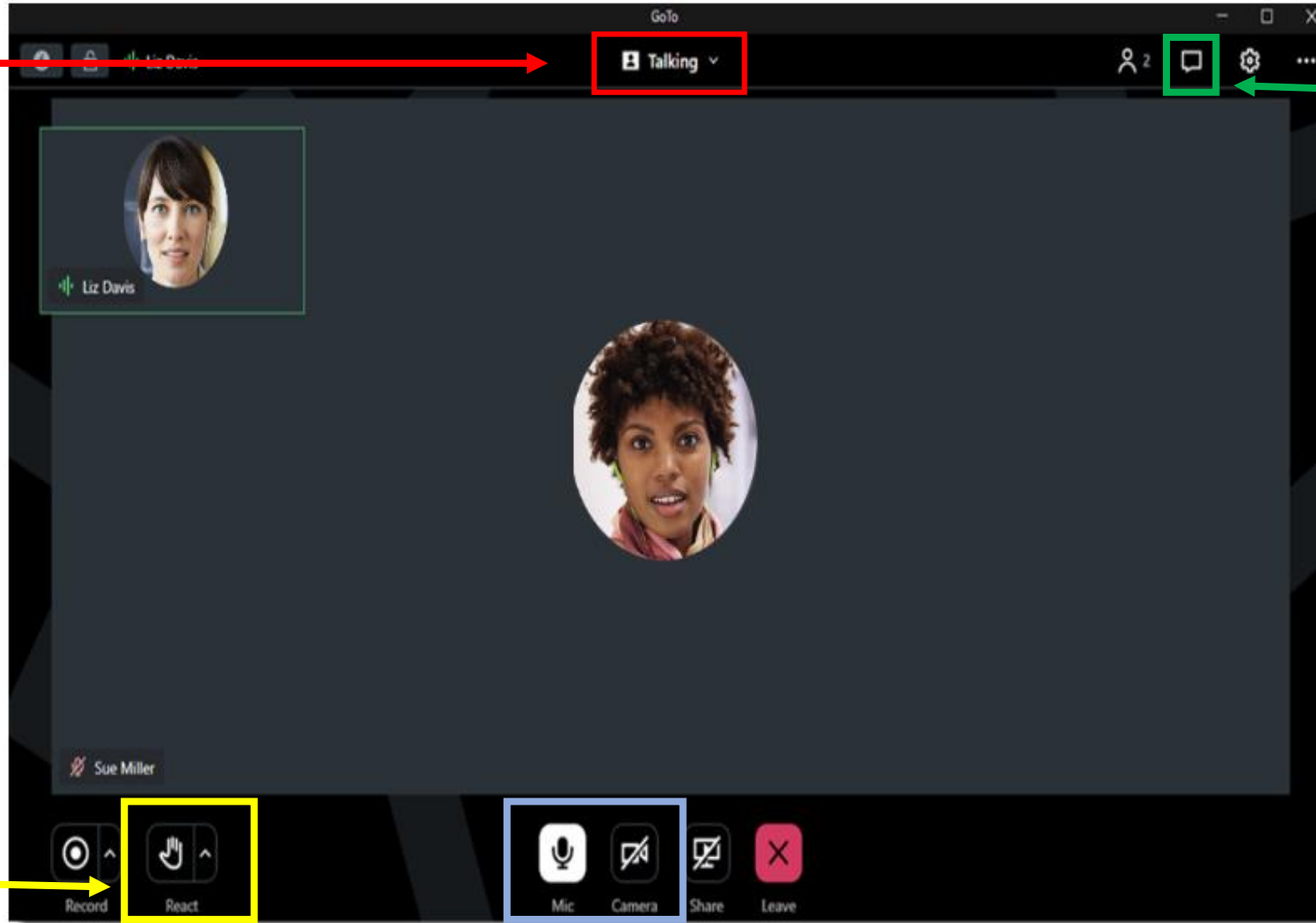
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North Carolina Diabetes Advisory Council

GoToMeeting Housekeeping: What You See as an Attendee

Change your view and how you see participants and speakers



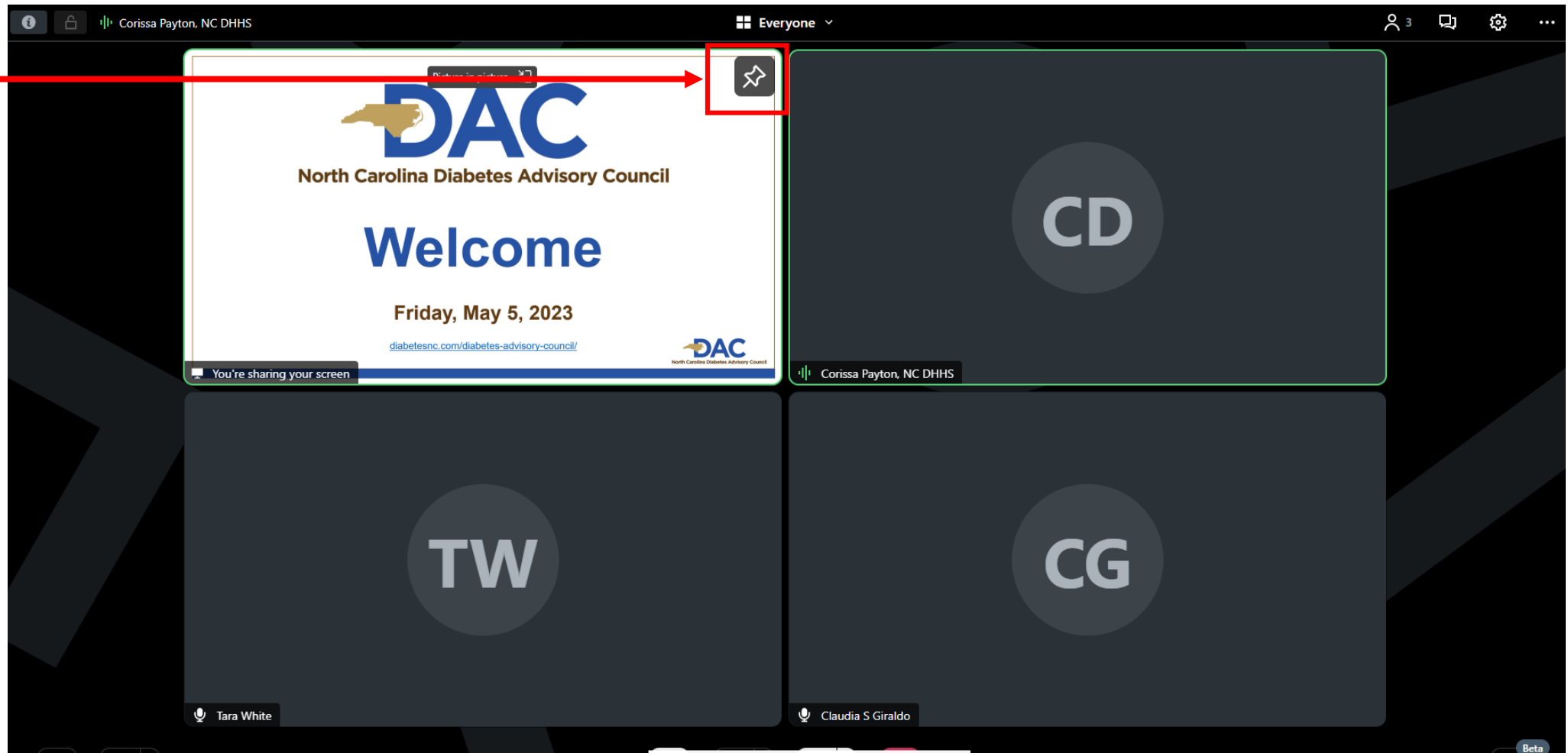
Chat box

Raise your hand and other reactions

Mic (mute) and Camera

GoToMeeting Housekeeping: What You See as an Attendee

Use the Push Pin icon to pin the slideshow to make it the main screen



GoToMeeting Housekeeping: What You See as an Attendee

Then it should be the main screen

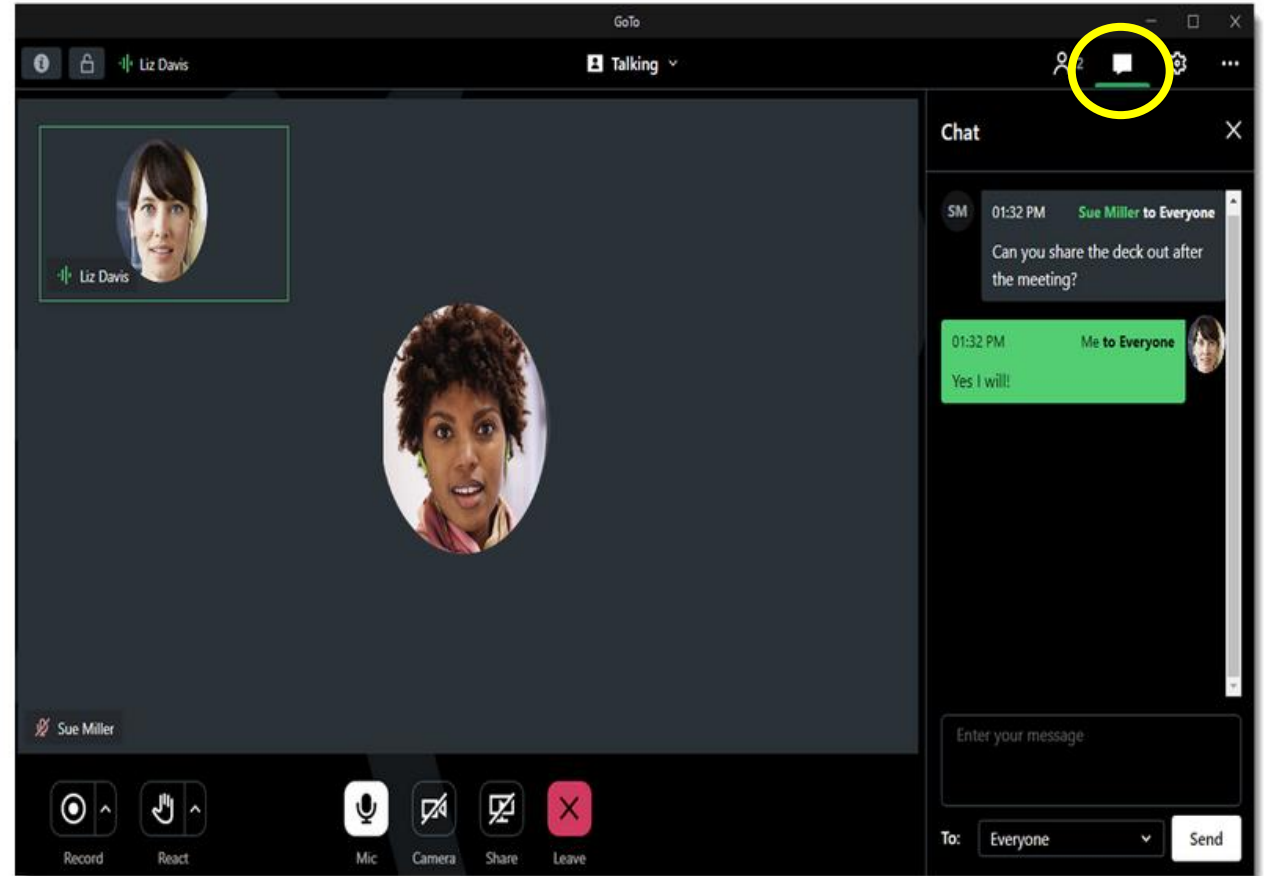


Roll Call

Please enter the following information in the chat for our attendance records:

Name

Organization/Affiliation



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North Carolina Diabetes Advisory Council

Agenda

- Welcome, Introductions and Review and Approval of February 3, 2023 Highlights
- Announcements
- DAC Workgroups
- Breakout Discussions
- Discussion Reporting
- Break
- Standards of Care Updates
- Medicaid Updates



Past Diabetes Advisory Council Meetings

October 29, 2021 [Agenda](#) | [Meeting Highlights](#)

[Register to Watch the Recording](#)

[Health Equity in Context – Cornell Wright](#)

[West Marion Community Forum](#)

[DSMES Updates](#)

June 4, 2021 [Agenda](#) | [Meeting Highlights](#)

[Register to Watch the Recording](#)

[Guide Webinar Evaluation and Metrics](#)

[Diabetes and Hearing](#)

[Diabetes and COVID-19](#)

February 19, 2021 [Agenda](#) | [Meeting Highlights](#)

[Register to Watch the Recording](#)

[2021 ADA Standards of Medical Care in Diabetes](#)

[2020-2025 USDA Dietary Guidelines](#)

[NC Diabetes Registry](#)

[DSMES Updates](#)

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Current DAC Member List

Name	Affiliation
Joanne Rinker, Co-Chair	Association of Diabetes Care and Education Specialist
Christine Memering, Co-Chair	Carolina East Medical Center; ADCES
Gideon Adams	Food Bank of Central and Eastern North Carolina
Caroline Blackwell Young	Wake Forest University, School of Medicine
Paul Bray	Vidant Health
Pat Cannon	Novo Nordisk
Leonor Corsino	Duke University Medical Center
Vandana Devalapalli	Blue Cross Blue Shield of NC
Kathy Dowd	The Audiology Project
Laura Edwards	Collaborative Health Solutions
Susan Houston	Vidant Health
Joseph Konen	
Diana Laursen	Academy of Nutrition and Dietetics
Monique Mackey	Area L AHEC
Melanie Mabrey	NC Board of Nursing
Jan Nicollerat	Clinical Specialist and Certified Diabetes Educator
Julie Paul	Wake Med Health & Hospitals
Sharon Pearce	Carolina Anesthesia Associates
Carmen Samuel-Hodge	University of North Carolina at Chapel Hill
Susan Spratt	Duke University Medical Center
Lynette Tolson Somers	American Diabetes Association
Sheree Vodicka	NC Alliance of YMCA's
Natasha Vos	UNC – Asheville
Linda Wooley	New Hanover Regional Medical Center
Marico Dove	JanusRx
Members Emeritus	
John Buse	
Liaison Member	
Ciara Ruske	NC Division of Public Health, Cancer Prevention and Control Branch
Amy Johnson	NC Division of Public Health, Children and Youth Branch
Joyce Swetlick	NC Division of Public Health, Tobacco Prevention and Control Branch

DAC Voting Members



DAC Announcements

Chris Memering

Joanne Rinker

Corissa Payton



2022 DAC Award Winners



Health Care Provider Award
Angie Watson, Pitt County Public Health Department



Health Care Provider Award
Dr. Karen Scherr, MD, PhD, Duke University

**Nominate your diabetes hero or
apply for the diabetes care and
education specialist scholarship!**

**The application and nomination form is open
June 1 – July 31, 2023**

The **North Carolina Diabetes Advisory Council Awards** recognize individuals or groups who have performed outstanding work in diabetes prevention and management.

