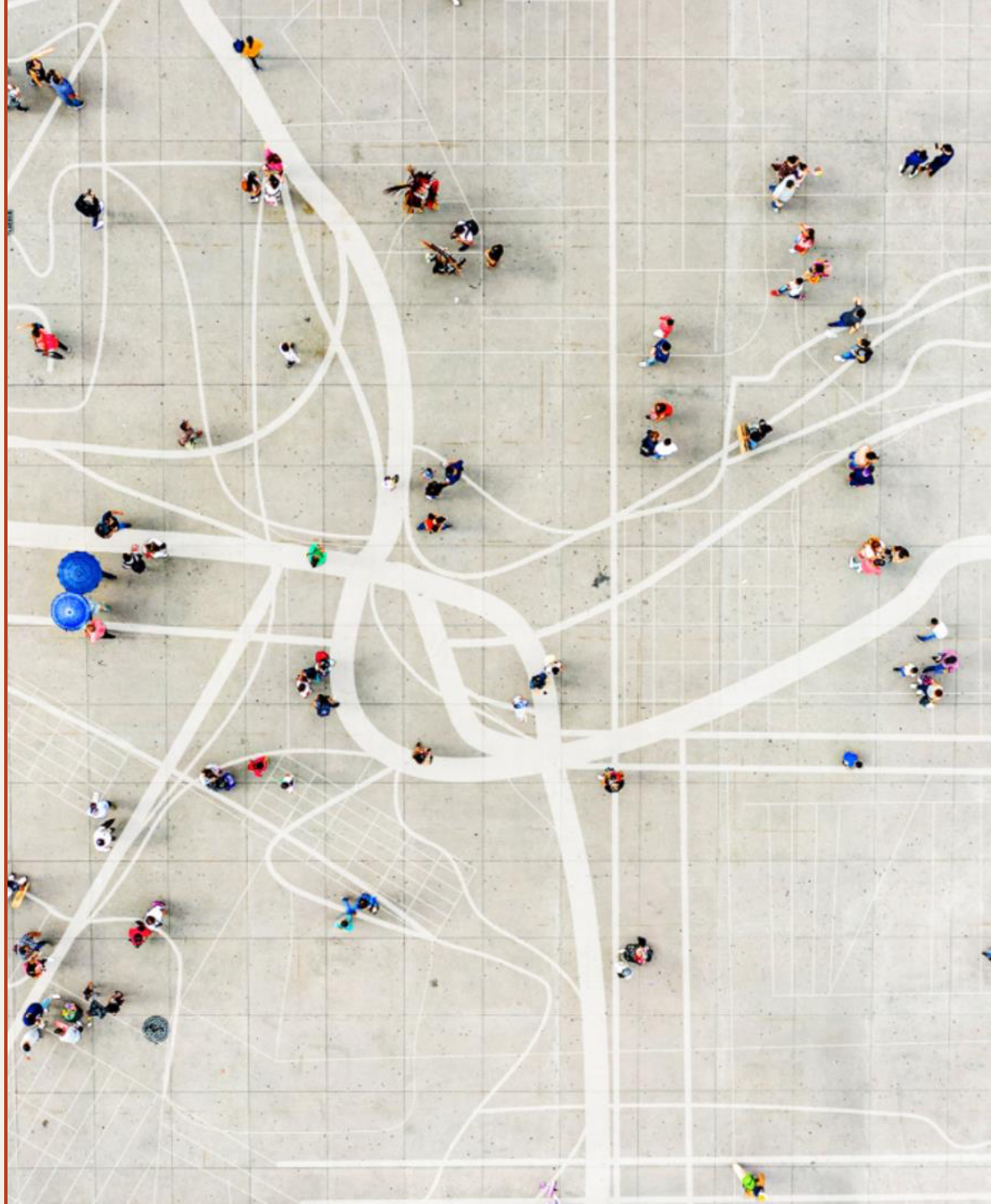
Using Real-Time Data to Drive Proactive Postpartum SUD Care and Strengthen Rural Care Continuity

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 Updates
  - Jolie Ritzo, CEO, Civitas Networks for Health®
- Opening Remarks
  - Steve Heard, J2 Interactive
- Rural Health HIE: Data to Outcomes Transformation Model
  - Kevin McAvey, Manatt Health
  - Joseph Watkins and Dr. Daniel Carnegie, North Carolina Department of Health and Human Services
  - Janet Oputa, North Carolina Health Information Exchange Authority
- Rural Care Leakage and Community Impact Reporting
  - Rama Thummalapalli and Trevor Jurjevich, CyncHealth
- Data-Driven Postpartum Support: HIE Infrastructure for High-Risk Populations
  - Arley Styler and Laura Sorenson, Camden Coalition
  - Jahnhoy Smith, Horizon Blue Cross Blue Shield of New Jersey
  - Jana Lang, NJ Medicaid
- Discussion & Q&A

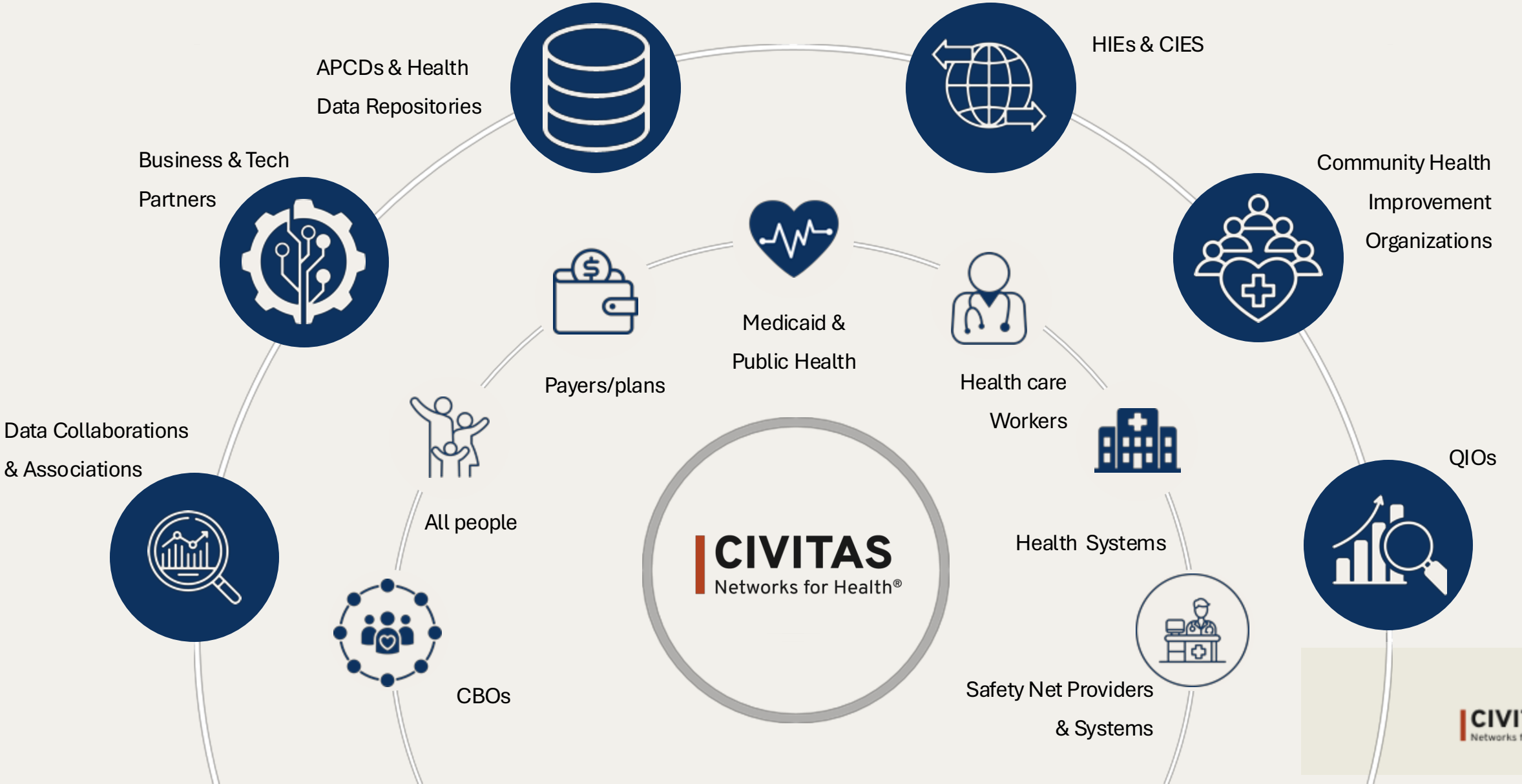
About Civitas Networks for Health®

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

Expert Convenors

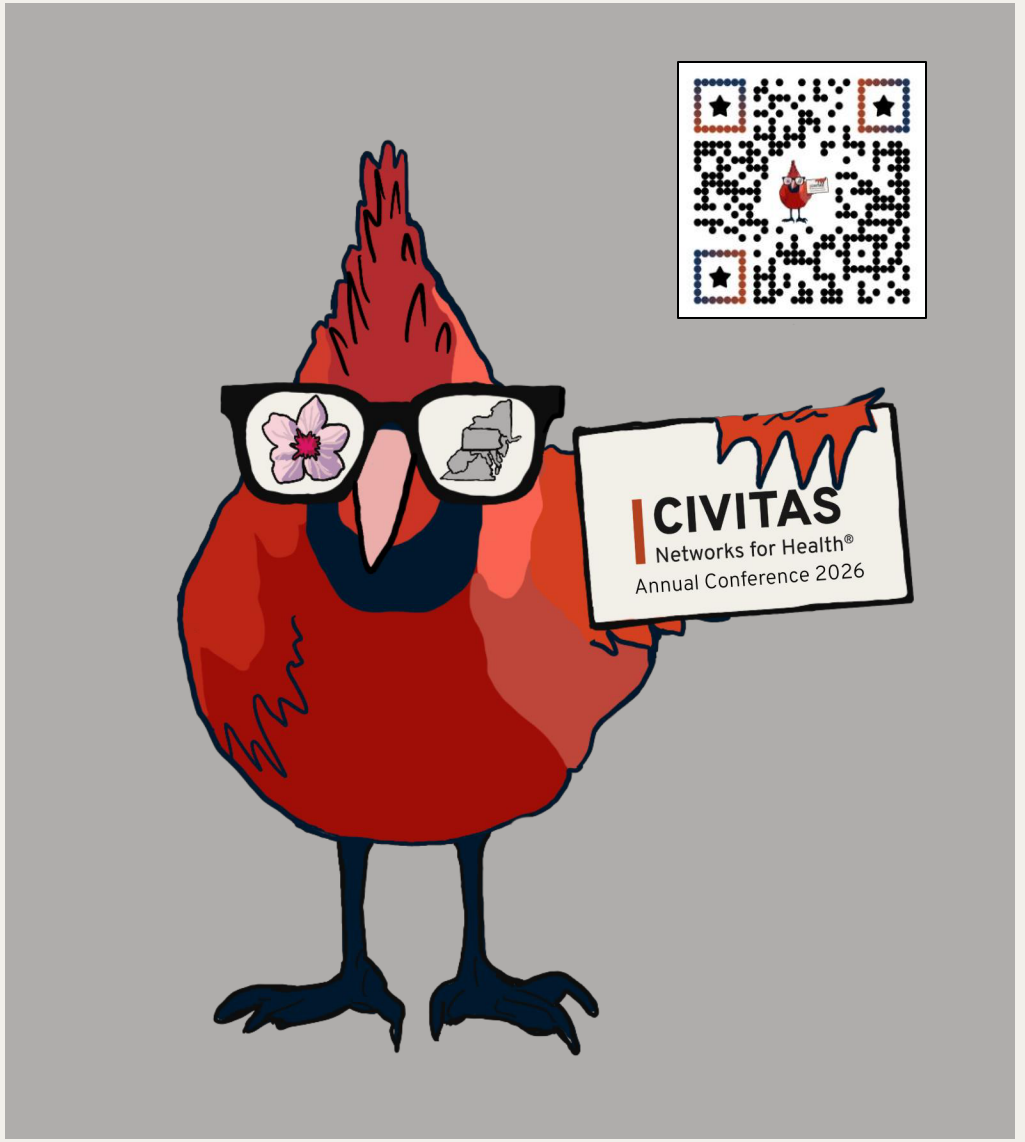
- Civitas provides a unique platform that connects collaborators working on health improvement across the country
- We believe that local communities should lead and influence national progress on health
- We offer forums for shared learning, education, networking, and advocacy, and have proven our strength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

