Equity and Practice Transformation (EPT) Payment Program
Data to Enable Population Health Management
Data Implementation Plan Example

Note and Acknowledgment: Thank you Opsam Health for your willingness to share your Data Implementation Plan with the EPT cohort.

PoF Measures are included below for your reference: Adults with Chronic Conditions

STRATEGY 1: IDENTIFFYING AND OUTREACHING TO THE ASSIGNED BUT UNSEEN POPULATION

1. **Please share baseline data/information for your assigned but unseen patients in your Medi-Cal Population. Please report on your whole Medi-Cal population, not just your selected PoF. This is a point-in-time measure: you take the assigned Medi-Cal members as of that specific moment and look back 12 months to see who has had a visit. This includes all visit types, not just well visits.**

Numeric:

Numerator: Number of assigned Medi-Cal patients who have had a visit in the past 12 months	**Denominator: Total number of assigned Medi-Cal patients**	**Assigned and Seen Rate (%) (Auto Calculated)**	**Assigned and Unseen Rate (%) (Auto Calculated) Assigned and Unseen Rate = 100% minus Assigned and Seen Rate**
6516	20389	31.96%	68.04%

Text:

What key information do you feel is still missing related to identifying your assigned but unseen patient population?	Opsam is able to obtain list of assigned lives from health plans and contain information as to their gender, age, and preferred language spoken, However, it would be helpful to have the list contain information as to their race and ethnicity, as well as sexual orientation and gender identity.
What is your plan for gathering the missing information?	When reaching out to individual assigned patient who opts to schedule their appointment with Opsam, part of initial patient registration is completing a form that asks for such information (Race, ethnicity, SOGI, income, household, etc). Within the form is also an explanation on why information is being obtained and what it is being used for, which clinical staff also should be able to explain when asked.

2. **Based on your baseline data, what is your SMARTIE Goal (s) for identifying and outreaching to patients assigned to your practice that have not yet been seen?**

SMARTIE Goal(s)	Specific: We will identify health plan-assigned patients who have not yet established care in our clinic and proactively reach out to them, ensuring that outreach efforts are culturally sensitive and inclusive of diverse race, ethnicity, sexual orientation, and gender identity considerations. Measurable: The goal is to contact 60% of these health plan assigned but not yet seen patients within the next 6 months from project kick-off and ensure that at least 50% of them are successfully connected with an Opsam healthcare provider. In those who successfully connected to a provider, 100% of these patients will provide demographic data such as race, ethnicity, sexual orientation, and gender identity via tailored outreach materials and communication methods. Achievable: We will collaborate with the health plan to obtain a list of patients who have been assigned to our clinic but have not yet established care. Outreach efforts will be supported by the clinic's care coordination team and include targeted phone calls, emails, or letters. We will also integrate inclusion and diversity best practices into communication strategies (e.g., culturally appropriate language, providing gender-neutral options, etc.). Relevant: This goal aligns with our clinic's mission to provide inclusive, accessible, and equitable care to all patients, especially those from historically underserved and marginalized communities. Ensuring that individuals who may face barriers to care based on their race, ethnicity, sexual orientation, or gender identity have the opportunity to engage with healthcare is critical to improving health outcomes and reducing disparities. Time-bound: The outreach and connection to these patients will be completed within the next 6 months, with progress reviews every 4 weeks. Inclusive: Outreach efforts will be designed to be culturally competent, ensuring that the methods of communication and the services offered are respectful and accessible to people of all racial, ethnic, and gender identities, and sexual orientations. We will use inclusive language in all outreach efforts, provide support in different languages as needed, and offer resources to assist in overcoming any barriers to establishing care.

	Equitable: We will track the engagement of patients from different racial, ethnic, gender, and sexual orientation groups to assess whether there are disparities in outreach effectiveness. Based on this data, we will adjust our approach to ensure that all communities have equal access to care and that no one is inadvertently excluded.

Additional Information:

What information, in addition to your baseline data, did you use to develop your SMARTIE Goal(s)?	The following key information helped us formulate a realistic and achievable goal, including staffing (the number of dedicated staff who will be tasked to reach out to these patients) and the length of time an outreach call to a patient takes including quick registration should they opt to connect to a provider.