Awards and Scholarship Categories:

- John Bowdish Community Award
- Myrna Miller Employer Award
- Health Care Provider Award
- Hugh Young Diabetes Care and Education Specialist Scholarship

diabetesnc.com



North Carolina Diabetes Advisory Council



Thank your diabetes hero with an NC Diabetes Advisory Council award or apply for our scholarship. Nominations open now through July 31, 2022

[Click here for photos](#) of the current and past award winners.

**2022 DAC Awards and Scholarship Application:
Open June 1 – July 31,
2022**

[Awards and Scholarship Descriptions and Requirements](#)

- ▶ [NC Diabetes Advisory Council Overview](#)
- ▶ [NC Diabetes Advisory Council Member List](#)
- ▶ [NC Diabetes Advisory Council Bylaws](#)

2022 DAC Meetings:

Upcoming DAC Meetings

Friday, June 17, 2022

Join us for a virtual DAC meeting on June 17, 2022 at 9:30 AM – 12:30 PM

[Meeting Agenda](#)

[Register Here](#)

Friday, October 28, 2022

Join us for a virtual DAC meeting on October 28, 2022 at 9:30 AM – 12:30 PM

[Register Here](#)

Previous DAC Meetings

Friday, February 18, 2022

[Watch the Recording](#)

- [Meeting Agenda](#)
- [DPP Referrals at Duke Family Medicine](#)
- [Dr. Dowler Medicaid and Diabetes](#)

[Past Diabetes Advisory Council Meetings](#)

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North Carolina Diabetes Advisory Council



Request: Volunteers for Awards Submission Review Committee



North Carolina Diabetes Advisory Council

NC Diabetes Camps

DIABETES CAMPS

CAMP MORRIS
June 10 - 17
King, NC
3rd - 11th graders

CAPE FEAR VALLEY DIABETES CAMP
June 22-25
Parkton, NC
Under 18

CAMP KUDOS
July 14 - 16 Day Camp
Fort Mill, SC
4 years old - Rising 9th graders

CAMP NEEDLES IN THE PINES
July 23 - 28
Blounts Creek, NC
8 - 14 years old



[Find a Camp – Diabetes Education & Camping Association \(diabetescamps.org\)](https://diabetescamps.org)

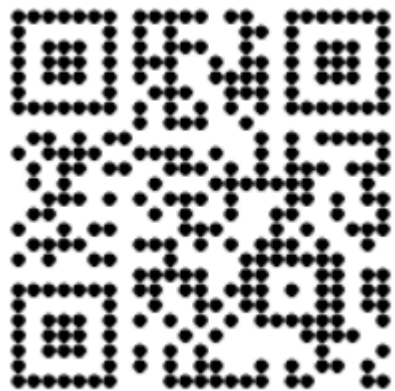


North Carolina Diabetes Advisory Council

NC Coordinating Body of ADCES 2023 Diabetes Conference

October 20, 2023 | 7:30am – 4:30pm | Friday Center – Chapel Hill, NC

In this one-day symposium, experts in the field of diabetes care and education will share their knowledge on improving patient care regarding a variety of diabetes related health concerns, as well as ideas on better care models for patients with diabetes.



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North Carolina Diabetes Advisory Council

Senate Bill 717 – Affordable Access to Insulin Act

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2023

FILED SENATE
Apr 6, 2023
S.B. 717
PRINCIPAL CLERK

S

SENATE BILL DRS15305-NE-117A

D

Short Title: Affordable Access to Insulin Act. (Public)

Sponsors: Senators Mohammed, Chaudhuri, and Adcock (Primary Sponsors).

Referred to:

1 A BILL TO BE ENTITLED
2 AN ACT TO LIMIT AN INSURED'S COPAYMENT FOR INSULIN AND TO STUDY THE
3 FEASIBILITY OF FURTHER REDUCING INSULIN COPAYMENTS.
4 The General Assembly of North Carolina enacts:
5 **SECTION 1.** Article 3 of Chapter 58 of the General Statutes is amended by adding
6 a new section to read:
7 "**§ 58-3-295. Coverage for insulin.**
8 (a) An insured's copayment under a health benefit plan that provides coverage for insulin
9 shall not exceed twenty-five dollars (\$25.00) for a month's supply of insulin, or a proportional
10 copayment for a quantity of insulin other than a month's supply, regardless of the amount or the
11 types of insulin needed.
12 (b) The provisions of this section apply to insurers and pharmacy benefits managers, as
13 defined in G.S. 56-56A-1."
14 **SECTION 2.** The Department of Insurance shall study (i) the feasibility of further
15 reducing the maximum copayment for insulin and (ii) imposing a maximum copayment on the
16 provision of diabetes-related equipment. The Department shall report the findings of this study,
17 including any legislative recommendations, to the North Carolina General Assembly, the chairs
18 of the Joint Legislative Committee on Health and Human Services, and the Fiscal Research
19 Division no later than January 1, 2024.
20 **SECTION 3.** Section 1 of this act becomes effective October 1, 2023, and applies to
21 contracts issued, renewed, or amended on or after that date. The remainder of this act is effective
22 when it becomes law.



Breakout Rooms

Membership Workgroup
Abstract Workgroup
Interest Survey Workgroup

30 Minutes



Breakout Discussion Reporting



Break

10 Minutes



North Carolina Diabetes Advisory Council

Standards of Care Updates

Dr. Susan Spratt, Duke Health
Dr. Leonor Corsino, Duke Health



North Carolina Diabetes Advisory Council



DukeHealth

Population Health Management Office

SUMMARY CHANGES IN STANDARDS OF MEDICAL CARE IN DIABETES

Susan E. Spratt, MD

Leonor Corsino, MD, MHS

Agenda

- Classification and Diagnosis of Diabetes
- Screening for NAFLD in patients with Diabetes
- Glycemic Targets and TIR based on age
- Changes in the ADA recommendations of Pharmacological Approaches to Glycemic Treatment
- Cardiovascular Disease and Risk Management: changes to BP and LDL guidelines
- SGLT2i indications in Chronic Kidney Disease and Risk Management.



Diagnosis of Diabetes

FPG \geq 126 mg/dL (7.0 mmol/L). Fasting is defined as no caloric intake for at least 8 h.*

OR

2-h PG \geq 200 mg/dL (11.1 mmol/L) during OGTT. The test should be performed as described by WHO, using a glucose

OR

A1C \geq 6.5% (48 mmol/mol). The test should be performed in a laboratory using a method that is NGSP certified and sta

OR

In a patient with classic symptoms of hyperglycemia or hyperglycemic crisis, a random plasma glucose \geq 200 mg/dL (11

In the absence of unequivocal hyperglycemia, diagnosis requires two abnormal test results from the same sample or in two separate test samples.



Considerations on testing / screening for Diabetes

2.1a To avoid misdiagnosis or missed diagnosis, the A1C test should be performed using a method that is certified by the National Glycohemoglobin Standardization Program (NGSP) and standardized to the Diabetes Control and Complications Trial (DCCT) assay. **B**

2.1b Point-of-care A1C testing for diabetes screening and diagnosis should be restricted to U.S. Food and Drug Administration–approved devices at laboratories proficient in performing testing of moderate complexity or higher by trained personnel. **B**

2.2 Marked discordance between measured A1C and plasma glucose levels should raise the possibility of A1C assay interference and consideration of using an assay without interference or plasma blood glucose criteria to diagnose diabetes. **B**

2.3 In conditions associated with an altered relationship between A1C and glycemia, such as hemoglobinopathies including sickle cell disease, pregnancy (second and third trimesters and the postpartum period), glucose-6-phosphate dehydrogenase deficiency, HIV, hemodialysis, recent blood loss or transfusion, or erythropoietin therapy, only plasma blood glucose criteria should be used to diagnose diabetes. **B**

2.4 Adequate carbohydrate intake (at least 150 g/day) should be assured for 3 days prior to oral glucose tolerance testing as a screen for diabetes. **A**



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Causes of False HgbA1c Readings

- Increased RBC turnover
 - sickle cell disease
 - pregnancy (second and third trimesters)
 - glucose-6-phosphate dehydrogenase deficiency
 - Hemodialysis
 - recent blood loss or transfusion
 - erythropoietin therapy
 - Postpartum state
 - Hemolysis
- Iron-deficient anemia
- B12 deficiency
- Sickle Cell trait: lowers A1C by about 0.3%
- X-linked glucose-6-phosphate dehydrogenase G202A, carried by 11% of African American individuals, was associated with a decrease in A1C of about 0.8% in homozygous
- HIV treated with certain protease inhibitors (PIs) and nucleoside reverse transcriptase inhibitors (NRTIs)



Who should be screened?

1. Testing should be considered in adults with overweight or obesity (BMI ≥ 25 kg/m² or ≥ 23 kg/m² in Asian American

- First-degree relative with diabetes

- High-risk race/ethnicity (e.g., African American, Latino, Native American, Asian American, Pacific Islander)

- History of CVD

- Hypertension ($\geq 130/80$ mmHg or on therapy for hypertension)

- HDL cholesterol level < 35 mg/dL (0.90 mmol/L) and/or a triglyceride level > 250 mg/dL (2.82 mmol/L)

- Individuals with polycystic ovary syndrome

- Physical inactivity

- Other clinical conditions associated with insulin resistance (e.g., severe obesity, acanthosis nigricans)

2. People with prediabetes (A1C $\geq 5.7\%$ [39 mmol/mol], IGT, or IFG) should be tested yearly.

3. People who were diagnosed with GDM should have lifelong testing at least every 3 years.

4. For all other people, testing should begin at age 35 years.

5. If results are normal, testing should be repeated at a minimum of 3-year intervals, with consideration of more freq

6. People with HIV

Adult is defined
as 18 or older



Assessment of Comorbidities

- **Autoimmune – Type 1DM**

- Thyroid
- Celiac
- B12
- Ai Hepatitis
- Addisions/ AI
- Mysthenia Gravis

- **Cancer**

- **Dementia**

- **Dental**

- **OSA**

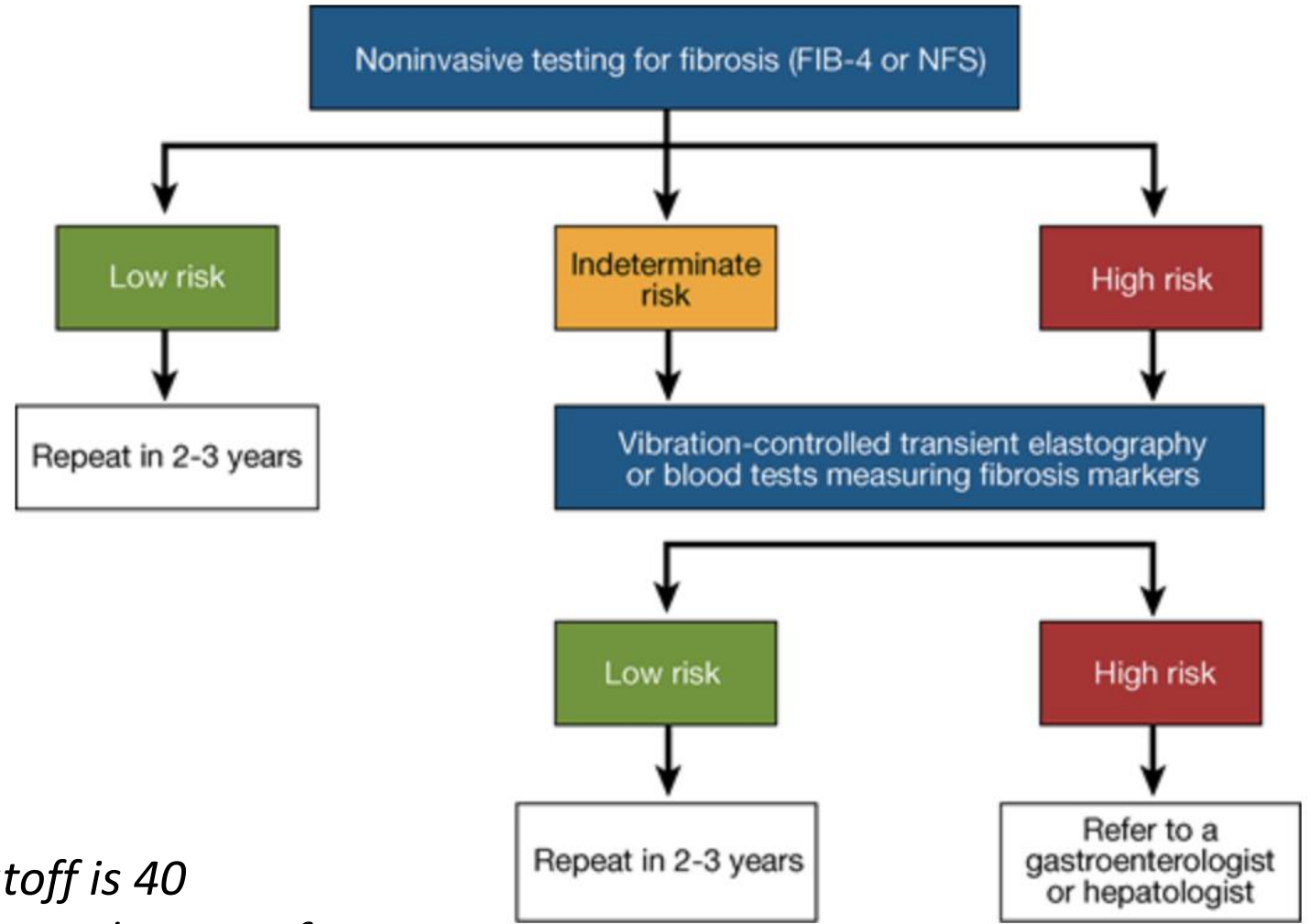
- **NAFLD/ NASH**

- People with type 2 diabetes or prediabetes with cardiometabolic risk factors, who have either ***elevated liver enzymes (ALT) or fatty liver on imaging or ultrasound***, should be evaluated for presence of nonalcoholic steatohepatitis .



