CIVITAS
Networks for Health®

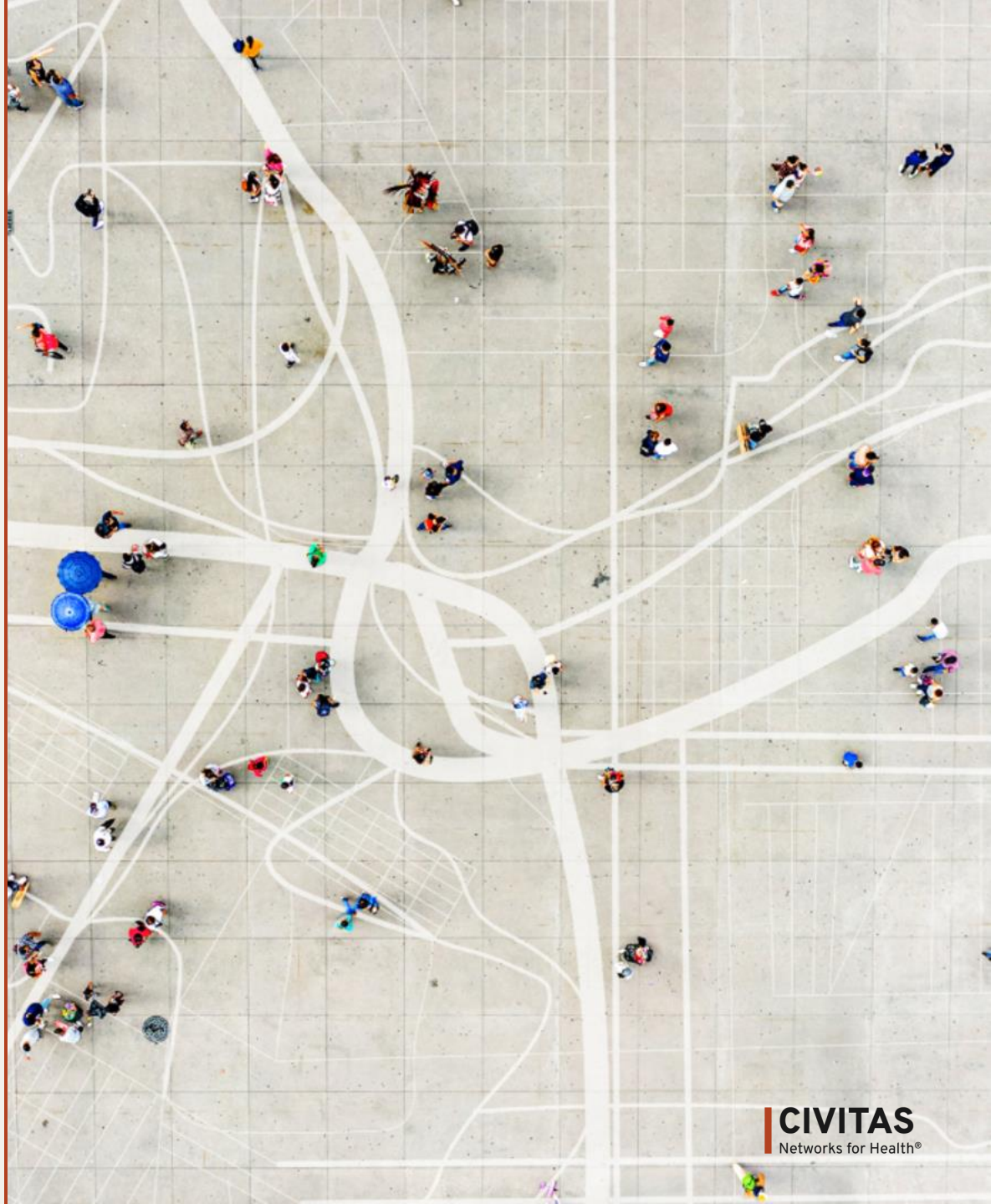
Bridging Public and Private: How Shared Data Infrastructure Is Closing the Gap in Care Transitions

Member-Led Webinar Presented by PointClickCare

August 6, 2026

Housekeeping Reminders

- This is a webinar where all participants are automatically muted and your video is not displayed.
- If you would like to ask a question, please use the Q&A function on the right-side taskbar.
- Please note that AI notetakers are not permitted and will be removed.
- This webinar is being recorded, and the recording will be shared after today's event.
- For questions following the webinar, please reach out to contact@civitasforhealth.org.