3. **What are the main interventions or steps you plan to test or implement to reach your SMARTIE Goal (s)? How did you identify the selected interventions or steps?** ***Please specify at least 5 and no more than 10.***

Intervention/Step	Data or Information Used for Selection	Patient Needs Addressed	Stakeholders Involved in Decision
Streamlined HIPAA compliant process to obtain managed medical health plan assigned list of patients monthly	Different health plans use different methods to allow us to obtain list on a monthly basis. With input from data specialist, process to streamline and standardize how and when to obtain the data is needed to effectively have baseline list of patients to reach out to	Patients will be informed of their assignment to Opsam health and be educated on the services we offer, not just primary care, that are available for them.	Clinical Directors, Data Specialist, EMR Technician, Health Plan liaison
Dedicated trained outbound call center agents specifically tasked to reach out to health plan assigned but not yet established patients	Having the dedicated staff to reach out to thousands of patients is crucial. Appropriate training is needed to ensure agents deliver message in a culturally appropriate manner and be	Patients will be informed of their assignment to Opsam health and be educated on the services we offer, not just primary care, that are available for them. They will have	Call center supervisor, Operations Director, QI Lead

	able to encourage patients to seek medical care, preventive or therapeutic.	opportunity to schedule an appointment easily via the call agents.	
Process to stratify patients based on key demographic information such as race, ethnicity, and preferred language spoken	From the health plan list, the data specialist will organize this based on race, ethnicity and preferred language	This will ensure patients will be given information in a culturally and linguistically appropriate manner.	Data Specialist
Create a shared real-time tracker with dashboard per health plan to monitor outreach progress	From the health plan list that are organized based on race, ethnicity, and spoken language, a real-time tracker will be added with status button to monitor progress.	This will ensure all patients in list are being reached out to and encouraged to connect with Opsam provider.	Data Specialist, IT Administrator
Create Welcome to Opsam letter with contact information introducing the organization and the services we provide to assigned but not yet seen patients.	This is needed to provide other avenue to be able to reach out to patients, especially those who are not reached telephonically.	This provides multi-modal approach for reaching out to these patients.	Marketing team
Improve in-bound call center process for scheduling new appointments	This is needed to ensure that patients calling to ask information and/or make appointment will be able to do so timely.	Patients wanting to ask about services and schedule appointment will be able to do so on their first call, addressed as timely as possible.	Call Center supervisor, QI Lead, Operations Director

a. How are these interventions or steps different from what you are currently doing to identify and outreach to assigned and unseen patients?

What were the limitations of your previous approach?	The following were our limitations that are being addressed: 1. There is no dedicated staff who focuses and reaches out proactively to assigned but not seen patients. Process had always been waiting for patients to call and schedule appointment. 2. The call center process we had did not address first call resolution. The outsourced call agents obtained basic patient info and reason for call and these data were sent to messaging

	portal accessed by our employed outbound agents who will then call patient back and address the reason for call. This imposed delay and patient frustration.
How does the new approach address gaps or barriers?	The new approach will address the gaps significantly 1. By having dedicated outbound agents solely responsible for reaching out to assigned but not yet seen patients. This will ensure we are being proactive in identifying and ensuring these patients establish care with any of our providers, not just primary care (ie dental, behavioral, vision care, etc) 2. By removing the "middle call agents", patients' needs will be immediately addressed as soon as they call, rather than having to wait for a call-back to have the issues addressed.
What new strategies, technologies, or partnerships are being introduced?	The following are being introduced 1. Newly hired outbound call center agents 2. Partnership with American Healthcare Connections that will provide timely inbound call center resolution for our patients. 3. HIPAA compliant sftp file sharing tool to obtain data from health plans 4. More robust marketing strategies geared specifically for patients who have yet established care with Opsam 5. Tableau driven data stratification and dashboard creation

4. What is your high level workplan for reaching your SMARTIE goal (s)? List the specific interventions or steps of who will do what, how, and by when? Ensure the plan aligns with your SMARTIE Goal(s). Use realistic timelines and responsible parties to track accountability.

Intervention/Step	Who Is Responsible?	How Will It Be Implemented?	Implementation Timeline (By When?)
Streamlined HIPAA compliant process to obtain managed medi-cal health plan assigned list of patients monthly	QI Lead	Using HIPAA compliant file sharing platforms, data exchange with managed medi-cal health plans will be established and streamlined	Milestone 1: Determine Health Plan Data Access Channels Timeline: January 2025 Status: Completed Identify the most efficient method for obtaining data from health plans (e.g., secure data transfer via SFTP, API integration, manual data request forms or Health Plan web portal access and file download).