CIVITAS
Networks for Health®

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.

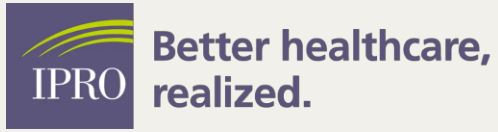
Register to Attend the Remaining Virtual Preconference Sessions (Open to the Public!)

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

- **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

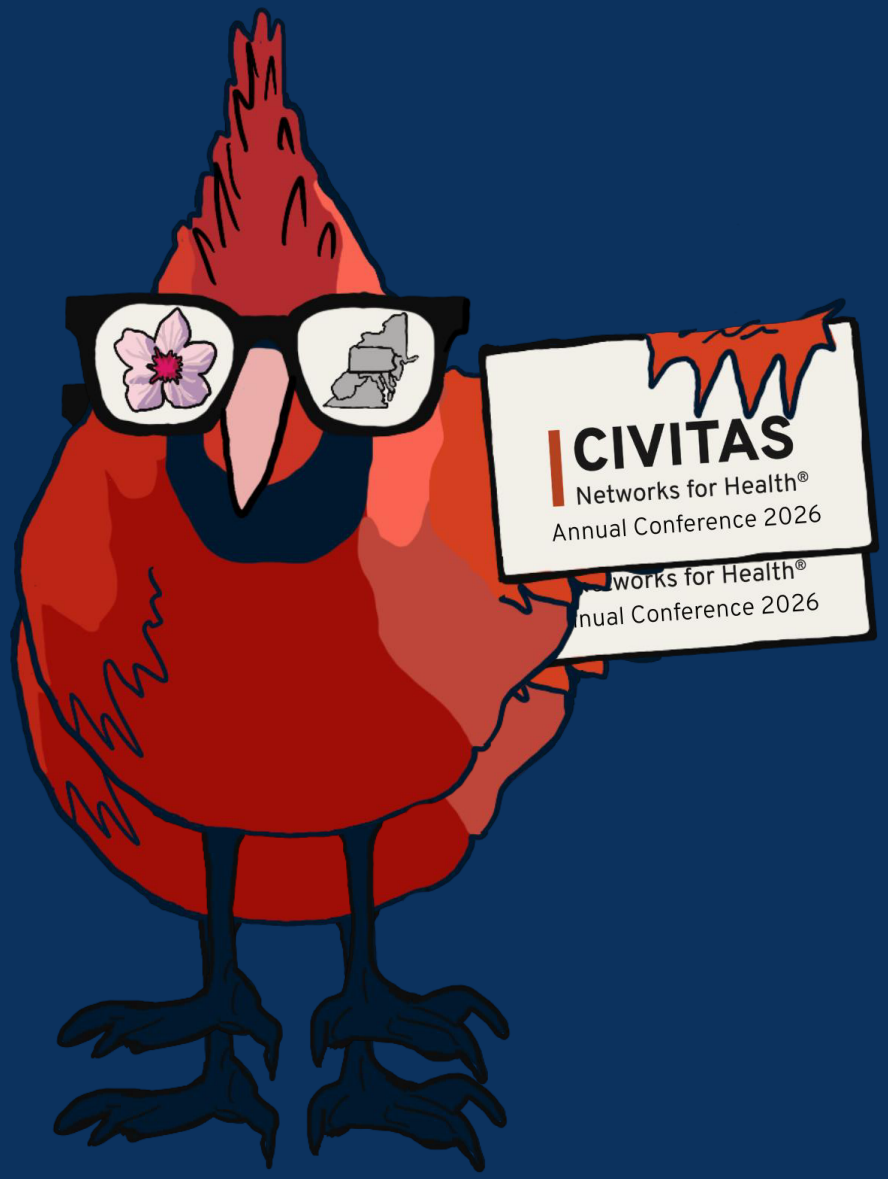


...And Thank You to Our Civitas 2026 Annual Conference Silver & Host Committee Sponsors

Easy SDOH Data

Steve Heard

Chief Innovation Officer | J2 Interactive



About J2

Since 2007
Building and advancing HIEs

2,000+
Customer projects

Facilitating key projects:
NCQA DAV, TEFCA compliance, RHTP

100M+
Patient lives covered

Supporting clean data,
strategy, and technical integrations

2 x BEST IN KLAS TECHNICAL SERVICES 2020

1 x DEVELOPERWEEK THE 2025 DEVIES AWARDS BEST INNOVATION IN Services: Strategic & Technical

1 x CIVITAS Networks for Health® Community Excellence Award Winner 2025

Solution Vision

Provide a starting framework for existing HealthShare HIEs to implement Social Determinants of Health data and workflow as guided by HL7 FHIR Gravity Project.

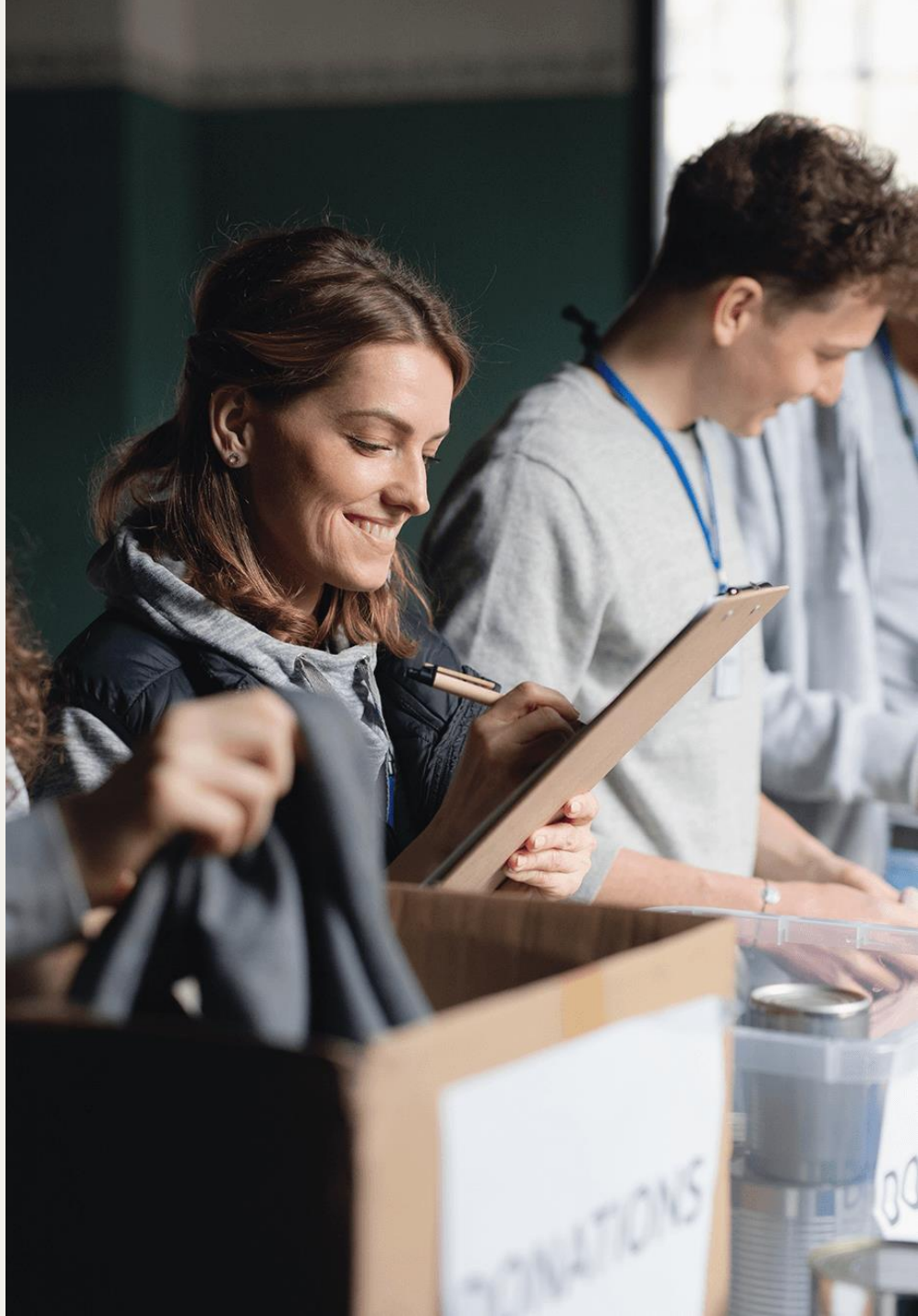
InterSystems® HealthShare

gravity PROJECT®

J2 SDOH HealthShare Solution Pack

- Support Gravity domains and standards
- Start with a collection of common assessments
- Integrate the display of the data in a meaningful way
- Allow access to the data through expected API’s, channels, and analytics
- Provide the ability for participants to use the HIE as a point of entry and capture of assessments
- Provide an easy-to-follow framework for adding additional Gravity-recognized assessments or provider-defined alternatives

Schedule a demo at J2Interactive.com/SDOH



Rural Health HIE: Data to Outcomes Transformation Model

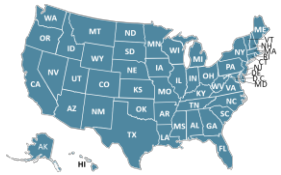
Kevin McAvey, Manatt Health

August 18, 2026

Stevens Amendment Disclosure: This presentation is supported by the Centers for Medicare and Medicaid Services (CMS) of the U.S. Department of Health and Human Services (HHS) as part of a financial assistance award totaling $213,008,356.47 with 100% funded by CMS/HHS. The contents are those of the author(s) and do not necessarily represent the official views of, nor an endorsement, by CMS/HHS, or the U.S. Government.