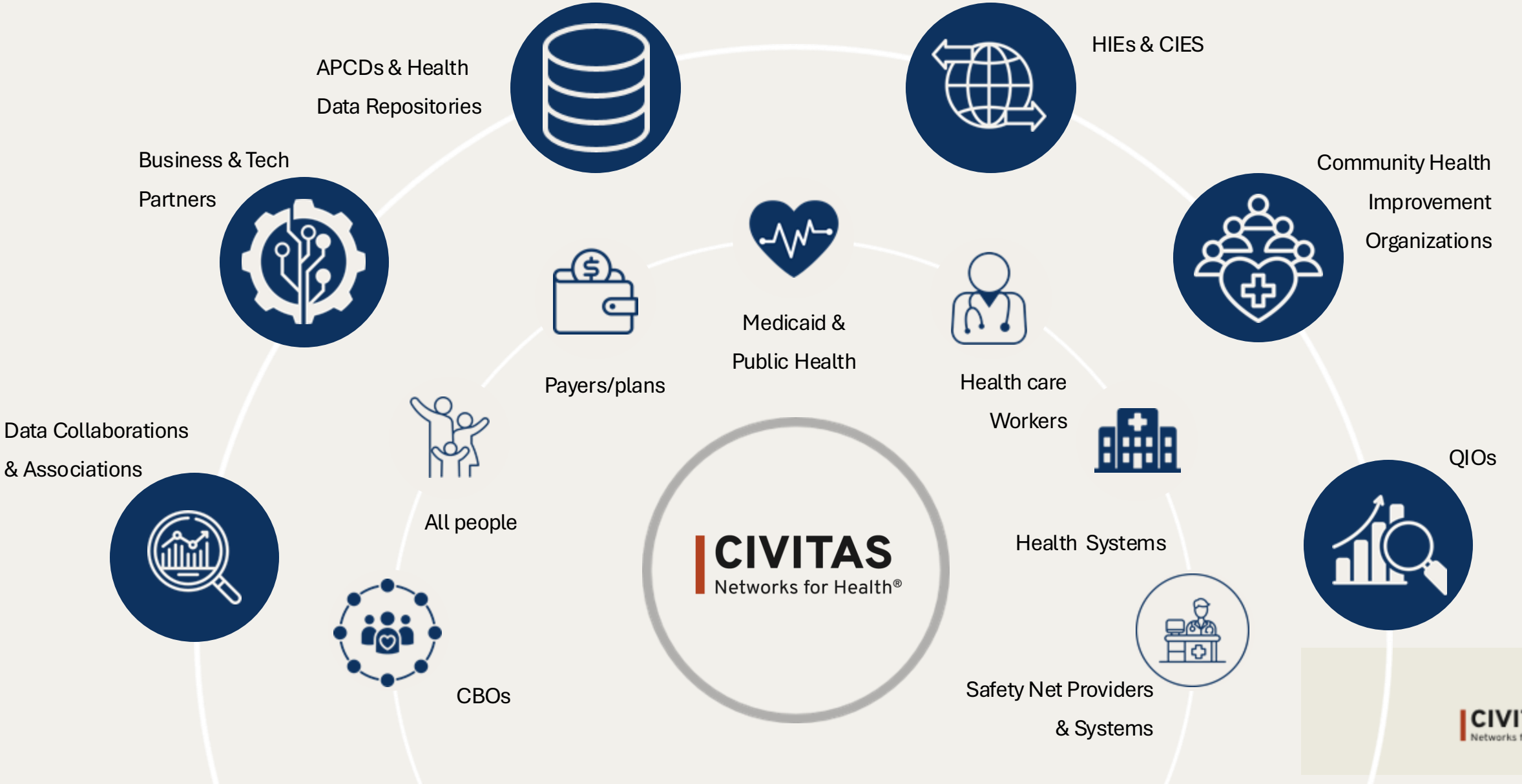


About Civitas Networks for Health®

Who we are, who we serve, and what we do

CIVITAS
Networks for Health®

The Network and Who We Serve



CIVITAS
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Expert Convenors

- Civitas provides a unique platform that connects collaborators working on health improvement across the country
- We believe that local communities should lead and influence national progress on health
- We offer forums for shared learning, education, networking, and advocacy, and have proven our strength at helping our members in the ever-changing health landscape

