CDAQ - HCCN Champions Session

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September 29, 2023

What is HCCN?

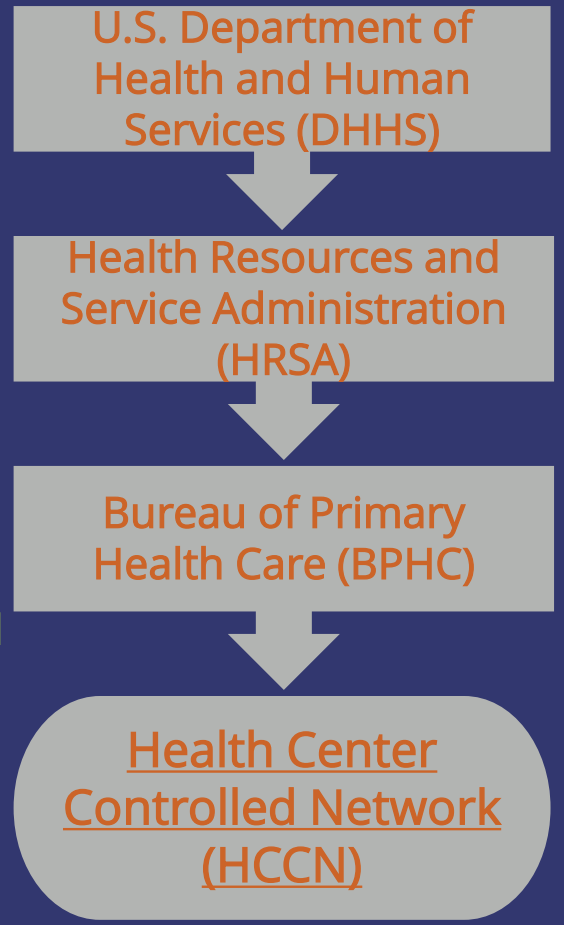
1. Virginia Community Healthcare Association (VCHA) is designated as Health Central Controlled Network (HCCN) by Bureau of Primary Health Care (BPHC) which a part of Health Resources and Service Administration (HRSA).

2. HRSA is an agency of the U.S. Department of Health and Human Services. It is the primary federal agency for improving access to health care services for people who are uninsured, isolated or medically vulnerable.

3. The Bureau of Primary Health Care (BPHC) is a part of HRSA that funds health centers in medically underserved communities, providing access to affordable, comprehensive, high-quality, primary health care services for people who are low-income, uninsured, or face other obstacles to getting health care.

4. Health Center Controlled Networks (HCCNs) help health centers improve quality of care and patient safety by using health information technology (HIT) to reduce costs and improve care coordination. They offer specialized training and technical assistance (T/TA) to take advantage of economies of scale, including:

- Group buying power
- Shared training
- Data analytics to support quality measurement and improvement.



VIRGINIA COMMUNITY HEALTHCARE ASSOCIATION

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What is CDAQ?

Center of Data, Analytics, and Quality (CDAQ) is one of the six pillars of VCHA

1. VCHA is designated as both –
   a. Primary Care Association (PCA)
   b. Health Center Controlled Network (HCCN)
2. Center of Data, Analytics, and Quality (CDAQ) was created specifically to overcome challenges as a designated Health Center Controlled Network (HCCN).
3. Every HCCN receives a "3–year Work Plan" from BPHC and is funded by BPHC for the same. CDAQ is responsible for making sure that the activities and objectives approved in the HCCN Work Plan are carried on up to BPHC's standards and Health Center's satisfaction.
4. CDAQ is responsible for the HCCN Work Plan however, responsibilities of the health centers are not limited to the Work Plan. CDAQ has both HCCN and non-HCCN projects ongoing which are designed to benefit the Community Health Centers in one way or another.

HCCN Individual Work Plan

- As a designated HCCN, CDAQ must make sure that every year, an individual workplan (IWP) is created for each member FQHC and distributed to the health center for approval.
- This approval makes sure that the HCCN champion is agreeing the workplan and wants CDAQ to go forward with the work plan for the health center.
- HCCN year starts from Aug 1st and end on July 31st. We have concluded Year 1 for the HCCN grant period and we are ready to move to Year 2.
- HCCN Champions should receive their IWP by the end of Sep 2023 for approval. Once approved, CDAQ will start working on the updated work plan.

Note: HCCN Champions are not responsible to work with CDAQ on all project but is responsible to make sure that the CDAQ projects are forwarded to the right individual at their organization.

Individual Health Center Controlled Network (HCCN)
Participating Health Centers Work Plan
for the period August 2022 – July 2023

Please review the HCCN Work Plan for your CHC. Objectives, activities, timeline, and expected outcomes are pre-populated.

