NC HealthConnex
Powering Health Care Outcomes

NORTH CAROLINA HEALTH INFORMATION EXCHANGE AUTHORITY

June 17, 2025
Advisory Board Meeting

NCDIT NORTH CAROLINA DEPARTMENT OF INFORMATION TECHNOLOGY

Welcome &
Call to Order

North Carolina Health Information Exchange Authority

Overview of Topics

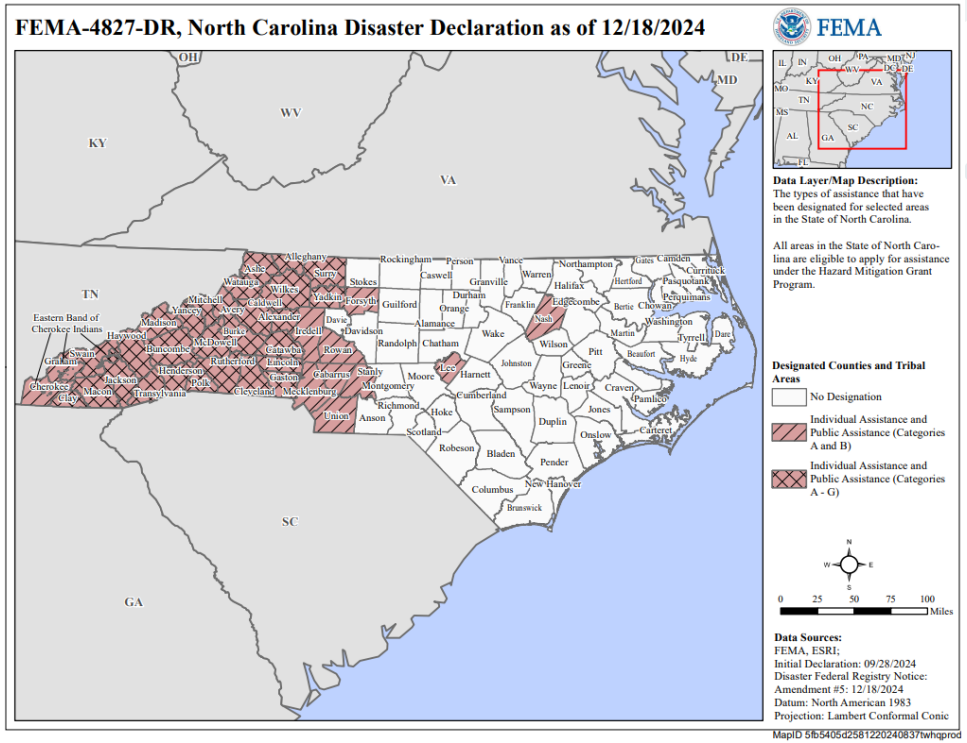
1. Helene Response Debrief
2. GLP 1 Analysis
3. Risk Assessment and HITRUST Certification
4. Operations Update
5. Supporting Behavioral Health
    a. Integrated health and health information exchange
    b. NC HIEA behavioral health numbers
    c. NC HIEA behavioral health data target
    d. Implementation plan

NC HIEA Helene Response Debrief

Hurricane Helene: Unprecedented Impact and Strategic Response

On September 27, 2024, Hurricane Helene struck North Carolina with unprecedented force. The accompanying flooding, landslides, strong winds, and tornadoes caused:

- **107** fatalities[1]
- **~$59.6 billion** in damage[2]
- **>73,000** homes destroyed[2]
- **>6,900** road and bridge sites damaged[2]
- **145** health care facilitates evacuated[2]
- Sewage and water treatment systems disrupted in multiple communities and **44** emergency response facilities[2]



By October 16, 2024, the federal government had declared an emergency for **39** of the state's 100 counties.[3]

[1] NCDHHS, https://www.ncdhhs.gov/assistance/hurricane-helene-recovery-resources/hurricane-helene-storm-related-fatalities
[2] NC OBSM, https://www.osbm.nc.gov/hurricane-helene-dna/open
[3] FEMA, https://www.fema.gov/disaster/4827
Picture from NOAA, https://www.nhc.noaa.gov/data/tcr/AL092024_Helene.pdf

NC HIEA's Role in Supporting the Hurricane Response

NC HealthConnex's expansive connectivity footprint was crucial in facilitating patient lookup services and sustaining clinical data access during Hurricane Helene.

Identifying Missing Populations

NC HIEA identified the location and latest health care information of medically vulnerable and missing persons, providing timely and actionable information about the well-being of these populations.

- NC HIEA **queried clinical data** for nearly 27,500 individuals to search for health care encounters.
- NC HIEA also **established alerts** to inform participants when missing and vulnerable individuals received clinical care.

Enabling Provider Access to Clinical Data

NC HIEA maintained provider access to patient data, ensuring that providers could continue to deliver informed medical care, even if they lacked access to their medical facilities or electronic health record systems.

- Existing NC HIEA participants were able to **access data via the Provider Clinical Portal** at no cost.
- NC HIEA expedited the **processing of new access (i.e., participation) agreements** for more than 92 providers.

Lessons Learned for Enhancing Future Responses

NC HIEA played an instrumental role in supporting the state's hurricane response; however, there were several lessons on how it and its resources could be of greater use in future emergencies.

Lesson Learned	Description	Recommendations
(1) Clarity in NC HIEA Role in Disaster Responses Important for Meeting Future Expectations	NC HIEA's role in disaster response should be clearly defined and communicated to all stakeholders.	▪ Formalize NC HIEA's disaster response role and functions ▪ Develop internal playbook
(2) Cross-Stakeholder Collaboration Necessary for Timely, Effective Responses	NC HIEA collaborated across state agencies to coordinate resources to address emergent health needs.	▪ Sustain disaster preparedness collaboration and develop formal cross-department response protocols
(3) Strong Legal Foundation Essential for the Exchange of Disaster Response Data	NC HIEA encountered legal barriers that delayed its ability to support missing persons identification.	▪ Provide statutory authority for data exchange during emergencies ▪ Establish legal agreements with relevant parties
(4) Enhanced Technical Capabilities Would Support Missing Persons Identification	NC HIEA processes to support missing persons identifications were manual and labor intensive.	▪ Standardize data sharing formats ▪ Centralize data exchange platform ▪ Increase stakeholder utilization of existing services ▪ Improve completeness of NC HealthConnex data ▪ Explore other data sources for real-time person-tracking

Future Directions

Peer HIE Engagement

The Critical Role of HIEs in Natural Disaster Responses
Monday, September 29th, 2025

- *Kevin McAvey, Manatt Health*
- *Pamela King, Florida Agency for Health Care Administration*
- *Ali Modaressi, Los Angeles Network for Enhanced Services (LANES)*
- *Sam Thompson, NC HIEA*

Public Health Research

The NC HIEA will support research into health care and public health topics, such as:

- Analyzing which health care providers are most likely to have patient encounters post-disaster
- Reviewing health outcomes after natural disaster or environmental exposures
- And more…

NC Medicaid GLP-1 Analysis

Current Exchange of Priority Data Elements

1. The NC HIEA has been sharing a monthly extract of data elements with NC Medicaid and the health plans since 2021, known as the **Priority Data Elements**.
2. These files include*:
   a. Demographic information (e.g., address, phone number, race, ethnicity, gender, etc.)
   b. Observations (e.g., systolic/diastolic blood pressure values, height, weight, BMI, etc.)
   c. Diagnosis, Procedures and Problems (e.g., depression screen, bipolar diagnosis, etc.)
   d. Labs (e.g., HbA1c, glucose, total cholesterol, cervical cytology, HDL, LDL, etc.)
   e. Medications
   f. Future: Health-Related Social Needs (HRSN) screening information

OBSERVATION CODE	OBSERVATIONDESCRIPTION	OBSERVATIONCODING STANDARD	OBSERVATION VALUE	OBSERVATION UNITS
3141-9	WEIGHT	LN	18.597	KG
8480-6	SYSTOLIC BLOOD PRESSURE	LN	171	MM[HG]
8462-4	DIASTOLIC BLOOD PRESSURE	LN	86	MM[HG]
8302-2	BODY HEIGHT	LN	166.4	CM
29463-7	BODY WEIGHT	LN	77.111	KG
39156-5	BMI	LN	27.86	KG/M2
39156-5	BMI	LN	46.92	KG/M2
29463-7	WEIGHT	LN	282	[LB_AV]
8302-2	HEIGHT	LN	65	[IN_I]
8480-6	BLOOD PRESSURE SYSTOLIC	LN	122	MM[HG]
8462-4	BLOOD PRESSURE DIASTOLIC	LN	85	MM[HG]
8480-6	SYSTOLIC BLOOD PRESSURE	LN	131	MM[HG]
8462-4	DIASTOLIC BLOOD PRESSURE	LN	70	MM[HG]
8480-6	SYSTOLIC BLOOD PRESSURE	LN	111	MM[HG]
8462-4	DIASTOLIC BLOOD PRESSURE	LN	70	MM[HG]
8302-2	BODY HEIGHT	LN	165.1	CM
29463-7	BODY WEIGHT	LN	95.074	KG
39156-5	BMI	LN	34.88	KG/M2
8462-4	DIASTOLIC BLOOD PRESSURE	LN	68	MM[HG]

*Associated encounter information is sent where available.