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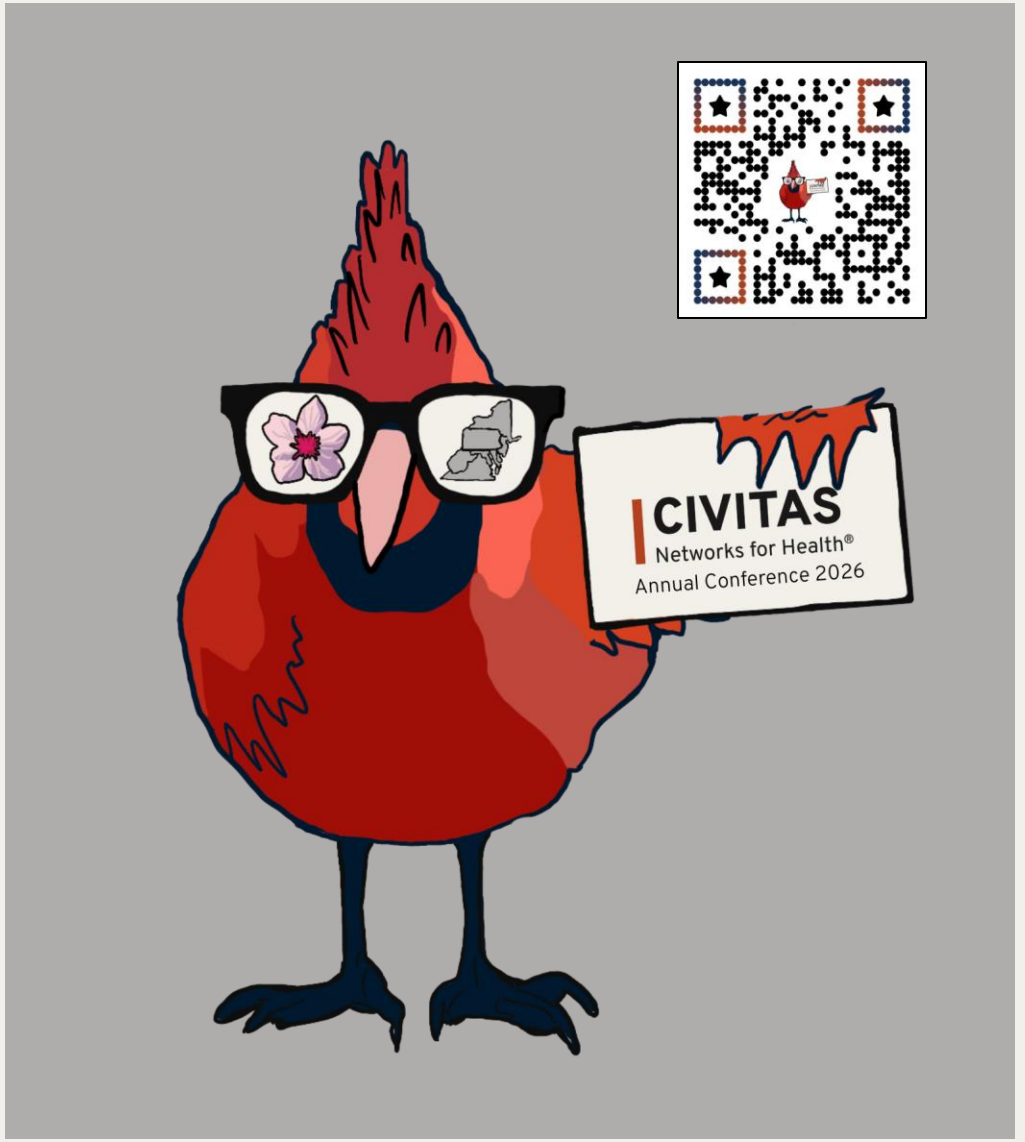
Only One Day Left of Early Bird Pricing for the Civitas 2026 Annual Conference is Open!

Join 750+ leaders from across the health data and improvement ecosystem. Hosted in collaboration with our Mid-Atlantic Host Committee, just minutes from Washington, D.C. in Arlington, VA.

- Registration is open – secure your spot today at a discounted rate (closes tomorrow, August 7)
- Plan early and save with discounted hotel and flight options.
- Interested in sponsoring? Get in front of a national audience shaping interoperability, data exchange, and health transformation. Review the Sponsorship Prospectus and email contact@civitasforhealth.org if you're interested in learning more.



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Submit a Community Excellence Award Nomination by August 31

The Civitas 2026 Community Excellence Awards recognize outstanding Civitas member organizations and individuals advancing community health through innovation, leadership, and partnership. These awards highlight impactful contributions in areas such as data use, quality improvement, governance, and mentorship. Please browse this year's award categories below and submit a Civitas member organization or one of your peers that you think exemplifies the award description.

Thank you in advance for helping us recognize the amazing organizations across our networks!

Learn more and submit a nomination by August 31 to be considered.

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Register to Attend Virtual Preconference Sessions (Open to the Public!)

Join us for virtual preconference sessions designed to deepen learning and spark meaningful discussion ahead of the Civitas Annual Conference. Register to attend:

- **August 12, 2-3:30 p.m. ET** – Building Healthier Communities Through Coordinated and Highly Collaborative Statewide Action
- **August 18, 2:30-4 p.m. ET** – Using Real-Time Data to Drive Proactive Postpartum SUD Care and Strengthen Rural Care Continuity
- **September 10, 3-4:30 p.m. ET** – From Data to Impact: Using APCD Analytics to Shape Policy and Improve Population Health
- **September 16, 2-3:30 p.m. ET** – Co-Designing Trusted CIEs: Privacy, Coordination, and Data Systems for Whole Person Health

Thank you to our returning virtual preconference sponsor, J2 Interactive!

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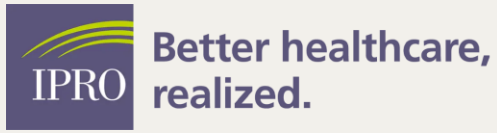
Thank You to Our Civitas 2026 Annual Conference Upgrade Sponsors



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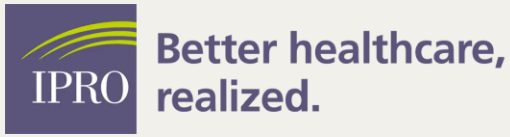
...And Thank You to Our Civitas 2026 Annual Conference Silver & Host Committee Sponsors



CIVITAS NETWORKS FOR HEALTH WEBINAR

Bridging Public and Private:

How Shared Data Infrastructure is Closing the Gap in Care Transitions

Phil Beckett · CEO, Texas Health Services Authority
Jennifer Quereau · Market Director, PointClickCare

THSA
Texas Health Services Authority
+ PointClickCare®

YOUR PRESENTERS

Two sides of one partnership

Phil Beckett

CEO, Texas Health Services Authority

Brings the state view: the quasi- governmental governmental HIE chartered by the Texas Legislature to move health data securely across across the state.

