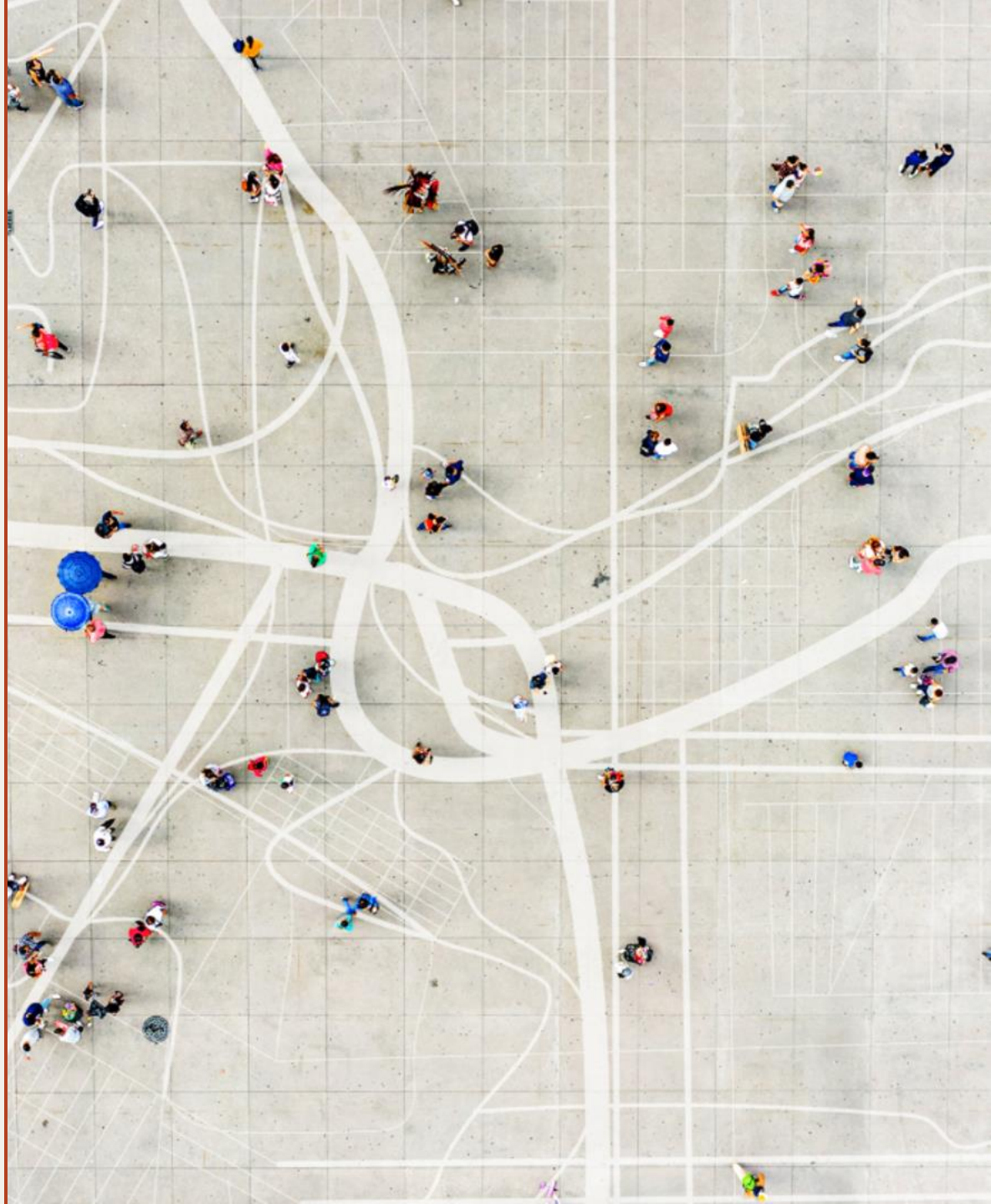
Building Healthier Communities Through Coordinated and Highly Collaborative Statewide Action

Civitas 2026 Annual Conference: Virtual Preconference Session

Sponsored by: J2 INTERACTIVE

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.
- 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.



Agenda

- Welcome – Civitas Team
  - Jolie Ritzo, CEO, Civitas
- From Doulas to Data: How North Carolina is successfully Transforming Maternal Health Outcomes for It
  - Shawn McCartt, Senior Consultant, J2 Interactive
  - Anita Valiani, Health Analytics & External Services Lead, NC DIT HIEA
  - Jennifer Tang, Professor, UNC Department of OB-GYN
  - Rachel Peragallo Urrutia, Associate Professor, General Obstetrics, Gynecology, and Midwifery, UNC Department of OB-GYN
- Advancing SDOH Through Cross-State Collaboration
  - Tessa McInnis, Manager, SDOH Technology, Contexture
  - Kelly McGann, Director, SDOH, Contexture
- State Directed Payments to Drive Multi-Year Maternal and Behavioral Health Improvements
  - Gabe Malseptic, Senior Consultant, Public Consulting Group
  - Dak Ojuka, Consultant, Public Consulting Group
- Discussion & Q&A

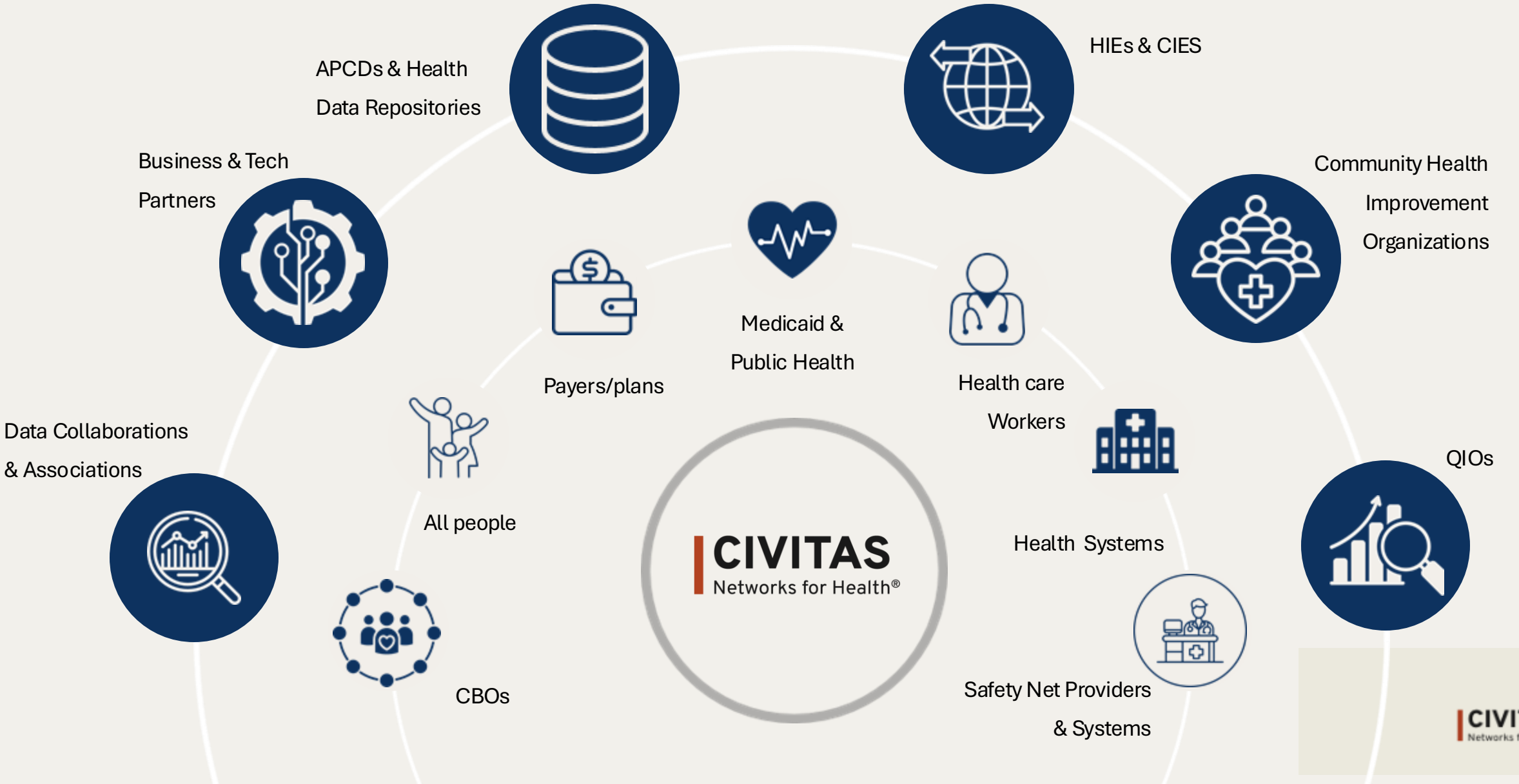
About Civitas Networks for Health®

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

Who We Are

- Civitas members include a wide range of organizations:
  - Health Information Exchanges (HIEs)
  - Health Data Utilities (HDUs)
  - Community Information Exchanges (CIEs)
  - Regional Health Improvement Collaboratives (RHICs)
  - All-Payer Claims Databases (APCDs)
  - Quality Improvement Organizations (QIOs)
  - Strategic Business and Technology Partners
  - Affiliated Associations
- We work together at the local, regional, state, and national levels
- Together, we invest in data-driven multistakeholder collaboration to enhance health, addressing cost, equity, quality, and safety