Use of the Priority Data Elements for Department Quality Measurements

Initial use for population health monitoring, beneficiary outreach and the production of annual HEDIS measures, such as:

Controlling High Blood Pressure (CBP)

Glycemic Status Assessment for Patients with Diabetes (GSD)

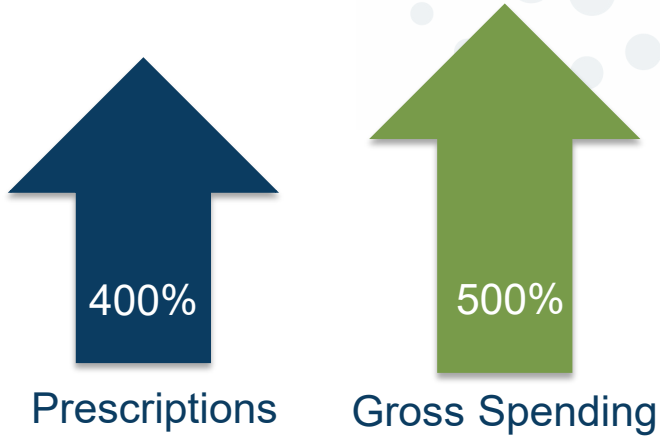
Screening for Depression and Follow-up Plan (CDF)

CMS aims to transition ALL quality measures used for reporting into Digital Quality Measures (dQMs).[1]

[1] North Carolina's Medicaid Quality Measurement Technical Specifications Manual for Measurement Year 2025.

Beyond Quality Measurement: Monitoring Health Outcomes Among GLP-1 Agonist Users

1. From 2019 to 2023, the number of Medicaid GLP-1 (glucagon-like peptide-1) prescriptions reported by CMS increased by more than **400%**, with gross spending up more than **500%**.[1]
2. In August 2024, NC Medicaid began covering GLP-1 medications for obesity management.[2]



3. NC Medicaid is assessing whether GLP-1 use is associated with improved clinical health outcomes for beneficiaries – an analysis that relies on the clinical observations captured in the Priority Data Elements.

[1] Medicaid Coverage of and Spending on GLP-1s.
[2] NC Medicaid to Add Coverage for Obesity Management Medications.

Leveraging Priority Data Elements to Evaluate GLP-1 Health Outcomes

1. We need timely, measurable evidence to assess the impact of policy decisions, but traditional claims data only tell us what services were delivered, not whether those services improved members' health.
2. The HIE Priority Data Elements fill this gap by providing real-time, high quality clinical data such as blood pressure, BMI and lab results, allowing us to track short-term health outcomes.*
    a. **90%** of GLP-1 users (vs. **69%** of non-users) have at least one blood pressure reading
    b. **85%** of GLP-1 users (vs. **63%** of non-users) have at least one Body Mass Index (BMI) reading

*Only Members with a paid claim included in denominator for GLP-Users. Non-User denominator inclusive of members with partial benefits, members <18, and members who may be dual-eligible

Next Steps in Health Outcomes Research

To date, the Program Evaluation team has progressed from descriptive statistics to regression modeling to better understand the impact of GLP-1 use on clinical outcomes such as blood pressure, BMI, and HbA1c.

Preliminary models suggest that GLP-1 use may be associated with improvements in several key health outcomes tracked through the Priority Data Elements.

Beyond GLP-1s, we hope to apply this approach – leveraging the Priority Data Elements – to evaluate other drug therapies, treatments and policy decisions to better understand their real-time impact on member health.

2025 Security Risk Assessment and HITRUST Certification

Enterprise Risk Assessment Before HITRUST

Overview

- Conducting an internal risk assessment before HITRUST is a strategic move.
- Ensures early alignment with HITRUST expectations and identifies gaps.
- Demonstrates maturity in governance and readiness for certification.

Internal Risk Assessment Summary

Last Internal Risk Assessment 2022

The table below represents the aggregate risk identified from the assessment. High risks are 0% of total risks for the system. Moderate risks are 0% of total risks for the system. Low risks are 100% of total risks for the system.

Risk Category	Total	% of Total Risks
High	0	0%
Moderate	0	0%
Low	25	100%
Total Risks	**25**	**100%**

Current Internal Risk Assessment Scheduled - 2025

Pre-requisite for HITRUST Certification planned for 2026

HITRUST Requirement

HITRUST mandates a formal risk assessment process to:

- Identify threats and vulnerabilities
- Evaluate likelihood and impact
- Align control decisions to risk
- Maintain documentation of a repeatable risk process

Strengthens External Readiness

External assessors expect risk-informed control decisions.

Internal assessment ensures control rationale is documented.

Avoids surprises during formal HITRUST validation.

Prioritize Gaps Early

Early detection of weaknesses or gaps

Enables use of compensating controls

Drives corrective action plans (CAPs)

Smoother HITRUST process overall

Benefits Summary

Aligns with HITRUST controls: 03.b, 03.e, 05.g, 09.l

Reduces delays and costly rework

Rationalizes controls based on real risk

Improves HITRUST assessment outcomes

Demonstrates risk governance maturity

Initial Certification Timeline

i1 Start: August 2025

i1 Complete: March 2026

r2 Start: March 2026

r2 Complete: December 2026

NOTE:

To ensure the integrity of HITRUST certifications, HITRUST maintains a set of requirements and expectations as documented in their handbook. One key requirement is that we must show proof of an annual risk assessment. For these reasons we have taken the appropriate actions by adding additional resources to perform our annual risk assessment. Expected timeline: Start kickoff - **June 2025** with a completion of the risk assessment by the end of **August 2025**.

HITRUST Certification – Roles and Responsibilities

Role	Responsibilities
Compliance Lead	Oversee assessment planning and QA
IT Security	Implement technical controls (MFA, logging, etc.)
Risk Officer	Risk alignment and control maturity mapping
HR & Training	Staff security/privacy training rollout
Vendor Mgmt	Vendor assessments, BAA updates
Internal Audit	Pre-assessment QA & readiness checks
Project Manager	Track timeline, coordination, and milestones

Operations Updates:

1. Shifting Q3 meeting date
2. Metrics
3. Budget & Contracts
4. Legislative

Metrics Handout

NC HealthConnex
Powering Health Care Outcomes

Legislative Update

1. Remove Exemption of Substance Use Disorder Treatment Records - ❌
2. HIEA Advisory Board seat for NC DHHS's Division of Health Benefits (NC Medicaid) - ❌
3. Designate NC HealthConnex as a Health Data Utility - ❌
4. Allow federal health services providers to access the NC HealthConnex clinical portal - ❌
5. Make connection voluntary for dentists - ❌
6. Revised Compliance Framework for HIE Act - ❌
7. Authority to recover costs - ❌
8. Allow HIEA to facilitate patient access on behalf of participants that opt to use NC HealthConnex as their onramp to the Trusted Exchange Framework and Common Agreement (TEFCA) - ❌
9. Remove obstacles to share missing and vulnerable persons data with NC HIEA and GDAC - ❌
10. Continue funding received in the SFY24-25 biennium to build technical connections between providers and the HIE - ❌

Budget & Contract Update

- State Fiscal Year Begins July 1
- General Fund appropriation for SFY25-26 –

Base Appropriation:	*$15,584,205*
~~*Nonrecurring:*~~	~~*+ $3,800,000*~~
Total =	***$15,584,205***

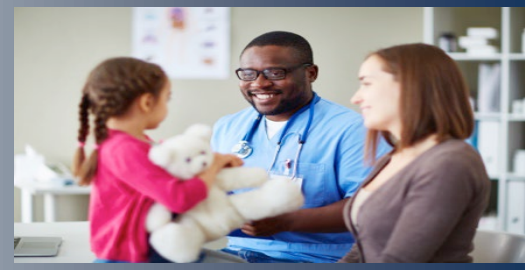
- Operational Advanced Planning Document (OAPD) submitted June 11, 2025
- Scheduled to submit Implementation Advanced Planning Document (IAPD) June 11, 2025
- Base SAS contract extended through June 30, 2026

10-Minute Break

Supporting Behavioral Health







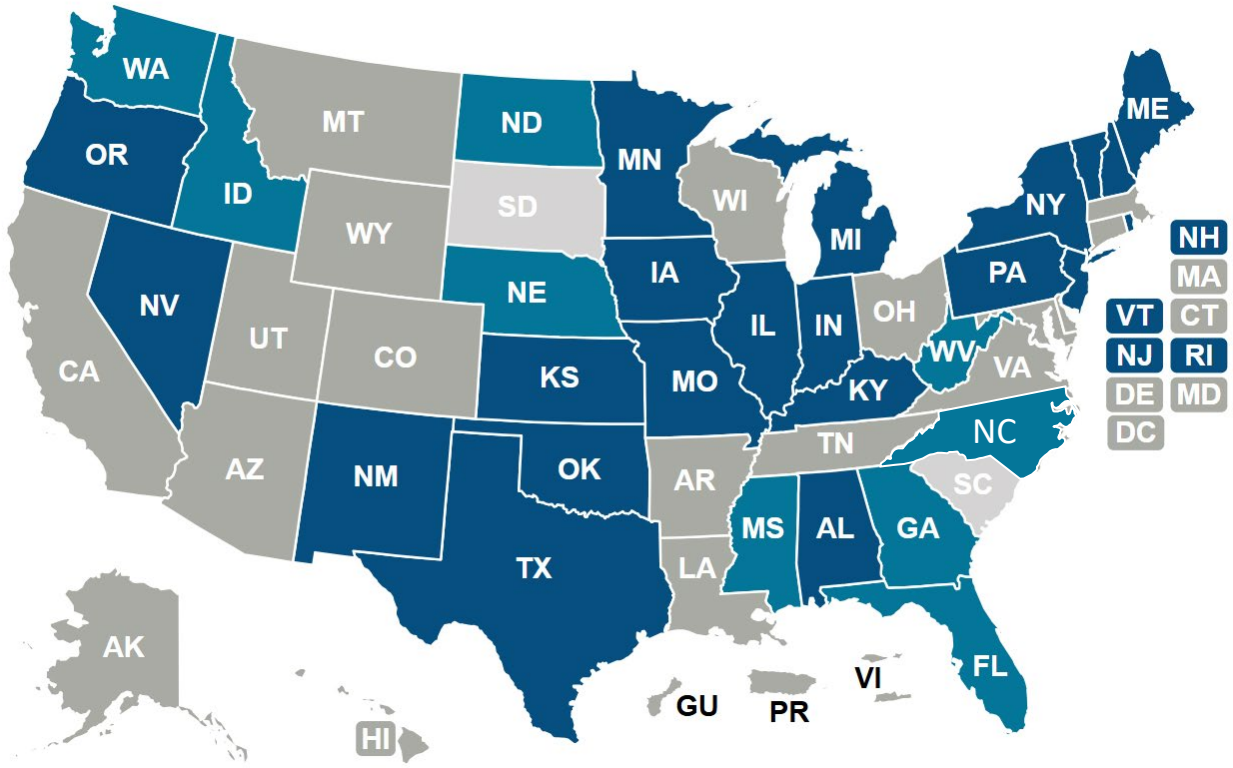
North Carolina's Certified Community Behavioral Health Clinics (CCBHCs): Overview