Jennifer Quereau

Market Director, PointClickCare

Brings the private-sector view: the acute and and post-acute data network that follows patients between hospitals and skilled nursing nursing facilities.

WHERE WE'RE HEADED

One shared goal in three parts

01

The Visibility Problem: Care Handoffs Happen Blind

Where patients move and where the data doesn't

02

What We're Doing in Texas

THSA + PointClickCare, and the impact so far

03

Where This Goes Next

Visions of future collaboration

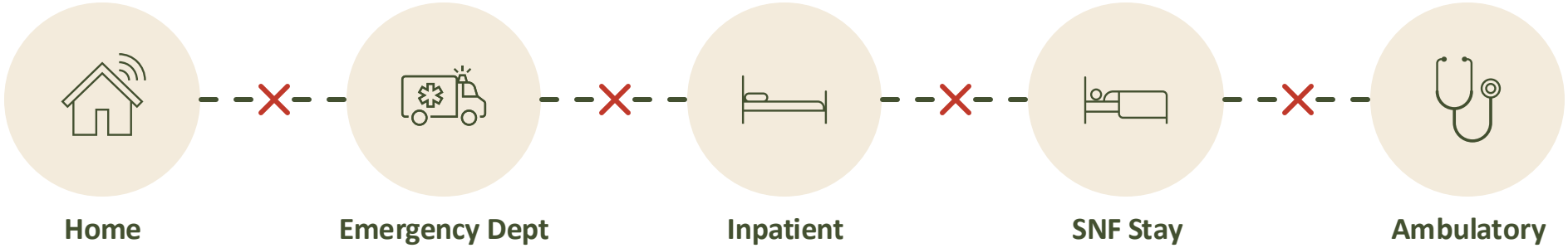
01

The Visibility Problem

High-risk patients move constantly between acute and post-acute care — and almost no one can see the whole journey.

THE STRUCTURAL GAP

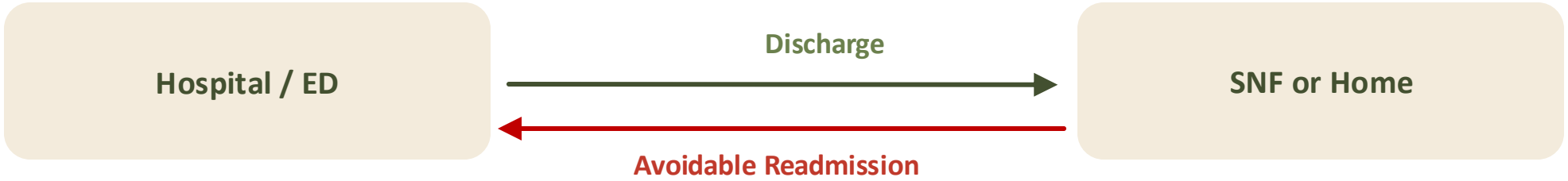
Care Handoffs Happen Blind



The patient moves. The record doesn’t.