			Milestone 2: Data Specification & Format Agreement Timeline: February 2025 Status: Completed Work with health plans to define the exact format and fields required for the patient list (e.g., patient name, Medicaid ID, date of birth, assigned primary care provider). Milestone 3: Define Data Frequency & Delivery Schedule Timeline: Feb 2025 Status: Completed Establish a routine schedule for receiving the assigned patient list (e.g., monthly, weekly), along with frequency for any updates or revisions. Milestone 4: System Integration Timeline: March 2025 Status: Completed Work with your IT team and the health plan's technical support to set up automated or semi-automated data transfer protocols (e.g., set up secure FTP, API integrations, etc.).
Dedicated trained outbound call center agents specifically tasked to reach out to health plan assigned but not yet established patients	Call center supervisor	Hire and train a dedicated outbound call center staff focused on calling patients assigned but not yet seen	Milestone 1: Create Job Description & Requirements Timeline: Feb 2025 Status Completed Collaborate with HR to create a job description for the outbound call agent role. The description should clearly define the responsibilities, including making outbound calls, updating patient records, and adhering to privacy guidelines (e.g., HIPAA).

			Milestone 2: Post Job Opening and Source Candidates Timeline: Feb 2025 Status Completed Post the job on relevant job boards (e.g., Indeed, LinkedIn, Ziprecruiter) and reach out to local staffing agencies if needed. Use a screening process to shortlist candidates based on skills (communication, empathy, customer service, etc.), availability, and experience. Milestone 3: Interview and Select Candidates Timeline: March 2025 Status Completed Interview shortlisted candidates, prioritizing communication skills, patient care orientation, and familiarity with healthcare or call center environments. Select top candidates based on their qualifications and cultural fit with the clinic's mission. Milestone 4: Hiring, Onboarding and Training Timeline: March 2025 Status Completed Onboard new hires by providing them with the necessary equipment (phones, computers, software access). Ensure they have completed any required HR paperwork and compliance training (e.g., HIPAA, workplace policies). Finalize training materials that cover the specific tasks (e.g., scripts for calling patients, customer service protocols, data entry guidelines), clinic policies, and patient confidentiality. Milestone 5: Full Launch of Outreach Efforts

			Timeline: April 2025 Ensure agents are consistently making calls, logging data, and connecting patients to care providers.
Process to stratify patients based on key demographic information such as race, ethnicity, and preferred language spoken	Data Specialist, Clinical Director	By reviewing data set obtained from individual health plan, the clinical director and data specialist will define how data will be structured and formatted to ensure accurate and complete information for race, ethnicity, and preferred language.	Milestone 1: Define Categories & Stratification Criteria Timeline: April 2025 Status: In Progress Work with stakeholders to define the categories for stratification. Ensure these categories align with current social determinants of health and are in compliance with legal or regulatory standards. Milestone 2: Create Data Stratification Model Timeline: April 2025 Status: In Progress Design the process or algorithm that will sort the patient data into the predefined categories. This could be done through a variety of tools such as Excel, Python scripts, or data management software. Ensure the stratification model is flexible and can handle new data additions over time. Milestone 3: Implement Data Transformation and Stratification Timeline: April 2025 Status: In Progress Apply the stratification model to the patient data to categorize patients by race, ethnicity, and preferred language. This step involves transforming the raw data into structured, easy-to-interpret groups based on these factors.
Create a shared real-time tracker with dashboard per	Data Specialist , QI Lead , Call	With input from QI lead and call supervisor, the	Milestone 1: Define Tracker & Dashboard Requirements Timeline: April-May 2025 Status: In Progress