Screening for NAFLD in patients with Diabetes

- First: Check LFTs and CBC
- Second: Secondary evaluation
 - Hepatitis B and C
 - Hemochromatosis
 - Autoimmune
 - Wilson's
 - Assess EtOH intake
- Third:
 - Calculate Fib-4
- *Checking LFTs is not enough – Miss if cutoff is 40*
- *70% of patients with type 2 DM have some element of NAFLD*
- *The goal is to prevent fibrosis.*



Glycemic Targets and CGM

6.3 Standardized, single-page glucose reports from continuous glucose monitoring (CGM) devices with visual cues, such as the ambulatory glucose profile, should be considered as a standard summary for all CGM devices. **E**

6.4 Time in range is associated with the risk of microvascular complications and can be used for assessment of glycemic control. Additionally, time below range and time above range are useful parameters for the evaluation of the treatment plan ([Table 6.2](#)). **C**

Glucose Range	Target Time
Time in Range 70-180 mg/dl	70 % or higher
Time Above Range (TAR) >250 mg/dl	5% or lower
Time Above Range (TAR) 181-250 mg/dl	25% or lower

Standardized CGM Metrics

Number of days CGM device is worn (14 days)

Percent time CGM is active (Target 70% or higher)

Mean Glucose

Glucose management indicator (approximates A1c)

Glycemic Variability (%CV) (Target <36%)

BGM and CGM can be useful to guide medical nutrition therapy and physical activity, prevent hypoglycemia, and aid medication management.



Glycemic Targets and TIR older patients or at risk

Glucose Range	Target
Time in Range 70-180 mg/dl	50 % or higher
Time Above Range (TAR) >250 mg/dl	5% or lower
Time Above Range (TAR) 181-250 mg/dl	25% or lower
Time Below Range (TBR) 54-69 mg/dl	1 % or lower
Time Below Range (TBR) <54 mg/dl	1% or lower

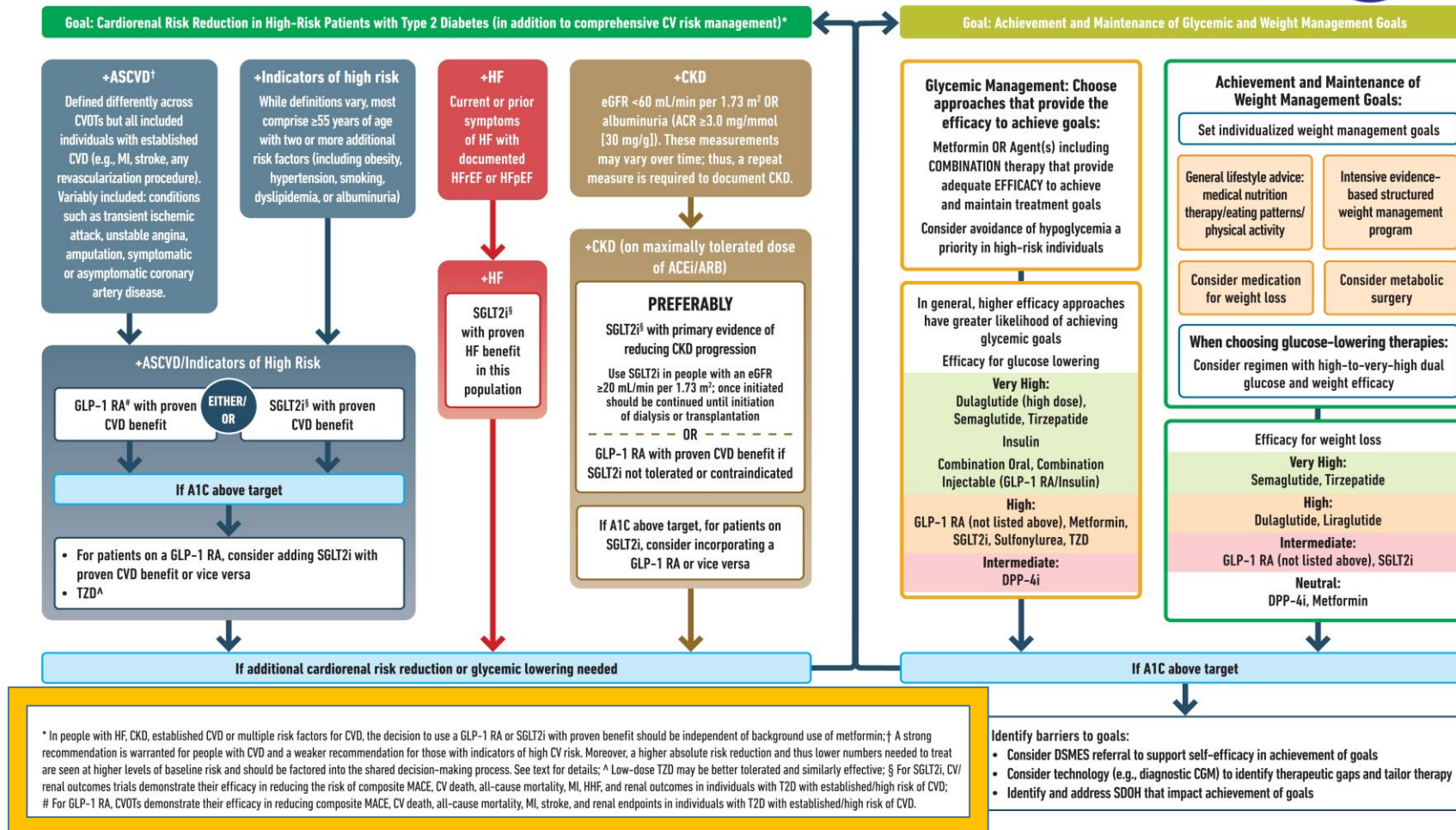
Each 1 % time in range is approximately 15 minutes.



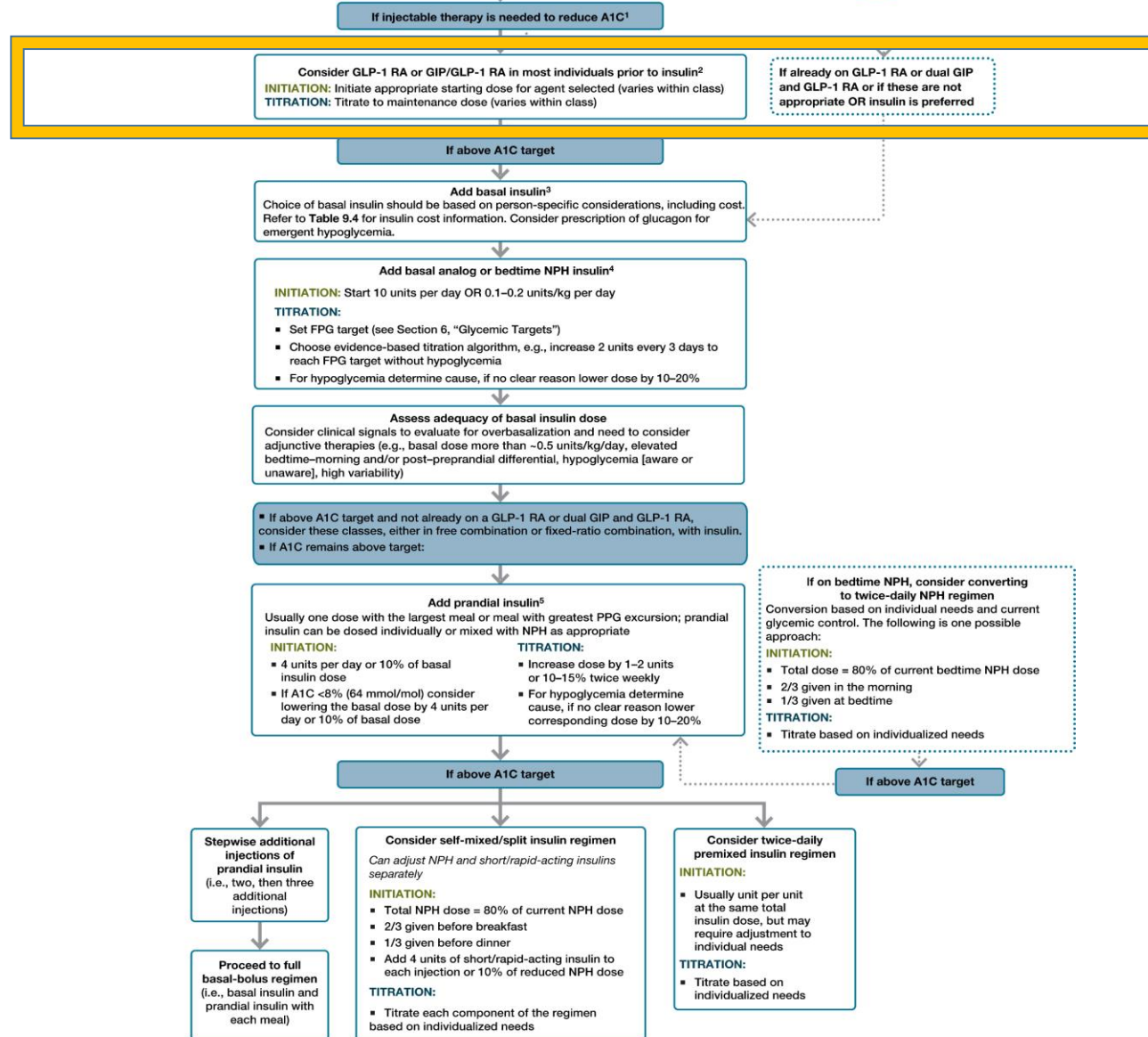
Pharmacological Approaches to Glycemic Treatment-Updates ADA 2023

USE OF GLUCOSE-LOWERING MEDICATIONS IN THE MANAGEMENT OF TYPE 2 DIABETES

HEALTHY LIFESTYLE BEHAVIORS; DIABETES SELF-MANAGEMENT EDUCATION AND SUPPORT (DSMES); SOCIAL DETERMINANTS OF HEALTH (SDOH)



Use principles in Figure 9.3, including reinforcement of behavioral interventions (weight management and physical activity) and provision of DSMES, to meet individualized treatment goals



1. Consider insulin as the first injectable if evidence of ongoing catabolism, symptoms of hyperglycemia are present, when A1C levels (>10% [86 mmol/mol]) or blood glucose levels (300 mg/dL [16.7 mmol/L]) are very high, or a diagnosis of type 1 diabetes is a possibility.

2. When selecting GLP-1 RA, consider individual preference, A1C lowering, weight-lowering effect, or frequency of injection. If CVD is present, consider GLP-1 RA with proven CVD benefit. Oral or injectable GLP-1 RA are appropriate.

3. For people on GLP-1 RA and basal insulin combination, consider use of a fixed-ratio combination product (DegrLira or iGlarLixi).

4. Consider switching from evening NPH to a basal analog if the individual develops hypoglycemia and/or frequently forgets to administer NPH in the evening and would be better managed with an A.M. dose of a long-acting basal insulin.

5. If adding prandial insulin to NPH, consider initiation of a self-mixed or premixed insulin regimen to decrease the number of injections required.

