Fiscal Year 2022 Health Center Controlled Networks
Sample Topic Areas for Activities

The Fiscal Year (FY) 2022 Health Center Controlled Networks (HCCN) Notice of Funding Opportunity (NOFO) requires you to submit 2-4 activities for each of the 10 HCCN objectives. The table below provides some topic areas for each of the 8 defined objectives that may help guide you when developing your activities that will drive measure progress. You are encouraged to explore additional topic areas and innovative approaches for each objective that support the needs of your Participating Health Centers (PHCs).

Objective 1: Patient Engagement
Objective: Increase the percentage of PHCs that support patients and families' participation in their health care through expanded use of integrated digital health tools (e.g., electronic messages sent through patient portals to providers, telehealth visits, remote monitoring devices). **Measure:** Number of PHCs with at least 80 percent of patients who have used integrated digital health tools between in-person visits to communicate health information with the PHC (a patient must have used a digital health tool at least once between visits). **Sample Topic Areas:** • Supporting mobile health IT tools and technologies adoption • Remote patient monitoring device selection training • Trainings to address barriers to patient use of digital health tools
Objective 2: Patient Privacy and Cybersecurity
Objective: Increase the percentage of PHCs with formally defined health information and technology policies and practices that advance security to protect individual privacy and organizational access. **Measure:** Number of PHCs that have implemented formally defined and secure health information and technology policies and practices that advance security to protect individual privacy and organizational access in at least 2 of the following areas: protection from misuse, threats like cybersecurity attacks, fraud, or other harms. **Sample Topic Areas:** • HIPAA privacy, security, and patient data protection training • HIPAA compliance assessment of data collection, analysis, and reporting processes • Data breach response planning

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Objective 3: Social Risk Factor Intervention

Objective: Increase the percentage of PHCs that use patient-level data on social risk factors to support patient care plans for coordinated, effective interventions.

Measure: Number of PHCs that use health IT to share social risk factor data with care teams and use this data to inform care plan development and, if applicable facilitate closed-loop referrals on at least 75 percent of patients identified as having a risk factor (e.g., care teams use patient reported data on food insecurity or other social risk factors to better tailor care plans/interventions and community referrals to improve chronic disease management and outcomes).

Sample Topic Areas:

- Training on using health IT tools to collect and utilize social determinants of health data
- Developing and sharing social risk factor screening tools implementation guides to support automated patient referrals
- Facilitating closed-loop referrals with community-based organizations that provide transportation, housing, financial and food support to patients

Objective 4: Disaggregated, patient-level data

Objective: Increase the percentage of PHCs with systems and staff aligned with submitting disaggregated, patient-level data via UDS+.

Measure: Number of PHCs that have sent successful test messages for electronic clinical quality measures (eCQM) and UDS+ data fields using Fast Health Interoperability Resources (FHIR) based application programming interfaces (APIs).

Sample Topic Areas:

- Test file production of disaggregated, de-identified data
- Readiness assessments to submit disaggregate patient level data in 2023 UDS
- Technical assistance with FHIR-based API selection and implementation guides

Objective 5: Interoperable Data Exchange and Integration

Objective: Increase the percentage of PHCs with the capacity to integrate clinical information with data from clinical and non-clinical sources across the health care continuum (e.g., hospitals, specialty providers, departments of health, health information exchanges (HIE), care coordinators, social service/housing organizations) to optimize care coordination and workflows.

Measure: Number of PHCs that have integrated data into structured EHR fields (i.e., not free text or attachments) from at least 3 external clinical and/or non-clinical sources.

Sample Topic Areas:

- Connection facilitation to HIE(s)
- Developing patient data dashboard for clinical decision and transition of care support
- Promoting and facilitating bidirectional immunization data exchange with state registries and ability to query data

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Objective 6: Data Utilization

Objective: Increase the percentage of PHCs that use data strategies, such as use of predictive analytics with data visualization, to support performance improvement and value-based care activities.

Measure: Number of PHCs that used advanced data strategies, such as predictive analytics with data visualization, natural language processing, and machine learning, to present useful data to inform performance improvement and value-based care activities (e.g., improve clinical quality, cost-efficient care).

Sample Topic Areas:

- Business intelligence solutions exploration using mobile health tools and remote patient monitoring devices data
- Visualization of clinical data through the use of dashboards

Objective 7: Leveraging digital health tools

Objective: Increase the percentage of PHCs that support providers and staff in achieving and maintaining proficiency in the use of digital health tools (e.g., telehealth and remote patient monitoring tools).

Measure: Number of PHCs providing at least 2 formal trainings annually, along with routine support (e.g., on-demand reference materials, regular communications sharing tips or best practices, help desk) to providers and staff that promote proficiency in the use of digital health tools.

Sample Topic Areas:

- Digital health tool train-the-trainer trainings
- Telehealth optimization, patient dashboards, and clinical workflow trainings and technical assistance
- Technical assistance on identifying improvements to clinical and operational processes using digital health tools

Objective 8: Health IT Usability and Adoption

Objective: Increase the percentage of PHCs that improve health IT usability and adoption by providers, staff, and patients (e.g., align EHRs with clinical workflows, improve structured data capture in and/or outside of EHRs, use of metadata to improve EHR user experience).

Measure: Number of PHCs that reduced operational barriers to health IT usability and adoption through implementation of at least 1 health IT facilitated intervention annually that focuses on topics such as aligning EHRs with clinical workflows, improving structured data capture in and/or outside of EHRs, regular EHR support and trainings, or use of metadata to improve EHR user experience.

Sample Topic Areas:

- Telehealth vendor selection and EHR integration training and technical assistance
- EHR lean transformation trainings and technical assistance
- HIT solution (e.g., virtual nursing assistants, medical scribes for EHR documentation) implementation technical assistance