If you would like to add additional activities and/or objectives, please contact Kevin Ajmera, Population Health Data Analyst for assistance in developing objectives and activities that are consistent with HRSA's guidelines/requirements for the project. Return to Kevin's attention at kajmera@vcha.org no later than ***October 30th, 2022***.

Community Health Center Name:

***HIT/Data Champion at CHC*:** The Champion will be responsible for assisting Association staff in the implementation of the HCCN project at your health center and serve as the main point of contact for the Association Staff.

Champion Name:	
Title:	
Address:	
City:	
State:	
ZIP:	
E-mail:	
Phone:	

Date of Approval - _____

Please check one: (Type "x" in the first column to check one)

★	Work Plan Accepted/No Additions
____	Work Plan Accepted with Additions (Complete the "Additional Objective" section at the end of each goal. Add as many "additional objectives" as needed.)

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HCCN Work Plan Update

Year 1 August 2022 – July 2023	Year 2 August 2023- July 2024	Change Description
Objective 1: Patient Engagement 1.1 Patient Engagement & Portal Best Practices Training 1.2 Function-based EHR Vendor Collaboration 1.3 Patient-facing Marketing Templates	Objective 1: Patient Engagement 1.1 Patient-facing Marketing Templates 1.2 Patient Engagement & Portal Best Practices Training	Moved objective 1.2 to combine with objective 8.1. Our EHR user groups will focus on function based EHR collaborations.
Objective 2: Patient Privacy and Cybersecurity 2.1 HITEQ Patient Privacy and Cybersecurity Resources 2.2 Security Risk Assessments 2.3 Breach Mitigation	Objective 2: Patient Privacy and Cybersecurity 2.1 HITEQ Patient Privacy and Cybersecurity Resources 2.2 Security Risk Assessments 2.3 Breach Mitigation	No changes.
Objective 3: Social Risk Factor Intervention 3.1 PRiZiM Implementation for Comparative Dashboarding 3.2 Social Risk Factor Best Practice Training Webinars 3.3 Support Development and Training of SDOH Reporting Dashboards	Objective 3: Social Risk Factor Intervention 3.1 PRAPARE Assessment Tool Evaluation 3.2 Support Development and Training of SDOH Reporting Dashboards 3.3 Social Risk Factor Best Practice Training Webinars	Moved objective 3.1 to objective 6.1 to closely align with Data Utilization objective and PriZiM aggregation efforts. Moved objective 9.2 to objective 3.1 to better align with Social Risk Factor Intervention efforts.
Objective 4: Disaggregated, patient-level data 4.1 eCQM Transmission Methodology 4.2 Technology Readiness Assessment	Objective 4: Disaggregated, patient-level data 4.1 eCQM Transmission Methodology 4.2 Technology Readiness Assessment	No changes.
Objective 5: Interoperable Data Exchange and Integration 5.1 Collaboration with ConnectVirginia (HIE) for Emergency Department Care Coordination Program (EDCCP) 5.2 PRiZiM Utilization for Process Improvement.	Objective 5: Interoperable Data Exchange and Integration 5.1 Collaboration with ConnectVirginia (HIE) for Emergency Department Care Coordination Program (EDCCP) and Partner with VHI 5.2 PRiZiM Utilization for Process Improvement	Moved objective 10.2 to combine with objective 5.1 as VHI manages the ConnectVirginia HIE.

HCCN Work Plan Update

Year 1 August 2022 – July 2023	Year 2 August 2023- July 2024	Change Description
Objective 6: Data Utilization 6.1 PRiZiM Data Aggregation Platform Technical Assistance 6.2 State-wide Data Analytics & Dashboarding Clinical Quality Committee	Objective 6: Data Utilization 6.1 PRiZiM Data Aggregation Platform Technical Assistance 6.2 PRiZiM Implementation for Comparative Dashboarding	Moved objective 3.1 to objective 6.2 as more appropriate objective category surrounding data utilization. Moved objective 6.2 to combine with objective 10.1
Objective 7: Leveraging digital health tools 7.1 Digital Health Tools Best Practice Workgroups 7.2 Health Promotion and IT	Objective 7: Leveraging digital health tools 7.1 Digital Health Tools Best Practice Workgroups 7.2 Health Promotion and IT	No changes.
Objective 8: Health IT Usability and Adoption 8.1 Function-based EHR Optimization Assessment 8.2 CDAQ EHR Hosting Services 8.3 Combating Provider Burden through Technology and Innovation	Objective 8: Health IT Usability and Adoption 8.1 Function-based EHR Optimization Assessment & EHR Vendor Collaboration 8.2 CDAQ EHR Hosting Services 8.3 Combating Provider Burden through Technology and Innovation	Moved objective 1.2 to combine with objective 8.1. Our EHR user groups will focus on function based EHR collaborations.
Objective 9: Health Equity (Applicant Choice) 9.1 (PriZiM User Group) Data Warehouse User Group 9.2 PRAPARE Assessment Tool Evaluation 9.3 Best Practices Showcase	Objective 9: Health Equity (Applicant Choice) 9.1 (PriZiM User Group) Data Warehouse User Group 9.2 Best Practices Showcase	Moved objective 9.2 to objective 3.1 to better align with Social Risk Factor Intervention efforts.
Objective 10: Improving Digital Health Tools (Applicant Choice) 10.1 Improve Clinical Workflow and Enhance Process Improvement 10.2 Partner with VHI	Objective 10: Improving Digital Health Tools (Applicant Choice) 10.1 Support Epic health center due diligence 10.2 State-wide Data Analytics & Dashboarding Clinical Quality Committee	Moved objective 6.2 to combine with objective 10.1 as the committee will be focused on clinical workflow and process improvement collaboration efforts. Added new objective 10.2 to capture new initiative to support health center due diligence with Epic.