THE COST OF THE GAP

When the record stalls, the patient comes back



78%
Are Avoidable Readmissions

23.5%
Readmitted within 30 days

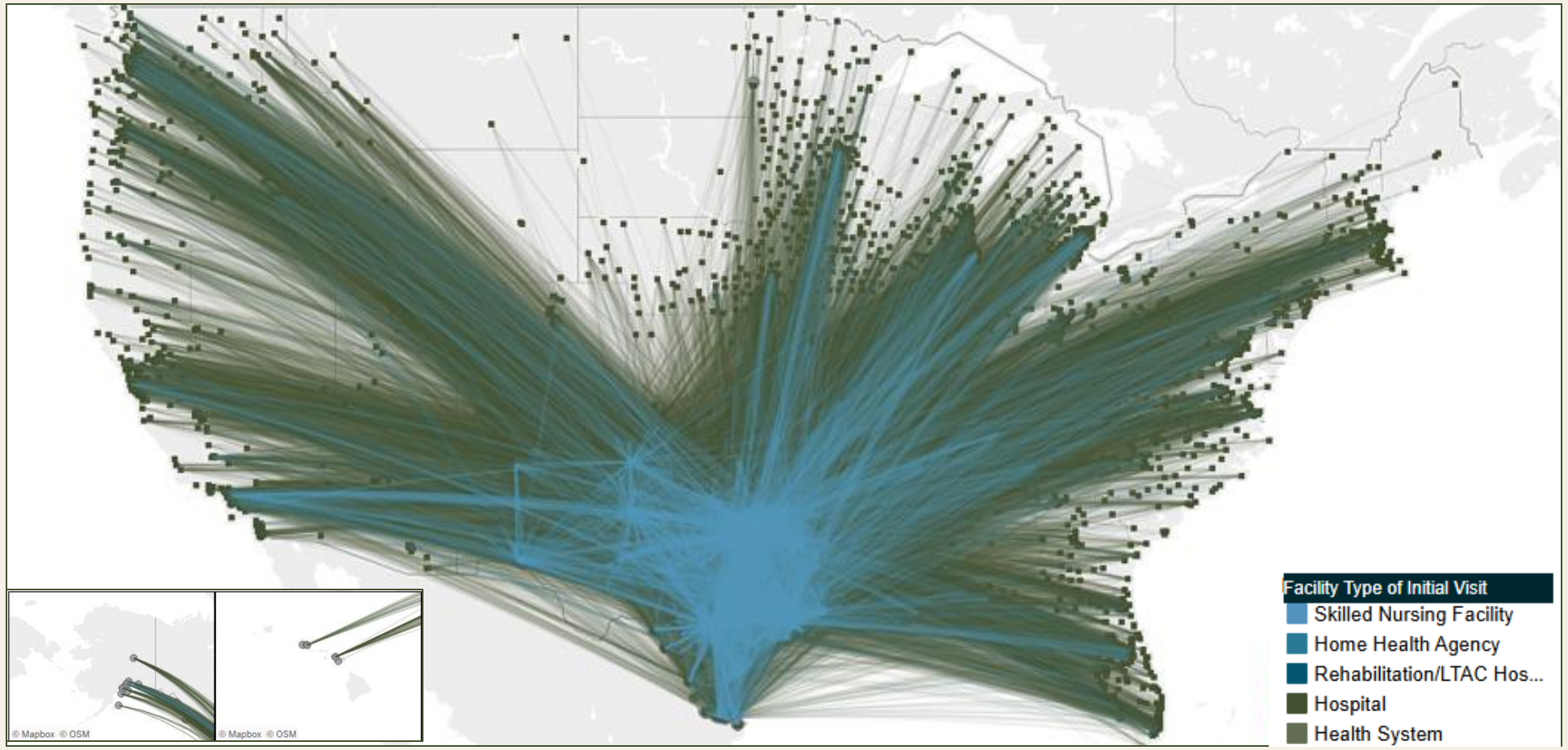
~$15k
Average cost for each readmission

Sources: CMS SNFRM; HealthStream; AHRQ/HCUP.

PATIENT MOVEMENT

Patients don't stay in one place

A single high-risk patient can pass through multiple EDs, hospitals, a skilled nursing facility, and home health in a matter of weeks, often across different organizations and even states.



14,425,681
visits within Texas

443,943
visits outside Texas

This map shows travel between facilities on the PointClickCare network between August 2025 to August 2026 for patients with an initial visit in Texas.

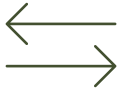
PointClickCare

WHY IT MATTERS

The frequency and cost of blind transitions

When the record doesn't travel with the patient, the risk does.

01 · HOSPITALS TRY



57%

%

of hospitals made some level of effort to effort to exchange clinical data with with long term care facilities.

02 · IT BREAKS DOWN

83%

of post-acute facilities report problems caused by inadequate information from the hospital.

03 · PATIENTS PAY

71%

of patients transferred to a SNF arrive with at least one medication discrepancy.

Kruse et al. Applied Clinical Informatics 2018 · Jones et al., JAMDA 2017 · Tjia et al., JGIM 2009.

25%

of Medicare SNF patients are readmitted to the hospital

"One in four hospitalized Medicare beneficiaries makes the complicated transition to skilled nursing facilities (SNFs) for post-acute care, and these transitions are becoming more common. **Nearly 25% of these patients will be readmitted to the hospital…"**

Valverde et al. Journal of General Internal Medicine 2021

02

What We're Doing in Texas

A public–private partnership connecting acute and post-acute encounter data across the state.

THE PUBLIC PARTNER

Texas Health Services Authority

A quasi-governmental authority created by the Texas Legislature in 2007 to move health data securely across the state. It is the backbone connected to Texas Medicaid, and its board is appointed by the Governor of Texas.

Interoperability Collaborative

A facilitated forum for a free and open discussion of diverse opinions on how to implement HIE in Texas. Monthly general meetings with workgroup committees tackling specific interoperability issues.

EDEN

Real-time encounter notifications pushed to providers and payers when a patient arrives at, moves between, or leaves facilities. Care teams act on transitions as they happen, not days later.

PULSE

Patient lookup for disaster response and displaced individuals. Supports treatment at temporary care sites, family reunification, and locating evacuated patients for their care teams.

SECURE Texas

Privacy and security certification program for Texas covered entities that demonstrates compliance with state and federal privacy and security rules. Certification is weighed positively by courts in the event of a breach.

REACH TODAY

The EDEN Network

What is EDEN?