Cardiovascular Disease and Risk Management: LDL Goals

Primary
Prevention

10.18 For people with diabetes aged 40–75 years without atherosclerotic cardiovascular disease, use moderate-intensity statin therapy in addition to lifestyle therapy. **A**

10.19 For people with diabetes aged 20–39 years with additional atherosclerotic cardiovascular disease risk factors, it may be reasonable to initiate statin therapy in addition to lifestyle therapy. **C**

10.20 For people with diabetes aged 40–75 at higher cardiovascular risk, including those with one or more atherosclerotic cardiovascular disease risk factors, it is recommended to use high-intensity statin therapy to reduce LDL cholesterol by $\geq 50\%$ of baseline and to target an LDL cholesterol goal of < 70 mg/dL. **B**

10.21 For people with diabetes aged 40–75 years at higher cardiovascular risk, especially those with multiple atherosclerotic cardiovascular disease risk factors and an LDL cholesterol ≥ 70 mg/dL, it may be reasonable to add ezetimibe or a PCSK9 inhibitor to maximum tolerated statin therapy. **C**

10.22 In adults with diabetes aged > 75 years already on statin therapy, it is reasonable to continue statin treatment. **B**

10.23 In adults with diabetes aged > 75 years, it may be reasonable to initiate moderate-intensity statin therapy after discussion of potential benefits and risks. **C**

10.24 Statin therapy is contraindicated in pregnancy. **B**



10.25 For people of all ages with diabetes and atherosclerotic cardiovascular disease, high-intensity statin therapy should be added to lifestyle therapy. **A**

10.26 For people with diabetes and atherosclerotic cardiovascular disease, treatment with high-intensity statin therapy is recommended to target an LDL cholesterol reduction of $\geq 50\%$ from baseline and an LDL cholesterol goal of < 55 mg/dL. Addition of ezetimibe or a PCSK9 inhibitor with proven benefit in this population is recommended if this goal is not achieved on maximum tolerated statin therapy. **B**

10.27 For individuals who do not tolerate the intended intensity, the maximum tolerated statin dose should be used. **E**



Cardiovascular Disease and Risk Management: Blood Pressure

10.3 For people with diabetes and hypertension, blood pressure targets should be individualized through a shared decision-making process that addresses cardiovascular risk, potential adverse effects of antihypertensive medications, and patient preferences. **B**

10.4 People with diabetes and hypertension qualify for antihypertensive drug therapy when the blood pressure is persistently elevated $\geq 130/80$ mmHg. The on-treatment target blood pressure goal is $<130/80$ mmHg, if it can be safely attained. **B**



SGLT2 inh indications in CKD and Risk Management

11.5a For people with type 2 diabetes and diabetic kidney disease, use of a sodium–glucose cotransporter 2 inhibitor is recommended to reduce chronic kidney disease progression and cardiovascular events in patients with an estimated glomerular filtration rate ≥ 20 mL/min/1.73 m² and urinary albumin ≥ 200 mg/g creatinine. **A**

11.5b For people with type 2 diabetes and diabetic kidney disease, use of a sodium–glucose cotransporter 2 inhibitor is recommended to reduce chronic kidney disease progression and cardiovascular events in patients with an estimated glomerular filtration rate ≥ 20 mL/min/1.73 m² and urinary albumin ranging from normal to 200 mg/g creatinine. **B**

11.5c In people with type 2 diabetes and diabetic kidney disease, consider use of sodium–glucose cotransporter 2 inhibitors (if estimated glomerular filtration rate is ≥ 20 mL/min/1.73 m²), a glucagon-like peptide 1 agonist, or a nonsteroidal mineralocorticoid receptor antagonist (if estimated glomerular filtration rate is ≥ 25 mL/min/1.73 m²) additionally for cardiovascular risk reduction. **A**

11.5d In people with chronic kidney disease and albuminuria who are at increased risk for cardiovascular events or chronic kidney disease progression, a nonsteroidal mineralocorticoid receptor antagonist shown to be effective in clinical trials is recommended to reduce chronic kidney disease progression and cardiovascular events. **A**

11.6 In people with chronic kidney disease who have ≥ 300 mg/g urinary albumin, a reduction of 30% or greater in mg/g urinary albumin is recommended to slow chronic kidney disease progression. **B**

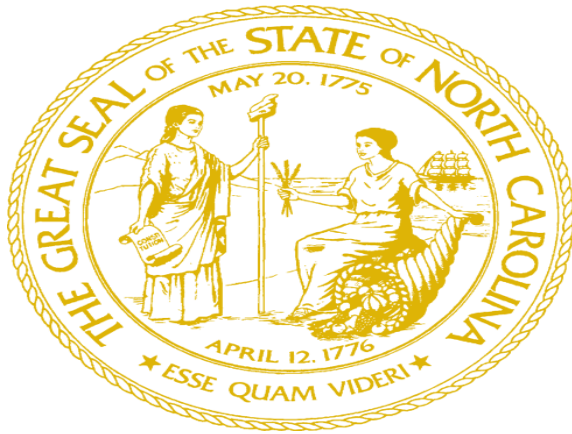


Medicaid Updates

Dr. Shannon Dowler, NC DHHS



North Carolina Diabetes Advisory Council



Updates from NC Medicaid

Shannon Dowler, MD

Chief Medical Officer NC Medicaid

Assistant Secretary Health Access NC DHHS

May 2023

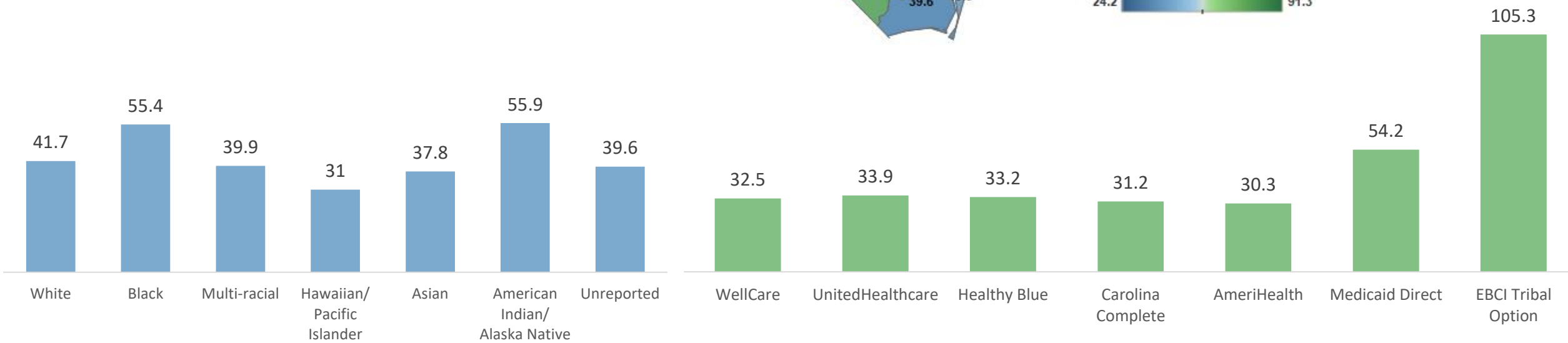
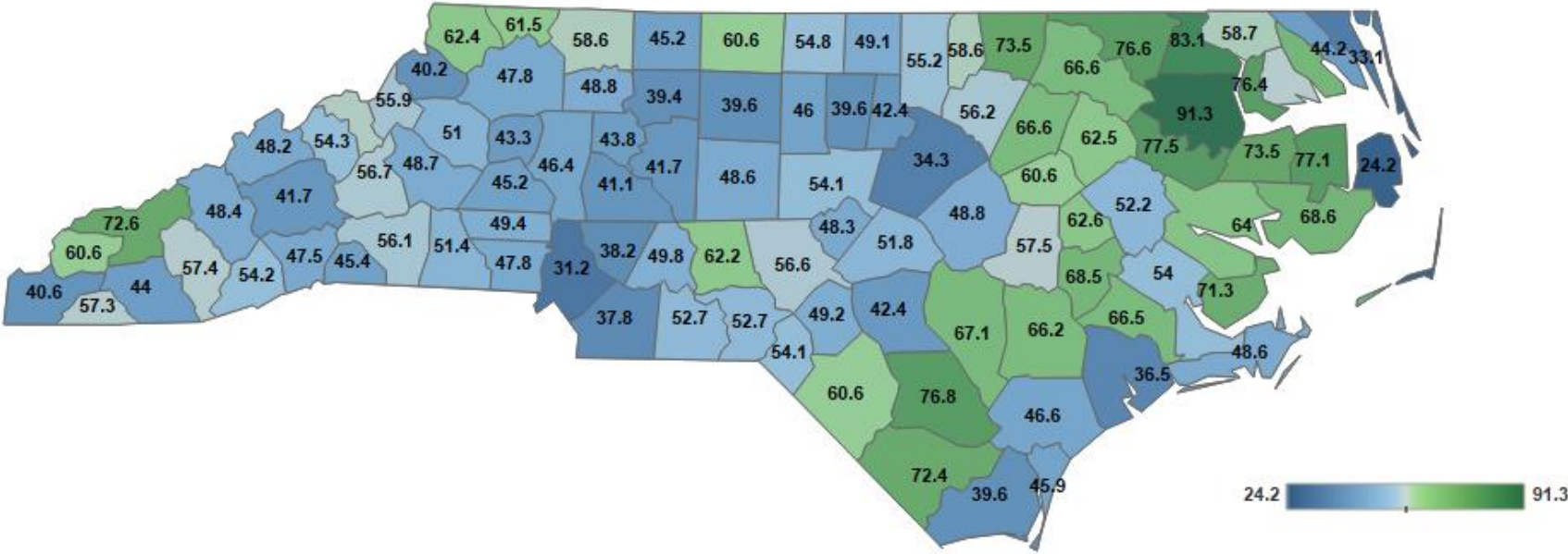
A Few Things Going On Worth a Mention



Summary of Diabetes Quality Measures with Data

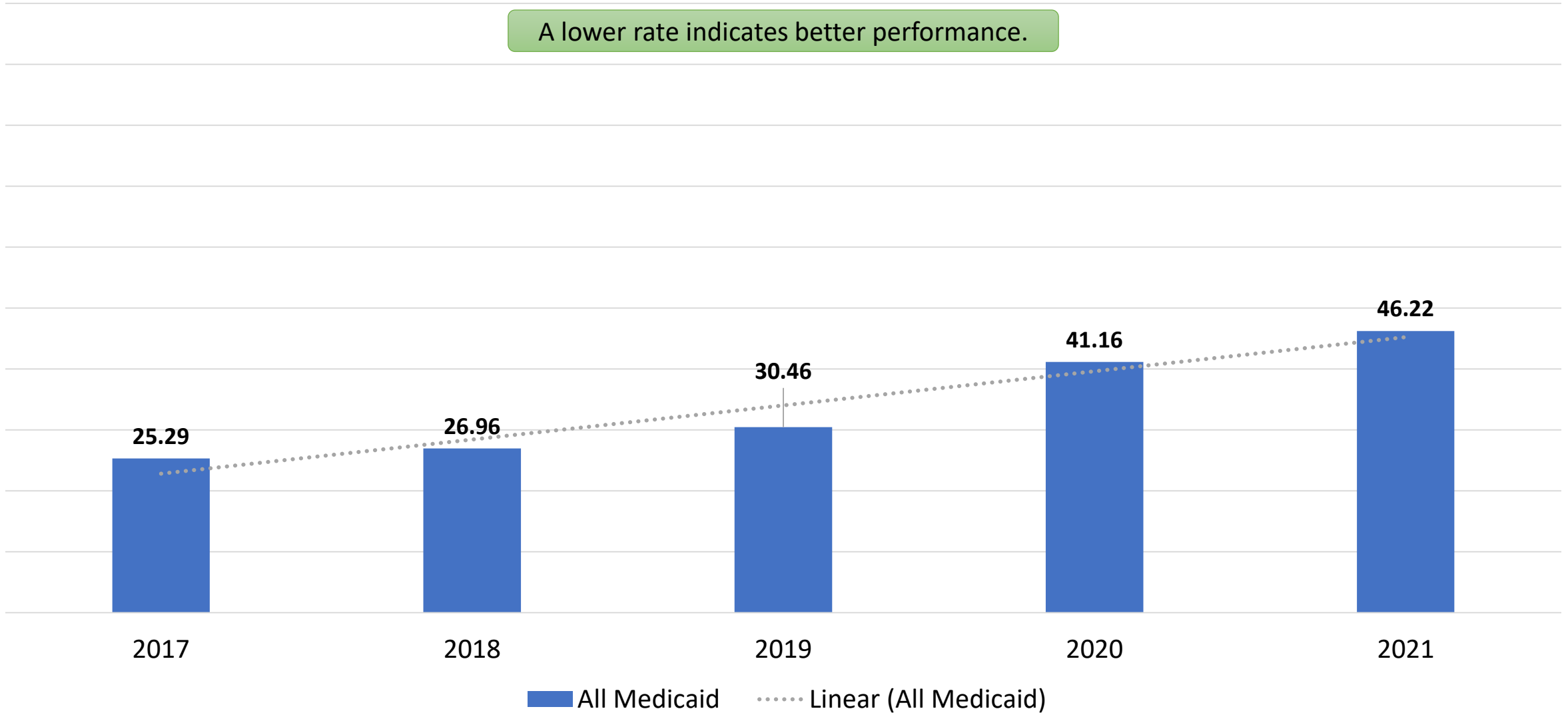
Measure Name (Linked to applicable slides)	Steward/NQF #	Measure Description	Additional Information
Diabetes Short-Term Complications Admission Rate (Pediatric) (PDI 15)	AHRQ / NA	Hospitalizations with a principal diagnosis of diabetes with short-term complications (ketoacidosis, hyperosmolarity, or coma) per 100,000 population, ages 6 through 17 years. Exclude transfers from other institutions; and obstetric discharges. <i>A lower rate indicates better performance.</i>	<ul style="list-style-type: none"> Department-calculated measure for Standard Plans and Tailored Plans
Diabetes Short-Term Complications Admission Rate (Adult) (PQI 01)	AHRQ / #0272	Hospitalizations for a principal diagnosis of diabetes with short-term complications (ketoacidosis, hyperosmolarity, or coma) per 100,000 population, ages 18 years and older. Excludes obstetric hospitalizations and transfers from other institutions. <i>A lower rate indicates better performance.</i>	<ul style="list-style-type: none"> Department-calculated measure for Standard Plans and Tailored Plans CMS Adult Core Measure
Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM)	NCQA / #2800	Assesses the percentage of children and adolescents with ongoing antipsychotic medication use who had metabolic testing during the year. Three measures are reported: (1) Blood Glucose Testing, (2) Cholesterol Testing, and (3) Total Metabolic Testing (Blood Glucose <i>and</i> Cholesterol Testing).	<ul style="list-style-type: none"> Tailored Plan measure only CMS Child Core Measure
Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)	NCQA / #1932	Assesses adults 18–64 years of age with schizophrenia or bipolar disorder, who were dispensed an antipsychotic medication and had a diabetes screening test during the measurement year.	<ul style="list-style-type: none"> Tailored Plan measure only CMS Adult Core Measure
Statin Therapy for Patients with Diabetes (SPD)	NCQA / NA	Assesses adults 40-75 years of age who have diabetes and who do not have clinical ASCVD, who received and adhered to statin therapy. Two rates are reported: (1) Received Statin Therapy, and (2) Statin Adherence 80%.	<ul style="list-style-type: none"> Not in our measure set but still monitored
Diabetes Monitoring for People with Diabetes and Schizophrenia (SMD)	NCQA / #1934	Assesses adults 18–64 years of age with schizophrenia and diabetes who had both an LDL-C test and an HbA1c test during the measurement year.	<ul style="list-style-type: none"> Not in our measure set but still monitored

Rate of Diabetes Diagnosis per 1,000 NC Medicaid Beneficiaries (CY 2022)



Avoidable Pediatric Utilization: Diabetes Short-Term Complications Admission Rate (PDI 15)
Rate per 100,000 Member Months, All Medicaid (CY 2017-2021)


A lower rate indicates better performance.