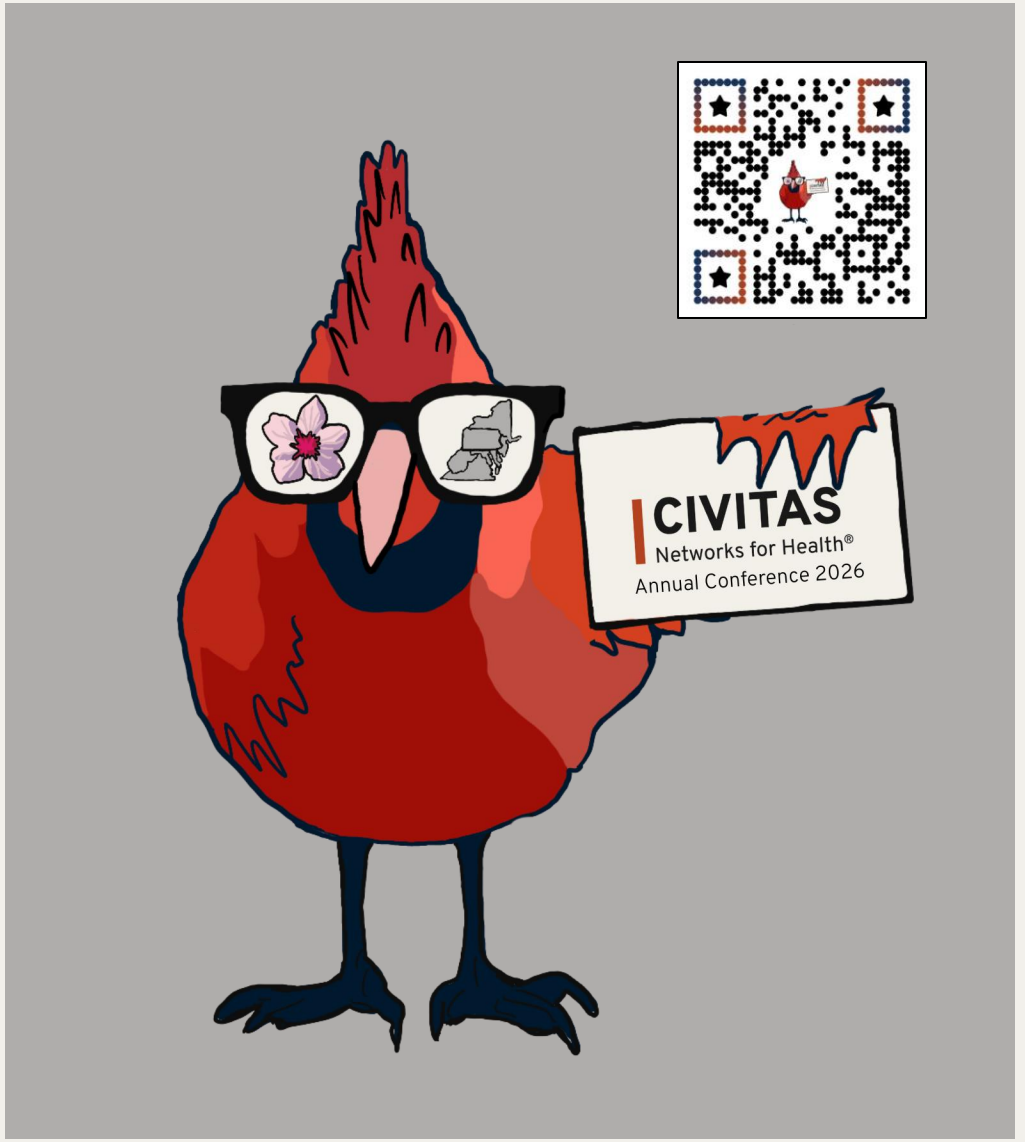
Who We Serve


APCDs & Health
Data Repositories
HIEs & CIES
Business & Tech
Partners
Community Health
Improvement
Organizations
Medicaid &
Public Health
Payers/plans
Health care
Workers
Data Collaborations
& Associations
All people
QIOs
CIVITAS
Networks for Health®
Health Systems
CBOs
Safety Net Providers
& Systems

Join Us at the Civitas 2026 Annual Conference!

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!
- Plan early and save with discounted hotel and flight options.
- Interested in sponsoring? We still have a select few opportunities available for you to 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.



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.

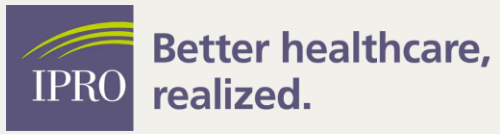
Register to Attend Virtual Preconference Sessions (Open to the Public!)

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

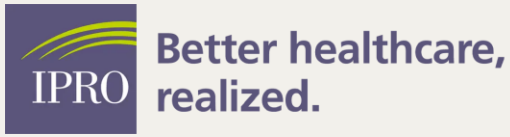
- **August 18, 2:30-4 p.m. ET** – Using Real-Time Data to Drive Proactive Postpartum SUD Care and Strengthen Rural Care Continuity
- **September 10, 3-4:30 p.m. ET** – From Data to Impact: Using APCD Analytics to Shape Policy and Improve Population Health
- **September 16, 2-3:30 p.m. ET** – Co-Designing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

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

Thank You to Our Civitas 2026 Annual Conference Upgrade Sponsors



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



ACURE4Moms

Accountability for Care through Undoing Racism and Equity for Moms

A collaboration to improve maternal health outcomes

ACURE4Moms
Accountability for Care through Undoing Racism & Equity

NC HealthConnex
Powering Health Care Outcomes

J2 INTERACTIVE

The University of North Carolina at Chapel Hill

sas

The Dream Team

Anita Valiani
Health Analytics Lead
NC HIEA

Shawn McCartt
Senior Consultant,
J2 Interactive

Jennifer Tang, MD, MSCR
Professor,
UNC Dept of OB-GYN

Rachel Peragallo Urrutia, MD
Associate Professor,
UNC Dept of OB-GYN

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ACURE4Moms Explained

- **ACURE4Moms is a study** designed by the University of North Carolina and implemented in prenatal practices across NC, in collaboration with N.C. Health Information Exchange Authority (NC HIEA), with technical support from J2 Interactive and SAS.
- **Goal:** Decrease pregnancy complications for all women, centering on Black women, by improving data accountability and community-based social support.
- **Evaluation:** 39 prenatal practices across NC participated in a cluster randomized controlled trial, randomized to 1 of 4 study arms:
  1) Standard Care Management (Control Arm) – 9 practices
  2) Data Interventions-Only (Data Arm) – 9 practices
  3) Community-Based Doula Support-Only (Doula Arm) – 11 practices
  4) Data Interventions + Doula Support (Data + Doula Arm) – 10 practices

ACURE4Moms
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ACURE4Moms Study Aims & Outcomes

- Aim 1: Compare proportion of Black women who deliver a **low birthweight** baby between Arms (**Primary Outcome).**
  - Secondary: **Maternal Morbidity and Mortality**
- Aim 2: Compare **# of ED visits and hospitalizations** during pregnancy and up to 1 year after delivery between Arms.
- Aim 3: Explore trends in **self-reported racism** during pregnancy and up to 4 months after delivery between Arms through patient surveys.

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Community-Based Doula Arms (3 and 4)

- Community-Based Doula support
  - Reduces Cesarean section, pain medication and improves satisfaction with birth
  - Associated with ↓LBW in Greensboro
- Linkage between the practice and community-based doulas → Quarterly meetings together
- Practices refer patients at high risk for low birth weight for doula support, prior to 28 weeks gestation
- Doulas support up to 6 births per month/clinic x 2 years
  - Prenatal support
  - Birth Support
  - Postpartum support

maame
Mobilizing African American Mothers through Empowerment

Momma's Village
Fayetteville

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ACURE4Moms Development

- NC HIEA staff began work with the ACURE4Moms team and technical partners weekly to work on project deliverables.
  - Use NC HealthConnex data for key maternal health and quality of care indicators from HealthInsight
  - Hold quarterly meetings to present data to practice through Maternal Health Equity Education & Training (MHEET) sessions
  - Build the Maternal Early Warning System, powered by NC*Notify, which flags patients who are missing key preventive services or have a risk factor for low birthweight.

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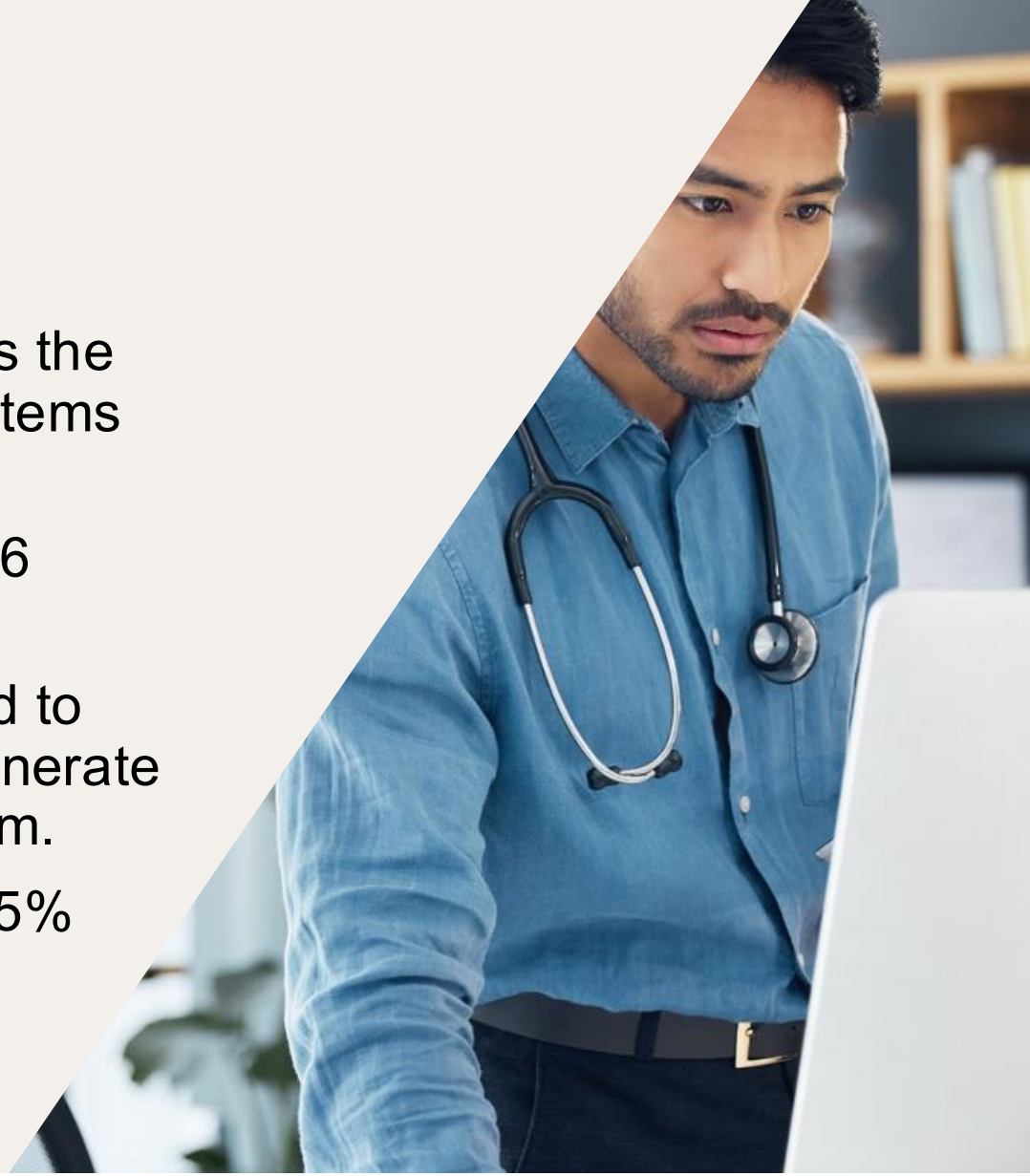
Technical Development