health plan to monitor outreach progress	center supervisor	data specialist will create an actionable real-time spreadsheet per health plan (Containing list of assigned but not yet established patients) accessible to agents and supervisors that will track status of outreach completion and appointment scheduling.	Collaborate with QI Lead, Chief Medical Officer, Operations Director, call center supervisor, and IT to define what information needs to be tracked (e.g., calls made, call outcomes, patient contact status, appointments scheduled). Also, determine key metrics for the dashboard (e.g., call volume, engagement rates, conversion rates). Milestone 2: Select Tracking & Dashboard Tools Timeline: April-May 2025 Status: In Progress Determine which software or tools will be used to create the real-time tracker (e.g., Excel with live data). For the dashboard, evaluate options such as Power BI, Tableau, or custom web dashboards. Milestone 3: Develop Real-Time Tracker Timeline: April-May 2025 Status: In Progress Begin developing the real-time tracker for outbound call agents. This can be done by creating a shared document or database where agents log each call and its outcome (e.g., patient contacted, appointment made, message left). It should allow data entry and updating in real-time. Milestone 4: Integrate Tracker with Dashboard Timeline: April-May 2025 Status: In Progress Integrate the real-time tracker data with the supervisor dashboard. This ensures that supervisors can view live updates as agents input their data. Ensure data syncing and accuracy between the tracker and the dashboard.

			Milestone 5: Go-Live with Tracker & Dashboard Timeline: June 2025 Status: Not yet started Launch the real-time tracker for all outbound call agents and the supervisor dashboard. Ensure the systems are up and running smoothly and that agents are successfully entering data in real-time.
Create Welcome to Opsam letter with contact information introducing the organization and the services we provide to assigned but not yet seen patients.	Outreach and Marketing Lead	Using multi-modal approach (EMR messaging, mails, emails), team will develop a tailored marketing materials and welcome to Opsam packet that will educate them of our services and encourage them to contact us and schedule their appointments	Milestone 1: Define Goals & Target Audience Timeline: April 2025 Status: In Progress Determine the primary goals of the welcome packet: to promote clinic services, explain how to schedule an appointment, provide necessary contact information, and make patients feel valued. Identify the target audience—patients assigned but not yet seen in the clinic—taking into account any relevant demographics (age, language, health needs, etc.). Milestone 2: Determine Format & Design Timeline: April 2025 Status: In Progress Decide on the format for the welcome packet. This could be physical (printed letter and informational materials) or digital (PDF or email). Consider accessibility and design preferences such as font size, colors, and graphics. Milestone 3: Print/Prepare Digital Versions Timeline: April 2025 Status: In Progress

			If physical, send the final designs to a printing company for production of the welcome letters and packets. Ensure that materials are printed on quality paper and in an easy-to-handle format. If digital, finalize the PDF version or prepare the email template for distribution. Ensure that links (e.g., to scheduling or registration pages) are functional and that the format is mobile-friendly. Milestone 4: Prepare Mailing/Distribution List Timeline: April-May 2025 Status: In Progress Obtain the list of patients who have been assigned but not yet established care, ensuring all contact details (mailing addresses or emails) are up to date. Clean and organize the list for accurate delivery.
Improve in-bound call center process for scheduling new appointments	CEO, CMO, OPs Director, Call center supervisor , IT Administrator	Key Executives and call supervisor will collaborate to vet and select healthcare only call center solution provider to accept all in bound calls with clear focus on patient first call resolution, timely access, and patient satisfaction	Milestone 1: Identify and Evaluate Call Center Vendors Timeline: October-Dec 2024 Status: Completed Research and shortlist call center vendors that specialize in healthcare services, focusing on those with a proven track record in:First call resolution (FCR), Patient scheduling and healthcare-related inquiries2, Compliance with healthcare regulations (e.g., HIPAA, patient confidentiality) Milestone 2: Select Call Center Vendor Timeline: January 2025 Status: Completed Choose the most suitable vendor based on cost, capabilities, alignment with clinic objectives, and experience in healthcare settings. Negotiate contract terms, including performance metrics (e.g., FCR rates, patient satisfaction scores), penalties for non-compliance, and confidentiality agreements.

			Milestone 3: Develop Implementation Plan Timeline: January-March 2025 Status: Completed Collaborate with the chosen vendor to develop a detailed implementation plan, including timelines, roles, responsibilities, and technology requirements (e.g., integration with clinic scheduling system, CRM tools). Ensure alignment on key performance indicators (KPIs), such as FCR rate, patient satisfaction, and call handling time. Milestone 4: Train Call Center Agents Timeline: Mar-April 2025 Status Completed Conduct training for call center agents on: a.Clinic-specific services, specialties, and procedures b. Patient scheduling workflows, including insurance verification, slide fee scale program, and appointment booking c. First call resolution techniques and problem-solving strategies d. Compliance with HIPAA and other healthcare regulations Milestone 5: Go-Live with Call Center Operations Timeline: April 9, 2025 Status: Completed Officially launch the call center, with full functionality for answering patient calls, scheduling appointments, handling inquiries, and ensuring FCR. Monitor call volume, agent performance, and patient satisfaction closely during the first few weeks.