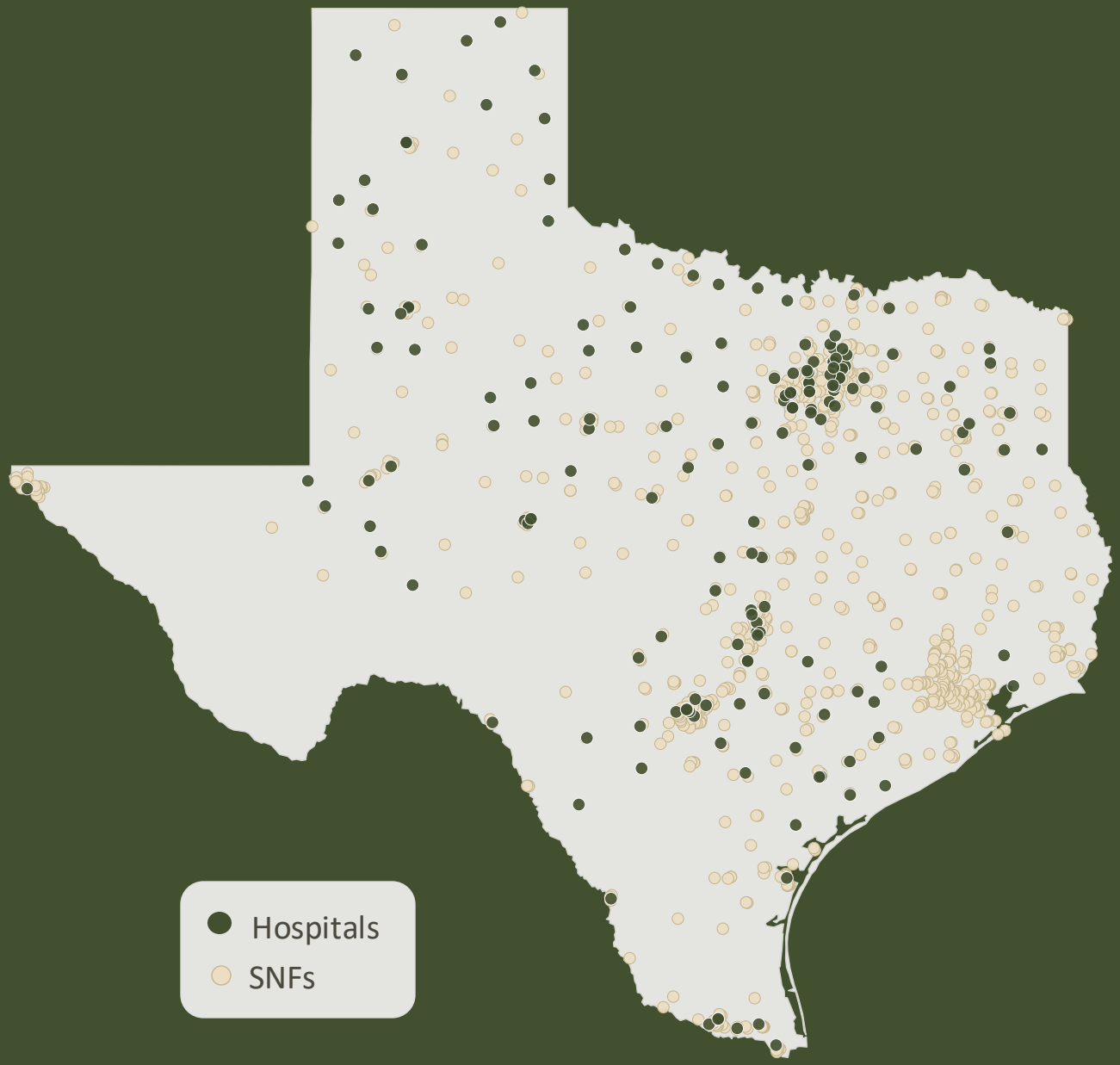
- A portfolio of solutions giving providers real-time notice of patient encounters across acute and post-acute facilities in Texas.
- Facilities send admit-discharge-transfer (ADT) messages in real time, matched against subscriber patient lists.
- When a listed patient gets care, subscribers receive an alert with that encounter's details.