National Rural Health Challenges Highlight Need for Better Data Sharing

Rural health care providers are disproportionately disconnected from health information exchanges (HIEs), disadvantaging the populations they serve.



National Challenge

- Rural and small providers continue to participate in HIE at lower rates than larger health systems, limiting access to complete patient information.
- Financial constraints, workforce shortages, and technology barriers remain significant obstacles to HIE adoption in rural communities.

Impact on Care Delivery & Outcomes

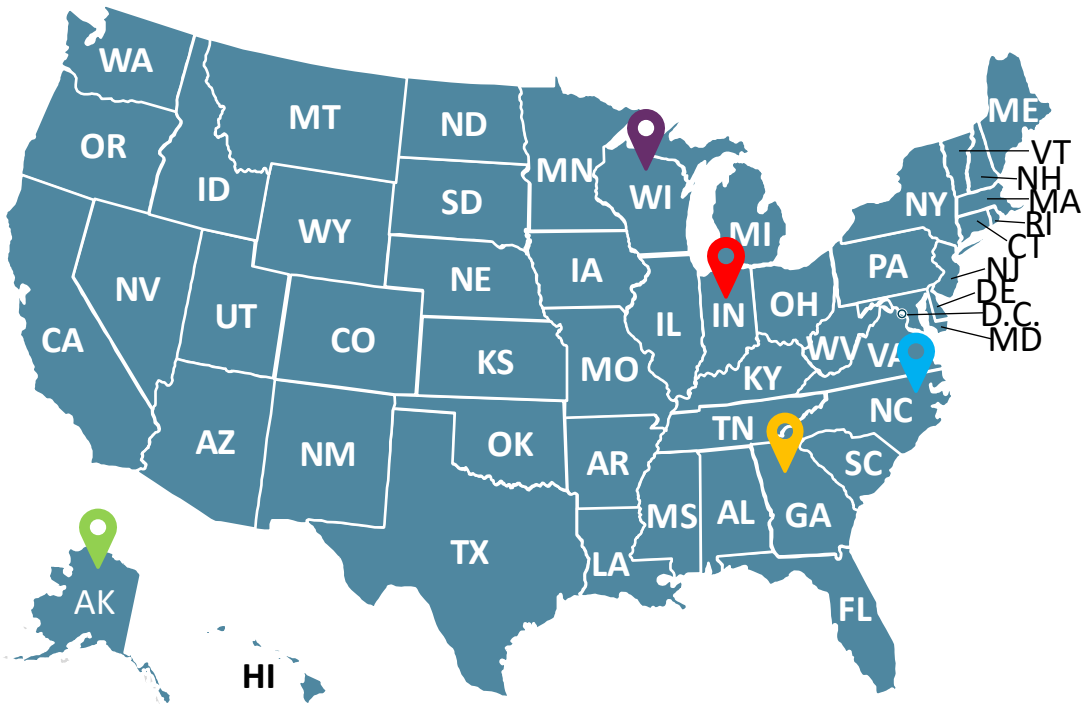
- Incomplete clinical information can contribute to fragmented care, missed follow-up responses, and challenges coordinating care across providers and care settings.
- Rural communities experience higher rates of chronic disease, preventable hospitalizations, and barriers to accessing timely care.

Impact on Healthcare Costs

- Limited information sharing can result in duplicative services, avoidable utilization, and inefficiencies across the healthcare system.
- Studies have linked HIE-enabled care coordination and population health management to reductions in hospital utilization and other costly downstream services.

State RHTP Investments in HIE and Interoperability

States are increasingly leveraging RTHP funding to support HIE and broader data interoperability initiatives.



North Carolina

North Carolina aims to modernize rural care delivery by increasing participation in NC HealthConnex, the state-designated HIE, to bridge the gap of digitally isolated providers and enable interoperable, data-driven clinical decision-making.

Indiana

Indiana will connect approximately 450 additional rural healthcare facilities to its statewide HIE and modernize the provider data portal with AI-enabled decision support and targeted dashboards to coordinate EMS and other provider types.

Wisconsin

Wisconsin plans to enhance its state-designated HIE (WISHIN) and Community Information Exchange (CIE) to build a digital rural health care collaborative where providers join a shared "digital backbone" for secure, longitudinal data sharing.

Georgia

Georgia will develop HIE infrastructure and EMR population health enhancements for rural hospitals and clinics to ensure providers use data to drive population health initiatives and maintain interoperability standards aligned with the AHEAD model.

Alaska

Alaska's "Spark Technology and Innovation" initiative will expand its statewide HIE, healthEconnect Alaska to rural and remote providers while integrating patient data from remote monitoring devices directly into clinical workflows

NORTH CAROLINA

RURAL HEALTH TRANSFORMATION

NC DEPARTMENT OF HEALTH AND HUMAN SERVICES

Initiative 6: Digital Health Overview

Presented by: Joseph Watkins | Daniel Carnegie, MD

August 18, 2026

Stevens Amendment Disclosure: This presentation is supported by the Centers for Medicare and Medicaid Services (CMS) of the U.S. Department of Health and Human Services (HHS) as part of a financial assistance award totaling $213,008,356.47 with 100% funded by CMS/HHS. The contents are those of the author(s) and do not necessarily represent the official views of, nor an endorsement, by CMS/HHS, or the U.S. Government.

RHTP OVERVIEW

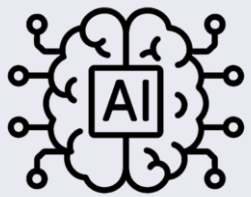
NORTH CAROLINA RURAL HEALTH TRANSFORMATION

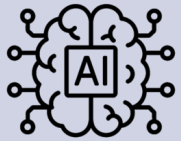
What is it?	On Dec. 29, 2025, the U.S. Centers for Medicare and Medicaid Services (CMS) awarded North Carolina over $213 million in federal funding through the Rural Health Transformation Program (RHTP). North Carolina applied for the funds to improve health care for rural North Carolinians and their communities.
How did it come into existence?	RHTP is part of H.R. 1, a federal reconciliation bill signed into law in July 2025 that includes significant changes to Medicaid. RHTP provides one-time funding to states to support rural communities in improving health care access, quality and outcomes. The program is a cooperative agreement designed to help states transform rural health care delivery systems by investing in innovation, infrastructure, partnerships and workforce development. It is not a replacement for Medicaid funding, but rather a strategic opportunity to strengthen rural health systems in the face of longstanding challenges. The first $25 billion from RHTP will be split evenly between all 50 states and will equal about $200 million each year for the next five years for North Carolina. The second $25 billion will be split at CMS' discretion among all 50 states over the next five years.

Six Initiatives Work Together to Achieve NCRHTP Goals

Required Federal Elements	*Improving Access | Improving Outcomes | Partnerships*			*Workforce*	*Cause ID | Financial Solvency*	*Technology Use | Data-Driven Solutions*
NC Rural Health Priorities	1 **Build Rural Community Care Network "Hubs"**	2 **Create Models and Capacity for Expanded Primary Care, Prevention, and Chronic Disease Management**	3 **Expand and Integrate Behavioral Health and SUD Services**	4 **Build a Robust and Resilient Workforce and Innovative Care Team Models for Rural Communities**	5 **Ensure Fiscal Sustainability of Rural Health Providers Through Innovative Financial Models**	6 **Modernize Rural Care Delivery Through Digital Forward Solutions**
Results	By FY2031, NCRHTP will increase rural provider-to-population ratios, reduce preventable hospital readmissions and emergency visits, lower chronic disease risk factors, and expand access to integrated behavioral, mental health and substance use services. All while simultaneously investing directly into communities and stimulating rural economic development and job creation.					

NORTH CAROLINA
RURAL HEALTH TRANSFORMATION

Why?	"Rural providers and residents navigate a fragmented care ecosystem in which workforce shortages, financial constraints, disconnected information, procurement complexity, geography, and uneven access to implementation support can compound one another. Providers and residents have different levels of access, experience, confidence, accessibility needs, and preference for digital services. The system should offer trusted navigation and meaningful choices rather than assume digital participation."
Initiative 6 Purpose	"Initiative 6 does not attempt to solve these challenges with technology alone. It helps rural communities and providers identify where digital tools and shared information can remove friction, strengthen care delivery, and support locally defined priorities."
Activities	    

NORTH CAROLINA RURAL HEALTH TRANSFORMATION	6a.	6b.	6c.	6d.	6e.
Activity Name	Institutionalize the Rural Health Innovation Fund (RHIF) 	Support Rural Providers in Adoption AI and Emerging Digital Technologies 	Connect Rural Providers to the state HIE: Advancing Data Sharing and Care Coordination 	Improve Digital Health Literacy in Rural Communities: Empowering Patients Through Embedded Support 	Integrate RPM and CCM into Rural Health Care 
Purpose	Provide a **catalytic investment fund** to help rural health providers **modernize their business operations and health IT infrastructure**. Provide an opportunity to test and scale innovative digital solutions and emerging technologies to improve care, streamline workflows, and enhance patient engagement.	Establish a collaborative that will provide a **community of practice and a technical assistance center for health care providers**. This provides infrastructure to assist rural providers in navigating AI, remote monitoring, robotics, and other digital solutions. The collaborative will equip rural providers with **the knowledge, tools, and support needed to confidently adopt AI** and other tech solutions.	Provide the operational, technical, and financial support for providers to **connect to the state-designated HIEA.** This activity will support new connections and upgrade existing connections to improve statewide data quality, availability, and timeliness.	Expand access to **digital health literacy (DHL) statewide through over-the-phone and in-person resources**. NCDHHS will partner with NC 211 and an to be determined in-person support partner to assist rural residents in more fully participating in the rapidly advancing digital health environment.	Establish a resource for working with providers to **deploy remote patient monitoring (RPM), chronic care management (CCM), Hospital at Home, and virtual first care-type models.** These models and services will integrate with NC HealthConnex to improve patient throughput, enhance workforce efficiency, and expand access in underserved communities.
Agreement Signed?	Y	N	Y	Y	N
Primary Partner	NCDIT – Division of Broadband and Digital Opportunity (BDO)	TBD	NCDIT – N.C. Health Information Exchange Authority (HIEA) – NC HealthConnex	NCDIT – Division of Broadband and Digital Opportunity (BDO)	TBD
Audience	Providers and practices	Providers and practices	Providers and practices	NC residents (focused on	Providers and practices

I6 DEEPER DIVE

NORTH CAROLINA
RURAL HEALTH TRANSFORMATION

Rural Health Innovation Fund (RHIF)

- Online intake assessment and application with a tiering model.
- Grant technical assistance and management provided by DIT.