CDAQ Baseline Assessment and Progress

Objective	CDAQ Quality Metric	Baseline Percentage	Current Percentage	Total Progress
1	Have at least 80 percent of your patients used integrated digital health tools between in-person visits to communicate health information with the PHC? (Count only if a patient have used a digital health tool at least once between visits).	14.81%	33.33%	**18.52%**
2	Has your PHC 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 two of the following areas: protection from misuse, threats like cybersecurity attacks, fraud, or other harms?	96.30%	100.00%	**3.70%**
3a	Does your organization use health IT to share social risk factor data with care teams and use this data to inform care plan development? (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).	66.67%	74.07%	**7.40%**
3b	If yes, does your PHC facilitate closed-loop referrals on at least 75 percent of patients identified as having a risk factor?	44.44%	44.44%	**0.00%**
4	Has your PHC 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)?	25.93%	25.93%	**0.00%**
5	Has your PHC integrated data into structured EHR fields (i.e., not free text or attachments) from at least three external clinical and/or non-clinical sources?	48.15%	55.56%	**7.41%**
6	Has your PHC 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).	25.93%	37.04%	**11.11%**
7	Does your PHC provide at least two 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?	59.26%	74.07%	**14.81%**
8	Has your PHC reduced operational barriers to health IT usability and adoption through implementation of at least one 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?	74.07%	81.48%	**7.41%**
9	Does your health centers currently partner with at least two community-based organizations to address health equity for your patient population?	81.48%	85.19%	**3.71%**
10	Does your health center receive notifications from the state HIE system when patients seeks emergency medical services in an Emergency Room setting?	44.44%	59.26%	**14.82%**

Baseline Percentage

Baseline was calculated using the HCCN needs assessment Aug 2022.

Current Percentage

Current Percentage was calculated using the Feb 2023 NCC Progress Report

Total Progress

Total Progress represents progress made in the first 6 months.

HCCN Champions Responsibilities

Approve HCCN Individual Work Plan

HCCN Champion is responsible for the approval of Individual Work Plan.
This workplan is used by CDAQ to assess the training opportunities at the organization.
Once approved, CDAQ will work with you to make sure that the IWP goals are been met.

Main Point of Contact for HCCN/CDAQ projects

HCCN Champion is appointed by the health center CEO to serve as a primary contact for CDAQ.
This person will be the only person who will receive communication from CDAQ regarding the initiative and project going on.

Distribute information to peers at organization

HCCN Champion is responsible for distributing the information like Trainings, Technical Assistance, on going Peer groups, Data Projects and other opportunities which might be beneficial to the employees working at the health center.
This creates a standardized approach to invite attendees.

CDAQ Best Practice Webinar Series

CDAQ has outlined key thematic areas to provide ongoing Best Practice Webinars to the membership tackling common clinical and operational challenges and best practices.

These webinars were conducted on the mentioned date. Recordings/ presentations are available on VCHA's CommUnity Portal.

To be conducted on the mentioned date. Zoom/Calendar Link available on VCHA's CommUnity Portal.