Standard Plan Demographic Variance for Avoidable Pediatric Utilization: Diabetes Short-Term Complications Admission Rate (PDI 15), Rate per 100,000 Member Months (CY 2021)

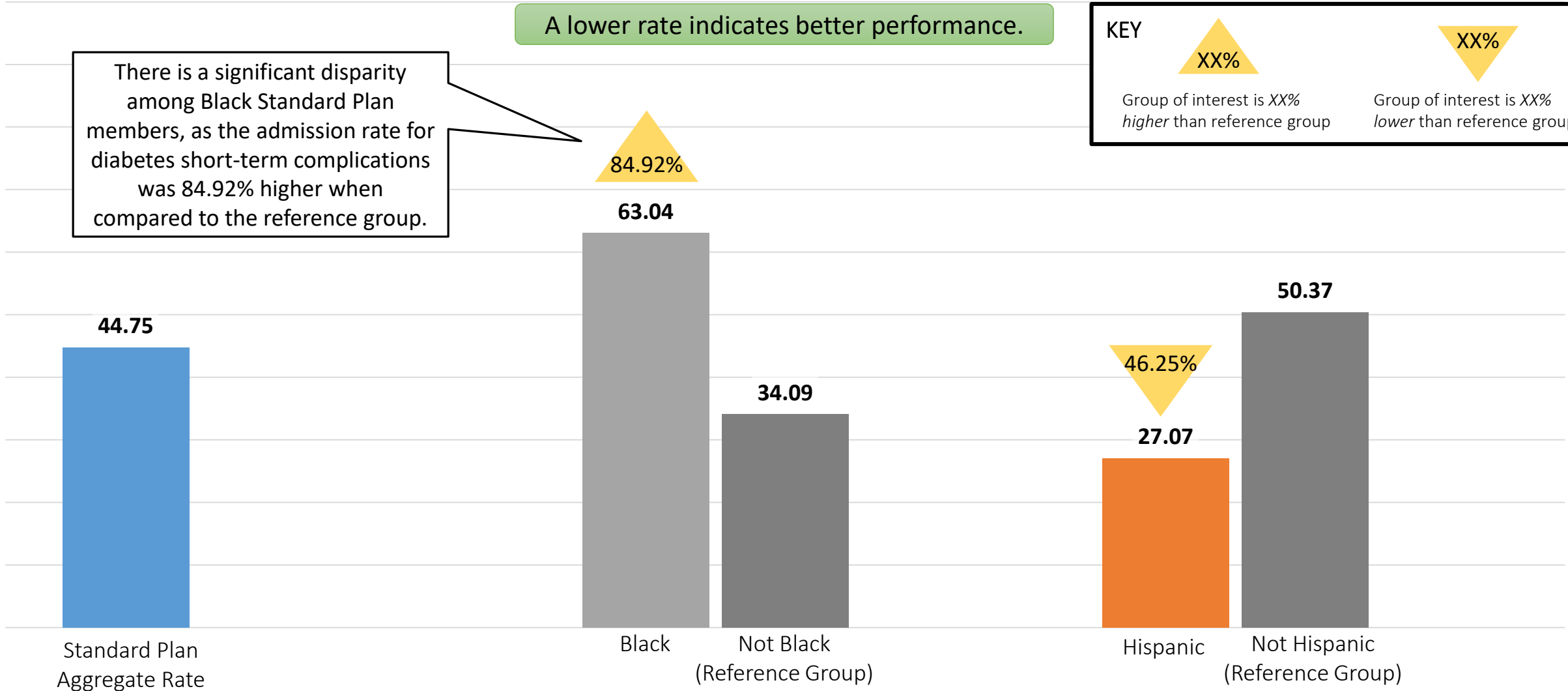
A lower rate indicates better performance.

KEY

 XX%
 Group of interest is XX% higher than reference group

 XX%
 Group of interest is XX% lower than reference group

There is a significant disparity among Black Standard Plan members, as the admission rate for diabetes short-term complications was 84.92% higher when compared to the reference group.



Tailored Plan Demographic Variance for Avoidable Pediatric Utilization: Diabetes Short-Term Complications Admission Rate (PDI 15), Rate per 100,000 Member Months (CY 2021)

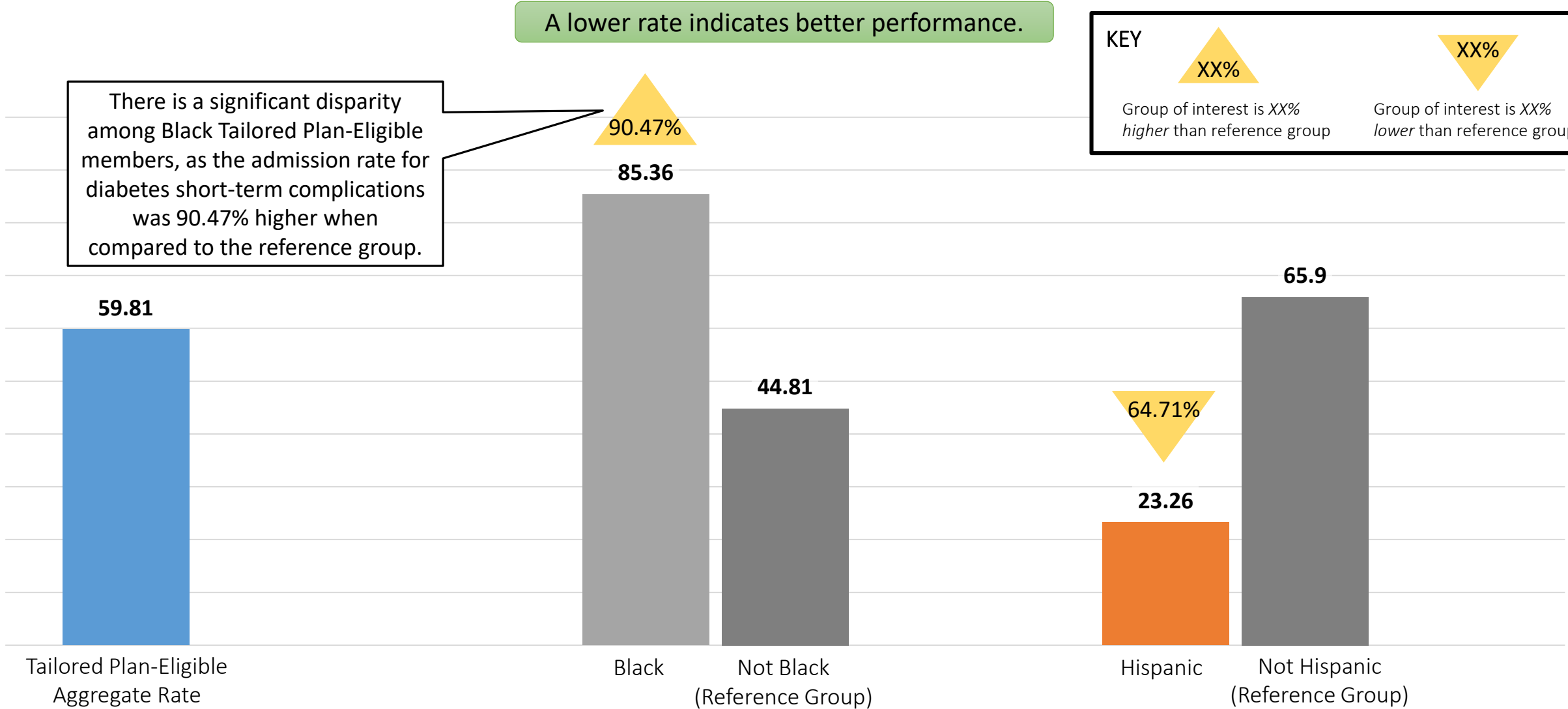
A lower rate indicates better performance.

KEY

▲ XX%
Group of interest is XX% higher than reference group

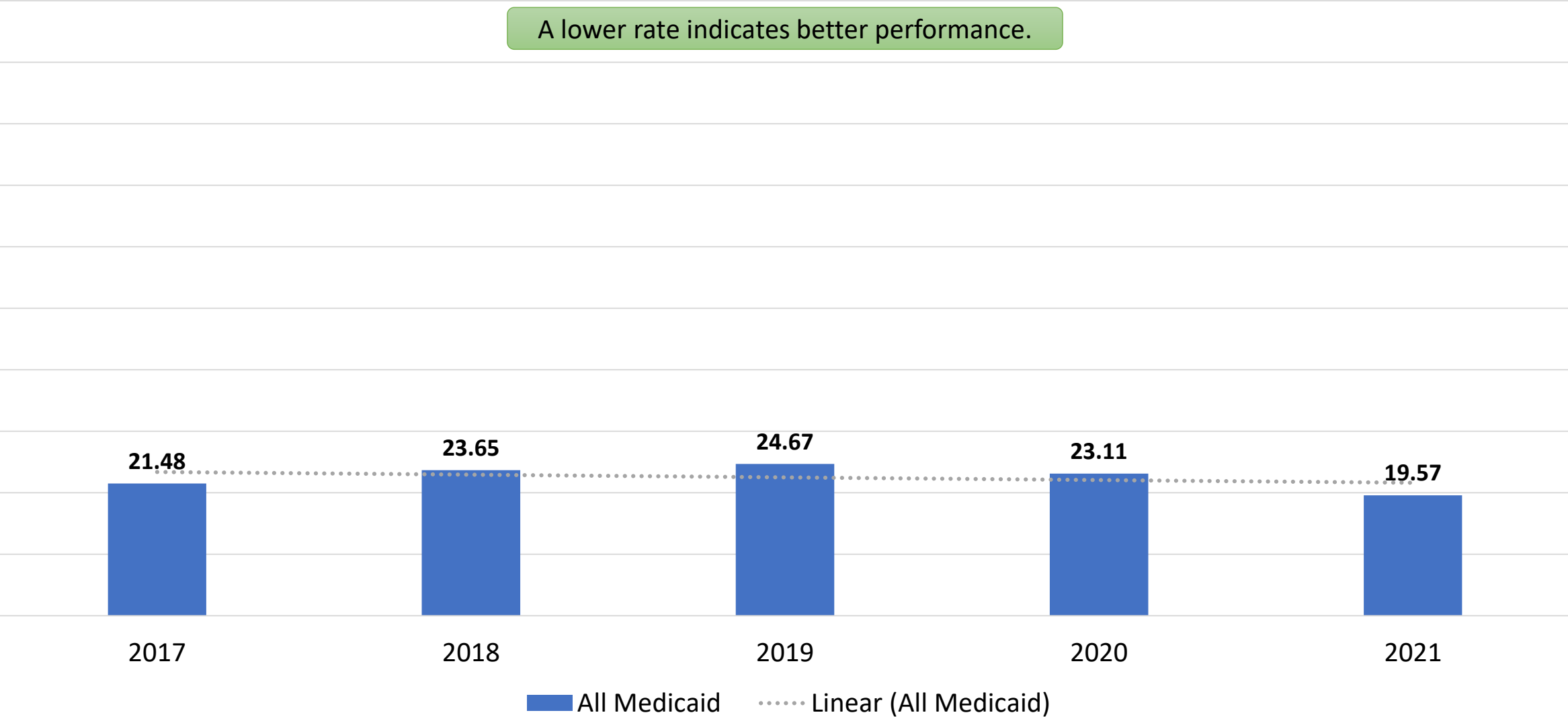
▼ XX%
Group of interest is XX% lower than reference group

There is a significant disparity among Black Tailored Plan-Eligible members, as the admission rate for diabetes short-term complications was 90.47% higher when compared to the reference group.



Avoidable Adult Utilization: Diabetes Short-Term Complications Admission Rate (PQI 01)
Rate per 100,000 Member Months, All Medicaid (CY 2017-2021)

A lower rate indicates better performance.



