HRSA
Health Center Program

Health Center Controlled Networks (HCCN) PROGRESS REPORT TABLE

HCCN NAME: Health Tech Family Network	APPLICATION TRACKING NUMBER: 556034823	GRANT NUMBER: H80CS47688
Number of Participating Health Centers (Baseline): 16 Number of Participating Health Centers (Current):17		

PARTICIPATING HEALTH CENTER

Participating Health Center Name	XYZ Health Center
Grant/Look alike Number	H80CS#####

PATIENT DETAILS

Total Patients (UDS Definition)	12,467
Number of Sites (Baseline)	3
Number of Sites (Current)	3

ENHANCE THE PATIENT AND PROVIDER EXPERIENCE

1. What percentage of patients at this PHC accessed their patient portal within the last 12 months?	67%
2. What patient portal features are currently available to patients? (Select all that apply)	[X] medical history [X] lab/test results [ ] shared care plans [ ] education/self-management tools [X] appointment scheduling [X] appointment reminders [ ] medication refill [ ] remote monitoring devices [ ] other (explain)
3. What percentage of patients 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 in the last 12 months?	58%
4. What percentage of providers reported increased satisfaction post implementation of at least one health IT-facilitated intervention?	52%
5. What health IT-facilitated intervention has this PHC used within the last 12 months to improve provider satisfaction? (Select all that apply)	[X] improved clinical descision support (CDS) [X] EHR template customization/optimization [X] telehealth [ ] eConsults [ ] mobile health [ ] dashboards [X] other reporting tools (please explain) Enhanced diabetes reporting tool for remote glucose monitoring

ADVANCE INTEROPERABILITY

1. In the last 12 months, did this PHC complete a security risk analysis?	[X] Yes [_] No

2.	In the last 12 months, did this PHC implement a breach mitigation and response plan based upon the completion of a security risk analysis?	[X] Yes [_] No
3.	In the last 12 months, did this PHC experience a data breach or ransomware event?	[_] Yes [X] No
4.	In the last 12 months, did this PHC transmit a summary of care record to at least 3 external health care providers and/or health systems using certified EHR technology through platforms that align with HL7 or national standards specified in the ONC Interoperability Standards Advisory?	[X] Yes [_] No
5.	If you answered yes to Question 4 above, please provide details about the platform you are using to transmit a summary of care record.	We are using a population health tool to create better community resource connections based on social risk factors. Based on summary of care records, patients are connected to resources through various health care providers and/or health systems (e.g., local hospitals, specialists, other health systems). The ONC-certified EHR platform transmits summary of care records (e.g., test results, upcoming vaccines needed for pediatric patients, risk factors for older adults with chronic conditions) to other health care providers and partners who can enhance the patient experience (specialists, behavioral health providers, care coordinators, and other providers that patients are referred to).
6.	In the last 12 months, did this PHC integrate data into structured EHR fields (i.e., not free text or attachments) from at least 3 external clinical and/or non-clinical sources?	[X] Yes [_] No
USE DATA TO ENHANCE VALUE		
1.	What other health IT tools and solutions did this PHC use in the last 12 months to analyze data in support of value-based care activities? (Select all that apply)	[ ] Business Intelligence Software [X] Data Analytics [ ] Predictive Analytics [ ] SMART Apps [X] Patient-Centered Tools [ ] other (please explain)
2.	In the last 12 months, did this PHC use 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)?	[X] Yes [_] No
3.	In the last 12 months, did this PHC 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?	[X] Yes [_] No

4. Describe progress to date on the applicant choice objective.	Objective: Increase the percentage of PHCs that improve access, quality, and cost of care by providing substance use disorder or opioid use disorder services through telehealth innovation.

Senior behavioral health specialists attended an online training in September to gain skills in providing substance use disorder treatment via telehealth. Staff also received training on our EHR module update that allows for online scheduling for telehealth behavioral appointments. Health center leadership developed telehealth policies and procedures to successfully implement the new care option, including navigating insurance coverage for telehealth visits. XYZ Health Center is now serving 38 patients who indicated they could not have accessed weekly substance use disorder treatment if our new telehealth option was not available. Many of our patients are not able to get to the site that provides behavioral health services on a regular basis. All 38 new patients began substance use disorder counseling via telehealth following an in-person consult. |