Kelly Crosbie, MSW, LCSW

Director, Division of Mental Health, Developmental Disabilities, and Substance Use Services (DMHDDSUS)

Additional Background on CCBHCs

- The 2014 Protecting Access to Medicare Act authorized the creation of the CCBHC Demonstration Program.
- CCBHCs are intended to "ensure access to coordinated comprehensive behavioral health care" by providing integrated and coordinated community-based care in partnership with collaborating organizations.
- CCBHCs focus on individuals with serious mental illness or serious emotional disturbance, severe substance use disorders, and co-occurring mental, substance use or physical health disorders.
- It is envisioned that CCBHCs provide a comprehensive range of services—required by statute—that are tailored to the local needs of the population and integrate evidence-based practices to be the hub of service delivery and care coordination for individuals served.



Source: National Council for Mental Wellbeing

CCBHC Requirements

SAMHSA Certification Criteria for CCBHCs (1/3)

SAMHSA has established CCBHC Certification Criteria that all providers participating in federal or state CCBHC programs must adhere to.

CCBHC Requirements Include:

1. **Staffing.** Ensure staffing is multidisciplinary and able to meet cultural and linguistic needs of CCBHC's patient population.
2. **Availability and accessibility of services.** Ensure crisis management services are available 24/7; cannot deny services for lack of ability to pay and must offer a sliding scale for payment.
3. **Care coordination.** Offer care coordination to "ensure seamless transitions for patients across the full spectrum of health services including acute, chronic, and behavioral health needs." Must partner with FQHCs, hospitals, a range of mental health and substance use service providers, and other health and social service providers.
4. **Scope of services.** Offer or have the ability to refer patients to a minimum set of nine services.
5. **Quality and other reporting.** Meet requirements for reporting encounter, clinical outcomes, and quality data.
6. **Organizational authority.** Be a non-profit, state-operated clinic, or tribal health organization.

SAMHSA Certification Criteria for CCBHCs (2/3)

DHHS has the option of matching SAMHSA criteria or establishing additional standards. In certain areas, SAMHSA requires States to develop specific requirements (e.g., define Targeted Case Management). DHHS will focus on developing a limited scope of specific requirements that are a priority for the State and BH system (e.g., justice-involved populations).

Staffing	• Staff both clinical and non-clinical employees based on the community needs assessment • Employ a care management team that is appropriate for the size and needs of the clinic • Comply with state and federal licensure • Train staff on EBPs, cultural competency, person- and family-centered care, trauma-informed care, co-occurring needs • Provide linguistic access to services (e.g., interpreters, auxiliary aids, etc.)
Availability and Accessibility of Services	• Accept all individuals seeking service, regardless of ability to pay or residence (may employ a sliding scale for payment) • Provide emergency crisis services 24/7 • Utilize methods to make services more accessible for CCBHC members (e.g., telemedicine, transportation vouchers) • Respond to member needs in a timely manner (e.g., follow up to routine needs within 10 business days)
Care Coordination	• Coordinate care across settings and providers to address an individuals' acute, chronic, and behavioral health needs • Partner with community providers delivering care to CCBHC patients as well as social and human services entities (e.g., schools, child welfare agencies, criminal justice agencies and facilities).

SAMHSA Certification Criteria for CCBHCs (3/3)

There are areas in the SAMHSA Certification Criteria where DHHS will need to establish specific standards, such as the use of certain evidence-based practices (EBPs) for mental health, SUD, and psychiatric rehabilitation services.

Scope of Services	• Provide the 9 core services (crisis services, screening/assessment/diagnosis, person- and family-centered treatment planning, outpatient mental health and substance use services, primary care screening and monitoring, targeted case management services, psychiatric rehabilitation services, peer/family/caregiver supports, community care for uniformed service members and veterans) directly through the CCBHC or through a DCO • Deliver the majority (51%) of encounters through the CCBHC vs. DCOs • Establish a minimum set of required evidence-based practices for outpatient mental health and SUD services, as well as psychiatric rehabilitation services
Data and Quality Reporting	• Collect, report, and track encounter, outcome, and quality data, including clinic-collected quality measures for the Demonstration program.
Organizational Authority	• Operates as a non-profit, local government BH authority, Indian Health Service authority, or urban Indian organization • Establishes a governing board consisting of people with lived experience

Deeper Dive: SAMHSA's CCBHC Service Requirements

CCBHCs must provide an array of service under 9 categories. DHHS is seeking feedback on the specific services that CCBHCs will provide so patients can receive comprehensive behavioral health care in one setting.

Minimum Required Service Categories

- **Crisis behavioral health services**
- **Screening, assessment, and diagnosis, including risk assessment**
- **Outpatient mental health and substance use services**
- **Psychiatric rehabilitation services**
- **Outpatient clinic primary care screening and monitoring**
- **Peer support and counselor services and family supports**
- **Targeted case management**
- **Mental health care for members of the armed forces and veterans**
- **Patient-centered treatment planning or similar processes**

SAMHSA Required and Allowable Services

- CCBHCs are **required** to provide the minimum nine service categories, either directly or through DCOs.* These services are paid for using the PPS methodology.
  - States have the flexibility to establish whether specific services are provided directly by CCBHCs or through DCOs.
  - 51% of the encounters for the required scope of services must be directly provided by the CCBHC (excluding crisis).
- If indicated in their community needs assessments, CCBHCs can establish **allowable** (i.e., optional) services, which can also qualify for the PPS rate.
- States can also establish required services that are not part of the PPS rate.

NC's Requirements

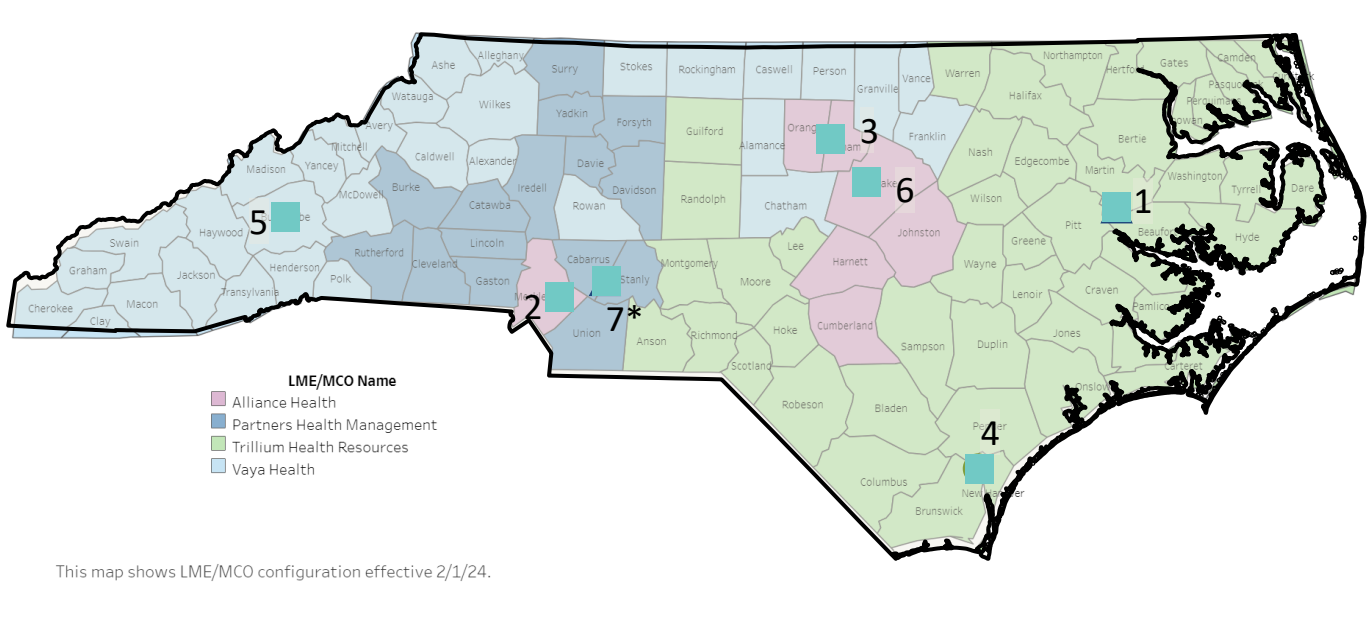
- CCBHCs will be required to provide most of NC's State Plan services for outpatient mental health and substance use directly. State will permit some services to the delivered by DCOs.

*A DCO is an entity that is not under the direct supervision of the CCBHC but is engaged in a formal relationship with the CCBHC to deliver one or more (or elements of) of the required services

North Carolina's Vision and Care Model

Current State of CCBHCs in North Carolina

Over the past several years, North Carolina's CCBHCs have invested significant resources to meet SAMHSA requirements and deliver comprehensive behavioral health services to North Carolinians with behavioral health needs. North Carolina currently has seven clinics operating as CCBHCs.