			Ensure agents have access to the necessary resources (e.g., real-time scheduling system, patient data) to facilitate efficient and accurate interactions.

5. How will you track your progress in achieving your SMARTIE goal(s)? Identify key metrics that will help assess the effectiveness of your efforts.

Key Data Elements to Track Progress

Progress Indicator	Indicator Description (Numerator/Denominator)	Reporting Frequency
Outreach Contact Rate (The percentage of assigned patients who are successfully contacted during the outreach campaign (via phone, email, or other communication methods)	Number of successfully contacted patients / Total number of patients assigned	Monthly
Appointment Scheduling Rate (The percentage of contacted patients who schedule an appointment after receiving the outreach communication).	Number of Patients Who Schedule an Appointment / Number of Successfully contacted patients	Monthly
No Show Rate - Post Scheduling (The percentage of scheduled patients who fail to show up for their appointment)	Number of No-Show Appointments / Total number of scheduled appointments	Monthly
Patient Engagement Rate (The percentage of contacted patients who engage with the clinic (e.g., scheduling an appointment, responding to outreach, asking for additional information)	Number of Engaged Patients (made appointment, called back, requested information) / Number of Successfully contacted patients	Monthly
First Call Resolution Rate (The percentage of calls or outreach attempts that result in a resolution on the first contact, such as scheduling the first appointment, answering questions, or addressing patient concerns).	Number of First Contact Resolution /Total Number of Outreach Contacts	Monthly

STRATEGY 2: USING GAPS IN CARE REPORTS THAT INCLUDE PRACTICE AND MCP DATA

1. If you have baseline data, share your most recent care gap closure rate for one measure for your PoF.

Baseline Care Gap Closure Rates for PoF Measures

Measure	Population of Focus	Denominator (Eligible Population)	Numerator (Received Care)	Performance Rate (%) (Auto-Calculated)	Care Gap Rate (%) (Auto-Calculated) Care Gap Rate = 100% minus Performance Rate
Controlling High Blood Pressure	Adults with Chronic Conditions	3390	2198	64.8%	35.2%

2. Based on your calculated care gap rate, what is your SMARTIE (Specific, Measurable, Achievable, Relevant, Time-bound, Inclusive, and Equitable) goal to improve care gap closure?

SMARTIE Goal(s)	Specific: Increase the percentage of adult patients (ages 18–85) with a diagnosis of hypertension whose blood pressure is adequately controlled (<140/90 mm Hg). Measurable: Raise the HEDIS Performance Rate in Controlling High Blood Pressure (CBP) measure from the current baseline of 64.8% to 80%. Achievable: Implement team-based care strategies, including Medical Assistant-led BP rechecks, clinical decision support alerts in the EHR, and leverage of other technologies to help control blood pressure. Relevant: Controlling high blood pressure reduces the risk of heart attacks, strokes, and other complications—supporting Opsam health priorities of improving chronic disease outcomes and reducing disparities based on race and ethnicity. Time-bound: Achieve this improvement by December 31, 2025, aligning with the current UDS reporting year.

	Inclusive: Ensure designing a culturally and linguistically appropriate education materials and outreach strategies tailored to the clinic's diverse population. Equitable: Prioritize outreach to populations with historically lower control rates per Opsam data, using health navigators and multilingual outreach support.

3. Identify if you will prioritize specific subpopulations within your PoF. If so, what is your rationale for each priority subgroup?

Priority Subpopulation(s)	**Rationale for Prioritization**
Subpopulation based on race/ethnicity with lower performance measure based on current data (Blacks, Hispanics, Asians)	Opsam Health believes in provision of equitable care to all our patients by identifying challenges faced by the subpopulation and implementing strategies to address these challenges with the goal of not only increasing performance measure in controlling BP as a whole but increasing rate across race and ethnicity.

4. What are the interventions you plan to test or implement to achieve your SMARTIE (s) goal to close care gaps? Interventions should include clinical guidelines, patient outreach and engagement strategies, leveraging technology to provide alerts and clinical decision support, pre-visit planning and optimizing team-based care workflows. List the specific interventions or steps of who will do what, how, and by when?