320
Acute Hospitals

995
Post-Acute Facilities

19
Behavioral Health Hospitals

200
Counties Covered

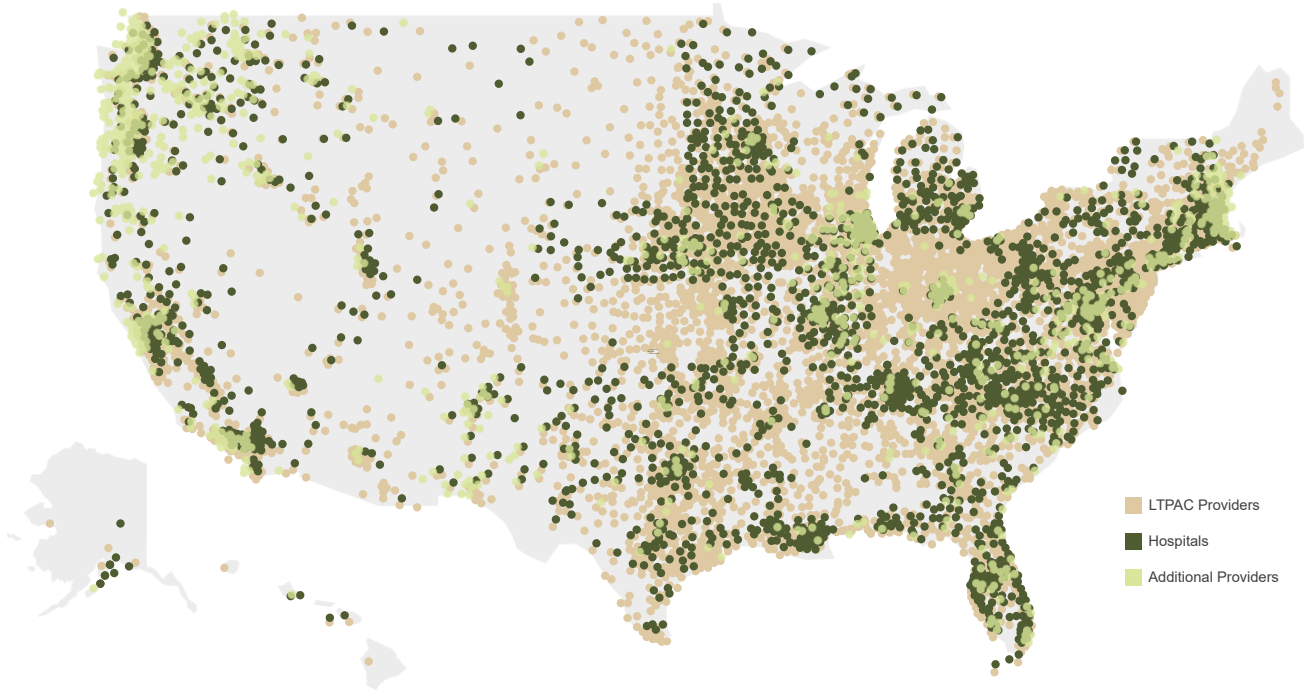


The PointClickCare Network Today

2,800+
Hospitals

350+
ACOs & Risk-Bearing Provider Organizations

3,600+
Ambulatory Clinics



27,000+
Long-Term & Post-Acute Care Providers

70+
State & Government Agencies

Every
Major U.S. Health Plan

400+ integrated solutions as part of the Marketplace

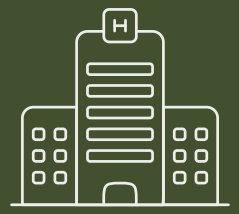
105M+ health plan lives

100+ national and regional association partnerships with organizations such as CMS, AHCA, Argentum, LeadingAge, HIMSS, and AHIP

THE PARTNERSHIP

How the data flows

ACUTE CARE



EDEN Hospitals

Hospital EHRs

National Networks
CCD document querying

THSA Statewide HIE
Texas health information exchange

PCC National Care Collaboration Network

POST-ACUTE CARE

Texas PCC SNFs

PCC SNF EHR

Care Coordinators
Coordinators

Work the shared record across every channel to manage
manage transitions of care

$8.6M

saved for Texas Medicaid in a single year — — because facilities on EDEN had fewer potentially preventable readmissions and ED ED visits.

Analysis of Texas Medicaid data, THSA 2025 Annual Report ($8,679,115.96). Network growth is anticipated to continue increasing the impact.

“I am on a mission to get this changed and would like to speak to someone in authority that can answer some questions on the ACTUAL implementation and use of the medical information sharing that is being rolled out in Texas. I have a call with a legislator next week and would like to provide real numbers and the roadblocks you have experienced trying to roll out your information sharing software and getting hospitals on board.

It is one thing to say you have this process going, it is another thing to get everyone on board so that another young mother does not die.

Let's work together.” – Yvette Buich

Lessons Learned from Statewide Collaboration

Neither side could do this alone

Trust

A neutral, state-chartered authority provides the governance and consent framework providers can rely on.

Adoption

The private EHR is already in daily use in post-acute settings. No new system for providers to learn.

Sustainability

Shared infrastructure and demonstrated provider and payer savings make the model durable, not grant-dependent.

WORKFLOW SOLUTIONS

Turning shared data into action

EDEN Portal

Providers, ACOs, and Payers get ADT event notifications pushed to alert care coordination staff.

PCC Connect

Clinical data flows into the receiving SNF EHR — no paper packet, no manual re-entry.

Emergency Department IQ

Surfaces a concise SNF-stay summary inside the hospital's ED trackboard the moment a patient returns to the ED.

PAC Management IQ

Monitor patients across multiple SNF facilities from a single view.

Reason-for-Transfer AI

A proprietary model flags why a patient is transferring, drawn from the post-acute record.

Access to data alone isn't enough: a hospital–SNF data portal showed no drop in readmissions until the information was built into the workflow — Cross et al., Health Services Research, 2019.

"We've seen a clear impact from **Emergency Department IQ** and **the SNF Summary**. It brings key patient information directly into our clinicians' workflow, helping them make faster and more confident decisions. In just a few weeks, we reduced readmissions by about 33 percent, avoided 120 unnecessary inpatient admissions, and cut ED length of stay by almost an hour. That's a big deal for our staff and our patients. **When SNF residents arrive without context, we're often flying blind. This solution closes that gap in real time and helps us deliver better care, avoid unnecessary inpatient stays, and make sure patients are admitted quickly when needed.**"

Patrick McGill, MD MBA FAAFP

Chief Transformation Officer, Community Health Network

“**PAC Management IQ** has become an integral part of our team. It's always there, never gets sick, and it helps us be proactive in patient care. **The most valuable impact is having real-time insight into what's happening with our patients, allowing us to catch significant changes and collaborate with SNFs to prevent avoidable ED visits and readmissions.** It's a feel-good moment knowing that we're making a real difference in patients' lives and supporting our SNF partners.”

Samantha Caruso

Manager, Care Manager, Ascension Illinois

03

Where This Goes Next

Models for public–private partnership — and a shared vision for the data underneath them.