1. Agape Health Services – Washington, NC
2. Anuvia Prevention & Recovery Center – Charlotte, NC
3. B&D Integrated Health Services – Durham, NC
4. Coastal Horizons Center, Inc. – Wilmington, NC
5. Mountain Area Health Education Center – Asheville, NC
6. SouthLight Healthcare – Raleigh, NC
7. Monarch – Statewide (Albemarle Administrative Office noted on map)

1. Previously funded CCBHCs include: The Carter Clinic, Winston-Salem State University BH Community Support Unit, Freedom House Recovery Center, Cape Fear Valley/Cumberland County Health, Daymark Recovery Services

North Carolina's Primary Goals for CCBHCs

Create Community-Based Hubs of Coordinated Behavioral Health Care

With the mandate to serve all individuals—regardless of Medicaid or housing status or ability to pay—CCBHCs will be an integral part of the state's behavioral health safety net providing person-centered, coordinated, and accessible behavioral health care for North Carolinians.

Address Service Gaps

Though NC has a robust array of Medicaid and state-funded BH services, there are service gaps that limit access. North Carolina will leverage the CCBHC prospective payment system (PPS) model to enhance access to needed care and begin to close service gaps.

Build Sustainable Care Models

The CCBHC PPS rate will enable CCBHCs to build innovative, sustainable care models that will incentivize the right care at the right time and promote a stable workforce.

Trauma-Informed, Culturally Humble, Person-Centered Care

CCBHC certification requirements will support the delivery of trauma-informed, culturally-humble, and person-centered services and practices.

Streamlined Certification Process

CCBHC provider certification process will be designed to minimize provider disruption and burden.

BH Integrated Care Supports for Primary Care

- NC Psychiatric Access Line (NC-PAL and NC MATTERS)
- Collaborative Care Model (CoCM)

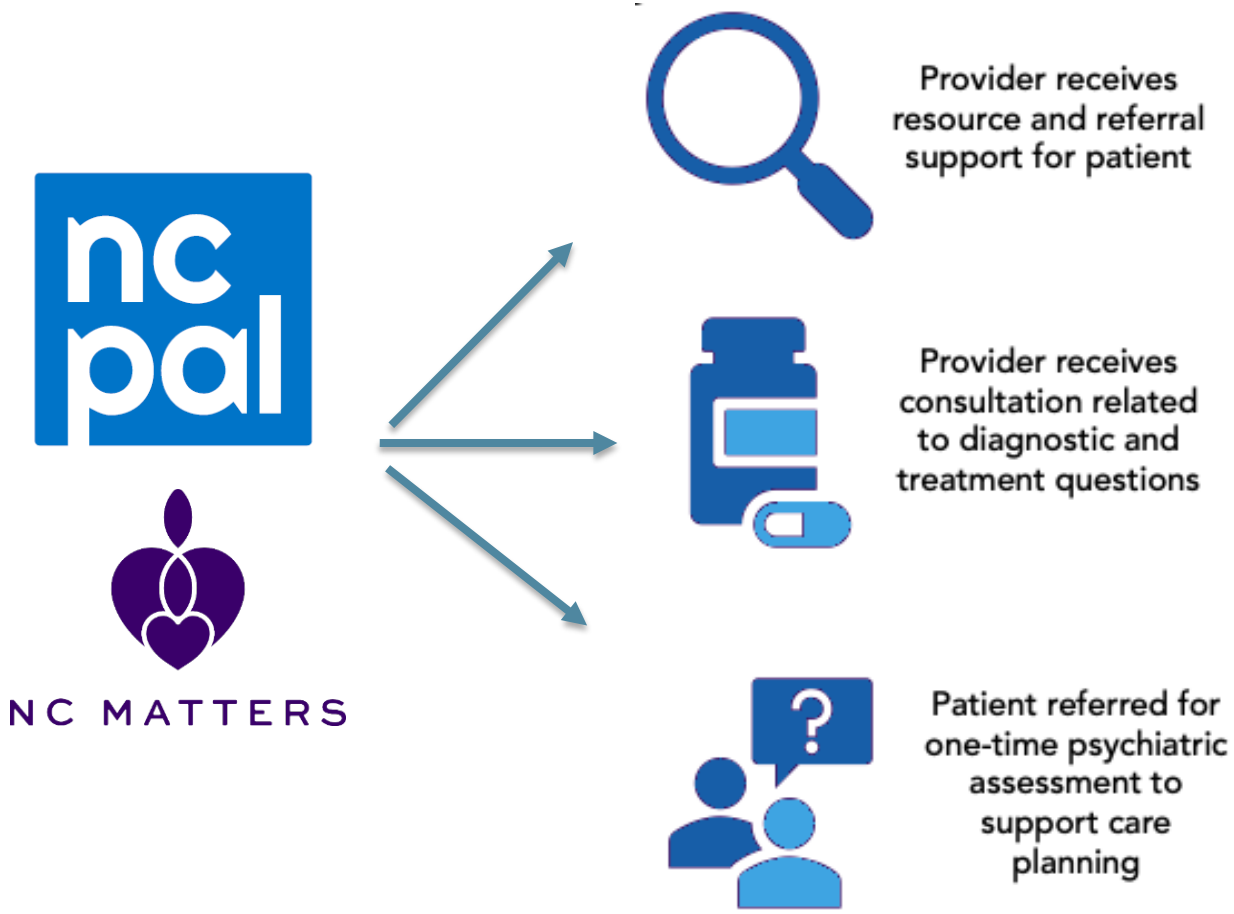
How Do NC-PAL and NC MATTERS Work?

- Provider Calls NC-PAL: **919-681-2909**

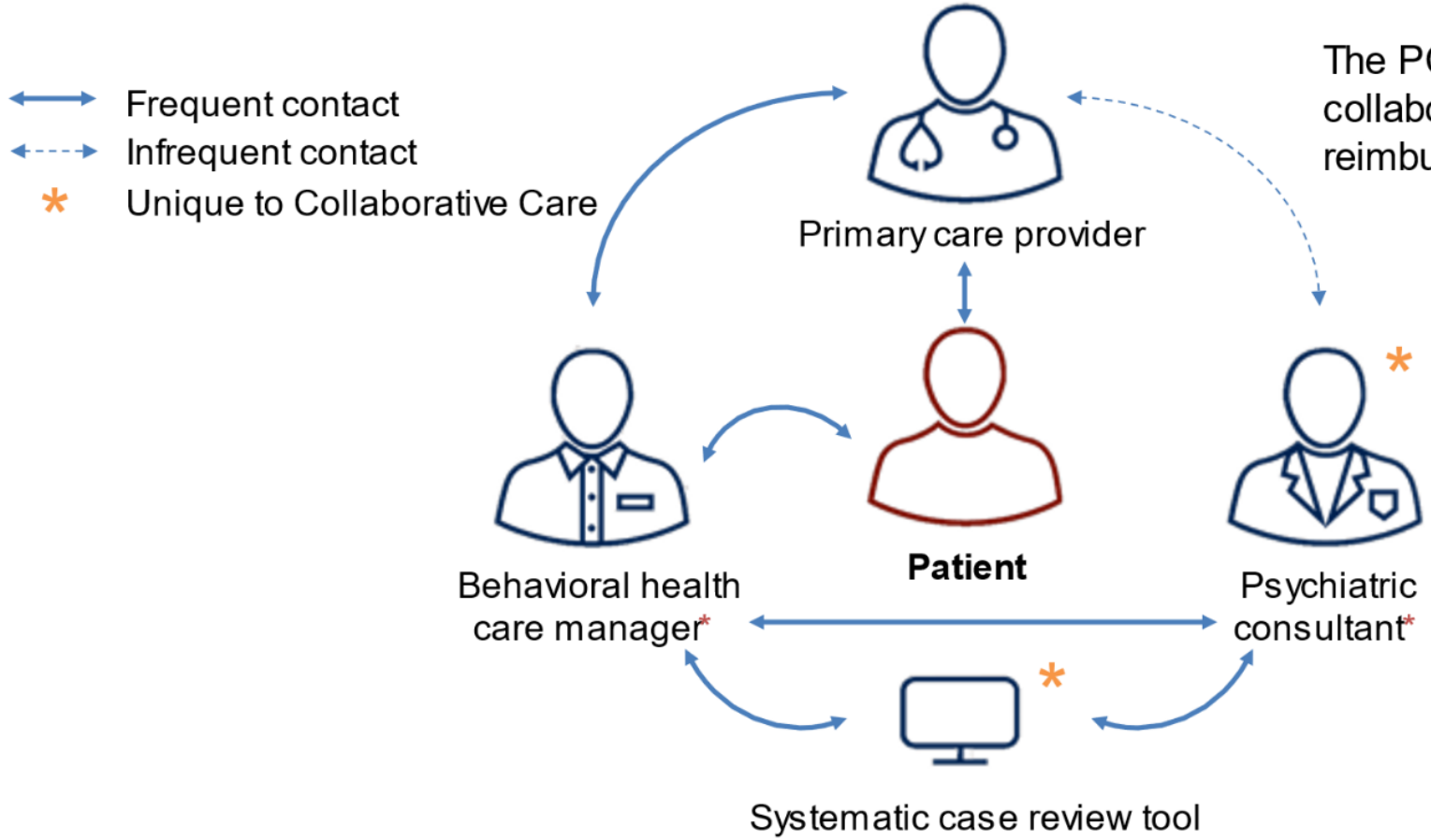
- Behavioral health consultant answers call, collects patient information, and determines how to support the caller's needs

- Pediatric or perinatal specialist will call back within 30 minutes

How Do NC-PAL and NC MATTERSS Help?