- Data collected from thousands of providers across the state is aggregated in near-real time into InterSystems HealthShare HealthInsight.
- Information is then queried for a set of criteria for 6 different maternal health alerts.
- UNC Sheps assembles the panels which are used to match patients from NC HealthConnex data to generate the alerts. Alerts show up in PointClickCare system.
- Alerts built from previously designed systems, ~85% clinician response rate.



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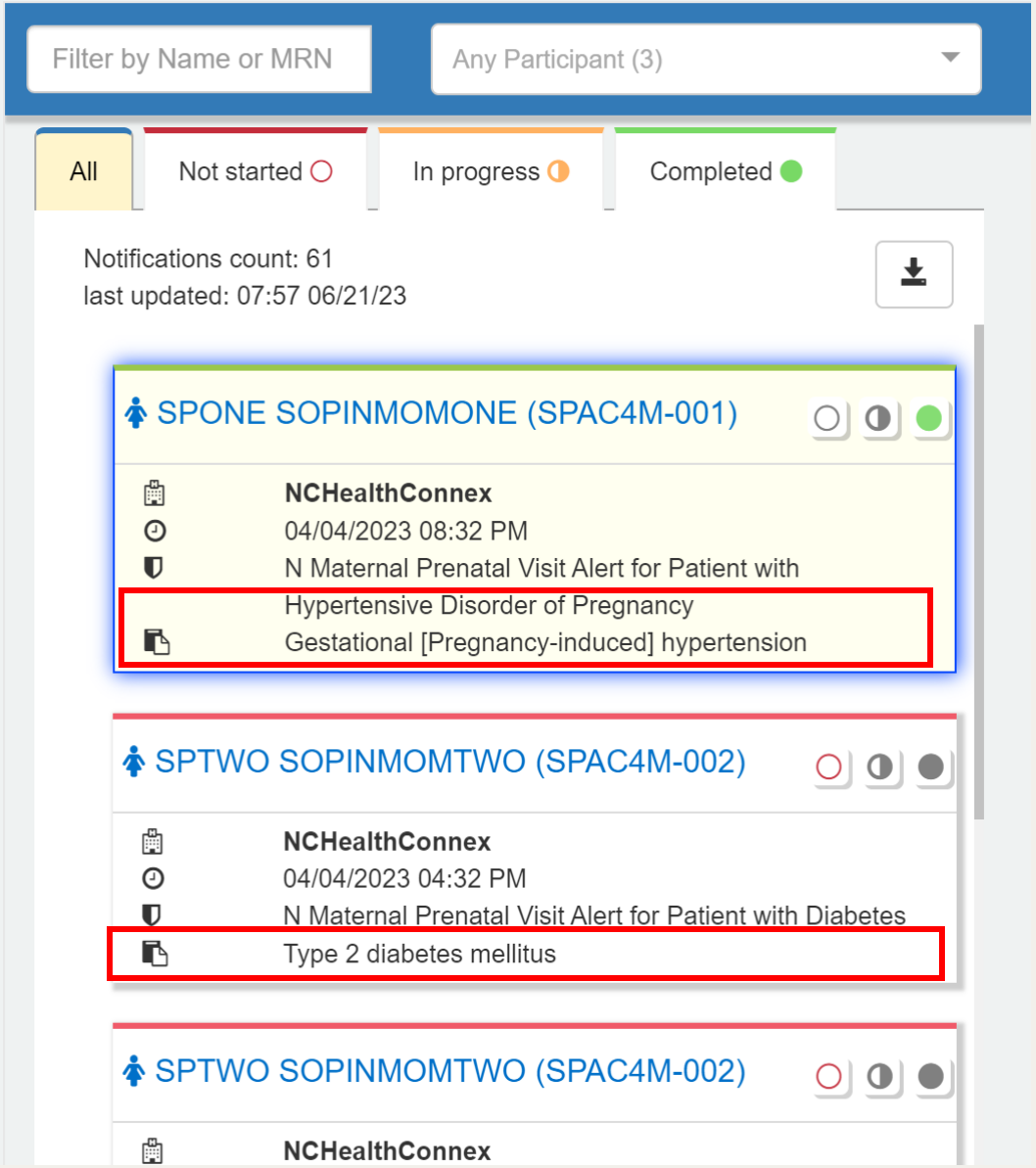
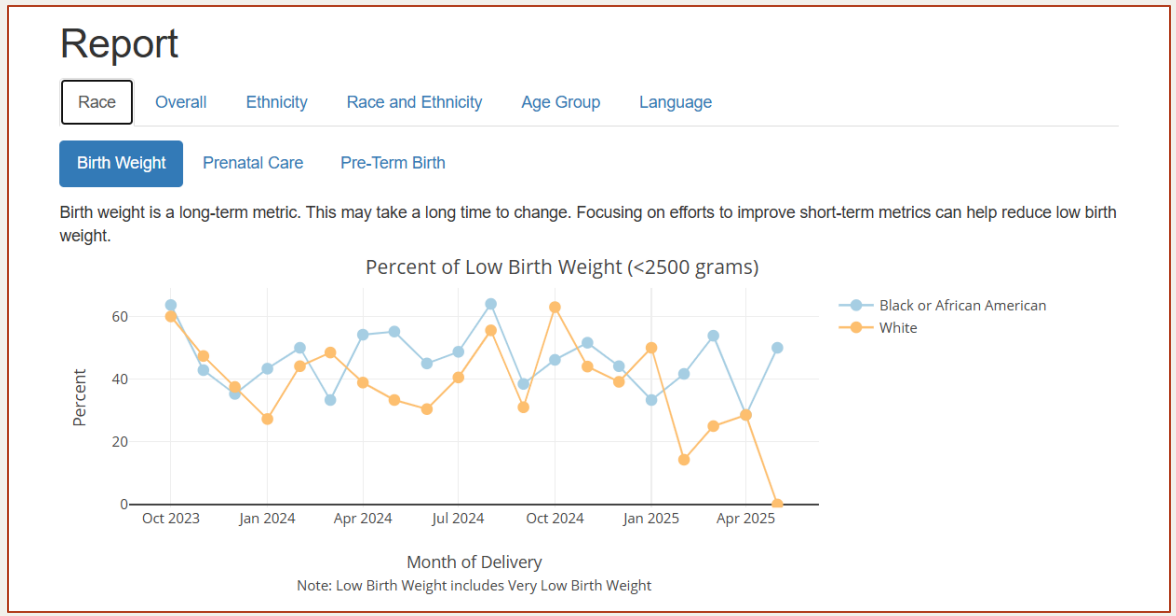
Maternal Alerts

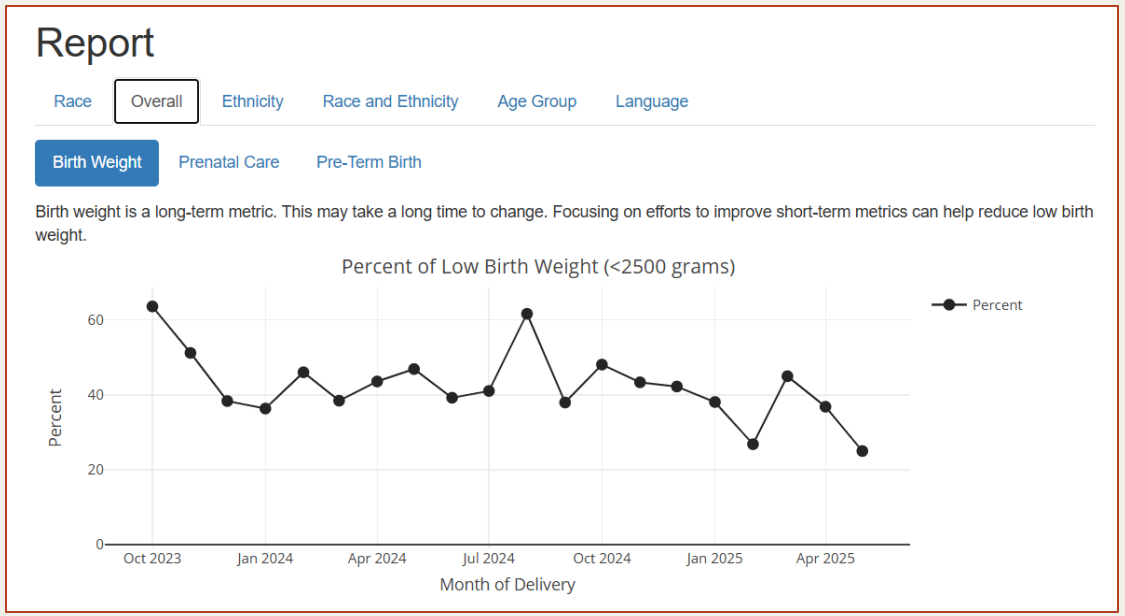
Alerts were built from previously designed systems and had 85% clinician response rate.

