



**FY 2019 Health Center Controlled Networks (HCCN) Goals and Objectives Development Guide**

All denominators are the total number of participating health centers.

| <b>Goal</b>  | <b>Objective</b>                    | <b>Objective Description</b>  | <b>Numerator</b>   |
|--|-------------------------------------|---|--|
| Goal A:<br>Enhance the patient and provider experience | Objective A1:<br>Patient Access     | Increase the percentage of PHCs using health IT to facilitate patients' access to their personal health information (e.g., patient history, test results, shared electronic care plans, self-management tools).                 | Number of PHCs with at least 50 percent of patients having accessed their patient portal accounts within the last 12 months.   |
|  | Objective A2:<br>Patient Engagement | Increase the percentage of PHCs improving patient engagement with their health care team by advancing health IT and training (e.g., patient use of remote monitoring devices, better medication adherence with text reminders). | Number of PHCs with at least 30 percent of patients who have used a digital tool (e.g., electronic messages sent through the patient portal to providers, remote monitoring) between visits to communicate health information with the PHC within the last 12 months.  |
|  | Objective A3:<br>Provider Burden    | Increase the percentage of PHCs that improve health IT usability to minimize provider burden (e.g., align EHRs with clinical workflows, improve structured data capture in and/or outside of EHRs).                             | Number of PHCs that have improved provider satisfaction (e.g. survey results) through implementation of at least one HIT facilitated intervention (e.g. improved CDS, EHR template customization/optimization, telehealth, eConsults, mobile health, dashboards, other reporting tools) within the last 12 months. |
| Goal B:<br>Advance interoperability                    | Objective B1:<br>Data Protection    | Increase the percentage of PHCs that have completed a security risk analysis and have a breach mitigation and response plan.  | Number of PHCs that have implemented a breach mitigation and response plan based on their annual security risk assessment.   |

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|                                   | Objective B2:<br>Health Information Exchange     | Increase the percentage of PHCs that leverage HIE to meet Health Level Seven International (HL7) standards or national standards as specified in the ONC Interoperability Standards Advisory and share information securely with other key providers and health systems.   | Number of PHCs that transmitted summary of care record to at least 3 external health care providers and/or health systems in the last 12 months using certified EHR technology through platforms that align with HL7 or national standards specified in the ONC Interoperability Standards Advisory.  |
|                                   | Objective B3:<br>Data Integration                | Increase the percentage of PHCs that consolidate clinical data with data from multiple clinical and non-clinical sources across the health care continuum (e.g., specialty providers, departments of health, care coordinators, social service/housing organizations) to optimize care coordination and workflows. | In the last 12 months, the 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.  |
| Goal C: Use data to enhance value | Objective C1:<br>Data Analysis                   | Increase the percentage of PHCs that improve capacity for data standardization, management, and analysis to support value-based care activities (e.g., improve clinical quality, achieve efficiencies, reduce costs).  | Number of PHCs using a dashboard and/or standard reports to present useful data to inform value-based care activities (e.g., improve clinical quality, achieve efficiencies, reduce costs) in the last 12 months.   |
|                                   | Objective C2:<br>Social Risk Factor Intervention | Increase the percentage of PHCs that use both aggregate and patient-level data on social risk factors to support coordinated, effective interventions.   | Number of PHCs that use health IT to collect or share social risk factor data with care teams and use this data to inform care plan development on at least 50 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) in the last 12 months. |

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|  | Objective C3:<br>Applicant<br>Choice | Applicants will develop an objective and outcome measure to address an emerging issue based on the needs of the PHCs in their network (e.g., addressing substance use disorder, improving interoperability with Prescription Drug Monitoring Programs, utilizing telemedicine to improve access, participating in precision medicine initiatives). | N/A |
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