

### **Empowering Rural Health Care Providers**

LEVERAGING DATA FOR QUALITY, EQUITY, AND RESEARCH

MAY 22, 2025

### **Topics**

Background on MN Community Measurement

A new strategic vision and approach for 2025-2030

Engagement opportunities for rural providers

Measurement and Reporting

Facilitated Data Sharing – MNCM CHIRP Program

Facilitated Engagement in Research – MN EHR Consortium



### Our Mission and Evolving Role

# MNCM empowers health care decision makers with meaningful data to drive improvement.

What we do









Public transparency



Facilitated Data Sharing

How MNCM data are used







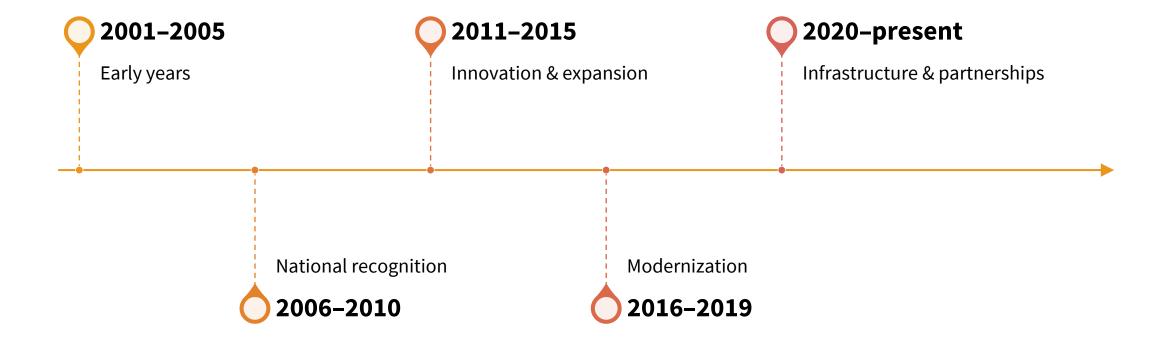
Value-based payment







### **MNCM From Inception to Today**





### **Diverse Support for Evolving Needs**





From health plan collaboration to a diverse model of grants, contracts, and services.

Key lesson: Adaptability and alignment with community needs have kept us relevant.



### Why change?



Transparency alone hasn't fully translated into improved outcomes.



Feedback from our partners:

Need for more collaboration, data-sharing, and shared accountability.



### Reimagining MNCM's Role









No single actor can solve these challenges alone.

Data as a tool for empowerment, not just evaluation.

A collective commitment to health as a shared goal.



### MNCM's Next Chapter



Measuring what matters to communities.



Creating shared tools and insights.



Fostering collaboration and innovation.



Centering equity.



Supporting action at all levels.





### **Examples of Change Already Underway**



Modernized measure review and prioritization



Statewide Performance Hub



Health Care in Minnesota: Summary Report



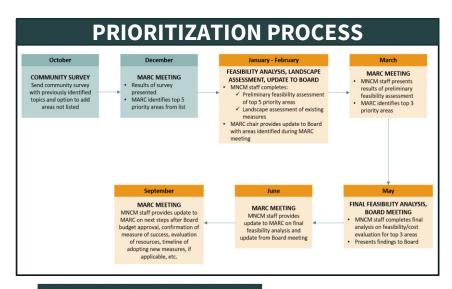
Community-focused infographics & blogs

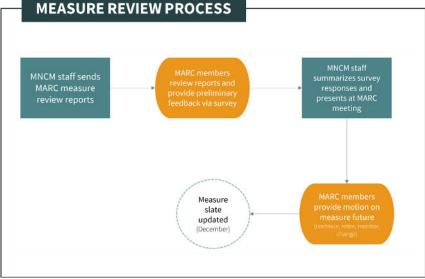




Facilitated research collaborations







### **Community Guided Measurement**

#### **Modernized Measure Review**

- Community input through MARC reviews and surveys.
- Ensures measures reflect current priorities and emerging needs.
- Always open for public comment.