Standard Plan Demographic Variance for Avoidable Pediatric Utilization: Diabetes Short-Term Complications Admission Rate (PDI 15), Rate per 100,000 Member Months (CY 2021)

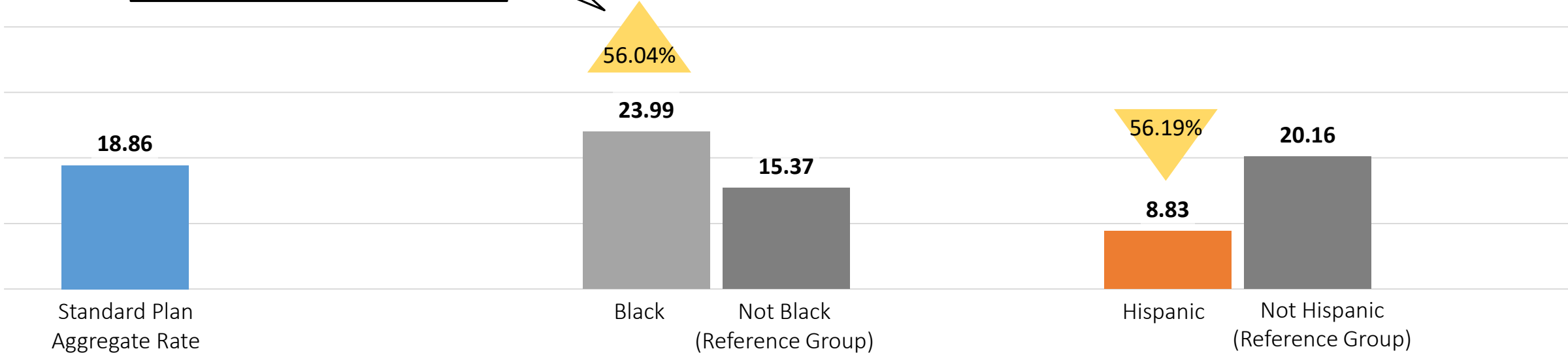
A lower rate indicates better performance.

KEY

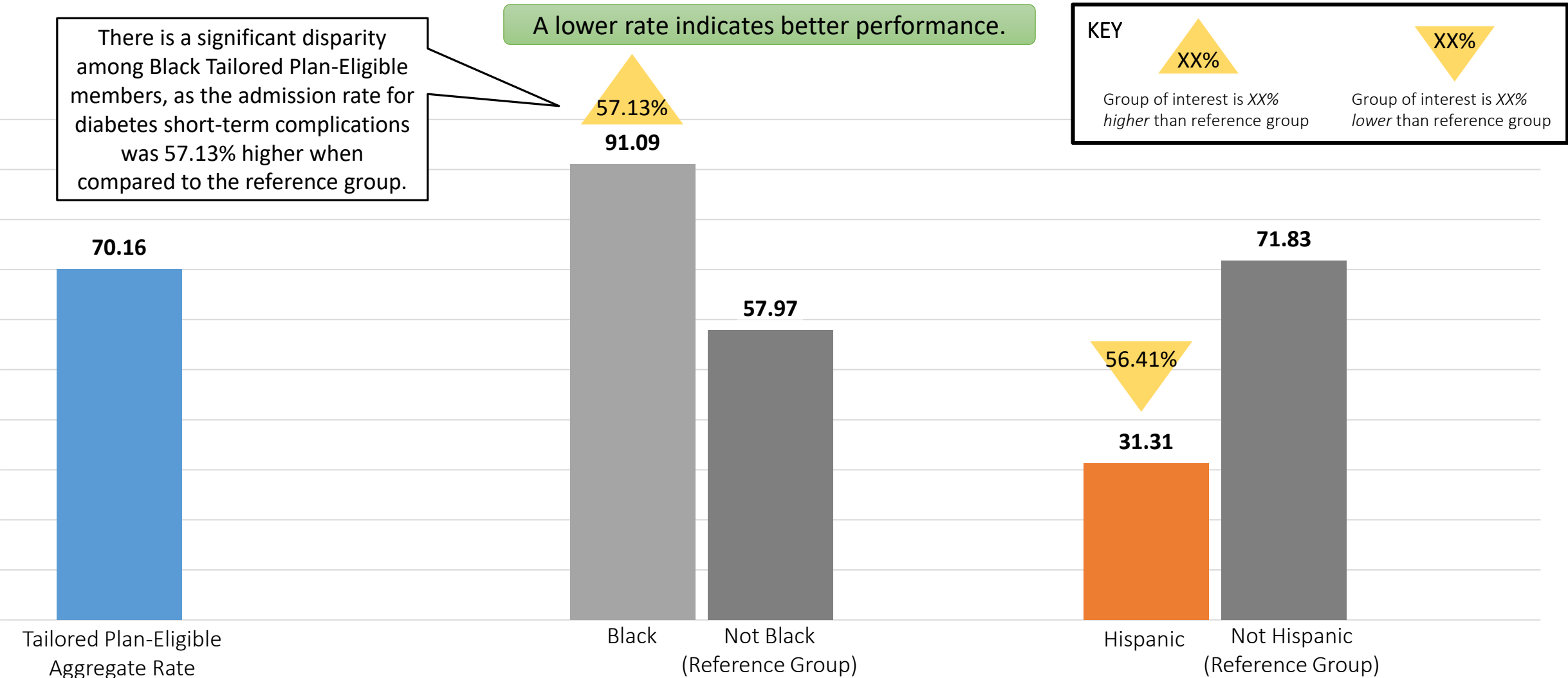
▲ XX%
Group of interest is XX% higher than reference group

▼ XX%
Group of interest is XX% lower than reference group

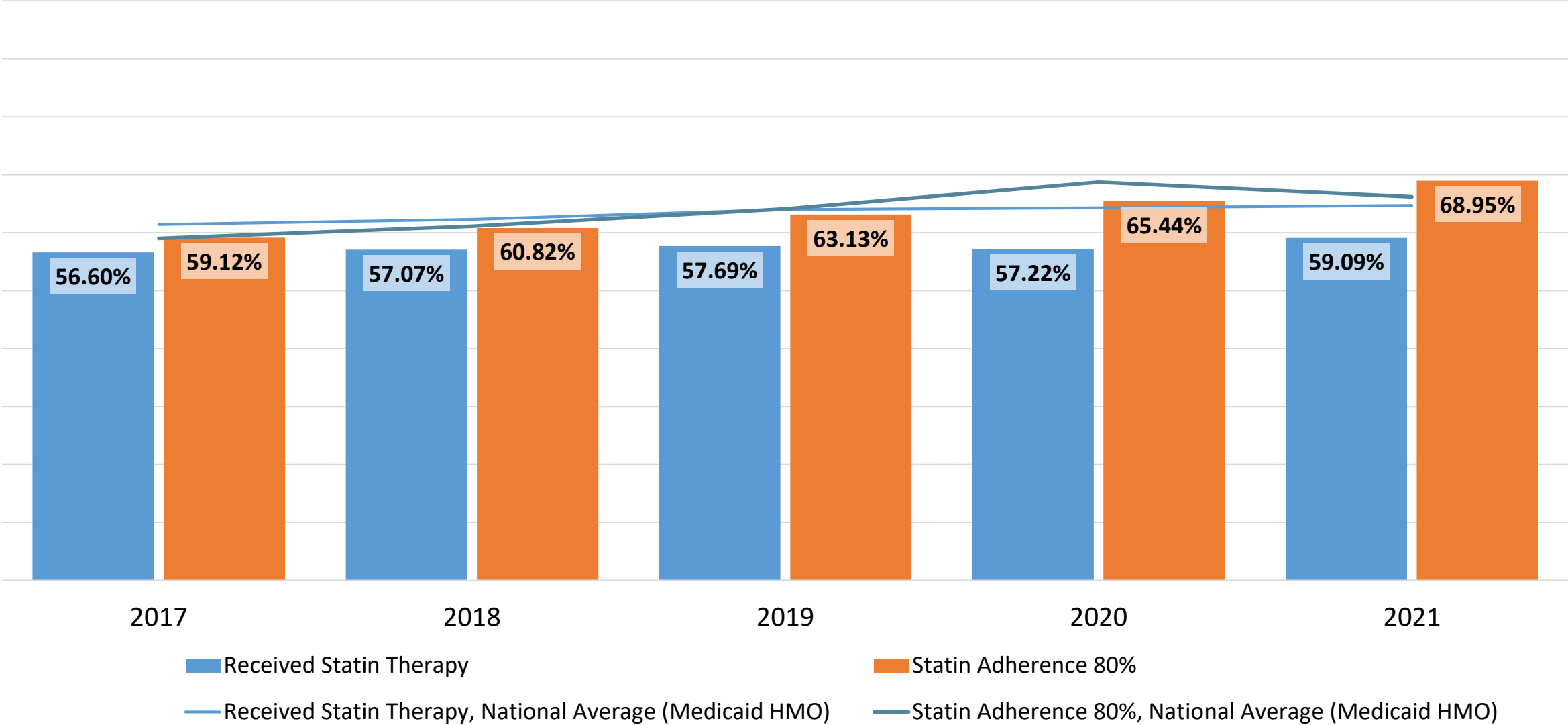
There is a significant disparity among Black Standard Plan members, as the admission rate for diabetes short-term complications was 56.04% higher when compared to the reference group.



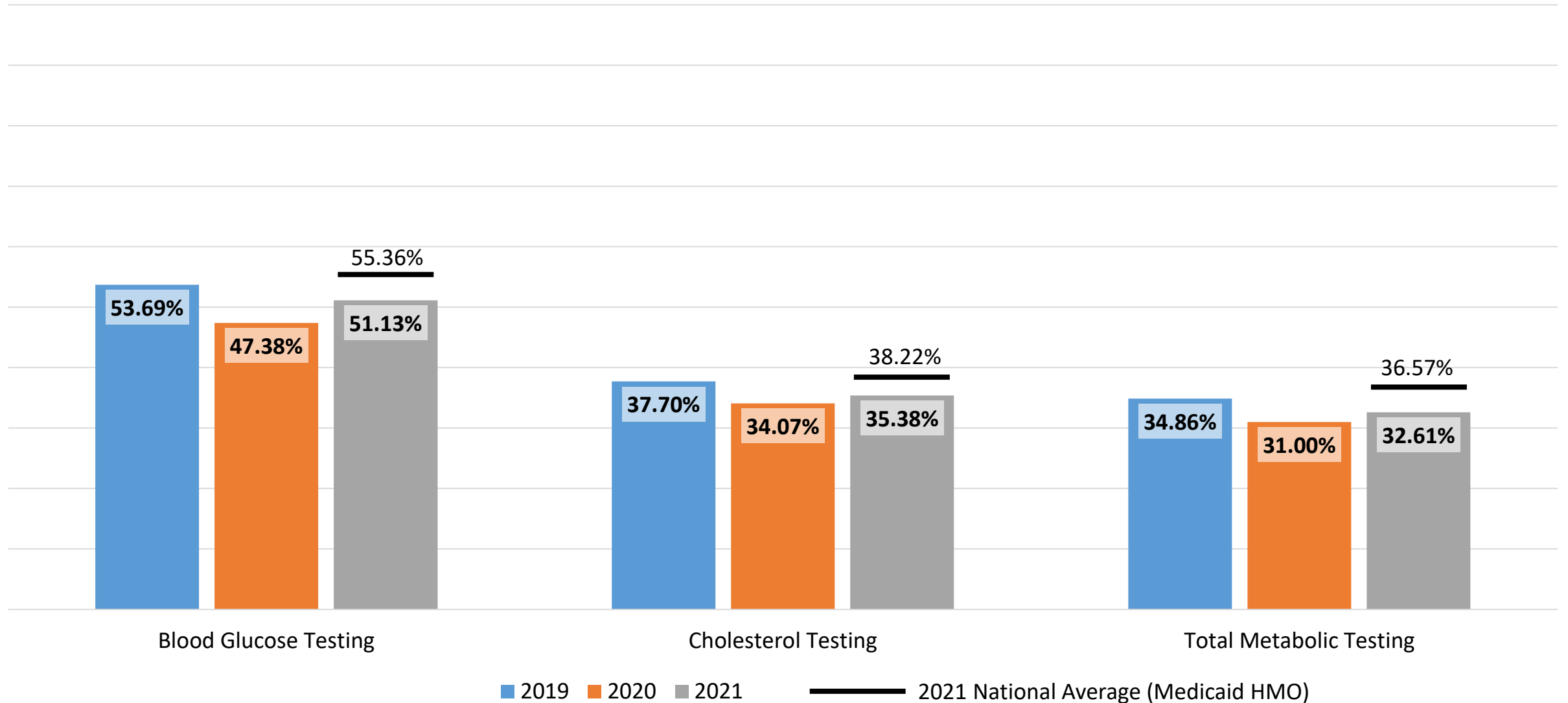
Tailored Plan Demographic Variance for Avoidable Adult Utilization: Diabetes Short-Term Complications Admission Rate (PQI 01), Rate per 100,000 Member Months (CY 2021)





Statin Therapy for Patients with Diabetes (SPD), All Medicaid (CY 2017 – 2021)