Intervention Description	**Intervention Type**	**Who Is Responsible?**	**Implementation Timeline (By When?)**
Adoption of an evidence-based clinical guideline aligned with the latest ACC/AHA recommendations and training of providers on a standardized treatment algorithm that includes appropriate medication selection, dose titration, and follow-up timing.	Clinical Guidelines	Medical Director, Operations Director	Ongoing regular training at least once yearly. Focused training on providers with low measures as needed

We will leverage technology by 1. Integrating automated alerts into the EHR to flag patients with uncontrolled hypertension at the point of care. 2.Remote patient monitoring to eligible patients for remote tracking, earlier intervention, and better engagement with hard-to-reach patients. 3. Clinical decision support tools in the EHR prompting appropriate interventions for patients with elevated readings, ensuring timely and equitable care adjustments.	Leveraging Technology to provide alerts and clinical decision support	EMR Tech, Medical Director	Completed
We will standardize pre-visit planning process (huddle) to identify patients with hypertension and prioritize them for BP control interventions. Medical assistants and care coordinators will review charts ahead of appointments to flag patients with recent elevated readings or missed follow-ups. This process ensures that every visit includes a BP recheck, medication compliance review, and follow-up scheduling if needed, streamlining care and reducing missed opportunities.	Pre-Visit Planning	Operations Director, Clinic supervisors	Completed
We will enhance patient outreach and engagement by: 1. More robust outreach to patients with uncontrolled hypertension by dedicated healthcare navigators 2. Creating educational materials that are culturally and linguistically tailored 3. Assigning patients with uncontrolled BP to dedicated clinic care planning coordinators to provide support, education, and address social barriers to care.	Patient Outreach and Engagement Strategies	Operations Director, Care coordinators	Completed. Ongoing activities.

Implementing a team-based care approach to patients with hypertension as follows 1. Daily huddle spearheaded by care coordinators flagging patients with uncontrolled hypertension or high reading from prior visit. Flagging patient with uncontrolled BP to enroll in care planning if desired 2. Medical assistants to ensure accurate blood pressure reading and repeating measurement if high and reinforcement of medication compliance 3. Providers applying evidence-based management strategies and regular counselling efforts 4. Case managers offering support and resources to patients with identified social determinants (such as transpo, housing, food support, mental health referral, etc)	Optimizing Team-Based Care Workflows	Medical Director, Operations Director	Completed. Ongoing activities.

5. What progress indicators will you track to understand your progress toward your SMARTIE goal(s) in closing care gaps? You may also attach an example of a report or screenshot of the data elements you will track to understand progress towards closing care gaps.

Key Data Elements to Track Progress

Progress Indicator	Data Source	Tracking Frequency
% of hypertensive patients (ages 18–85) with most recent BP <140/90 mmHg stratified to race/ethnicity, age, gender, language spoken	EMR	monthly
% of patients with uncontrolled BP (>140systolic or >90 diastolic) who have a repeat BP reading conducted by MA within same visit	EMR	monthly
% of patients with hypertension receiving After Visit Summary (AVS) with updated hypertension, medication list, counselling, along with education materials	EMR	monthly

% of patients with hypertension completing PRAPARE screening for social determinants of health identification	EMR	monthly
% of patients with uncontrolled hypertension and positive social determinants of health referred to care coordinator for care planning and support	EMR	monthly

STRATEGY 3: DATA EXCHANGE WITH TWO EXTERNAL PARTNERS, AT LEAST ONE OF WHICH IS A QHIO

Part 1: Data Exchange with a QHIO

Question	Response Options
1. Are you already connected with a QHIO? If not, what is your timeline for contracting?	Yes
1a. Which QHIO are you connected to?	[ ] None [ ] Cozeva - Applied Research Works, Inc. QHIO (Note: The Cozeva QHIO is not the same as the Cozeva Population Health Management Platform that some practices have access to via their MCP. The Cozeva PHM will not count toward the QHIO requirement. Cozeva QHIO participants will have completed the Data Exchange Framework (DxF) Data Signing Agreement (DSA)) [ ] Health Gorilla [ ] Long Health [ ] Los Angeles Network for Enhanced Services (LANES) [ ] Manifest MedEx [ ] Orange County Partners in Health - HIE [ ] SacValley MedShare [x] San Diego Health Connect [ ] Serving Communities Health Information Organization (SCHIO)
1b. If not already connected, which QHIO(s) do you plan to connect with as a source for additional data?	[ ] Cozeva - Applied Research Works, Inc. QHIO [ ] Health Gorilla [ ] Long Health [ ] Los Angeles Network for Enhanced Services (LANES) [ ] Manifest MedEx [ ] Orange County Partners in Health - HIE [ ] SacValley MedShare [ ] San Diego Health Connect [ ] Serving Communities Health Information Organization (SCHIO)