# **HEALTH CARE IN MINNESOTA** Summary Report on Quality, Disparities, and Cost For care delivered in 2023

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## Beyond the Data: Pathways to Action

#### **Health Care in Minnesota Report**

- Latest report delivers insights + action pathways.
- Customized recommendations for different audiences.
- Encourages every partner to find their role in improving health outcomes.

https://mncm.org/reports/#community-reports



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#### Welcome to MNCM's Performance Hub!

Our Performance Hub provides comprehensive analyses of health care quality and cost measures through an interactive platform. These insights are brought to life through our dynamic Performance Reports, delivering a detailed view of healthcare outcomes and disparities. Here's a snapshot of what you can explore:

- Statewide Rates & Trends: Track progress on measures over recent years.
- Medical Group Variation: Analyze performance variations among medical groups across health care quality and cost measures.
- Statewide Rates by Demographics: Gain insights into how health care quality measures vary by race, ethnicity, language, and country of origin.
- . Statewide Rates by Regions: Gain insights into how health care quality and cost measures vary by three-digit ZIP code region.

Dive into the reports to uncover valuable trends, identify areas of improvement, and support data-driven decision-making in health care quality improvement.

### **Turning Data Into Insight**

#### The Statewide Performance Hub

- Interactive dashboards showing:
  - Trends over time.
  - Variation across medical groups.
  - Disparities by demographics.
  - Geographic variation.

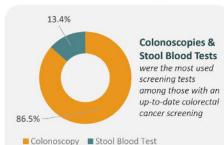
https://mncm.org/performancehub/

#### **Colorectal Cancer Screening** IN MINNESOTA

MARCH

For care delivered in 2023

The Colorectal Cancer Screening measure is defined as the percentage of patients aged 45-75 who had an up-to-date colorectal cancer screening. In 2023, the statewide average was 70.4%.





\*Minnesota Resident Average is a recalculated statewide average that includes only patients with a Minnesota ZIP code as their residence.



#### 5 out of 10

Patients between the ages of 45-49 had an up-todate screenina



#### 8 out of 10

Patients between the ages of 70-75 had an up-todate screening

patients



- (compared to females)
- Hispanic/Latinx patients (compared to non-Hispanic/Latinx patients)
- · Patients born outside of the U.S. (compared to those born in the U.S.)
- English-speaking patients (compared to non-English speaking patients)

MN Community
MEASUREMENT

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The number of additional patients with an up-to-date screening needed to close the gap in screening rates within the 45-49 age group by race



#### For more data, visit mncm.org For information on MNCM's methodology, visit https://tinyurl.com/data-methodology

### Infographics, Blogs, and Community **Sharing**

- Year-round releases aligned with health awareness months.
- Amplifying community stories and resources.
- Inviting partners to contribute their activities.

https://mncm.org/reports/#infographics

### **EHR Consortium & HTAC Overview**



#### **Minnesota EHR Consortium**

The Minnesota EHR Consortium unites 11 major health systems, the Department of Health, and partners like MNCM to support real-time public health analysis

Each system maps their EHR data to the OMOP Common Data Model and runs analyses locally, enabling coordinated insight while maintaining full data control.

#### **Key Points:**

**Federated model:** No data warehouse — analytics run at the health system.

**OMOP standardization:** Ensures cross-system consistency.

**Supports public health:** Chronic disease tracking, equity analysis, COVID response.

The Consortium creates shared capacity for data-driven decision-making statewide — fast, secure, and trusted.

#### **HTAC – Health Trends Across Communities**

#### **Neighborhood-Level Health Insights for Action**

HTAC is a public dashboard built on Consortium data, showing the prevalence of over 30 conditions across Minnesota's communities.

The data is updated quarterly, de-identified, and viewable by race, ethnicity, age, sex, geography, and payer — right down to the census tract.