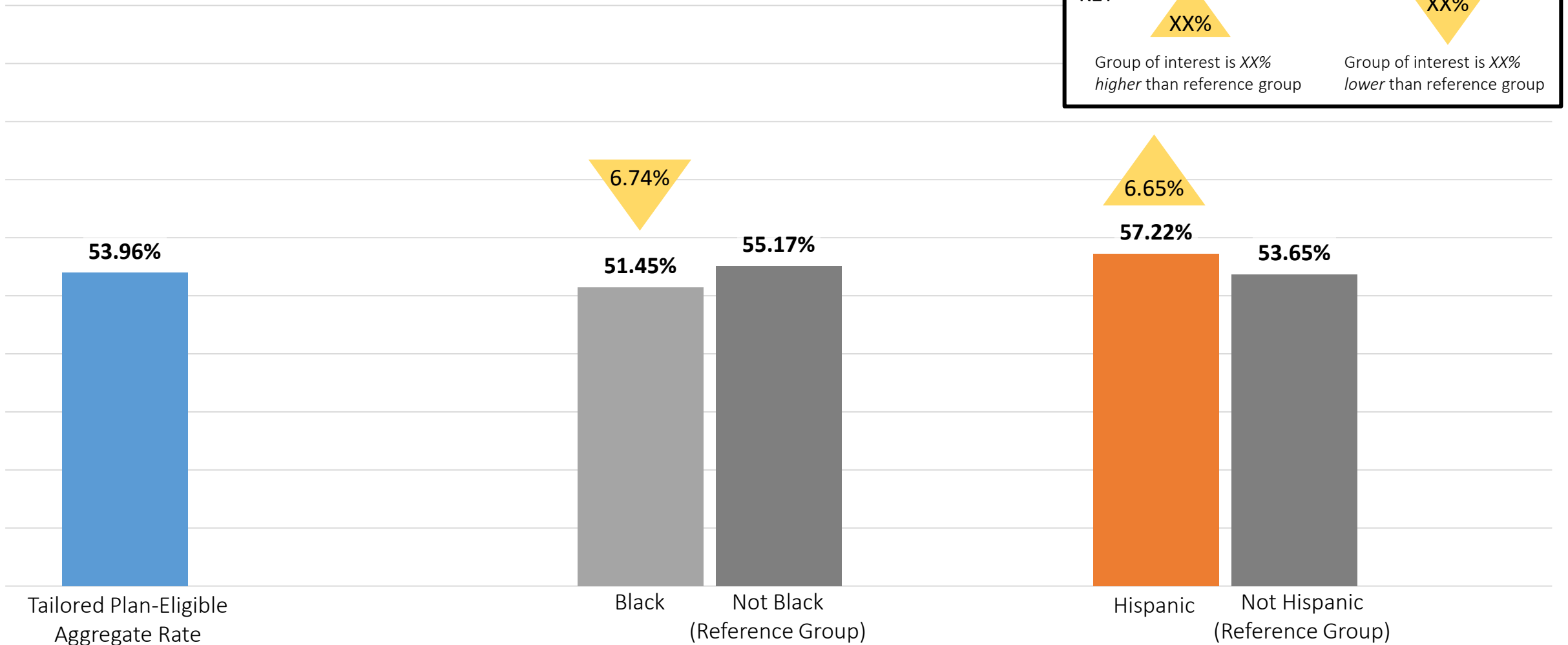


Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM), All Medicaid (CY 2019-2021)




Tailored Plan Demographic Variance for Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM), *Blood Glucose Testing (CY 2021)*


KEY  XX% Group of interest is <i>XX%</i> <i>higher</i> than reference group	 XX% Group of interest is <i>XX%</i> <i>lower</i> than reference group
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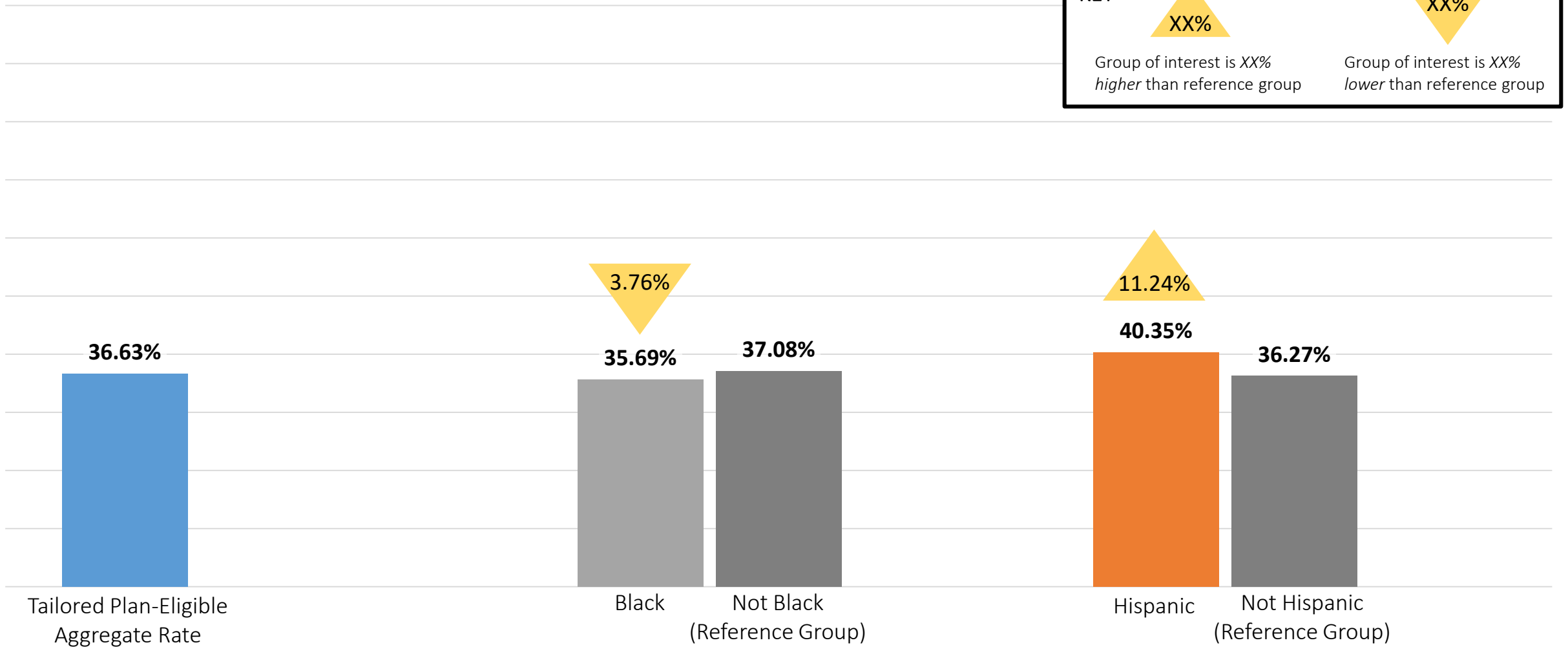


Tailored Plan Demographic Variance for Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM), *Cholesterol Testing (CY 2021)*

KEY


 **XX%**
Group of interest is *XX%*
higher than reference group

 **XX%**
Group of interest is *XX%*
lower than reference group




Tailored Plan Demographic Variance for Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM), *Total Metabolic Testing (CY 2021)*

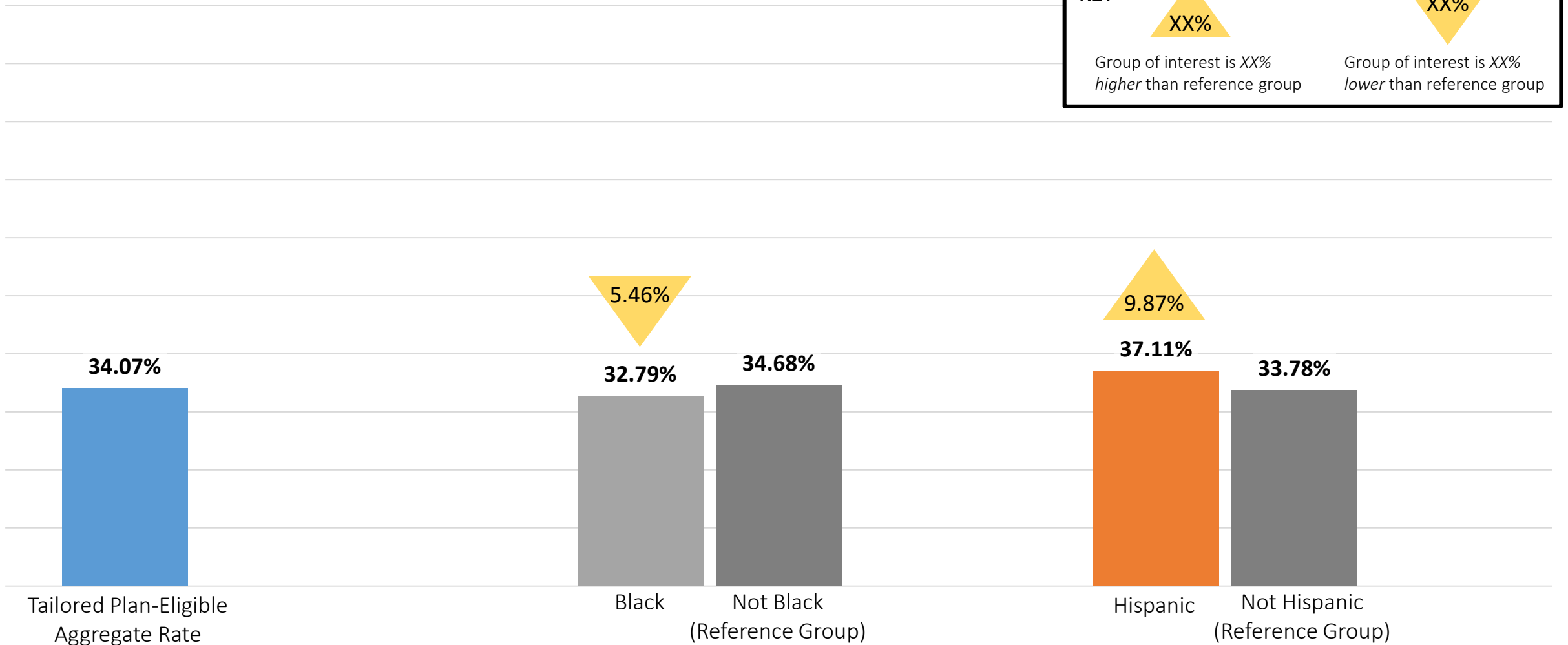
KEY



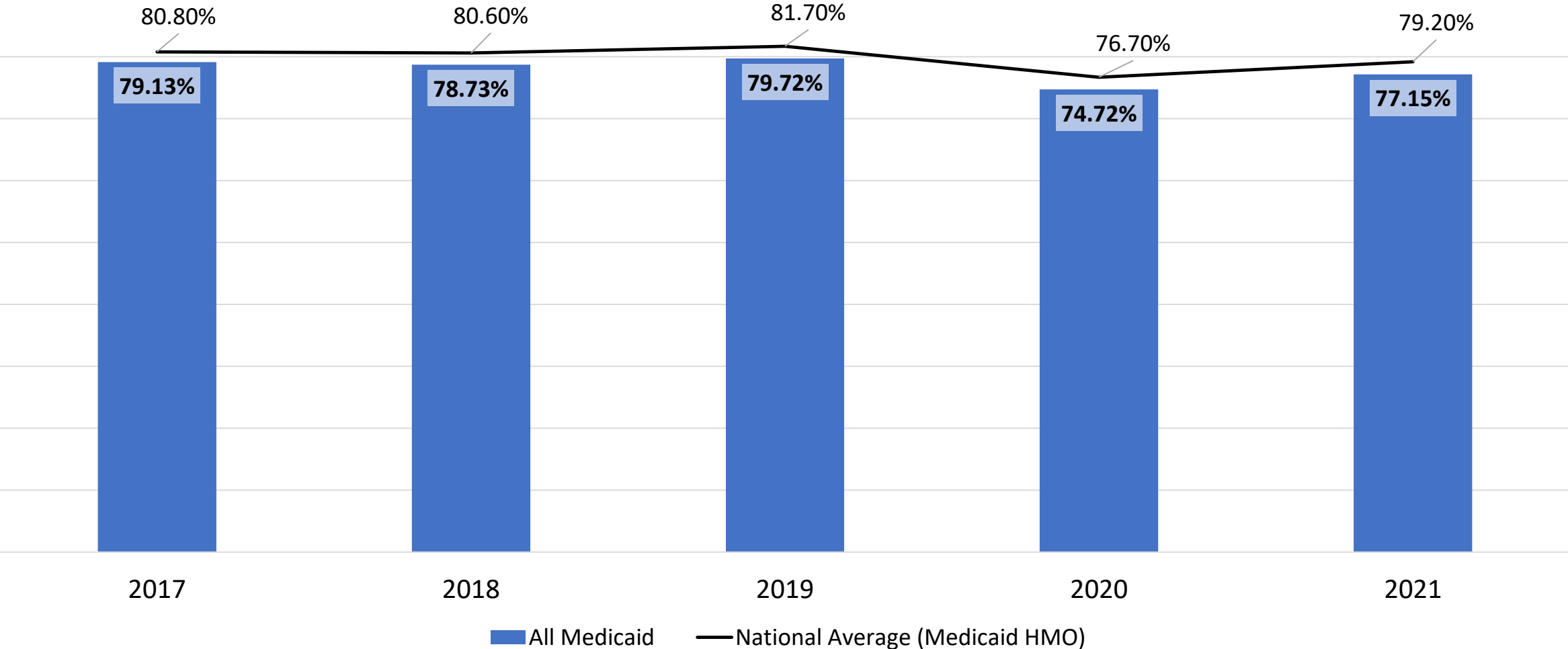
Group of interest is **XX%**
higher than reference group