- High BP Alerts
- CRITICAL High BP Alerts
- Missed Follow-up Visit for High BP
- Missed Prenatal Visit Alerts
- Aspirin Alerts



ACURE4Moms Alert Dashboard





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ACURE4Moms Impact

- Outcome data will be collected until all study participants are 1 year post-delivery.
- Ensures completeness of data capture.
- Final outcomes and impact to be analyzed in 2027-2028.

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Improving outcomes in your HIE

- Work with your vendors, look for these opportunities with providers in your area.
- Technical challenges will be present but work with all the stakeholders, keep communications open

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Building Healthier Communities Through Coordinated and Highly Collaborative Statewide Action

2026

Civitas Preconference

Contexture

Meet Our Speakers

Tess McInnis

Manager, SDOH Technology

Contexture

Kelly McGann

Director, SDOH

Contexture

Learning Objectives

After attending this session, participants will be able to:

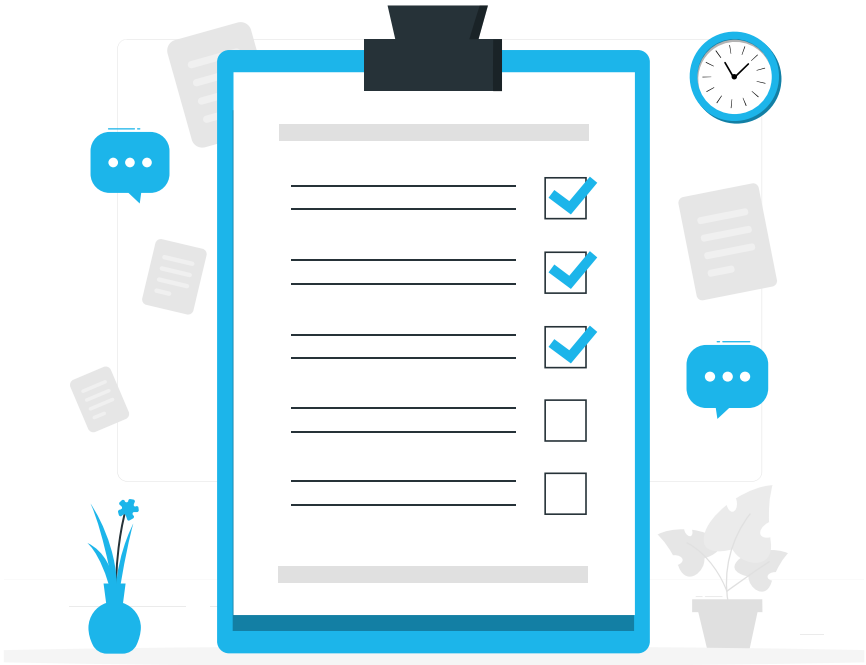
- **Objective 1:** Analyze how collaboration between HIEs and social, medical, and behavioral health organizations strengthens the quintuple aim by integrating data, coordinating services, and reducing fragmentation. Evaluate how these partnerships improve health outcomes, enhance patient and provider experiences, advance health equity, and support cost-effective, community-driven care.

- **Objective 2:** Evaluate the role of equitable interoperability in enabling under-resourced organizations to participate fully in data exchange. Analyze how HIEs provide the technical infrastructure, governance support, and workflow guidance needed to help these organizations achieve their data-sharing goals, enhance operational efficiency, and improve the quality and coordination of care.

- **Objective 3:** Analyze how HIEs can strengthen community SDOH response by applying their expertise in privacy protection, data normalization, and provider engagement. Evaluate how standardized data practices, secure exchange frameworks, and trusted relationships with clinical and community partners enable more coordinated interventions, improve data quality, and support scalable, whole-person care strategies.

Agenda

1. SDOH Solutions Overview
2. Equitable Interoperability
3. Leveraging HIE Expertise for SDOH solutions
4. Sustainability and Scalability
5. SDOH Driven Return on Investment



SDOH Solution Overview

Contexture SDOH Solutions

- Closed-loop Referral System
- Case management
- SDOH Screening tools and custom screening capabilities
- Resource Directory
- Data exports, analytics, dashboards
- Technical assistance and network monitoring

Equitable Interoperability

HIEs Support Equitable Interoperability & Affordable Access

Complex Hospital Information Systems

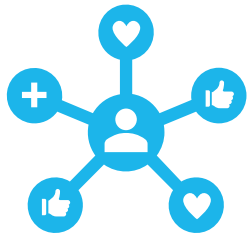
Community-Based Organizations with No Overarching System

Practices of All Sizes Using Electronic Health Records

HIEs have experience and tools to help entities connect, regardless of where they are with technology.

Leveraging HIE Expertise for SDOH Solutions

HIE Expertise



Building Networks

- Community and Stakeholder Networks
- Technical Efforts

Privacy and Security

- Extensive experience and knowledge about HIPAA
- Data sharing agreements and contracting

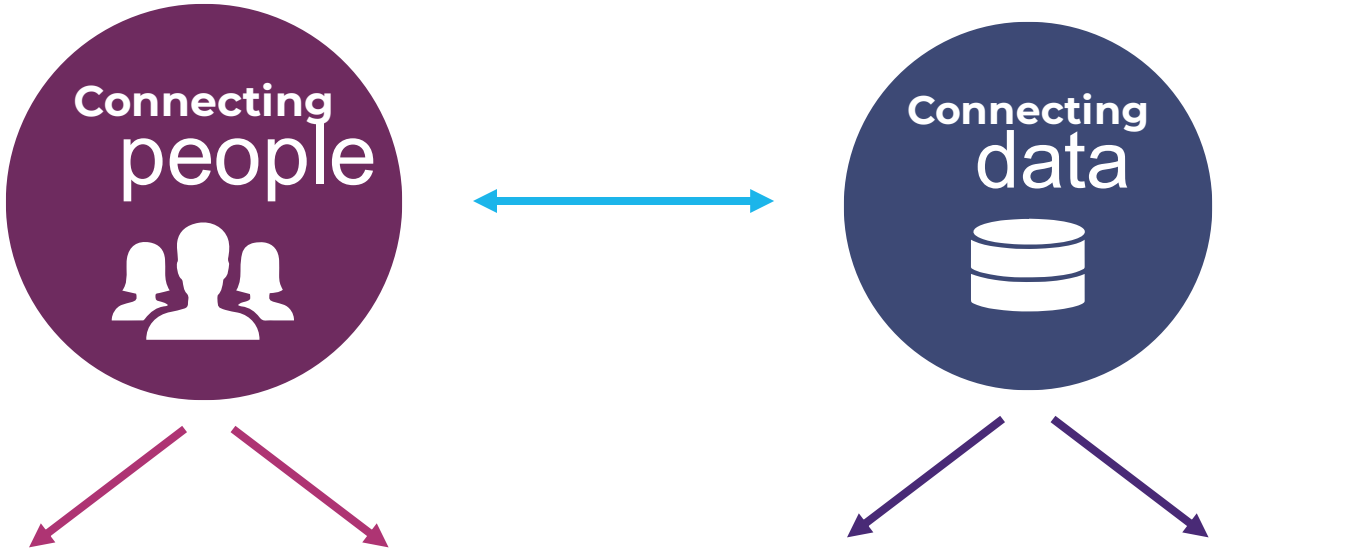
Data Normalization and Translation

- Healthcare data today
- Social data today

Identity Management

- Master Person Index Solution

How Does It Fit Together?



Creating opportunities for people who don't normally work together to communicate and collaborate

Hosting and supporting coalitions to foster coordination

Ensuring all types of providers have the information that they need, when they need it, to provide services and care

Organizations are different – solutions are low-tech and high tech

Scalability

- Strong community partnerships
- Standardized & customizable functionality& workflows
- Interoperable technology
- Customization to support community use cases and different size organizations
- Adaptable and tailored technical assistance and implementation

We are seeing more and more clients in need of practical resources along with their mental and physical health needs. I am thrilled to have a resource that will help us meet the needs of our clients. It is hard to do our work when the basic needs are not being met.

Arizona Partner

SDOH-Driven Return on Investment

What We Have Found So Far

A National Perspective

13 minutes saved per case

6.5x faster connections

700% increase in reach

$85 savings PMPM

89% increase in access to care

15 hrs. saved per week

Data Source: Data for this slide was obtained from Unite Us Research & Evaluation

Time Savings (Per Task, Per Client)

Client management tasks

CRN task/function	Minutes
Personal demographics	2
Intakes	5
Household and Social Graph	4
Consent forms	4
Document Vault	1
Task status, case notes	3
Calls and appointments	16
Screeners and eligibility forms	15

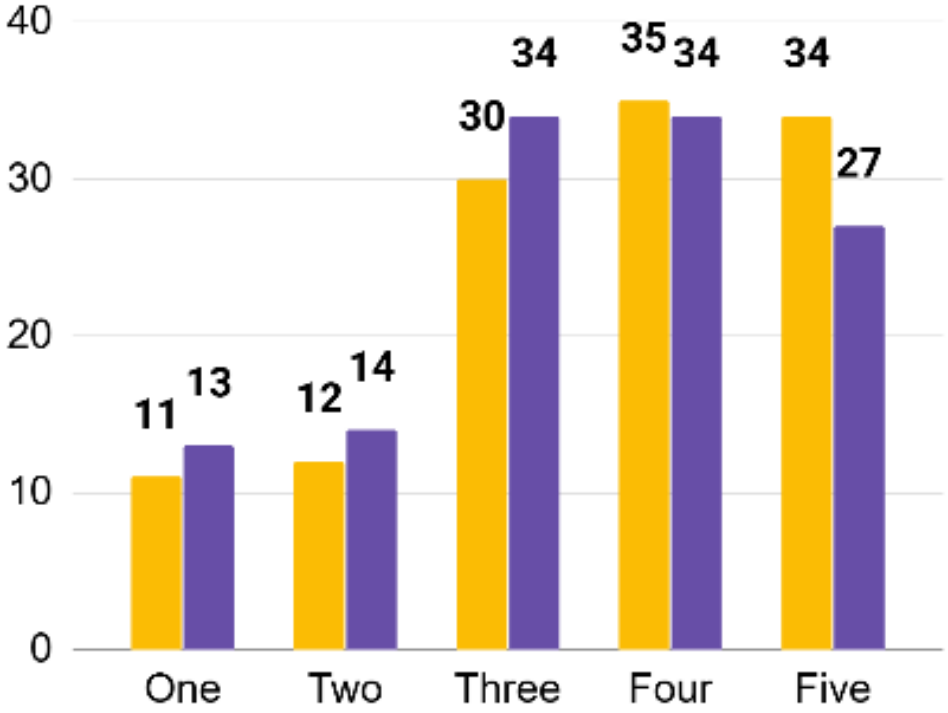
Referral tasks

CRN task/function	Minutes
Receiving referrals	10
Sending referrals (electronic)	8
Sending referrals (fax)	3
Logging non-electronic referrals	9