2. What specific types of data do you plan to receive from a QHIO? Select all that apply.	[x] Hospital Discharge Summaries (ADTs) [x] Emergency Medical Services Data [x] Behavioral Health Data [ ] Public Health Reporting Data [x] Social Service Data [x] Substance Use Disorder Data [ ] Pharmacy Data [x] Specialty Consult Data [ ] Claims Data [ ] Other
3. Which processes will be improved or automated by receiving additional data from a QHIO? Select all that apply.	<u>Population of Focus: Adult Chronic Care</u> [x] Ensuring that a patient with hypertension has a blood pressure captured at the visit [x] Sending blood pressure results to MCPs [x] Determining if a patient needs a new HbA1c order/should report GMI [x] Sending HbA1c results to MCPs [x] Administering depression screenings [x] Sending depression screening results to MCPs [x] Other: __Receiving colorectal screening results(coloscopy, fit or Cologuard)_____
4. If not already established, what date do you plan to complete your QHIO agreement?	
5. What barriers do you anticipate to establishing exchange with a QHIO? *(List potential challenges such as technical integration issues, data standardization, contract negotiations, or data privacy concerns. Please also indicate proposed mitigation strategies.)*	

Part 2: Data Exchange with External Partners

<table>
<tr><th>Question</th><th>Response Options</th></tr>
<tr><td>6. Which external partner(s) do you plan to exchange data directly with? Select all that apply.</td><td>[x] Managed Care Plans (MCPs)
[x] Hospitals/Emergency Departments
[x] Behavioral Health Providers
[x] Community-Based Organizations
[x] Specialty Consult Providers
[ ] Immunization Registries (CAIR2 or RIDE) (Only practices with children and youth PoF)
[x] Pharmacies
[ ] Other</td></tr>
<tr><td>7. What specific types of data do you plan to exchange with an external data sharing partner? Select all that apply.</td><td>[x] Supplemental Data
[ ] Hospital Discharge Summaries (ADTs)
[x] Behavioral Health Data
[x] Social Service Data
[ ] Substance Use Disorder Data
[ ] Pharmacy Data
[x] Specialty Consult Data
[ ] Other</td></tr>
<tr><td>8. Which processes will be improved or automated by exchanging data with an external partner? Select all that apply.</td><td><u>Population of Focus: Adult Chronic Care</u>
[x] Ensuring that a patient with hypertension has a blood pressure captured at the visit
[x] Sending blood pressure results to MCPs
[x] Determining if a patient needs a new HbA1c order/should report GMI
[x] Sending HbA1c results to MCPs
[x] Administering depression screenings
[x] Sending depression screening results to MCPs
[x] Other: __Sending colorectal screen results such as fit or cologaurd test_____</td></tr>
<tr><td>9. What is your plan for reaching the goal of receiving additional data from an external source? List the specific steps of who will do what, how, and by when?</td><td>
<table>
<tr><th>Step</th><th>Who is Responsible?</th><th>How Will It Be Implemented?</th><th>Timeline (By When?)</th></tr>
<tr><td>Requesting direct access to hospital EMR</td><td>CMO, Records Administrator</td><td>Via the records administrator, hospital</td><td>UCSD - completed</td></tr>
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</td></tr>
</table>

	to obtain ER / Hospital admission / discharge information		(Scripps, UCSD, Sharp) EMR access will be requested.	Scrips, Sharp - Dec 2025
	Implementation of another population health tool (Arcadia) to obtain information on medi-cal assigned patients information (demographics, screening results) by aggregating and analyzing data from various sources (including other FQHCs)	Data Specialist, IT Administrator , EMR Tech	Through Eclnicalwork (Opsam EMR) integration project engineer, an interface with Arcadia will be established to connect Opsam bidirectionally to the platform and exchange data with other FQHCs connected to it.	May- June 2025
	SFTP file sharing connection with managed care plans	Data Specialist, IT Administrator	By having SFTP server configured and activated between Opsam and managed medi-cal health plans for data exchange	Completed