#### **HTAC Enables:**

- Targeted CHNAs and equity planning
- Monitoring of mental health, substance use, chronic conditions
- Comparisons by location and demographic trends
- Built for health departments, hospitals, and nonprofits,
- HTAC turns EHR data into a tool for public health impact.





**EXPLORE OUR FINDINGS >** 

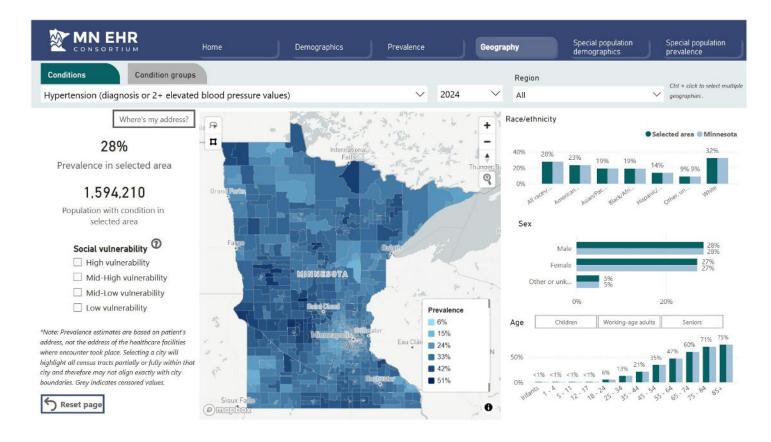
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#### https://mnehrconsortium.org/



### **Bridging the Gap for** Small & Mid-Sized **Practices**

- MNCM enabling access to research collaboratives via MN-EHRC.
- HTAC dashboards help track chronic & behavioral health trends statewide.

https://mnehrconsortium.org/health-trends-across-communities-minnesota-dashboard

### **Bridging the Gap**

#### **Enabling Access to Statewide Research Infrastructure**

Medical groups, regardless of size, can participate in advanced research and public health efforts — without needing to build their own infrastructure.

### Participation Made Simple: OMOP Integration via PIPE

Any medical group contributing data through PIPE can have that data seamlessly mapped into the OMOP Common Data Model.

- ➤ No need to build or maintain an internal OMOP environment.
- ➤ Enabled via a simple addendum to the existing PIPE agreement.
- ➤ Supports both daily and monthly data contributions.

#### **Access to HTAC**

Once data is in OMOP format, medical groups can participate in the **Health Trends Across Communities** (**HTAC**) initiative.

- ➤ Allows their data to be used in statewide chronic disease and behavioral health dashboards.
- ➤ Ensures inclusion in equity-focused public health initiatives and research collaborations. MNCM makes it possible for all medical groups large or small to connect to the

infrastructure powering statewide health intelligence.

### **Access for Everyone**

ENABLING SEAMLESS
INTEGRATION INTO OMOP





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#### CHIRP Facilitated Data Sharing Program

MNCM's Common Health Information Reporting Partnership (CHIRP) offers a facilitated data sharing program, streamlining the bi-directional sharing of patient-level data between health care payers and providers for specified use cases that have been defined and agreed upon by MNCM's CHIRP Governance Committee. The goal of CHIRP is to drive health care improvement by facilitating standardized data sharing that is timely, actionable, consistent, and complete. As part of the provider-to-payer component of CHIRP's facilitated data sharing program, medical groups participate with MNCM in data validation through NCQA's Data Aggregator Validation program.



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For more information, contact the CHIRP Program Manager, Maegi Yang, at support@mncm.org.

CHIRP Governance Committee Members	+
CHIRP Resources	+
CHIRP Payer Participants	+
CHIRP Provider Participants	+

### Facilitated Data Sharing via CHIRP

Shared governance to decide what data needs to be shared and for what purpose

Data standards for bi-directional data sharing (provider-to-payer and payer-toprovider)

Established cadence for sharing to ensure more complete, current data

Visibility to care delivered outside of medical group

Increased efficiencies for providers and payers

### **CHIRP Overview**

#### What is CHIRP?

A program by MN Community Measurement (MNCM) designed to facilitate secure, bi-directional data sharing between health care providers and payers, aiming to enhance health care quality, equity, and affordability.