Data Source: Data for this slide was obtained from User Survey Results

User Experience

Respondents Overall Experience with the Efficacy of Contexture SDOH Solution



Scale of 1 to 5 with 5 being the highest

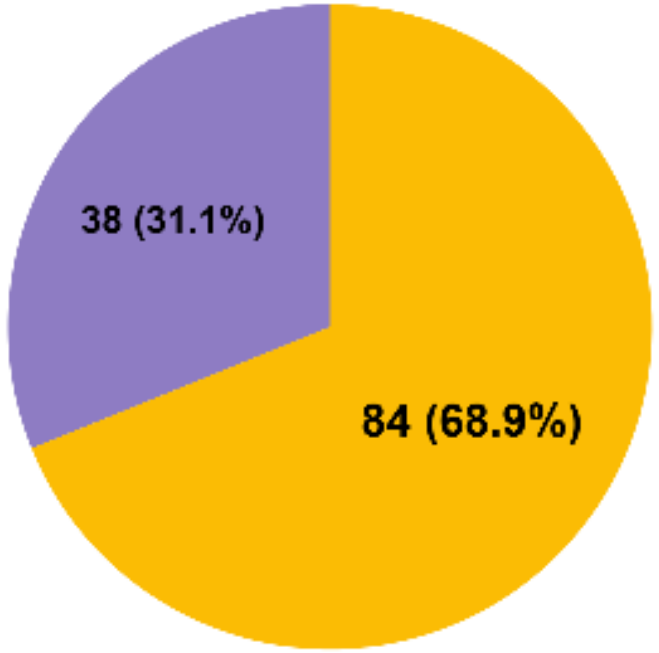
Respondents ranking of their belief in the statement Contexture SDOH solution helps improve access to care and resources

Respondents ranking on their overall experience of the solution

Data Source: Data for this slide was obtained from User Survey Results

User Experience

Respondents answer to the question is the solution improving your patients/clients access to community resources?



Yes (68.9%)
No (31.1%)

Data Source: Data for this slide was obtained from CommunityCares User Survey Results

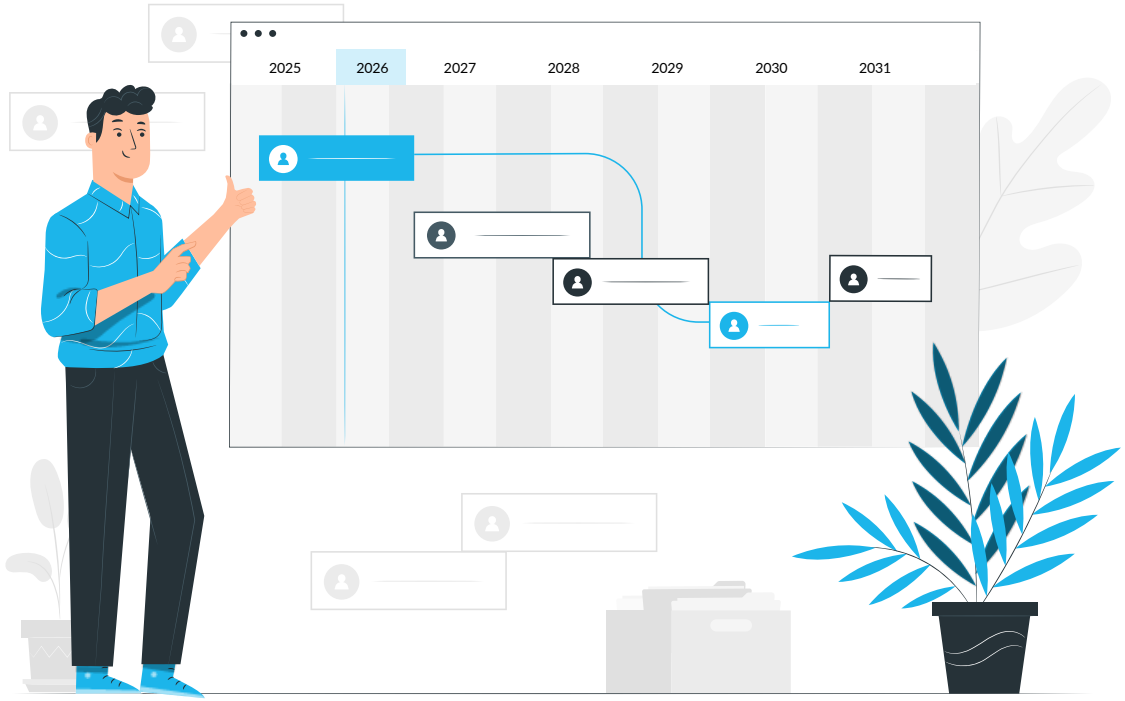
Value Added: Care Coordination and Data/Reporting

Themes from narrative responses

- Streamlined referral processes
- Enhanced communication, coordination and collaboration
- Centralized information
- Increased Access to Care
- Strong belief in efficacy and improved access to resources among participating organizations
- Improved data management and reporting

Care Coordination: *Contexture's SDOH solution has impacted not only the day role/function of the care coordinator but has impacted healthcare as a whole, seeing the patient through the SDOH lens and not only through chronic conditions.*

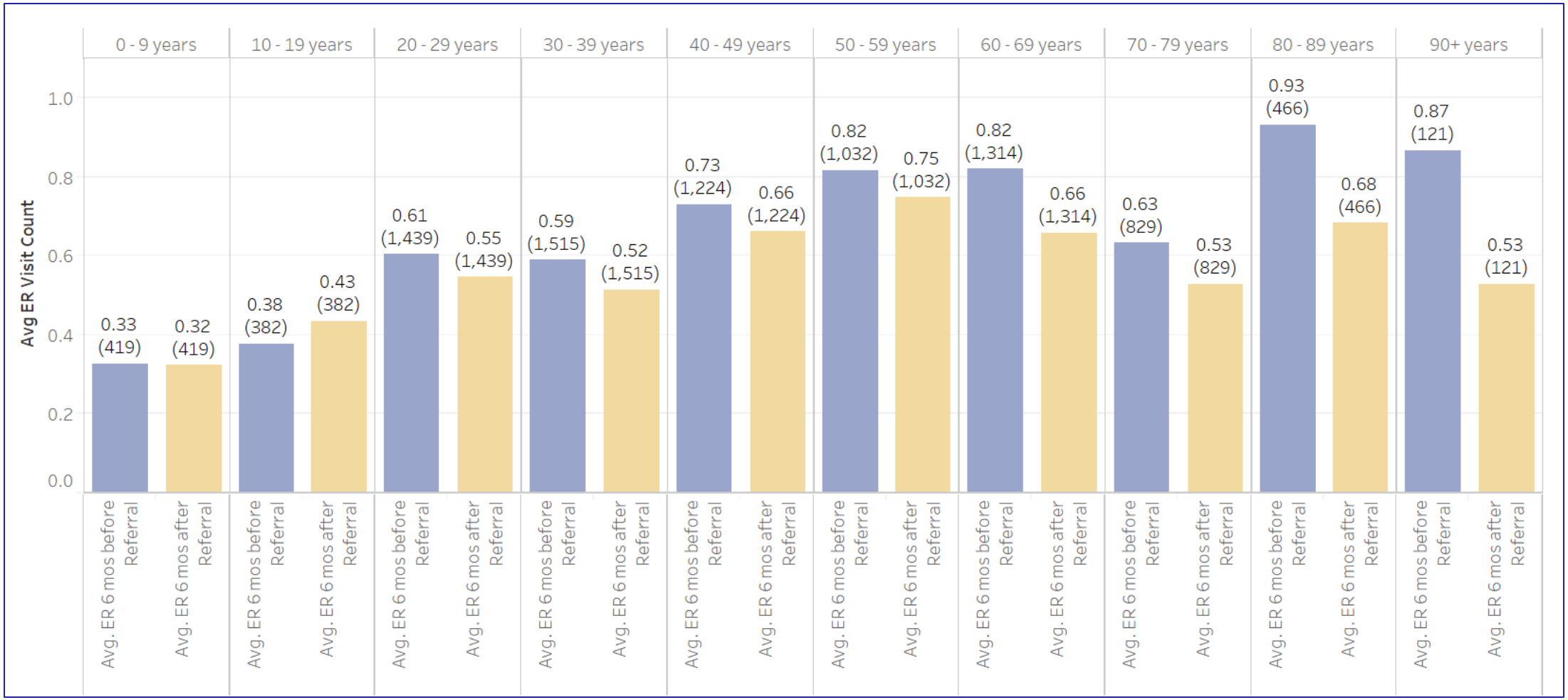
Looking Ahead



Critical Success Factors

- Trusted partner known for expertise in data sharing, security and privacy
- Community informed solutions
- Shared alignment across HIE and SDOH initiatives
- Needs based approach and tailored support
- Connection and alignment with others doing similar work
- Continued program evaluation

ER Visits Before and After Referral



Data Source: Data for this slide was obtained from the Community Resource Network

Literally days are saved. Something that would take me 24 work hours (three workdays), now can take as little as 1 hour to put together.