Adopting AI and Emerging Digital Technologies

- Establishing the NC Rural Digital Health Collaborative (RDHC) with a Community of Practice (CoP) and a Technical Assistance Center (TAC).
- TAC will provide hands on technical assistance in the identification, implementation, and change management of transformational technology.
- The Community of Practice will leverage existing, well-established networks for statewide coverage.

Connect Rural Providers to the State-Designated HIE

- Provide the operational, technical, and financial support to connect to NC HealthConnex.
- Connections will improve the statewide quality, availability, and timeliness of data.
- Establishing a representative Steering Workgroup this fall with periodic provider convenings moderated by Manatt to provide a forum for advisement on program. direction

Digital Health Literacy

- Expand access to digital health literacy statewide through over-the-phone and in-person resources.
- Partnering with United Way NC 211 (phone) and NC State University's Cooperative Extension (in-person).
- Cooperative Extension is targeting Tier 1 economically distressed counties as priority.

Integrate RPM and CCM into Rural Health Care

- Deploy remote patient monitoring (RPM) and chronic care management (CCM) first care-type models.
- The models will integrate with NC HealthConnex to improve patient throughput and enhance efficiency.

METRICS

CMS Metrics

- **Improve Rural Provider HIE Connectivity (6c.)**
  - Increase # of rural practices connected to NC HealthConnex

- **Increase Rural Provider Usage of AI Clinical Decision Support Tools (6b.)**
  - Increase the % of rural providers utilizing ambient CDS tools

- **Increase Rural Provider Capacity for Emerging Tech (6b.)**
  - Increase in the # of providers participating in the TAC

- **Improve Rural Resident Engagement (6d.)**
  - Increased # of rural residents who receive digital health education or training

SYNERGY AND FUTURE

NORTH CAROLINA
RURAL HEALTH TRANSFORMATION

- **Connection is necessary but is not coordination. Coordination creates value only when information is usable, incorporated into care workflows, and supported by people, trust, governance, and sustainable resources.**

- **Community-led. Care-model first. Technology-assisted. Outcomes-driven**

Local need → appropriate use case → supported implementation → workflow and data integration → trusted, sustained use → better care → better outcomes

NORTH CAROLINA
RURAL HEALTH TRANSFORMATION

Initiative 5: Strengthening the long-term financial stability of rural providers

- **Activity 5a: Rural Hospital Value-Based Payment Capacity Building**
  - Supports feasibility studies and redesign planning for rural and Critical Access Hospitals.
  - Builds readiness for participation in innovative financial models and improved services delivery.
  - Led regionally through the NC ROOTS Hubs.

- **Activity 5b: Rural Primary Care Capitation Pilot**
  - Develops and tests a new prospective payment model for rural primary care practices.
  - Provides upfront readiness funding and technical support through Hubs and practice coaching and training
  - Aligns with NC Medicaid's long-standing aim to "pay for health, not just health care".

- **Impact**
  - Support fiscal sustainability of rural health providers
  - Reduced reliance on fee-for-service
  - Pathway to more advanced value-based payment models
  - Help rural providers maintain essential services and respond to community health needs

NORTH CAROLINA
RURAL HEALTH TRANSFORMATION

Initiative 6 to Initiative 5 Synergy

- **The Crossover**
  - Initiative 6 is providing providers with tools, resources, and funding to advance their technological capabilities.
  - Initiative 5 tests and promotes readiness for innovative financial models that include predictable payments and performance-based quality incentives. Success in these models will require strong use of data and technology.
  - Innovative payment models can also drive resources and demand for advanced technological capabilities beyond the life of the grant. We want to connect providers to innovative financial models with the complementary support to mitigate the likelihood that investments will be unsustainable

- **The Mission**
  - We need to think about the provider journey, so we have both immediate and long-term, sustainable success

NORTH CAROLINA
RURAL HEALTH TRANSFORMATION

Desired Future State

- **Rural Providers**
  - Providers will have better tools, easier access to information, and more support to deliver high-quality, sustainable care to rural communities.

- **Rural Patients**
  - Rural patients will have more ways to get care, more support using technology, and better communication with their health team in a sustainable fashion — no matter where they live.

Thank you!

NORTH CAROLINA
RURAL HEALTH TRANSFORMATION

NORTH CAROLINA HEALTH INFORMATION EXCHANGE AUTHORITY

August 18, 2026

Rural Health and Health Information Exchange

Presented by: Janet Oputa, MPH, PMP I Program Lead, Rural Health Transformation Program

North Carolina Health Information Exchange Authority

Overview of Topics

1. Describe the evidence-based intervention – NC HealthConnex
2. Share examples of projects that increase HIE utilization and population health impact
3. Discuss HIE measurement efforts
4. Highlight RHTP investments and opportunities

The N.C. Health Information Exchange Authority (NC HIEA)

Overseeing NC HealthConnex, North Carolina's state-designated health information exchange

WHO WE ARE

Created in statute
Established by the NC General Assembly in 2015 (NCGS 90-414.7) to modernize health data exchange statewide.

State-operated infrastructure
Housed in the NC Department of Information Technology's Data Division; technology partner is SAS Institute.

Cross-agency governance
12-member Advisory Board including the Secretary of Health and Human Services, the State Chief Information Officer, and the Director of the Enterprise Data Office.

THE CONNECTION MANDATE

Statutory connection deadline
Providers paid with state funds — Medicaid and the State Health Plan — were required to initiate connection by January 1, 2023.

Good-faith compliance pathway
Signing a participation agreement or actively onboarding with the NC HIEA satisfies the mandate.

Defined provider scope
Mandated provider types are set in statute (NCGS 90-414.4) and updated by the legislature over time.

NC HealthConnex Services

NC HealthConnex Suite of Services

Exchange

Discover new opportunities to exchange patient records and improve patient outcomes through the NC HealthConnex Clinical Portal.

NC*Notify

Gain significant insights into patients' health care activity across North Carolina. NC*Notify is a subscription-based service that notifies providers as their patients receive services across the care continuum.

Controlled Substance Reporting System

NC HealthConnex is working with the N.C. Department of Health and Human Services and Appriss Health to combat the opioid epidemic in North Carolina.

Promoting Interoperability & Meaningful Use

NC HealthConnex helps providers meet specific requirements and measures set by the Centers for Medicare and Medicaid Services.

Public Health Reporting

Access reporting through the N.C. Immunization Registry, Diabetes Registry and Electronic Lab Reporting.

Direct Secure Messaging

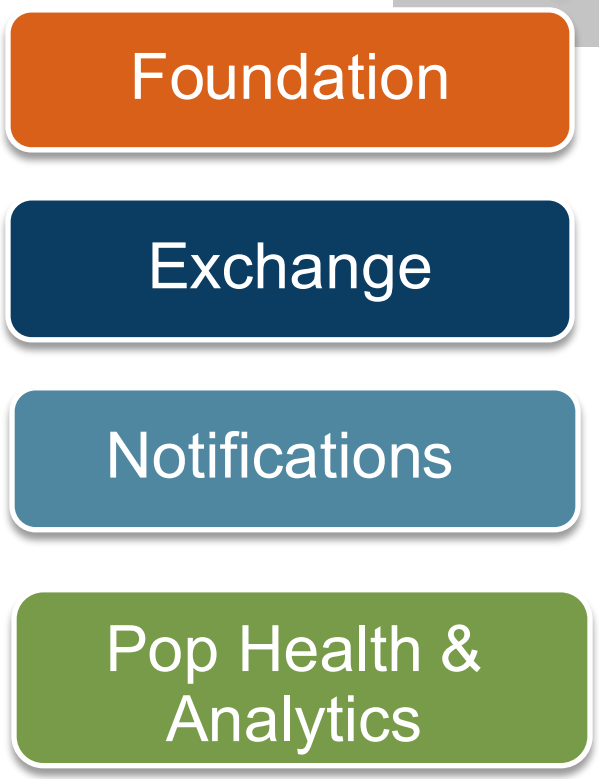
This encrypted email tool allows clinicians to send patients' protected health information through a secure network.

Data Quality

The NC HIEA places strong emphasis on NC HealthConnex's data quality.

Training

NC HIEA offers training for using the clinical portal, direct secure messaging and other HIE features.



NC HealthConnex Powering Health Care Outcomes

HIE Utilization and Rural Health

Strengthens rural communities by connecting healthcare providers to share critical health information and support whole-person care

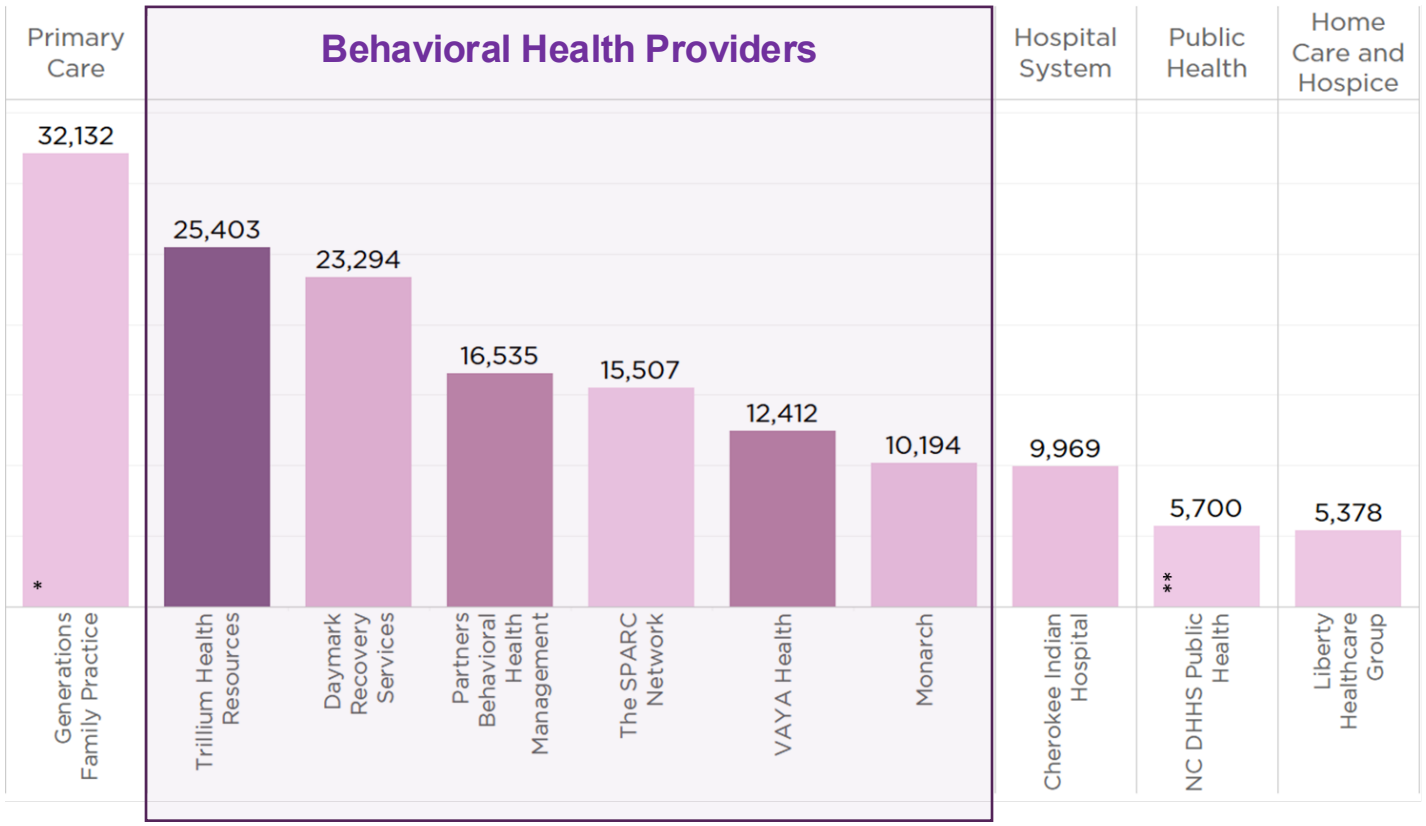
Benefits of NC HealthConnex

- Improves care coordination
- Improves patient care and safety
- Reduces healthcare costs
- Enhances efficiency in clinical workflows
- Faster emergency response and reporting