#### **Key Features:**

- Streamlines the exchange of clinical and claims data for specific use cases.
- Utilizes standardized data formats to ensure consistency and completeness.
- Supports timely and actionable information flow to drive improvements in care delivery.

#### **Benefits:**

#### For Providers:

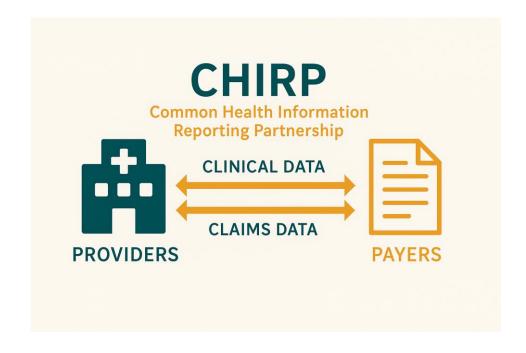
- Reduces administrative burden by minimizing redundant data requests.
- Enhances accuracy in identifying care gaps.
- Facilitates participation in value-based care initiatives.

#### For Payers:

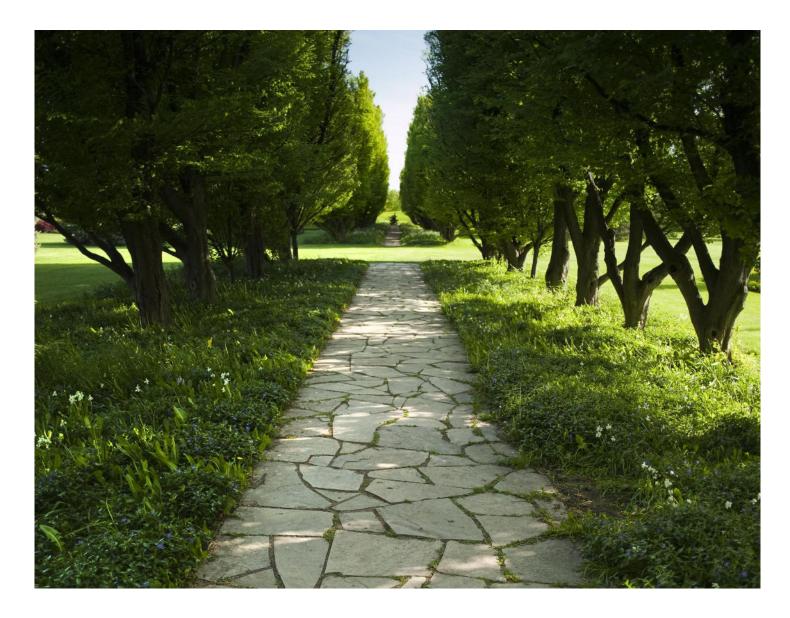
- Improves efficiency in quality measurement and risk adjustment processes.
- Provides access to more timely and comprehensive clinical data.
- Supports better care coordination and population health management.

#### **Participation Requirements:**

- Providers must be onboarded onto MNCM's PIPE system.
- Execution of a CHIRP Provider-to-Payer Legal Addendum.
- Regular submission of specified data files (e.g., Demographic, Encounter, Lab/Procedure, Blood Pressure.









- MNCM's belief: Data + Collaboration = Impact.
- Reinforce our commitment to working with you, for our communities.
- Invitation to engage, partner, and help shape what's next.



### **2025 Annual Conference**

The Power of Partnership: Connecting Care and Community

### **Celebrating Two Decades of Impact**

WEDNESDAY, SEPTEMBER 24, 2025 - MINNEAPOLIS MARRIOTT NORTHWEST

HTTPS://MNCM.ORG/CONFERENCE2025/



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- Let's build a healthier Minnesota together.



https://mncm.org/



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