As a patient, health system, health plan, clinic, or rural hospital, I should expect to be able to receive standardized data of a specific type through a single pipe.

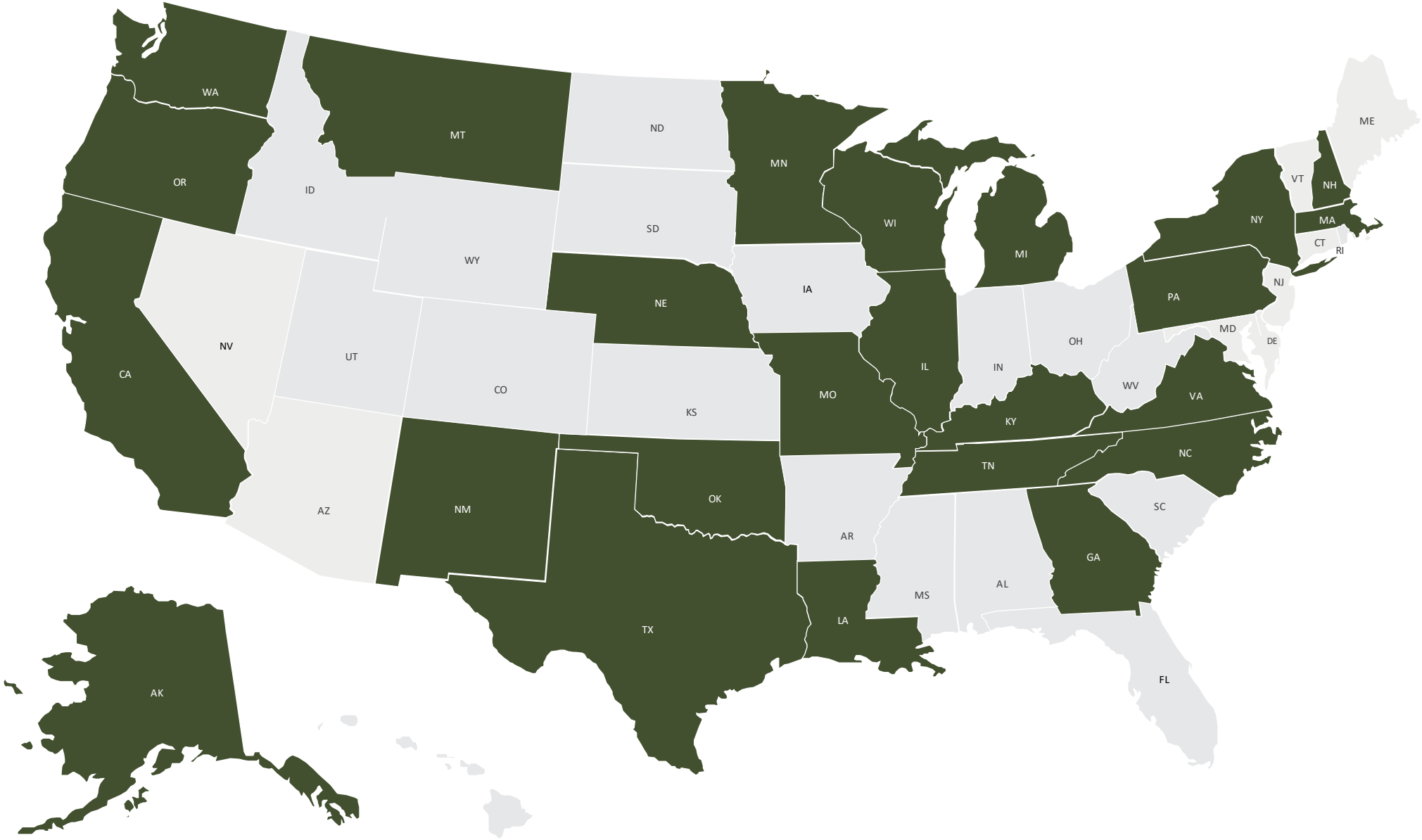
That might include:

- Authorization – the ability to opt in or out in one place
- Record locator service – what are the record locations associated with an individual stored
- Event notifications – what is happening real-time
- Clinical data – query or push, with high data-useability

There should be pipe options – whether that is an HIE, PointClickCare or a national network, so that a data consumer can select the one that best fits their needs. **Networks, or pipes, should compete on services and insights, not on data siloes or monopolies that force consumers to connect to multiple sources.**

PCC Vision: Grow the National Care Collaboration Network

We currently partner with organizations in 24 states, and we plan to maintain and grow partnerships in as many states as possible.



PointClickCare®

TAKE IT HOME

What this means for your community

Partner beyond your walls

You’ re already the trusted convener. Extend that trust to reach post-acute care.

Close the post-acute gap

Connect where patients go after the hospital, not just the hospital.

Prove it in payer data

Savings you can show are what make the work sustainable.

Let’s map your community’s post-acute network together.

Thank you.

Let's advance cross-sector collaboration in your community — questions welcome.

Jennifer Quereau · Market Director, PointClickCare
Phil Beckett · CEO, Texas Health Services Authority

THSA + PointClickCare®
Texas Health Services Authority

Stay in Touch with the Civitas Team

www.civitasforhealth.org

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