SUD Data Exchange: Providers' Use of NC HealthConnex Clinical Portal

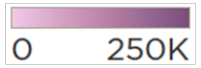
Behavioral health providers are some of the most intensive users of NC HealthConnex's Clinical Portal.

Top 10 NC HealthConnex Portal Logins by Provider Type and Member Count in 2025



- The Clinical Portal provides a single, web-based point of access to cross-provider clinical histories including patient search, Medicaid claims, event notifications, Direct Secure Messaging, and CSRS reports.
- NC HIEA participants can access the NC HealthConnex Clinical Portal as soon as they sign a participation agreement, before they are live submitting data.

Member Count



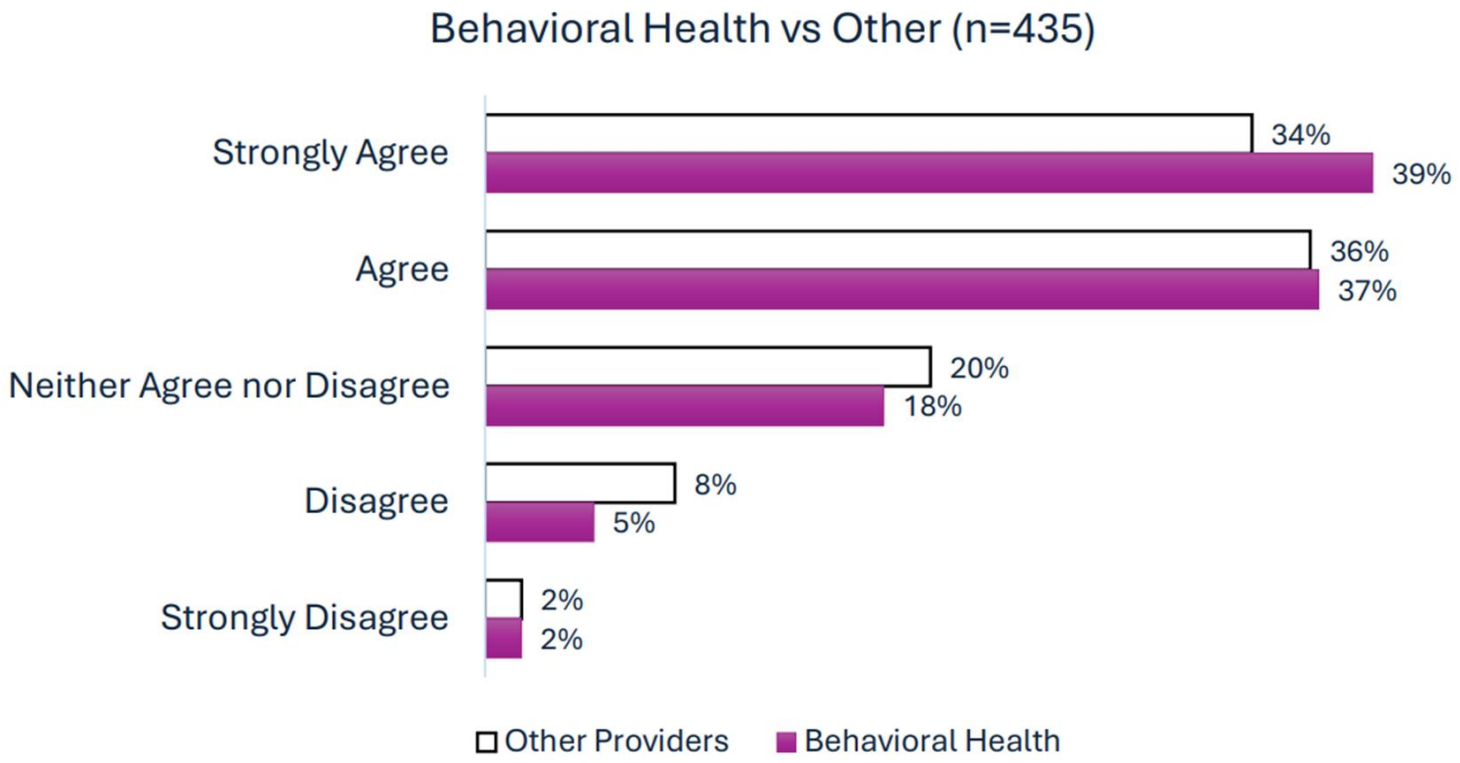
*Generations Family Practice employs an automated data-scraping service to extract portal information for population health management activities.
**No associated member count data is included or reflected in NC DHHS Public Health.

NC HealthConnex Powering Health Care Outcomes

SUD Data Exchange: Impact of Accessing HIE Data

Behavioral health providers find significant value in accessing information from the Clinical Portal.

Provider Response Rates to the Question: "Information in the Clinical Portal helps me provide more informed care"

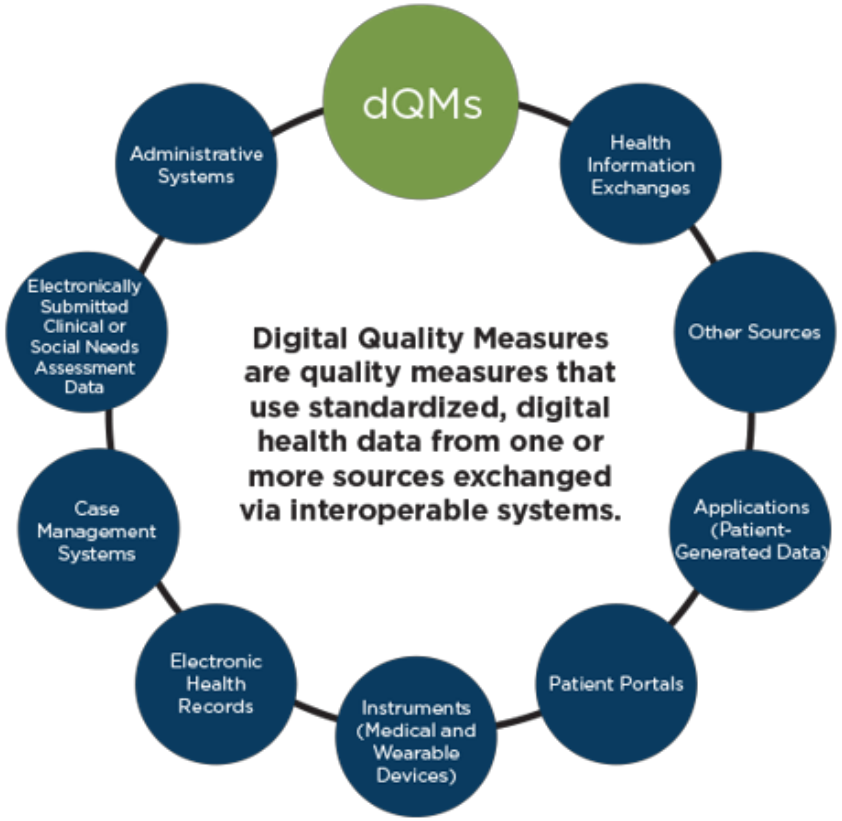


Population Health Measurement

Examples from NC HIEA

HIE Measurement: Digital Quality Measures & Priority Data Elements

Health data used to track population health, calculate quality measures, and support care management



Health-Related Social Needs (HRSN) Use Case

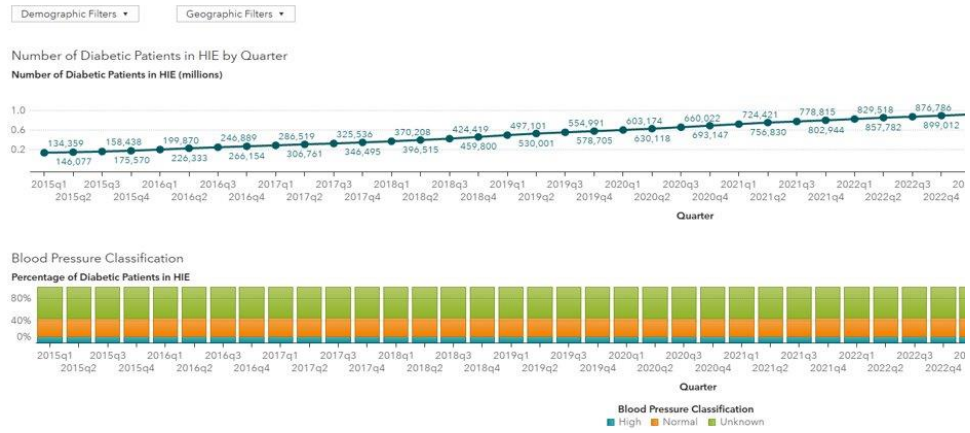
Statewide initiative to improve access and integration of Medicaid beneficiaries HRSN screening data through NC HealthConnex