Webinar	Date	Webinar Name
1	04/13/23	Health Promotion and IT Webinars
2	05/11/23	Combating Provider Burden through Technology & Innovation
3	05/30/23	Digital Health Tools: Alignment
4	06/08/23	Health Promotion and IT Webinars
5	07/04/23	COVID-19 Webinar Series (Part 1 of 2): New trends and Long COVID
6	07/13/23	Combating Provider Burden through Technology & Innovation
7	07/21/23	Health Promotion and IT Webinars
8	07/25/23	SDOH: Capturing SODH
9	08/03/23	Patient Engagement: Overview
10	08/10/23	Health Promotion and IT Webinars
11	08/29/23	Digital Health Tools: Operationalization
12	09/12/23	Combating Provider Burden through Technology & Innovation
13	09/21/23	Patient Engagement: Engaging Through Social Media
14	10/12/23	Health Promotion and IT Webinars
15	10/26/23	COVID-19 Webinar Series (Part 2 of 2): COVID and SDOH training
16	10/31/23	SDOH: Connecting to SDOH Services
17	11/09/23	Combating Provider Burden through Technology & Innovation
18	11/28/23	Digital Health Tools: Optimization
19	12/19/23	Patient Engagement: Patient Population & Engagement Alignment
20	01/30/24	SDOH: Tackling SDOH Beyond Face-to-Face Encounters
21	02/27/24	Digital Health Tools: Ongoing Monitoring & Quality Improvement
22	03/26/24	Patient Engagement: Workflow Support Strategies

EHR Assessment

- Part of the HCCN objective for Function-based EHR Optimization Assessment
- Also includes items from other HCCN objectives such as Social Determinants of Health (SDOH), eCQM transmission, and technology readiness for UDS+
- Capture current state information and make recommendations for actionable improvements

8-week timeline

30-minute Introduction

Complete HIT survey

Complete HIT questionnaire

Participation in 4 x 1-hour departmental meetings (Clinical, Operational, eCW Support/IT/Analytics, Revenue Cycle Management)

Findings & recommendations deliverable to be provided

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VCHA i2i Data Warehouse Project

PRiZiM® is a cloud-based, advanced analytics and reporting platform which aggregates disparate data sources into a single "source of truth", giving users flexibility to analyze rich data sets via dashboards, reports, and analytics tools.

CDAQ has invested in this tool to empower Participating Health Centers the data analytics capabilities at the health center while providing the visibility into data at the network level to support clinical quality efforts.

ALEXANDRIA NEIGHBORHOOD HEALTH	BLAND COUNTY MEDICAL CLINIC	BLUE RIDGE MEDICAL CENTER	CENTRAL VIRGINIA HEALTH SERVICES
CLINCH RIVER HEALTH SERVICES	COMMUNITY ACCESS NETWORK	COMMUNITY ACCESS NETWORK	EASTERN SHORE RURAL HEALTH SYSTEM
COMMUNITY HEALTH CENTER OF THE NEW RIVER VALLEY	GREATER PRINCE WILLIAM COMMUNITY HEALTH CENTER	HEALTHY COMMUNITY HEALTH CENTER (Harrisonburg Community Health Center)	HIGHLAND MEDICAL CENTER
HORIZON HEALTH SERVICES	JOHNSON HEALTH CENTER	NEW HORIZONS HEALTHCARE (Kuumba comm. health and wellness center)	HEALTHWORKS OF NORTHERN VIRGINIA (Loudoun Community health center)
MARTINSVILLE HENRY COUNTY COALITION FOR HEALTH AND WELLNESS	SOUTHEASTERN VIRGINIA HEALTH SYSTEMS (Peninsula Institute for Community Health)	PIEDMONT ACCESS TO HEALTH SERVICES (PATHS)	HAMPTON ROADS COMMUNITY HEALTH CENTER (Portsmouth Community Health Center)
ROCKBRIDGE AREA FREE CLINIC	SOUTHERN DOMINION HEALTH SYSTEMS	SOUTHWEST VIRGINIA COMMUNITY HEALTH SYSTEMS	STONE MOUNTAIN HEALTH SERVICES (St. Charles Health Council)
STONY CREEK COMMUNITY HEALTH CENTER	TRI-AREA COMMUNITY HEALTH (Laurel Fork Community Health)	CAPITAL AREA HEALTH NETWORK (Vernon J. Harris East End CHC)	

Onboarded | In Process | Not Started

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Other Projects

CDAQ is continuously making efforts to reduce provider burnout by leveraging Health IT and providing T/TA around efficient and effective use of technology.

CDAQ's Clinical Quality Council (CQC)	CDAQ's EHR and SDOH Assessment	CDAQ's vetting of Health IT vendors/services
CDAQ's Technology Peer Network (IT Peer Group)	1 on 1 session with CDAQ's CMO	CDAQ's Patient Facing Marketing Template
• CDAQ's eCW User Group	CDAQ's EPIC initiative	CDAQ's annual UDS reporting training

If you are interested in any project mentioned above, please feel free to reach out to Kevin Ajmera – kajmera@vcha.org for assistance

Questions?