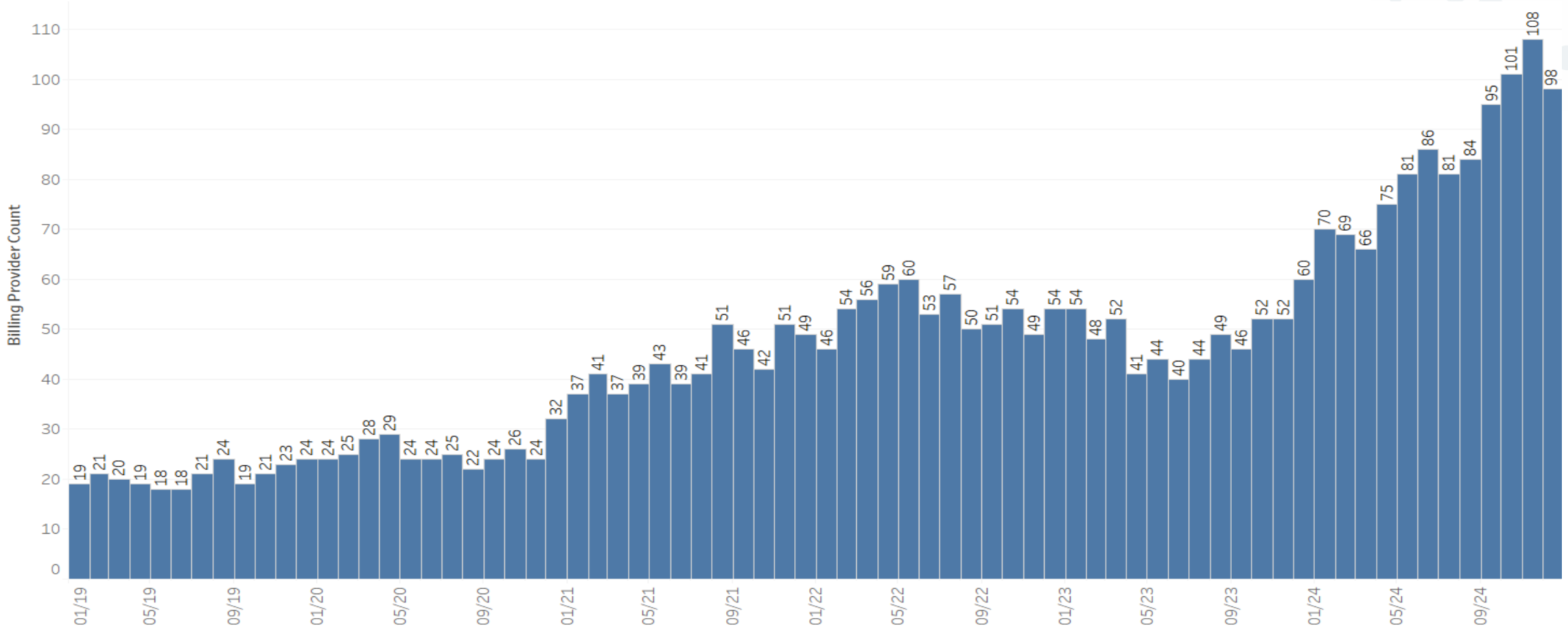
What is the Collaborative Care Model?



The PCP office bills the collaborative care codes and reimburses the psychiatrist.

* The psychiatrist and care manager talk weekly to review the behavioral health caseload.

Number of Providers Billing CoCM by Month



Collaborative Care Claims: 1/1/2019-12/31/2024

Provider defined at the billing NPI Level

NC HealthConnex Behavioral Health Numbers

NC HealthConnex Provider Accessibility

Provider Type

Choose Provider Type

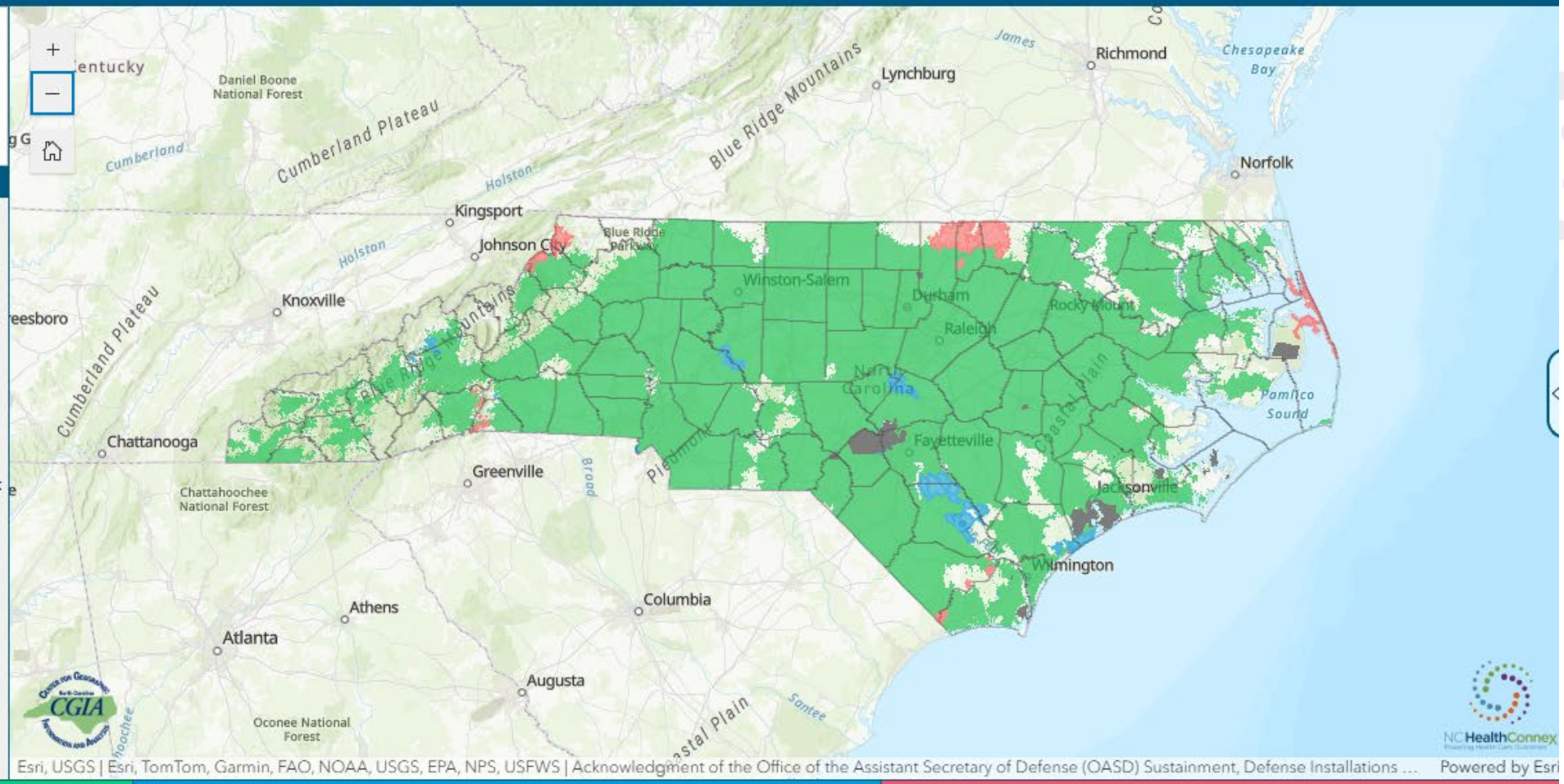
BEHAVIORAL HEALTH

These maps illustrate NC addresses within a 30-minute drive of a provider connected to NC HealthConnex, and how:

- Adding providers in queue for connection **puts more North Carolinians within driving distance** of a connected provider
- Providers disconnecting from the system **leaves more North Carolinians outside driving distance** of a connected provider

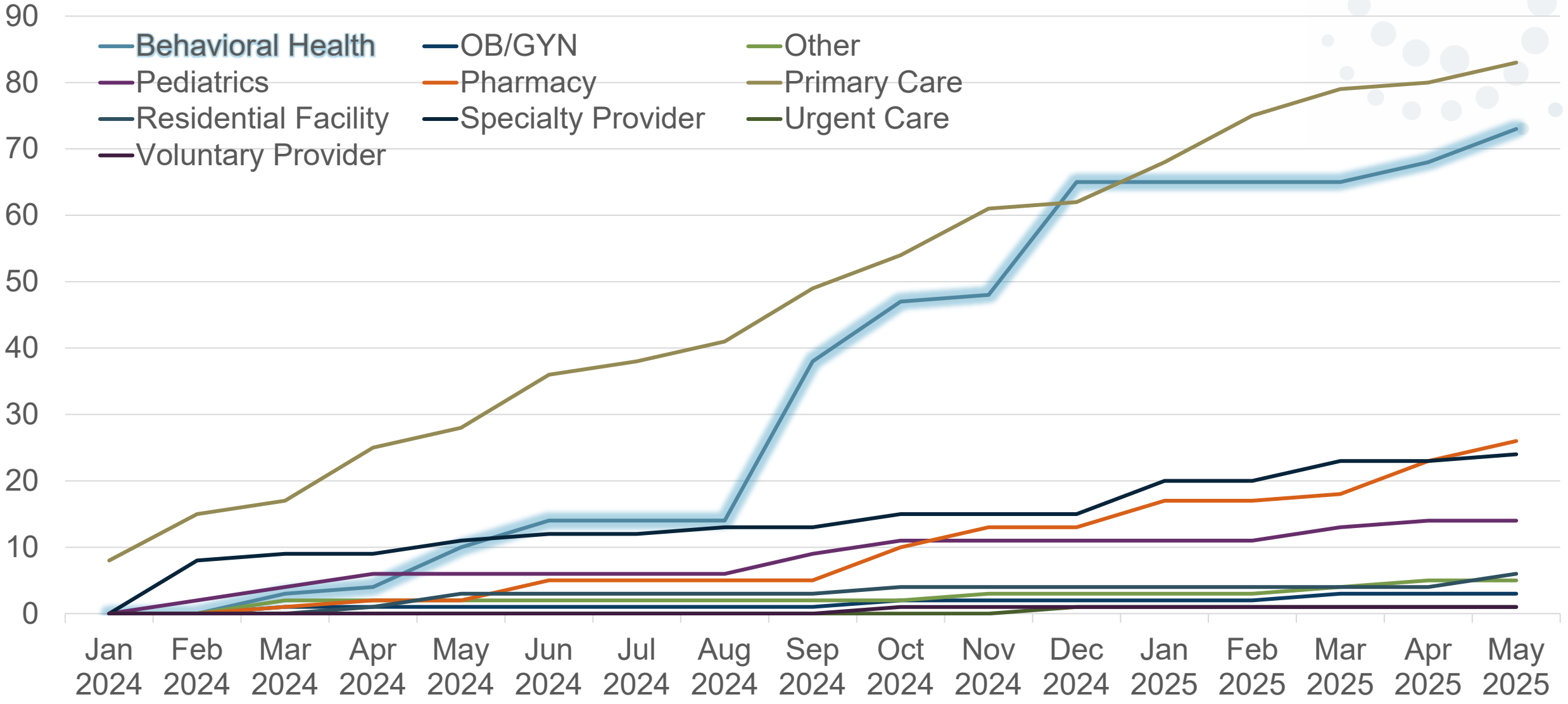
Our next phase will be to enhance the maps so they can be used to prioritize new connections by helping us understand:

- How much information/patients does a provider contribute within their geographic area?
- Of providers that are in queue or unengaged, that are in an area where HealthConnex has limited reach, which ones will contribute the most information/patients?

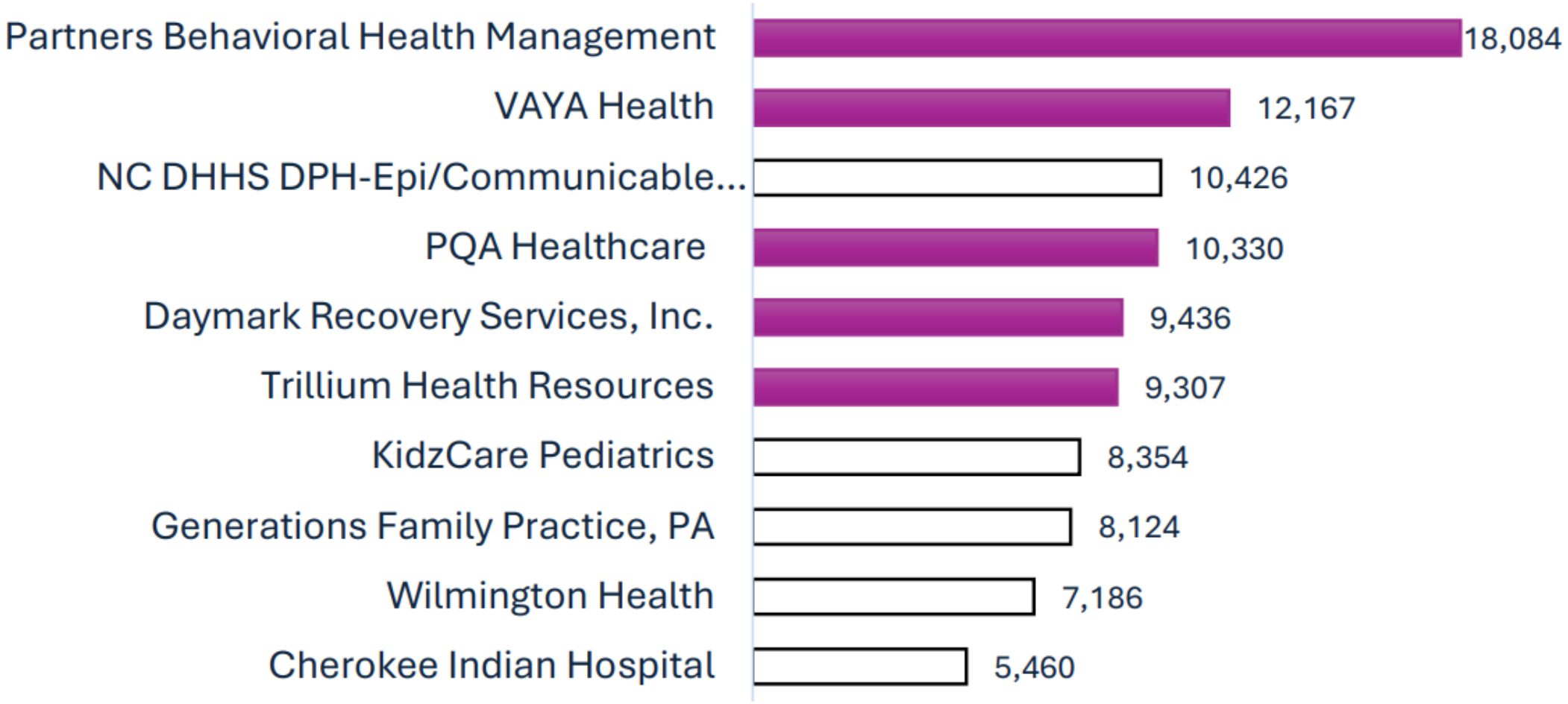


In Production	In Queue	Disconnected
# Providers	**# Providers**	**# Providers**
506	57	113
% Providers Connected	**% Providers Connected**	**% Providers Connected**
74.85	8.43	-16.72
# Addresses	**# Addresses**	**# Addresses**
5,679,152	17,079	-45,217
% Addresses Covered	**% Addresses Covered**	**% Addresses Covered**
96.03	0.29	-0.76

New Connections by Provider Type Since January 2024

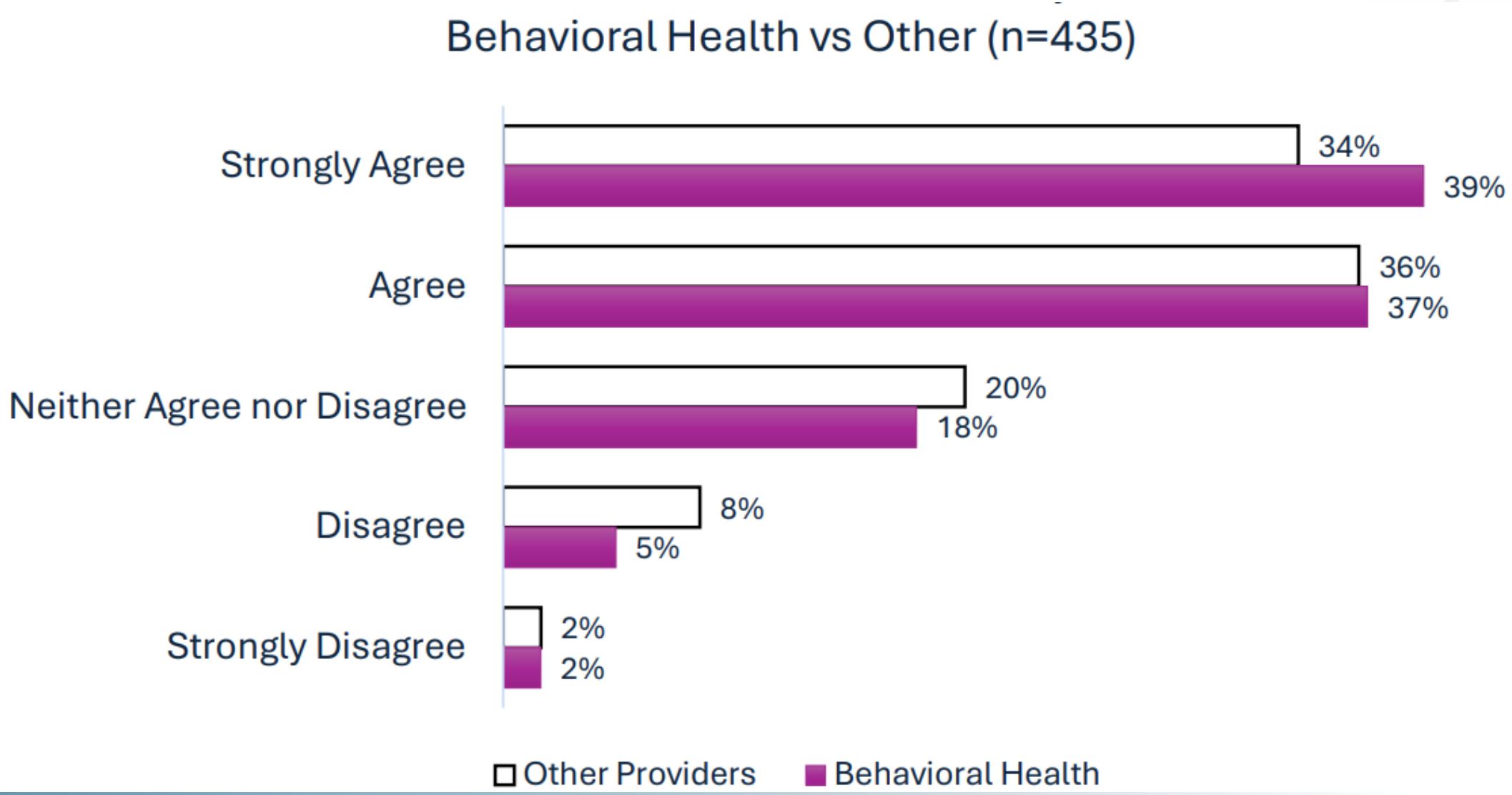


Top 10 Portal Logins by Organization 2024*



*Filled bars are Behavioral Health Providers

The Information in the NC HealthConnex Clinical Portal Helps Me Provide More Informed Care to My Patients