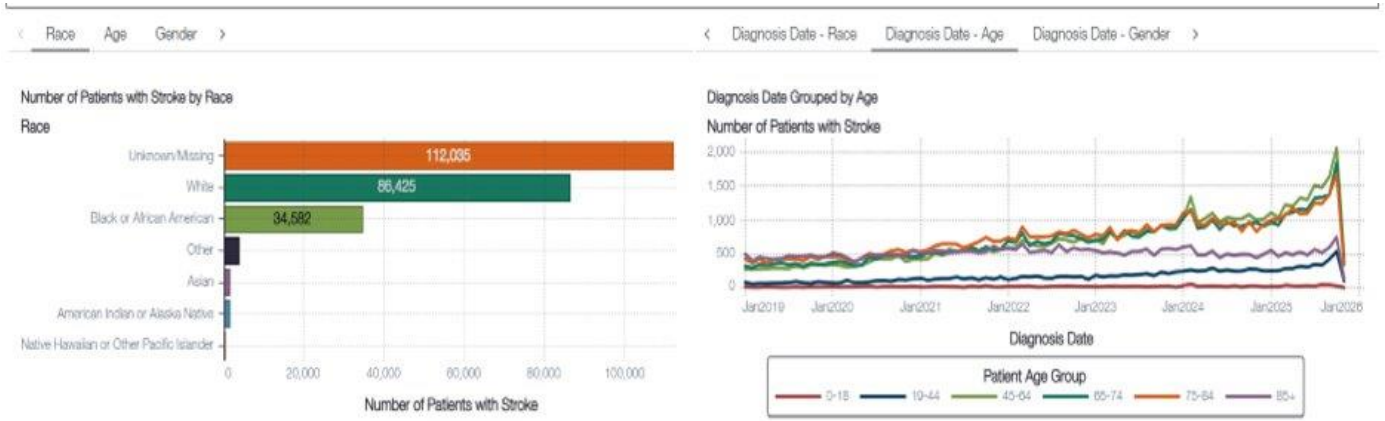
Supports data exchange between healthcare providers, Medicaid, and health plans to reduce duplicative screening work and standardize care

Based on: [eCQM Resource Center]

HIE Measurement: Chronic Disease Registry and Surveillance

Health data used to monitor chronic disease prevalence, clinical care quality, and outcomes





N.C. Diabetes and Stroke Registries

Created through partnerships with state public health authorities

The N.C. Health Information Exchange Authority proudly partners with the N.C. Division of Public Health to deliver reporting for NC HealthConnex's full participants through public health registries to help monitor chronic disease conditions for NC residents.

Data represented here is for demonstration purposes only

NC HealthConnex
Powering Health Care Outcomes

Rural Health Transformation Program(RHTP)

NC HIEA Overview

NC HIEA RHTP

NCDHHS's RHTP Award

In Dec 2025, CMS awarded NCDHHS $213 million for the first year of RHT Program implementation*

NORTH CAROLINA RURAL HEALTH TRANSFORMATION

North Carolina's Rural Health Transformation Program (NCRHTP) focuses on six interconnected initiatives.

1. Build Rural Community Care Network "Hubs"
2. Create Models & Capacity for Expanded Primary Care, Prevention, and Chronic Disease Management
3. Expand and Integrate Behavioral Health and SUD Services
4. Build a Robust & Resilient Workforce & Innovative Care Team Models for Rural Communities
5. Ensure Fiscal Sustainability of Rural Health Providers Through Innovative Financial Models
6. Modernize Rural Care Delivery Through Digital Solutions

Initiative 6

NC HIEA was allocated ~$10M over the first budget period (through Federal Fiscal Year 2027) to expand rural provider connections and support utilization of HIE tools/services.

*** Source**: RHTP ROOTS Hubs webinar 2-26-26 v2.24_TM.pdf

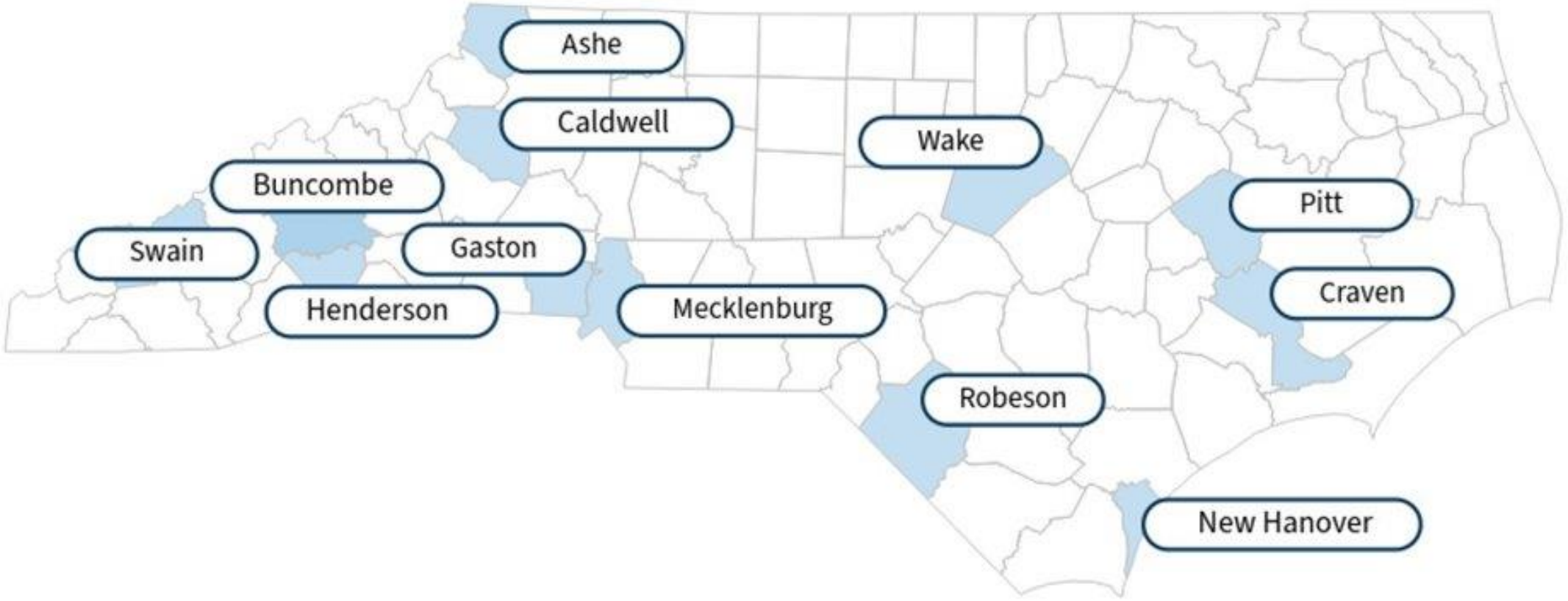
Overview of NC HIEA's RHTP Efforts

Expand rural provider participation and value from NC HealthConnex to promote the secure and efficient sharing of health information and improve health outcomes.

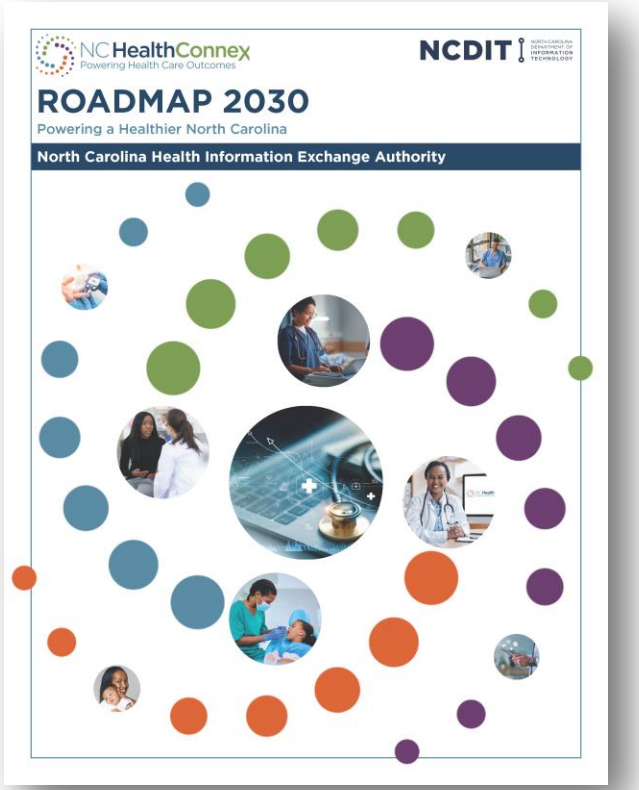
Program Administration	**Plan and administer the RHTP— onboard new staff, set up process, and track progress**
Provider Connectivity	**Identify RHTP-eligible providers for the pipeline and pursue connectivity initiatives to expand rural connectivity**
Technical Assistance and Training	**Provide hands-on technical assistance during implementation and tailored training for use of HIE tools**
Stakeholder Engagement and Convening	**Engage key stakeholders and rural providers to inform strategic direction, provide feedback, and promote RHTP**

NC HIEA RHTP Steering Workgroup

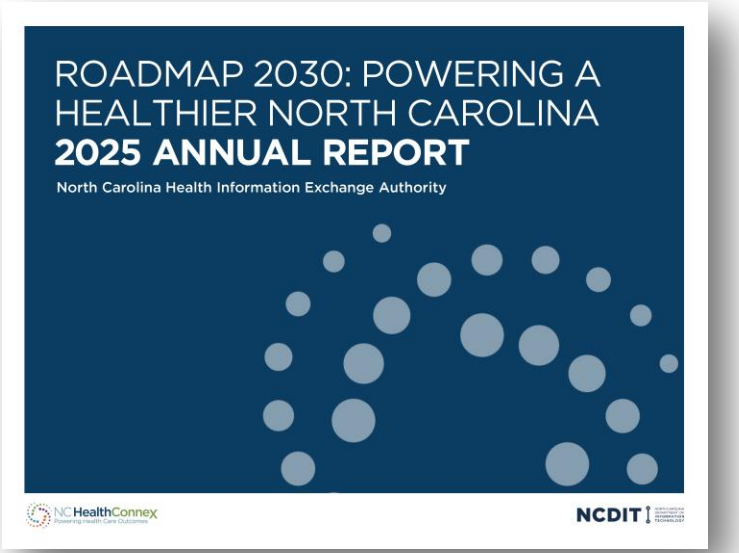
Map of Participants



NC HIEA: Additional Resources and Upcoming Projects



- Released in January 2025, the Roadmap 2030 is available on NC HIEA's website.
- The Roadmap is a strategic document outlining the vision for 2025-2030 and our overarching goals.



- Released July 2026, NC HIEA's inaugural 2025 annual report is available at on our website.
- The 2025 Annual Report establishes a foundation for accountability and transparency and provides a baseline for measuring progress towards Roadmap 2030 goals

NC HIEA Projects in the Pipeline: PIQXL Gateway; Terminology Services

QUESTIONS?

Rural Care Transitions

Leveraging Health Information Exchange (HIE) data to evaluate patient care-seeking patterns

Rama Thummalapalli, MS, CSSBB – Director of Health Data Insights

Trevor Jurjevich – Data Scientist

CyncHealth

About CyncHealth

A central data hub that drives personal and public health ***forward***.

Clinical data

Claims data

Pharmacy data

Public health

Health-related social needs

CyncHealth

Current Challenges

1. No visibility into community level utilization metrics
2. No clear basis for prioritizing community health needs
3. No information on patients seeking care outside the community

CyncHealth

Why Data Matters

Understanding care transitions by patients when they do not return for a defined service is critical to

Support care continuity and patient safety

Understand retention and referral patterns

Provide insights for rural service line planning

Help communities thrive across the state

What is Shown

Retention | **Destination Category** | **Transitions** | **Trends**

Creates a shared view of aggregate care patterns.