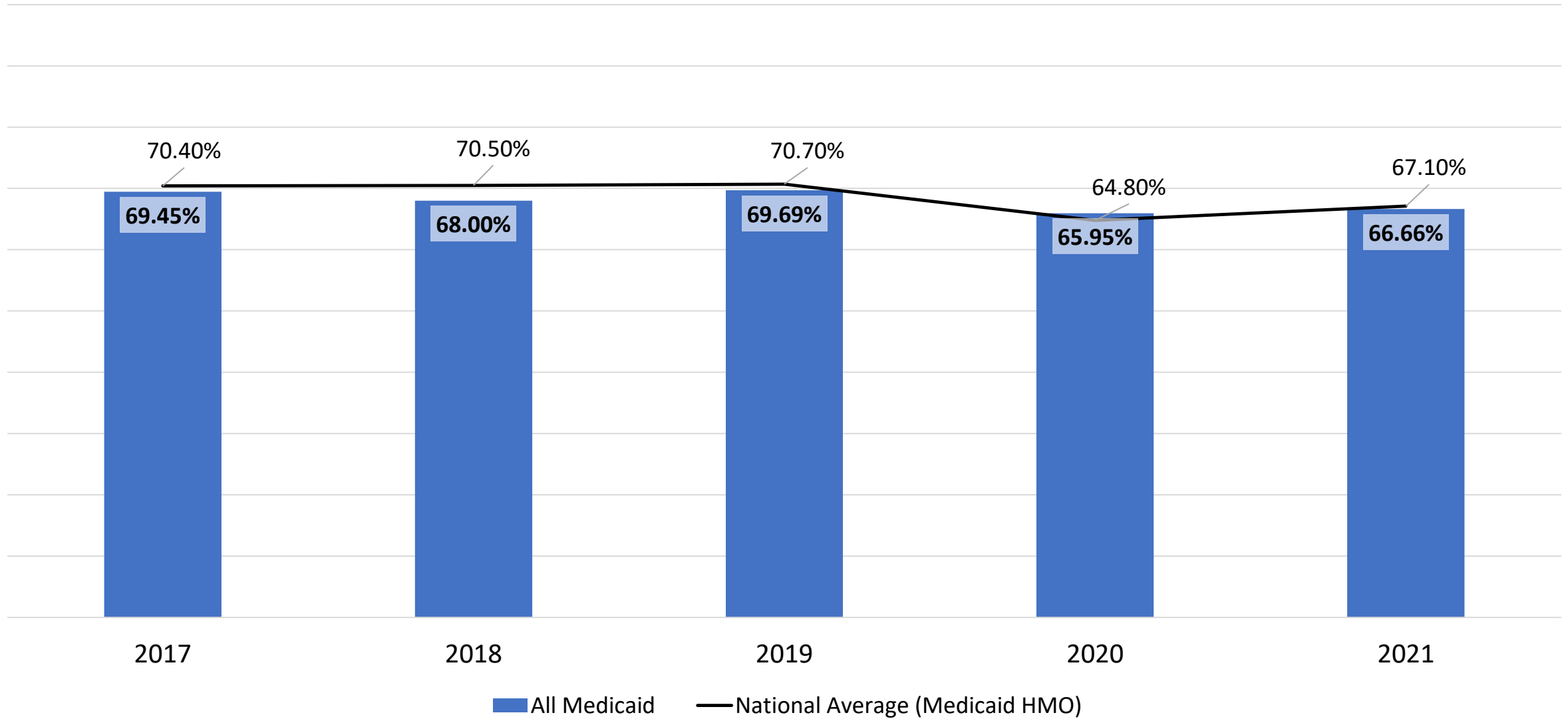
Group of interest is **XX%**
lower than reference group



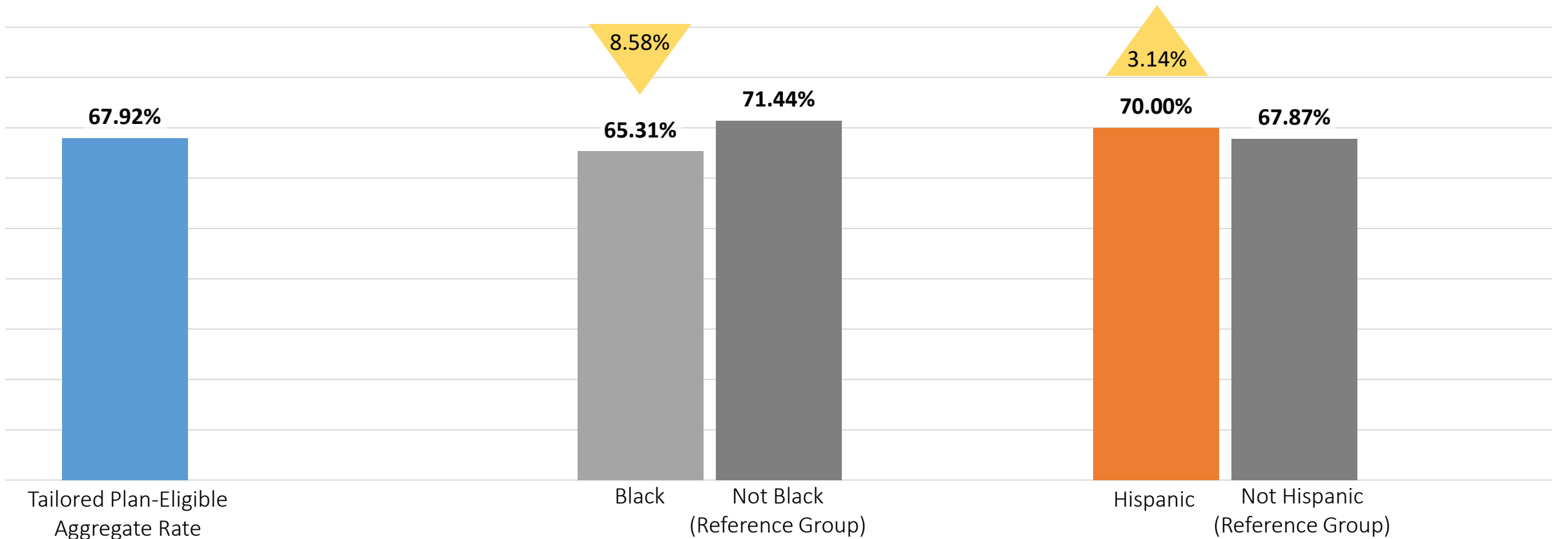
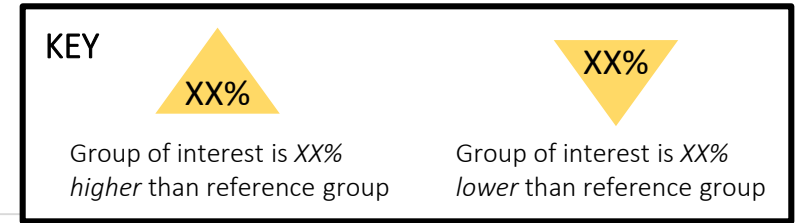
Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD), All Medicaid (CY 2017-2021)



Diabetes Monitoring for People with Diabetes and Schizophrenia (SMD), All Medicaid (CY 2017-2021)



Tailored Plan Demographic Variance for Diabetes Monitoring for People with Diabetes and Schizophrenia (SMD) (CY 2021)



Diabetes Quality Measures with Suppressed Data

Measure Name	Steward/NQF #	Measure Description	Additional Measure Information	Data
Hemoglobin A1c (HbA1c) Control for Patients with Diabetes (HBD)	NCQA / #0059	The percentage of members 18–75 years of age with diabetes (types 1 and 2) whose hemoglobin A1c (HbA1c) was at the following levels during the measurement year: <ul style="list-style-type: none"> HbA1c Control (<8.0%). HbA1c Poor Control (>9.0%). 	<ul style="list-style-type: none"> AMH Measure Standard Plan and Tailored Plan measure CMS Adult Core Measure 	Requires clinical data from NC HealthConnex. Current rates are not an adequate representation of NC Medicaid performance.
Blood Pressure Control for Patients with Diabetes (BPD)	NCQA / #0061	The percentage of members 18–75 years of age with diabetes (types 1 and 2) whose blood pressure (BP) was controlled (<140/90 mmHg) during the measurement year.	<ul style="list-style-type: none"> Department-calculated measure for Standard Plans and Tailored Plans 	Requires clinical data from NC HealthConnex. Current rates are not an adequate representation of NC Medicaid performance.
Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) (HPCMI)	NCQA / #2607	The percentage of patients 18–75 years of age with a serious mental illness and diabetes (type 1 and type 2) whose most recent HbA1c level during the measurement year is >9.0%.	<ul style="list-style-type: none"> Department-calculated measure for Standard Plans and Tailored Plans CMS Adult Core Measure 	Requires clinical data from NC HealthConnex. Current rates are not an adequate representation of NC Medicaid performance.

Pharmacy Thoughts

- July 2020 the State started covering Therapeutic Continuous Glucose Monitor supplies at Point-of-Sale to increase access to patients.
 - Currently there are around 1,073 claims per quarter for Therapeutic Continuous Glucose Monitor supplies at point of sale
- July of 2022 the State added Omnipod 5 to Preferred Drug List (PDL)(Omnipod is a tubeless insulin delivery device.)
 - Adding these supplies to the PDL allows beneficiaries to get their supplies at Point-of-Sale pharmacies which increases access points.
- The North Carolina Division of Health Benefits Drug Utilization Review (DUR) Program monitors Medicaid outpatient pharmacy claims to identify beneficiaries who are receiving medications that exceed the manufacturers' dosing recommendations or may be at risk for adverse events.
 - Recently the Board reviewed Medicaid beneficiaries with coronary artery disease or heart failure and diabetes and no evidence of using a sodium-glucose cotransporter-2 (SGLT2) inhibitor.
 - After discussion and review of national guidelines the DUR Board requested the Division mail a communication to prescribers who have fee-for-service beneficiaries meeting these criteria.
 - In April 2023, the Division mailed letters to over 1,300 prescribers and requested they evaluate their beneficiaries' current medication regimen to determine if adding a SGLT2 inhibitor would be clinically appropriate to improve health outcomes.
- NC Medicaid is considering coverage of anti-obesity medications, including GLP-1 agonists, to help decrease the risk of co-morbid type 2 diabetes and decrease the economic burden of diabetes care.
- The NC Medicaid PDL Panel voted to add the authorized biologic for Lantus (insulin glargine) as preferred on the PDL

Diabetes and Managed Care: Improvement Plans

- Focus for 2020-2022 was Diabetes Poor Control (A1C >9)
- Interventions for plans included:
 - Outreach to members with poor control for education and support
 - Outreach to providers to encourage them to
 - Identify care gaps
 - Code correctly on claims
 - Monitor A1C more frequently
- System changes to collect more accurate data
- Increase Value Added Benefits to improve DM control (gyms, Weight Watchers, food support)

**Education**

- \$120 GED voucher, including GED testing, tutoring, and reading scholarships

Prenatal

- Up to \$450 in rewards for baby products; stroller, playpen, car seat, or diapers

Wellness

- \$75/year rewards gift cards
- 20% CVS discount card
- 24-week voucher for Weight Watchers®

Youth

- Boy Scouts, Girl Scouts and 4-H Club membership

Other

- Hearing aid (up to \$300)
- Up to \$120 yearly for over-the-counter drugs
- Cell phone with 350 monthly minutes, free texts, 3 GB data
- Rides to covered services for Health Choice members and rides to classes and events for all members

**Education**

- Up to \$160 GED exam voucher, materials, and life skills training

Prenatal

- Free electric breast pump
- Up to \$100 in rewards for baby products

Wellness

- \$75/year rewards gift cards
- 13-week voucher for Weight Watchers®

Youth

- \$75 yearly for membership at Boys and Girls Club or YMCA

Other

- \$100 yearly value in alternative healing, acupuncture, massage therapy
- Up to \$150 for hypoallergenic mattress cover and pillowcase for asthma
- Cell phone with free minutes, data, and texts
- 14 prepared home-delivered meals after a qualified hospital or nursing facility stay, if qualify

**Education**

- \$50 annual gift card for school supplies
- Up to \$160 GED exam voucher
- 24 hours of online tutoring for eligible members ages 6-18, if qualify

Prenatal

- 1 safe sleep kit yearly for members who are pregnant, members with infants under age 1, or members under age 1

Wellness

- Up to \$75 yearly rewards for doctor visits
- 13-week voucher for WW® (formerly Weight Watchers)
- 3 months of fresh fruits & veggies for qualifying members

Youth

- \$75 yearly for membership like Boys and Girls Club, Boy Scouts, or Girl Scouts
- Up to \$150 for after school activities

Other

- Cell phone with monthly data, minutes and bonus minutes
- \$20 Uber gift card for college students for grocery stores, local events

**Education**

- GED program with free practice and regular tests

Prenatal

- High-risk pregnancy home educational visits

Wellness

- \$75/year rewards gift cards
- Weight Watchers® membership for qualifying members

Youth

- Boys & Girls Club membership, ages 18 and younger
- Home visits, supplies for children with asthma, ages 2-18

Other

- Pain management education and support
- Extra pair of glasses and eye exam every 2 years, ages 21-64
- 2 meals per day for up to 7 days after hospital stay
- Smart phone with 350 minutes, unlimited texts, & 4.5 GB data per month

**Education**

- GED exam voucher, study materials
- \$75/year value school supplies, online tutoring, members grades PreK-12 before GED

Prenatal

- Up to \$100 per year for new mothers; car seat, diapers, diaper bag, breast pump, high-risk pregnancy visits

Wellness

- \$75 per year rewards card
- \$120 per year for approved healthy foods at Walmart®
- Up to 14 weeks of Weight Watchers® and online tools

Youth

- \$75 per year value after school sports/activities/youth club membership, ages 6-18

Other

- \$125/year for glasses, contacts for members ages 21 & up
- \$120/year per household for over-the-counter products
- Cell phone with 250 monthly minutes, free calls, texts

Questions? Go to ncmedicaidplans.gov. Or call us toll free at **1-833-870-5500** (TTY: 711 or RelayNC.com). We can speak with you in other languages.



North Carolina Diabetes Advisory Council

Upcoming DAC Meetings

Friday, October 27, 2023

(DAC Awards Ceremony and Reception)

In-Person at **The McKimmon Center for Extension and Continuing Education**
1101 Gorman Street, Raleigh, NC 27606

diabetesnc.com/diabetes-advisory-council



North Carolina Diabetes Advisory Council



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THANK YOU FOR ATTENDING!

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Contact DAC staff coordinator with any questions

Corissa Payton

Corissa.Payton@dhhs.nc.gov



North Carolina Diabetes Advisory Council