Colorado Participant

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@ContextureHIT

State Directed Payments to Drive Multi-Year Maternal and Behavioral Health Improvements

Quality Improvement Program – New Jersey

August 12, 2026

PUBLIC CONSULTING GROUP

Solutions that Matter

Agenda

- **Public Consulting Group**
- **Quality Improvement Opportunity in NJ**
- **Today's Learning Goals**
- **State Directed Payments as Implementation Accelerators**
  - From DSRIP to VBP – 438.6c – Preprint
  - Core Policy and Implementation Design Levers
- **Translating Policy into Practice through Scalable Shared Learning Frameworks**
  - Case Study: Maternal Health Learning Collaborative
  - Case Study: Social Determinants of Health
- **Incorporating the Patient Experience Data Layer**
- **Closing and Q&A**

Public Consulting Group

1986
Founded in Boston

2,500+
Professionals worldwide

50 states
+ Canada & Europe

Who we are
Passionate professionals working toward a future where every person in every community can live to their full potential.

What we do
A leading public-sector solutions and operations-improvement firm partnering with health, education, and human services agencies to improve lives.

How we deliver
A multidisciplinary, holistic approach that builds lasting partnerships and sustainable, long-term solutions that matter.

Your presenters

- 20+ years leading provider system transformation
- Quality improvement/measurement expert
- Grew up in rural NY, now Boston-based, father of two, capoeira instructor

Gabriel Malseptic, MBA, PMP
Senior Consultant

- IHI-certified Improvement Advisor, data focused, expert in data visualization and measurement strategy
- Grew up in Randolph, MA, currently living in Austin TX, avid salsa/bachata dancer

Dak Ojuka
Consultant

Opportunities in New Jersey: Behavioral & Maternal Health

Behavioral Health

- **13.1% of NJ ED discharges** had a mental health disorder and 4.8% a substance use disorder (2019)[1]
- **8th highest** drug overdose rate and 5th highest opioid overdose rate in the U.S. (2018)[2]
- **8,000+** ED discharges for opioid or stimulant overdose (2019)[3]
- **Up to 80%** of psychiatric inpatients and up to two-thirds in SUD treatment may have experienced trauma[4]
- **30-day follow-up after ED:** 63.7% for mental health, but only 11.1% for substance use disorder (2019)[5]

Maternal Health

- **Hypertensive disorders** of pregnancy are a leading cause of maternal morbidity and mortality in the U.S. and globally[6]
- **Delayed treatment** of severe hypertension (SHTN) can lead to maternal death, stroke, or other serious complications[7]
- **30–60 minutes:** The American College of Obstetricians and Gynecologists' recommended window to begin treatment for persistent SHTN[8]
- Former First Lady Tammy Murphy launched a statewide initiative "Nurture NJ" to address **inequities in maternal care** (2019)[9]

Citations available at end of presentation.

Challenge: Incentivize Sustained System-Level Transformation

Improvement is systemic

Better maternal & behavioral health means changing screening, referral, care transitions, follow-up, coordination, data sharing, and workforce roles.

One-time funding falls short

Grants can launch activity but rarely change workflows, build reporting capacity, or create ongoing accountability.

Quality takes repeated cycles

Sustained change needs repeated measurement, provider feedback, technical assistance, leadership commitment, and time.

Investment that sustains

Payment policy can move states from funding activity to building durable implementation infrastructure.

Goals for Today's Session

Learning Goal 1

Medicaid State Directed Payments as Implementation Accelerators for Maternal and Behavioral Health Quality Improvement

Learning Goal 2

Translating Policy into Practice through Scalable Shared Learning Frameworks

Learning Goal 3

Incorporating the Patient Experience Data Layer

State-Directed Payment as an Implementation Accelerator

The 438.6(c) preprint

What it is
The state's vehicle for describing a proposed Medicaid managed care state-directed payment arrangement for CMS review and approval.

What it Forces you to Define
Policy goal, participating programs, provider classes, covered services, payment approach, funding, quality linkages, and evaluation.

Accountability Record
Documents how payment is tied to Medicaid services, eligible populations, managed care programs, quality goals, and measurement.

The value chain

Federal authority translates into measured outcomes only when each link is intentionally designed.

New Jersey's 438.6c Design, Governance, and Uptake

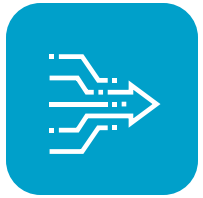
- **Purpose:** To address persistent behavioral health and maternal health challenges through financial and technical support. Program supports have included technical assistance and Learning Collaboratives to support hospitals in achieving performance goals.
- **Stakeholder Involvement in Design:** Program design and measure selection were informed by expert advisory input prior to and through project implementation.
  - Quality Measures Committee
  - Technical Advisory Committee
- **Incentive Model:** Funding is available to fund incentive payments to hospitals for meeting individual performance targets on state-selected quality measures that reflect:
  - **Improved maternal care processes**
  - **Reduced maternal morbidity**
  - **Improved connections to BH services**
  - **Reduced potentially preventable utilization for BH populations**
- **Eligibility & Participation:** Open to all acute care hospitals:
  - 55 hospitals participated in the behavioral health cohort
  - 45 hospitals participated in the maternal health cohort
  - 42 hospitals participated in both cohorts.

Design Levers — Eligibility & Quality Priorities

Intentional design around eligible participants in a directed-payment arrangement and the quality goals their payments should advance.

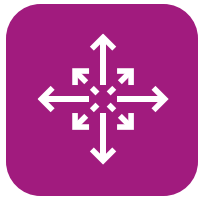
Define who participates

Eligibility sets who can join and receive payment under the arrangement, with assurances that it treats all eligible participating organizations fairly.



Target eligibility to intent

Use provider type, Medicaid participation, network status, patient volume, safety-net role, and geography to select providers positioned to influence the measures being incentivized.



Broad vs. targeted reach

Broad eligibility supports statewide alignment; targeted eligibility concentrates resources where need and disparities are greatest — and clear criteria give an auditable basis for payment.

Anchor quality to policy goals

Tie the program goals and measure sets to the state's managed care quality strategy and its maternal and behavioral health policy priorities.

Build a balanced measure set

Blend outcome, process, care-transition, access, and equity measures across maternal health — prenatal/postpartum care, obstetric safety, severe maternal morbidity — and behavioral health — screening, follow-up, warm handoffs, and crisis connections.

Fund the capacity that sustains it

Disparity training, data exchange, referral documentation, and record transmission build the systems that turn measures into lasting improvement.

Design Levers — Quality Priorities & Measures

BH	MH	Measure Steward	Measure Name	Data Source	VBP Strategy
✓		CMS	30 Day All-Cause Unplanned Readmission Following Psychiatric Inpatient Hospitalization	Claims	P4P
✓		NCQA	Follow-Up After Hospitalization for Mental Illness – 30 days Post-Discharge	Claims	P4P
✓		NCQA	Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (30 day)	Claims	P4P
✓		NCQA	Follow-Up After Emergency Department Visit for Mental Illness (30 day)	Claims	P4P
✓	✓	NCQA	Initiation of Alcohol and Other Drug Abuse or Dependence Treatment | *Pregnant Women Version for MH	Claims	P4P
✓	✓	NCQA	Engagement of Alcohol and Other Drug Abuse or Dependence Treatment | *Pregnant Women Version for MH	Claims	P4P
✓		CMS	Preventative Care and Screening: Screening for Depression and Follow-Up	Chart/EHR	P4P
✓		ASAM	Substance Use Screening and Intervention Composite	Chart/EHR	P4P
	✓	CDC	Severe Maternal Morbidity (SMM)	Claims	P4P
	✓	Joint Commission	PC-02 Cesarean Birth	Chart/EHR	P4P
	✓	NCQA	Postpartum Depression Screening	Chart/EHR	P4P
	✓	NCQA	Postpartum Care	Claims	P4P
	✓	Alliance for Innovation on Maternal Health (AIM)	Treatment of Severe Hypertension	Chart/EHR	P4P
✓	✓	AMA-PCPI	Timely Transmission of the Transition Record	Chart/EHR	P4P
✓	✓	University of Colorado Denver Anschutz Medical Campus	3-Item Care Transitions Measure (CTM-3)	Instrument	P4R
✓	✓	NJ DOH	Use of a Standardized Screening Tool for Social Determinants of Health	Instrument	P4R
✓	✓	NJ DOH	Reducing Disparities and Improving Patient Experience Through Targeted Training	Training Records	P4R

Design Levers — Reporting & Payment Methodology

Connecting what providers report to how they are paid across multiple years.

Define the Mechanics and the Data

Set the payment pool, allocation approach, performance thresholds, measure weights, timing, and consequences for non-performance — and the claims measures, clinical data, chart abstractions, care-transition documentation, and patient experience that feed them.

Choose the Payment Design

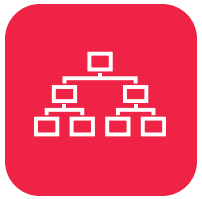
Weigh pay-for-reporting, pay-for-performance, gap-to-goal targets, achievement benchmarks, attainment/improvement hybrids, and how dollars attach to results.

Make Reporting Useful Feedback

Build reliable feedback loops providers can use to manage improvement — not paperwork for its own sake — backed by specifications, templates, validation rules, timelines, and technical assistance.

Reward the Full Multi-Year Arc

Emphasize baseline data and readiness in year one, then performance improvement, opportunities for stratification, and sustainability later — rewarding both early infrastructure-building and measurable gains.



Attribute Fairly and Stratify

Keep attribution understandable and aligned with care relationships, utilization, and the population a provider can influence — and stratify data where feasible to reveal disparities and target interventions.

Get the Timing Right

Payments should be predictable enough to plan on, yet tied closely enough to performance — and reporting mature enough — to preserve accountability.

Implementation: Performance Measurement Drives Payment

Participating hospitals earn funds by meeting individualized targets on quality measures that advance towards statewide goals per a CMS-approved Gap-to-Goal methodology.

Baseline Data

- One time baseline data captured to develop statewide goals and target schema

Performance Calculation

- Annual hospital attribution calculated
- Measure performance calculated against established targets and appeals outcomes

Target-Setting

- Target set using measure-level baselines, statewide goals, annual results, and CMS-approved Gap-to-Goal method.