CyncHealth

Project Framing

Understand

Goals of stakeholders.

Document

Criteria and timing.

Define

Acceptable use and governance needs.

Present

Metrics to assist with decision making.

CyncHealth

Metric Definitions

Care Transitions

% of procedures outside health system

=

Procedures performed **outside of** General Hospital for population of interest

÷

All procedures performed for population of interest

Care Retention

% of procedures retained

=

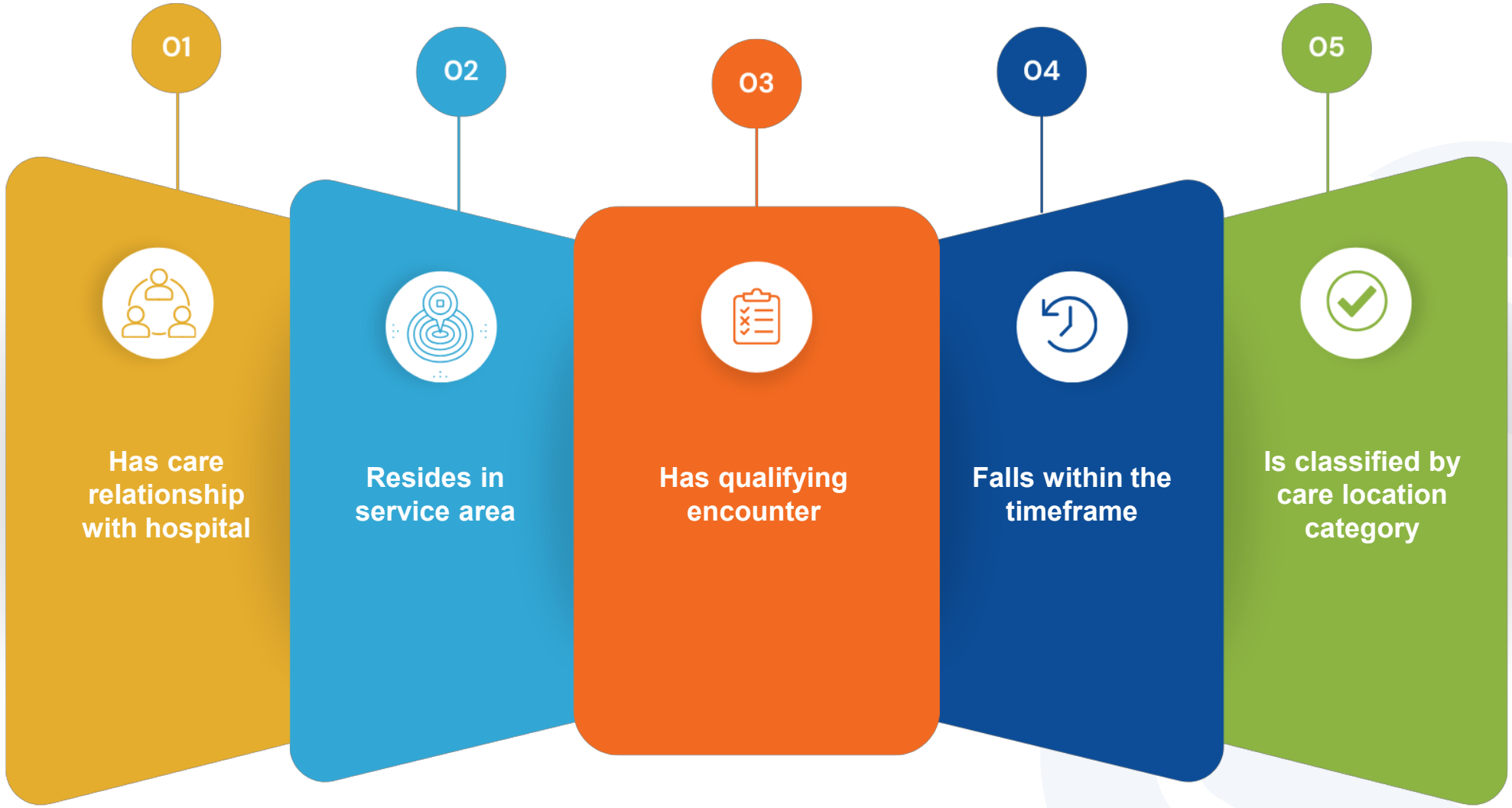
Procedures performed **within** General Hospital for population of interest

÷

All procedures performed for population of interest

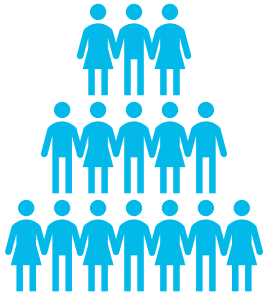
CyncHealth

Cohort Construction



CyncHealth

Technical Translation



Define the population of interest

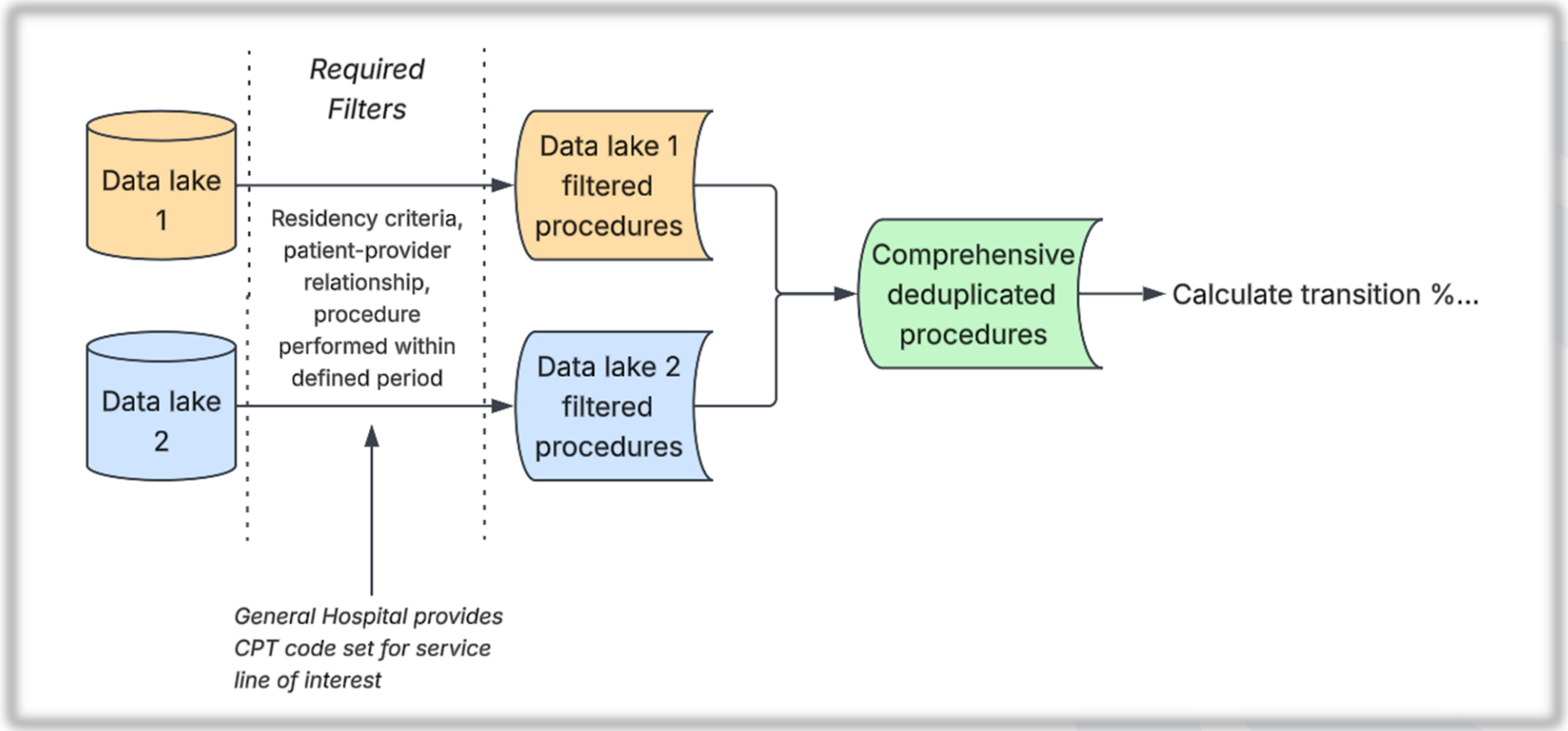
- Lived in set list zip codes
- Established relationship with General Hospital
- Underwent a procedure for the service line within date range

Cross-source involvement

- Requested information that resides in different data environments
- Added complexity due to duplicative HL7 feeds

CyncHealth

Calculation Workflow



CyncHealth

Results Interpretation

Metric output...

...stakeholder communication.

Numerator = **120**,
Denominator = **200**

"60% of your patients transitioned outside of your hospital for ABC procedures.

Year = [YYYY],
Quarter = [QQ],
Procedure = [PROC],
Numerator = **35**
Denominator = **75**

"During quarter [QQ] of [YYYY], only 25% of your patients had [PROC] outside your facility.

CyncHealth

External Sharing Guardrails

Use Aggregate Data Only

Use summarized counts and percentages.

Suppress small cells

Do not display low-count values or combinations that increase re-identification risk.