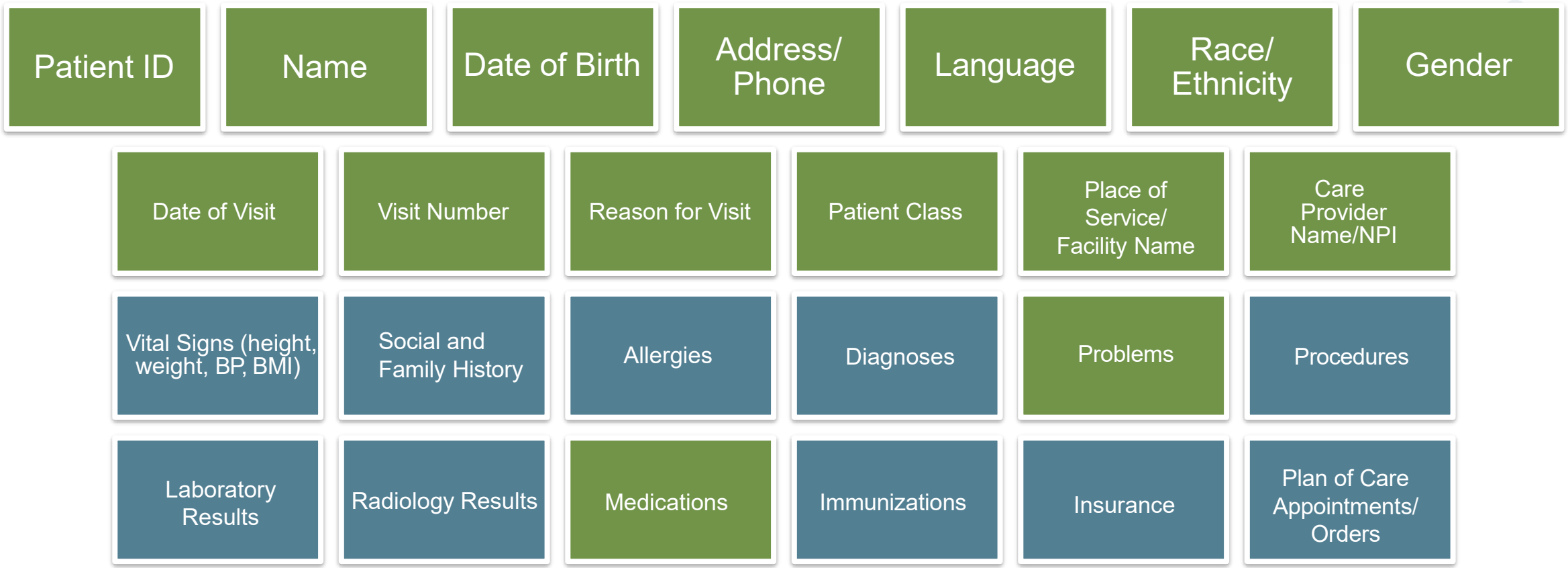


What Questions Should We Be Asking NC HealthConnex?

- To what extent are patients being screened for depression, and, if they screen positive, to what extent are they receiving appropriate follow-up care?
- To what extent are integrated care models improving outcomes for patients and reducing provider burden?
- To what extent is NC HealthConnex helping:
    - reduce duplicative care?
    - identify unmet needs?
    - reduce patient and provider abrasion?

NC HealthConnex Behavioral Health Data Target

What Data Elements Will BH/IDD Providers Need to Submit?



The NC HealthConnex Data Target (Sample)

USCDI V3 - Data Class	HIEA Field Name	Purpose of the field /Description	HL7 V2 Segment	HL7 V2 Component	HL7 V2 Component Name	CCD Path /ClinicalDocument(R2)	Data Type	Usage	Sample	Code system(USCDI V3 Code System)	Exclusion Criteria/Comments
Patient Demographics Information	Patient Last Name	Patient's family name	PID	5.1	Family Name	/ClinicalDocument/recordTarget/patientRole/patient/name[(@use='L' or not(@use)) and not(@nullFlavor)]	FN	R	Doe	N/A	N/A
	Patient First Name	Patient's given name	PID	5.2	Given Name	/ClinicalDocument/recordTarget/patientRole/patient/name[(@use='L' or not(@use)) and not(@nullFlavor)]	ST	R	John	N/A	N/A
	Date of Birth	Patient Birthdate	PID	7.1	Date/Time of Birth	/ClinicalDocument/recordTarget/patientRole/patient/birthTime/value	TS	R	19800101	N/A	N/A
	Patient First Name	Patient's given name	PID	5.2	Given Name	/ClinicalDocument/recordTarget/patientRole/patient/name[(@use='L' or not(@use)) and not(@nullFlavor)]	ST	R	John	N/A	N/A
Medications	Medication Code	Code representing the prescribed medication.	N/A	N/A	N/A	/ClinicalDocument/component/structuredBody/component/section[templateId/@root="2.16.840.1.113883.10.20.22.2.1.1"]/entry/substanceAdministration/entryRelationship[@typeCode="REFR"]/supply[@moodCode="EVN"]/product/manufacturedProduct/manufacturedMaterial/code	CE.1	R	860975	N/A	RxNorm (Medication) SNOMED (Drug Class)
	Code Description	Name or description of the medication.	N/A	N/A	N/A	/ClinicalDocument/component/structuredBody/component/section[templateId/@root="2.16.840.1.113883.10.20.22.2.1.1"]/entry/substanceAdministration/entryRelationship[@typeCode="REFR"]/supply[@moodCode="EVN"]/product/manufacturedProduct/manufacturedMaterial/code	CE.2	R	Amoxicillin 500 MG Oral Capsule	N/A	RxNorm (Medication) SNOMED (Drug Class)
	Medication Code System Name	Coding system used for the medication (e.g., RxNorm).	N/A	N/A	N/A	/ClinicalDocument/component/structuredBody/component/section[templateId/@root="2.16.840.1.113883.10.20.22.2.1.1"]/entry/substanceAdministration/consumable/manufacturedProduct/manufacturedMaterial/code	CE.3	RC	RxNorm	N/A	RxNorm (Medication) SNOMED (Drug
Problems	Problems Code	Code representing the diagnosed problem or condition.	N/A	N/A	N/A	/ClinicalDocument/component/structuredBody/component/section[templateId/@root="2.16.840.1.113883.10.20.22.2.5.1"]/entry/act/entryRelationship/observation/value	CE.1	R	249288007	N/A	SNOMED/ICD10
	Code Description	Description of the problem code.	N/A	N/A	N/A	/ClinicalDocument/component/structuredBody/component/section[templateId/@root="2.16.840.1.113883.10.20.22.2.5.1"]/entry/act/entryRelationship/observation/value	CE.2	R	Incomplete bladder emptying	N/A	SNOMED/ICD10
	Problems Code System Name	Coding system used (e.g., SNOMED CT, ICD-10).	N/A	N/A	N/A	/ClinicalDocument/component/structuredBody/component/section[templateId/@root="2.16.840.1.113883.10.20.22.2.5.1"]/entry/act/entryRelationship/observation/value	CE.3	RC	SNOMED CT	N/A	SNOMED/ICD10

NC HealthConnex Behavioral Health Implementation Plan

Objective

To improve health information exchange connectivity among behavioral health providers and support the state's health care and public health goals

Initial Focus on Part 2 Providers

NC HIEA will initially focus on supporting Part 2 providers as a specific subset of behavioral health providers subject to heighted federal data protections.

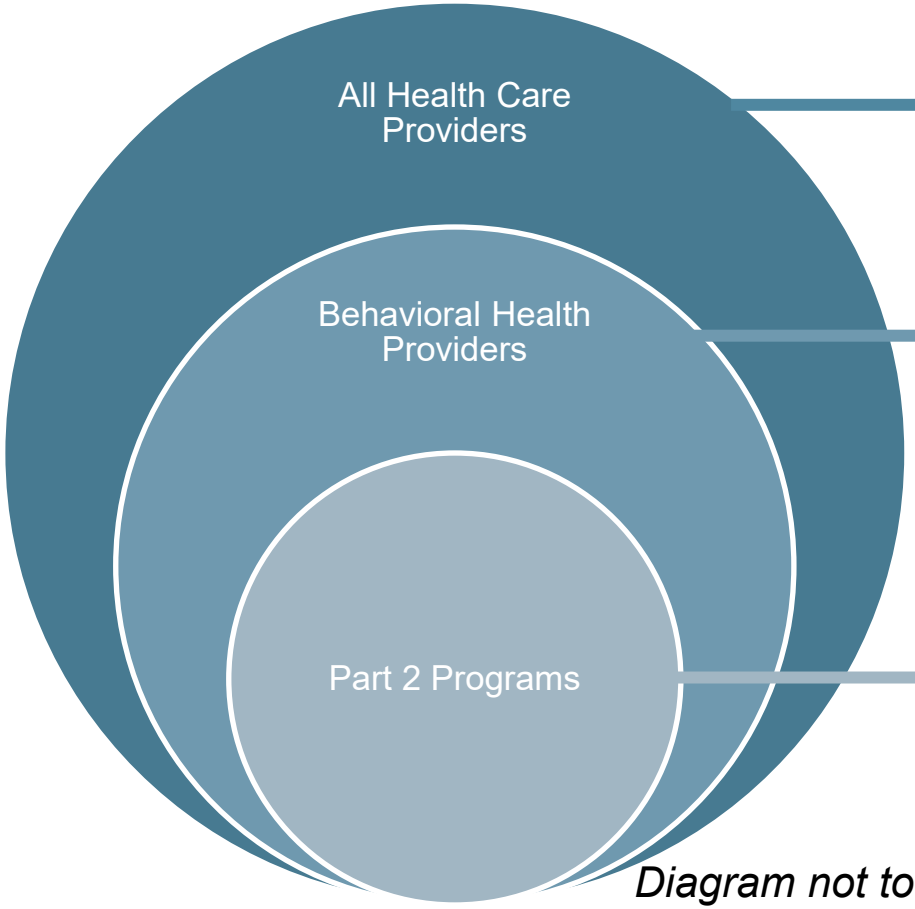


Diagram not to scale.