Payment Calculation

- Standard Performance Payment rules applied where Measure Met results in proportionate payment
- Redistribution Measures Selected and proportional payment added

Payment Guidance

- Hospitals receive detailed payment guidance
- MCOs and State receive level payment guidance including state/federal match

Give participants clear rules, timelines, appeal pathways, and consequences — delivering stewardship for policymakers, predictable operating rules for providers, and clearer intervention definition for researchers.

Design Levers — Evaluation & Accountability

Designing a multi-year evaluation with accountability guardrails built in.

Specify the Design up Front

Set the theory of change, evaluation questions, data sources, baseline, comparison approach, methods, and reporting cadence — and define what payments cover, which services and populations are included, and required documentation. It's both a requirement of CMS approval, contributes to research, and provides insights that can inform future performance design.

Evaluate what Matters

Test whether the SDP advanced quality goals, improved access or outcomes, and supported sustainable delivery-system capacity over time. Be mindful of reporting burdens that different evaluation designs carry. Distinguish short-term capacity gains, intermediate care-process changes, and long-term outcomes

Weigh results and implementation

Capture performance results and implementation evidence — what changed, where, and for whom — using mixed methods: quantitative analysis plus provider surveys, interviews, collaborative data, and patient experience.

Evaluation Data Collection & Analyses

Analysis of QIP-NJ metrics on the cohort and subgroup level to understand YOY changes and patterns of progress	Collect hospital perspectives though interviews with individuals in various roles at participating hospitals	Survey hospitals about data systems, health disparities, community partner processes, and infrastructure for change management	Synthesize hospital work products (Storyboards) and feedback from the Learning Collaboratives

Learning Goal 1

Medicaid State Directed Payments as Implementation Accelerators for Maternal and Behavioral Health Quality Improvement

Learning Goal 2

Translating Policy into Practice through Scalable Shared Learning Frameworks

Learning Goal 3

Incorporating the Patient Experience Data Layer

Beyond Payment: Wrap Around Program Supports for Participating Hospitals

- Monthly newsletters
- 1:1 and Group Technical Assistance sessions on measurement, program compliance, and policy
- Publicly-accessible website including interactive performance dashboard for Learning Collaboratives and P4P components
- Dedicated inbox support for inquiries
- Institute for Healthcare Improvement Breakthrough Series Learning Collaboratives aligned with the goals of QIP-NJ regarding behavioral health, maternal health and social determinants of health

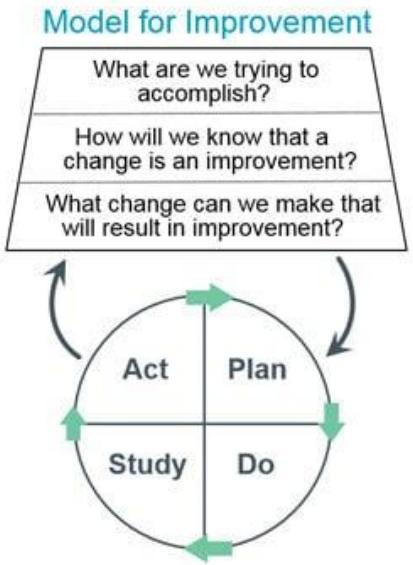
Learning Collaborative Components

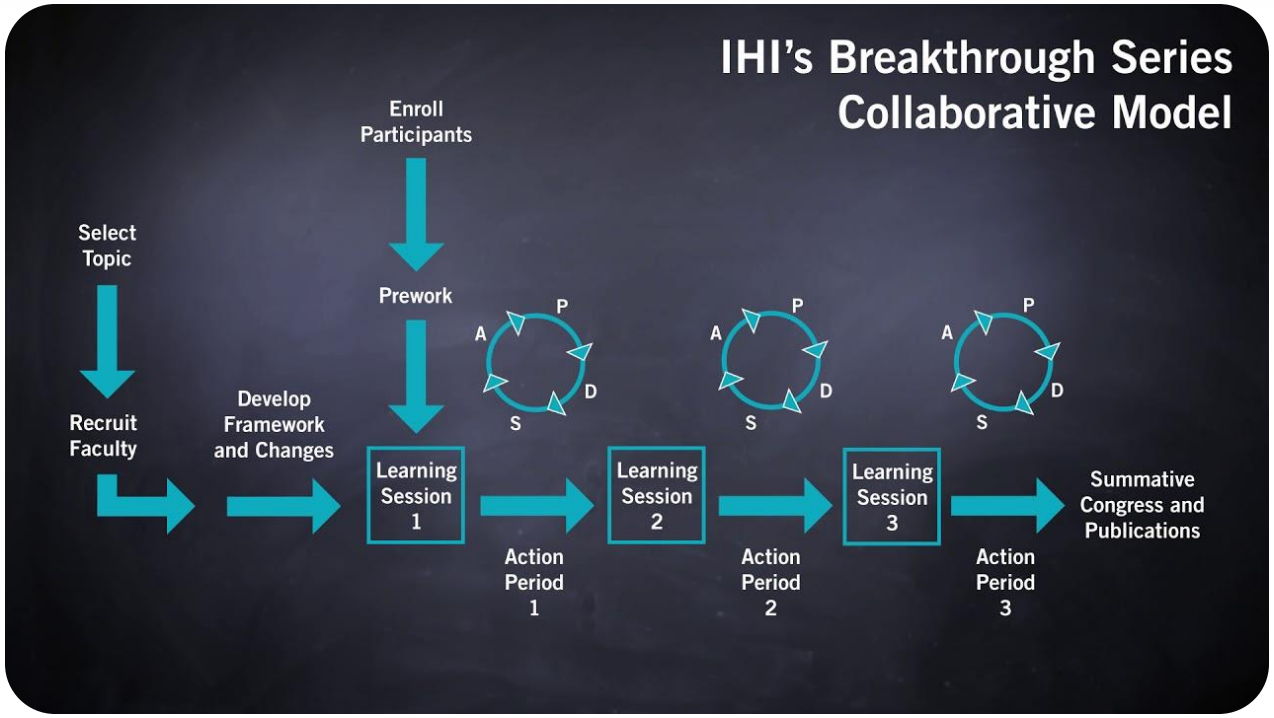
- Key Driver Diagrams and Change Packages
- Measurement Support
- Interactive dashboard, data collection, and analysis guidance
- Performance coaching
- CEU/CMUs for participants

Institute for Healthcare Improvement

Why a Breakthrough Series Works to Advance Policy Goals

- Desired outcomes often tied to strong evidence base.
- The IHI Breakthrough Series (BTS) Collaborative model engages high volume teams to implement changes that will result in desired outcomes.
- Model for Improvement (MFI) is the underlying QI methodology.
- BTS and MFI are accessible to individuals with all levels of skill and experience in QI.
- QIP-NJ featured a voluntary state-sponsored BTS Collaborative to augment the supports of a pay-for-performance program.





Core Components of QIP-NJ's BTS Collaboratives

01

Evidence Based and Expert Informed Program Design

Programs grounded in research and shaped by subject-matter experts to drive measurable outcomes.

02

Expert Support and Coaching

Hands-on guidance and coaching that build capacity and sustain change across teams.

03

Data Collection and Visualization Strategy

Structured data collection paired with clear visualization to track progress and inform decisions.

Case: Maternal Health Learning Collaborative

Focus area —
Timely identification and treatment of severe hypertension (SHTN)

Role of the Collaborative

- Strong hospital engagement and data submission
- High satisfaction with structure and supports
- Integrated equity-focused measurement alongside pay-for-performance
- Built provider capacity to act on disparities

Outcomes

- Improved timely treatment and triage measures
- Stronger ability to bring disparity-focused analysis into routine practice

Key Insight

Collaboratives moved providers beyond compliance toward deeper understanding of care processes and equity drivers.

Collaborative Participant Experience

93% of respondents from Maternal Learning Collaborative say participation added value to their organization's participation in the state sponsored P4P program.

Added Value to SDP Participation

90% of respondents indicated that participation in the Maternal Health Learning Collaborative accelerated their organization's improvement in the timely treatment of SHTN.

Accelerated Improvements

84% of respondents indicated that participation in the Maternal Health Learning Collaborative increased joy in work.

Increased Staff Joy!

Impact of a Collaborative – In Participants' Own Words

Case: Social Determinants of Health Collaborative

Focus area —
Screening, referral, and connection to care for social needs

Role of the Collaborative

- Drove meaningful delivery-system transformation even under pay-for-reporting
- Shared evolving practices as conditions changed
- Built relationships with community partners
- Refined SDOH screening and referral processes

Outcomes

- Sustainable workflows and cross-sector partnerships
- Greater provider readiness to address social needs within clinical care

Key insight

Collaboratives gave providers a structure for adapting to complexity while sustaining progress on policy-aligned goals.