Ensure Agreements Support Review

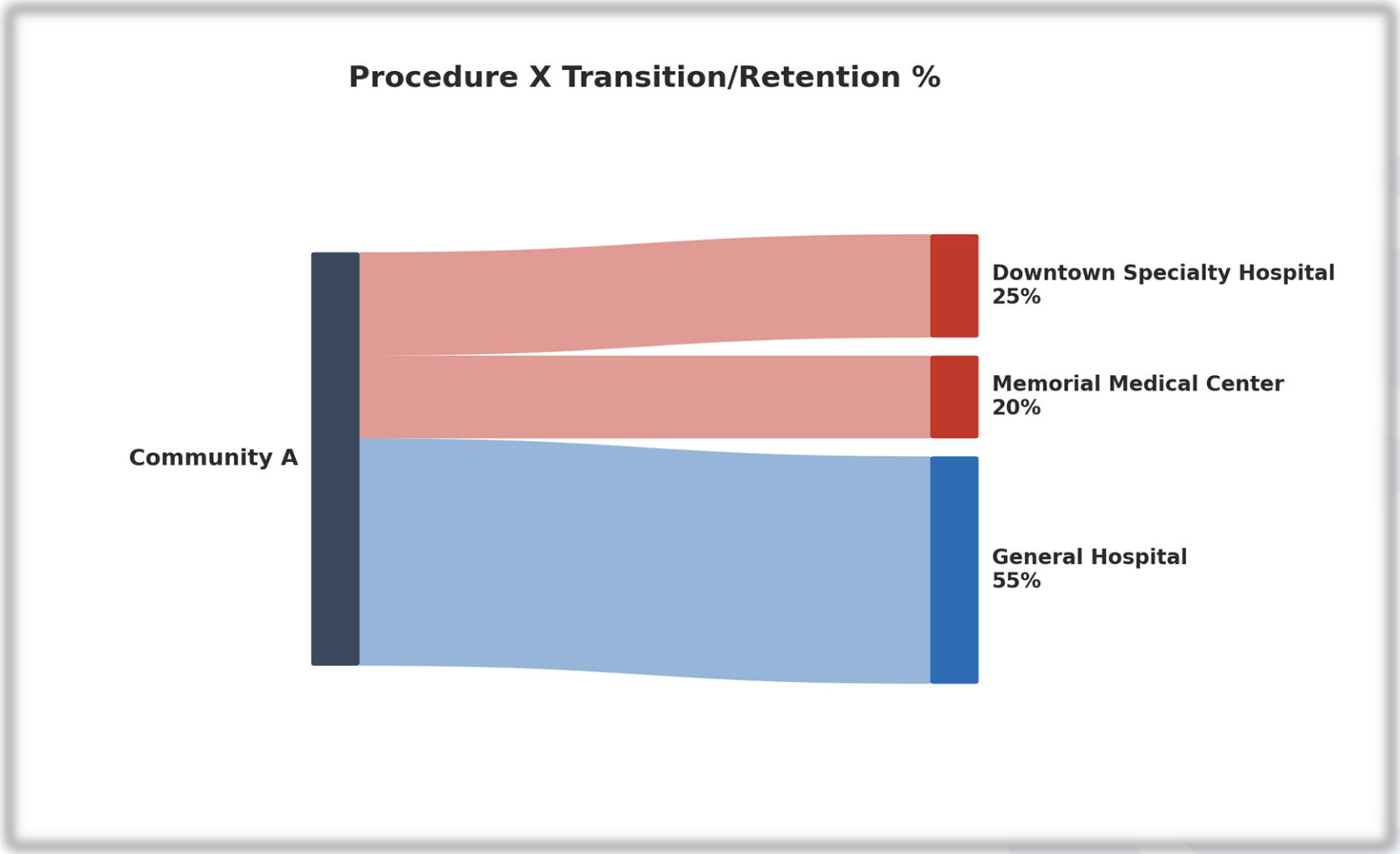
Ensure use case is allowed in participation agreements and aligned to data governance best practices.

Offer Insights Equally

Avoid providing insights that contribute to unequitable outcomes

CyncHealth

Final Product



CyncHealth

Data Driven Postpartum Support

HIE Infrastructure for High-Risk Populations

Jana Lang, NJ Family Care
Jahnoy Smith, Horizon NJ
Arley Styer, Camden Coalition
Laura Sorensen, Camden Coalition

Horizon | Horizon NJ Health

Camden Coalition

Pilot Overview

Substance use disorder is one of the leading causes of pregnancy associated maternal mortality, with nearly 20% of pregnancy associated overdose deaths occurring in the postpartum period. The postpartum period represents a critical moment in care to connect individuals with a history of substance use disorder to resources to allow them to prioritize their wellbeing and stay connected to substance use treatment.

Camden Coalition

Horizon

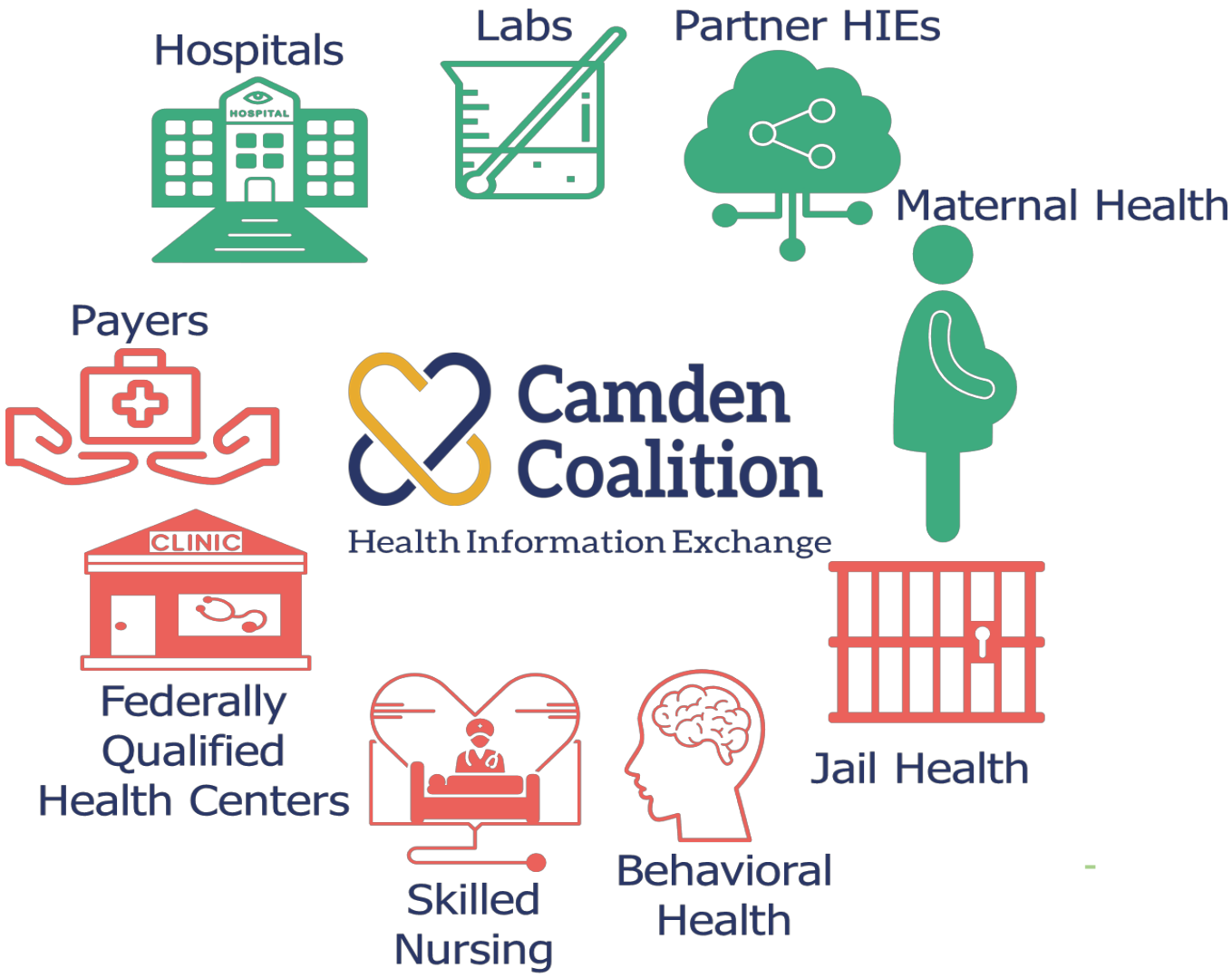
NJFAMILYCARE
Affordable health coverage. Quality care.

ADVANCING Health Equity

Health Information Exchange

- Launched in 2010
- **3.8m patient records** across South Jersey
- Anchored by 4 New jersey health systems (Cooper, Jefferson, Virtua, Inspira)
- 50+ Participating Organizations
- **Capabilities**:
  - Improves clinical decision making, and communication and collaboration across providers
  - Enriches regional healthcare ecosystems – for example, supporting collaborations between medical providers and social service providers
  - Population-level data analysis around individuals utilizing care across the region

Camden HIE Data Contributors



- Master Person Index
- Admission Discharge Transfer notifications
- Lab/Radiology Results
- Discharge Summaries
- Medication List
- Problem List
- Allergy List
- Inpatient Notes
- OBGYN Notes
- Progress Notes
- Radiology Text Notes
- Medicaid Prescription Data
- Perinatal Risk Assessment

Workflow overview

Step 1: Pre - Assignment

- **Horizon** sends Camden Coalition a monthly attribution list using following criteria:
  - Horizon Medicaid Members
  - Lives in one of 7 Southern NJ counties
  - Aged 18-49
  - Assigned female at birth
  - Has a history of SUD treatment in past 5 years
- **Camden Coalition** provides a beacon report, updated daily, that shows members from the attribution list who have had a recent delivery

Step 2: Assignments

Overview

Needs: HIE and Care Radius
Person Responsible: Team Supervisors
Schedule: Weekly

- Information from the beacon report can be entered into the patient chart during assignments.
- We will monitor the benefit vs burden of entering information

Process

- **Supervisor(s)** receives daily alert of eligible members and makes assignments weekly
- **Supervisor(s)** makes assignments to Care Management team in Care Radius
  - Create member profile if member is not in the system
- Alert care managers that member was identified through HIE workflow

For continuity, check for previous GEMs outreach during this pregnancy and assign to existing case manager

Step 3: Outreach

Outreach Cadence

- Initial outreach attempt: within 7 days of assignment
- Additional outreach cadence: 3 attempts within 30 days + a letter with Medicaid Resource Guide
- *GEMS team can contact supervisors to access additional contact information in HIE to support outreach*

GEMS Team Services

- General GEMs case management support
- Medicaid Resource Guide
  - Can be emailed or mailed

Successful contact

Documentation

- Successful outreach uses a workflow specific survey to capture offered/accepted SDOH services and HIE utilization for outreach
- Outreach attempts and other documentation is done within a workflow specific contact note
  - Contact note type will be used to identify pilot patients during evaluation

Operational Overview

Key Themes

Successful collaboration required trust, transparency and structured facilitation

Operational investments supported readiness for implementation

Infrastructure investments were necessary for launch and continuation

Initial Findings

Key Metric	Count	Percent
Members Included in Pilot	206	100.00%
Successfully Reached	179	86.89%
First Call Success	90	43.69%
Second Call Success	41	19.90%
Final Outreach Success	74	35.90%
Unable to Contact	26	12.60%
Outreach not Made (Eligibility)	1	0.49%
Enrolled/Engaged in Case Management	23	11.20%

Lessons Learned

Fear, stigma, and child welfare concerns can hinder postpartum engagement and disclosure.

An iterative spirit allowed to broaden the definition of success to include engagement, stabilization, and patient-centered harm reduction beyond SUD treatment.

Health information exchange data can identify members missed by traditional outreach but requires strong operational capacity to drive timely action.

Implementation Recommendations

Align	Align on definitions of success early and revisit them regularly.
Prioritize	Prioritize relationship development as core infrastructure.
Maintain	Maintain flexibility during implementation.
Invest	Invest in staff training and practical resources.
Build	Build sufficient time for contracting and data sharing approvals.

Thank you

Camden Coalition

Audience Q&A

Please enter any questions you have for today's speakers in the Q&A section of the right-side taskbar.

Thank You!