Almost all subject to **federal HIPAA requirements**

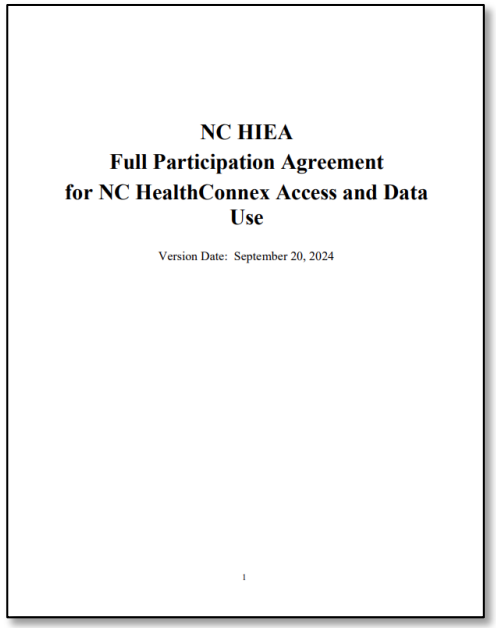
May be subject to **additional federal HIPAA (psychotherapy notes)** and **state mental health regulations**

Subject to **federal 42 CFR Part 2 regulations**, which require providers to obtain written patient consent to share substance use disorder (SUD) data from certain federally assisted programs

Regulatory Updates Support Greater Part 2 Data Exchange

Under current policy, NC HIEA does not accept Part 2 data. However, NC HIEA is exploring opportunities created by recent federal policy changes–simplifying consent processes required for entities to share Part 2 data–to support Part 2 data integration and exchange.

Current Policy



NC HIEA
Full Participation Agreement
for NC HealthConnex Access and Data Use

Version Date: September 20, 2024

1

*"Participant **shall not send Part 2 Data** to NC HealthConnex unless and until NC HIEA notifies Participant in writing that NC HIEA can accept Part 2 Data."*

Policy Changes Under Consideration

Revisions to authorizing statues to facilitate Part 2 data exchange once NC HIEA can appropriately protect such data

Technical changes:

- Data tagging and segmentation
- Consent solution
- Role-based access

Peer HIEs Use Varying Approaches to Support Part 2 Data Exchange

Interviews with four peer HIEs suggests that HIEs adopt different policy, technical and operational processes, tailored to state policy and market dynamics, to enable Part 2 data exchange.

HEALTHeLINK™

Opt in consent model in place for all data enables Part 2 data exchange between health care providers

CRISP

Provider champions to develop technology solutions for Part 2 data exchange

LANES

Connect · Innovate · Transform Health

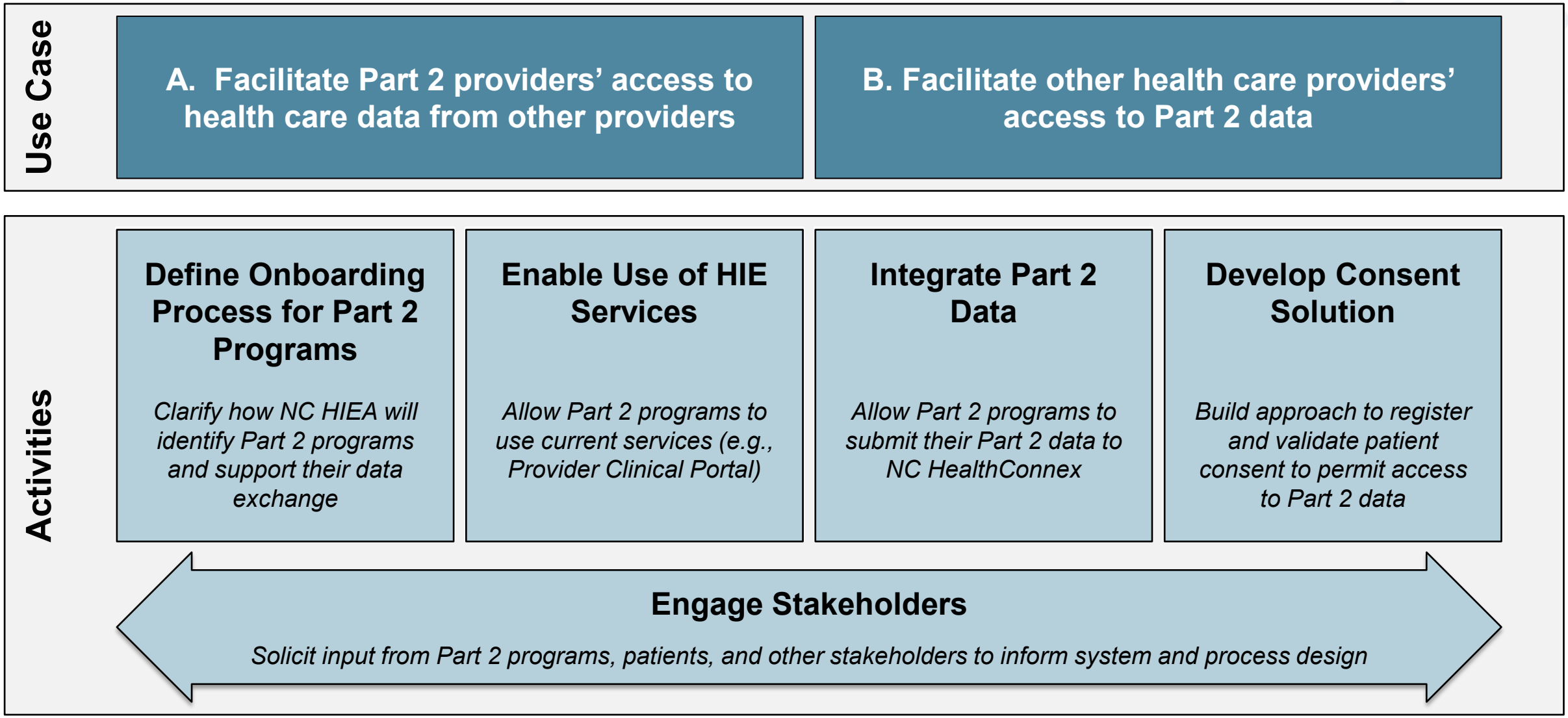
Federated model with a single large public behavioral health system

contexture®

Creating connections. Improving lives.

Deep collaboration with Medicaid incentives and supports Part 2 data integration and HIE use

Core Use Cases for Part 2 Providers



Activity: Define Onboarding Process for Part 2 Programs

Current State	Future State	Key Next Steps
Part 2 programs do not have defined processes to support their onboarding.	NC HIEA defines how it engages with Part 2 programs, including: - How Part 2 programs will be identified and what information will be collected about them; - How Part 2 programs can leverage NC HIEA services by designating NC HIEA as a Qualified Service Organization (QSO); - How any Part 2 data received by NC HIEA will be appropriately restricted.	❑ Refine current onboarding processes to support Part 2 program onboarding and monitoring ❑ Review contractual language establishing a QSO agreement between NC HIEA and Part 2 programs ❑ Address knowledge gaps shared by Part 2 programs and other stakeholder organizations

Activity: Enable Use of HIE Services

Current State	Future State	Key Next Steps
Part 2 providers generally do not use HIE services due to potential unauthorized disclosure of Part 2 data. For example, a Part 2 providers' use of the NC HealthConnex Clinical Portal may inadvertently create logs that document their relationship with a specific patient.	NC HIEA implements workaround solutions to allow for Part 2 providers to use HIE services without risk of unauthorized disclosure of Part 2 data when patient consent has not been obtained.	❑ Assess required technical modifications to prevent unauthorized Part 2 data disclosure ❑ Validate feasibility of technical modifications ❑ Implement technical modifications to allow for service use ❑ Offer education and training for Part 2 providers' use of HIE services

Activity: Integrate Part 2 Data

Current State	Future State	Key Next Steps
Part 2 providers are prohibited from sending Part 2 data to NC HealthConnex.	NC HIEA receives, segments and protects submitted Part 2 data from Part 2 programs.	❑ Assess landscape of electronic health records used by Part 2 providers and their technical capability to share data with NC HIEA ❑ Determine approach(es) to receive, segment, and protect Part 2 data ❑ Engage with providers and EHR vendors to begin to integrate Part 2 ❑ Provide technical assistance and other infrastructure transformation support for Part 2 data integration

Activity: Develop Consent Solution

Current State	Future State	Key Next Steps
NC HIEA is unable to register or validate patient consent for Part 2 data exchange.	NC HIEA registers and validates patient consent and enables access to Part 2 data for other treating providers.	❑ Assess approaches to collect, document and manage patient consent for Part 2 data sharing ❑ Build technical functionality within NC HealthConnex infrastructure for consent solution ❑ Work with public and private partners to facilitate patient consent documentation ❑ Provide technical assistance and other infrastructure transformation support for consent solution

Next Steps

- Manatt to finalize implementation plan by end of June
- NC HIEA will develop high level timeline to advance implementation activities
- NC HIEA will continue to engage Advisory Board and other stakeholders for input on policy, technical and operational design

New Business