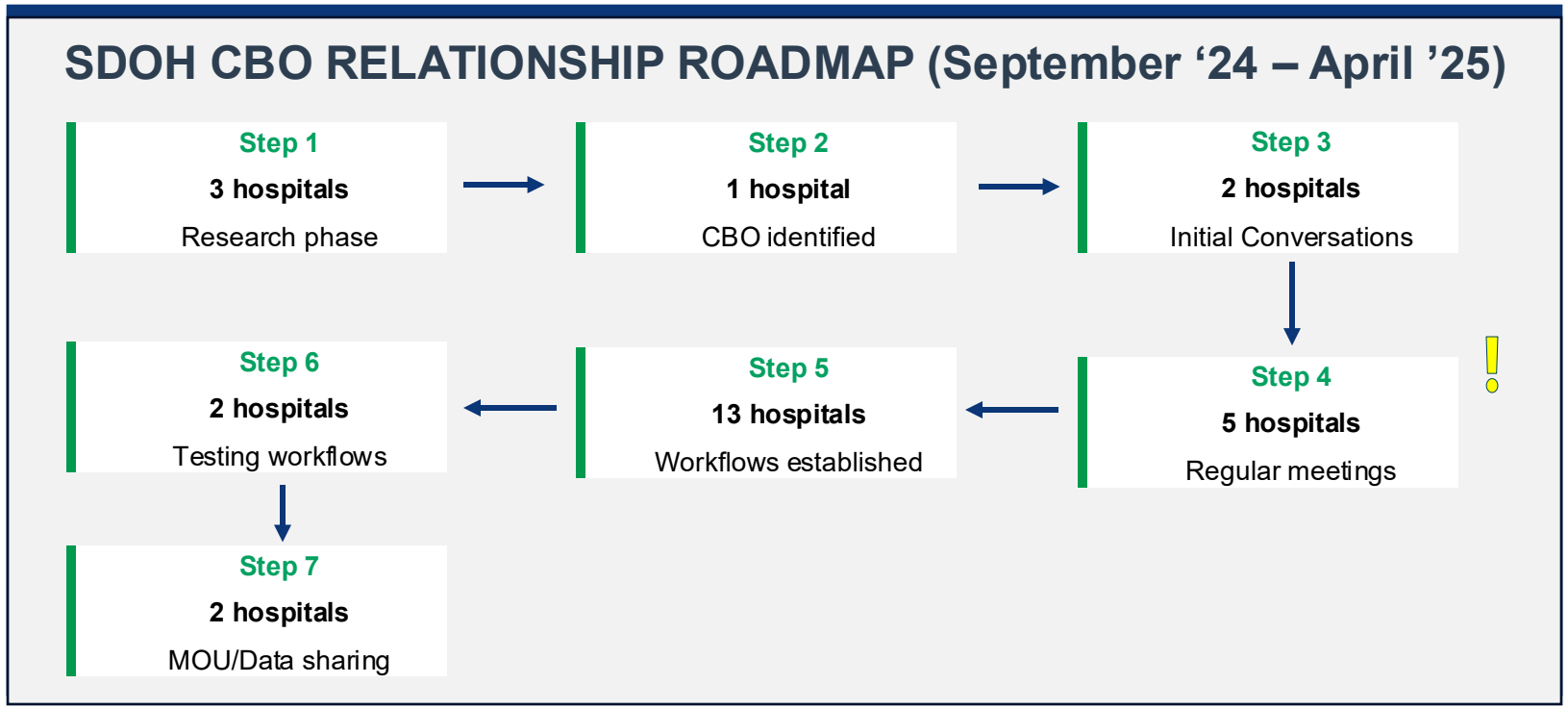
CBO Relationship Building Outcomes

Most hospitals (22 of 28) reached Step 4 with regular meetings with CBOs

79%

Of hospitals reached *at least* Step 4: Regular meetings with CBOs

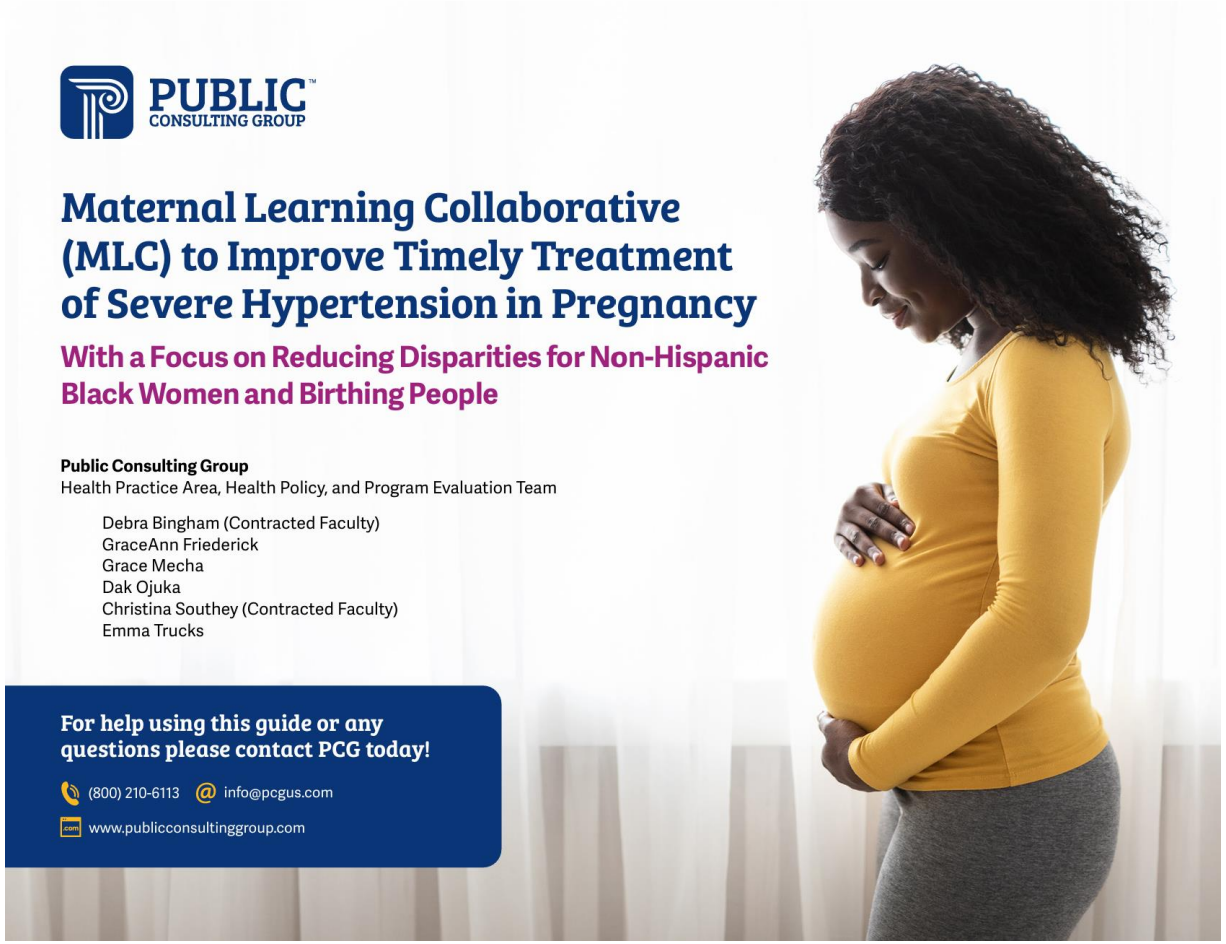
Each hospital counted once at their highest step. Most hospitals progressed to Step 4, suggesting that there was significant progress made in relationship building with community partners.



Based on highest CBO milestone achieved per unique hospital • N=28 hospitals

NJHealth New Jersey Department of Health

Building Sustainable, Scalable Capability



Learning Goal 1

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Incorporating the Patient Experience Data Layer

No single source tells the whole patient story

Layer what the system records with what patients reveal - then use the combined signal to guide the next test of change.

Routine measures What happened at scale

Targeted outreach What patients experienced

Closed-loop outcomes Whether connection occurred

Community insight What local context explains

Lived experience What trust affects disclosure

THE LAYERED VIEW

Fills blind spots

Builds belief

Improves the next test

Each source answers a different question; together they create decision-ready learning.

WHY IT MATTERS Layering overcomes small samples, fragmented data, and reluctance to disclose in any one setting.

Sources: Learning Goal 3 director transcript; MLC and SDOHLC measurement materials.

MLC: An independent survey heard what discharge questions did not

A CDC National survey in 2023 showed that

45%

of U.S mothers held back from asking questions or discussing concerns with their provider (CDC,2023)

What the added layer changed

CDC's national survey shows that nearly half of months hold back concerns from their providers, most often because they were told what they felt was normal, or expected to be seen as difficult, Hospital discharge questions inherit that filter.

In New Jersey, the NAACP Maternal Experience Survey (222 responses through Mar, 2023) captured patient authored accounts through trusted community channels. PCG brought those stories into MLC learning sessions, where they drove team conversations on disparities and respectful care.

MLC monthly data + statewide outcomes + MES stories

Source: CDC Vital Signs, "Maternity Care Experiences - United States, April 2023," MMWR, Aug. 22, 2023. cdc.gov/vitalsigns/respectful-maternity-care

Bringing patient experience into your own program

Inventory your touchpoints

Map where program teams already interact with patients. Every touchpoint can carry an experience question.

Collect where you already connect

Fold experience collection into contacts that already happen, like loop-closure calls. Added knowledge, no added burden.

Add an independently trusted channel

Partner with community organizations patients trust to hear what institutional channels miss.

Put voices into shared learning

Bring stories and survey findings into learning sessions. Belief in the change drives adoption of new practice.

QIP-NJ built data collection into policy design: pay-for-reporting measures such as CTM-3 and SDOH screening made patient experience part of the payment model.

What you're leaving with

Three learning goals, three takeaways — and one thing you can put to work with your team today.

LEARNING GOAL 1

Directed payment as an accelerator

A 438.6(c) directed payment turns federal authority into measured outcomes only when eligibility, measures, reporting, payment method, and evaluation are designed as one chain — shifting the state from funding one-time activity to building durable infrastructure.

TAKE BACK TODAY

Map one quality goal to the payment, reporting, and accountability levers that would move it — and name the capacity needed first.

LEARNING GOAL 2

Shared learning builds capability

Payment alone doesn't change workflows — supports do. An IHI Breakthrough Series gave hospitals a shared method, coaching, and a peer community; 93% said it added value and 90% said it accelerated their SHTN improvement.

TAKE BACK TODAY

Stand up a structured, peer-based improvement cycle on one measure: a key driver diagram, rapid PDSA tests, and shared data.

LEARNING GOAL 3

Layered data keeps it honest

No single source tells the whole patient story. Layering routine measures, independent voices, and closed-loop follow-up exposed equity gaps small samples hid — and turned a flat screening count into 70 more rides a month.

TAKE BACK TODAY

Inventory the patient touchpoints you already have, add one independently trusted channel, and bring those voices into your next learning session.

THE BOTTOM LINE Directed payment sets the direction, shared learning builds the capability, and layered patient data keeps it honest — together, they turn policy into sustained maternal and behavioral health improvement.

Sources

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Discussion

Please utilize the Q&A feature to ask our panelists questions.

Thank You!

Join our next preconference session on Tuesday, August 18 at 2:30pm ET!