MINNESOTA
HEALTH CARE HOMES

Health Care Homes: Benchmarking

RECOMMENDATIONS SUMMARY REPORT

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Health Care Homes: Benchmarking

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I. Introduction and Background

The Minnesota Department of Health (MDH)'s Health Policy Division administers the state's Health Care Homes (HCH) program, an initiative that emerged from Minnesota's nation-leading 2008 health reform law. As required by legislation, the HCH program established a benchmarking process in 2010 to recertify clinics, measuring their progress on quality improvement (QI) processes focusing on patient health, patient experience, and cost effectiveness. HCH seeks to understand if the current benchmarking process is supporting clinics in quality improvement initiatives, and where improvements to the process can be made.

Research Questions

1. Are clinics using the current benchmarking process for quality improvement?
2. Is the current benchmarking process necessary for the Health Care Homes program?
3. Are there other data points that can be used for the required benchmarking?

HCH Program Overview

The HCH program is currently seeking a legislative rule change to advance the program, and this effort provides an opportunity to review all program processes, including clinic benchmarking. Certified Health Care Home (HCH) clinics are required by HCH Rule (MINN. R. 4764) to engage in QI processes focusing on patient health, patient experience, and cost-effectiveness and participate in the Minnesota Statewide Quality Reporting and Measurement System (SQRMS). HCH established a benchmarking process for recertification using SQRMS data that all clinics in Minnesota were already required to report. HCH contracts with MN Community measurement to provide customized annual performance benchmarks and improvement benchmarks for all certified clinics. MNCM uploads the data to the HCH Benchmarking data portal that is used by the HCH program during recertification, and is available to HCH clinics to review.

Since the HCH program started certification in 2010, the recertification process has moved from an annual event to every three years, and many clinics have built more capacity for data analytics and have improved or implemented new data platforms that provide real-time data for QI. Though clinics are required to report data to SQRMS, many have become less reliant on state sources of data to drive QI and are more reliant on internal analytics. It has become increasingly clear to the HCH program that it needs to review the current process to ensure that the benchmarking process is beneficial to clinics as well as meeting the requirements of the program.

II. Methods

In September 2018 HCH brought the topic of improving the benchmarking process to the Measurement and Evaluation work group, and received the following recommendations:

- Reduce measurement burden
- Improve the process to have real time and actionable data
- Share best practices and support understanding of data to improve quality
- Collaborate and share measurement results with like clinics
- Use benchmarks that align with financial incentives (e.g. MIPS, IHP)
- Consider the value of HCH specific measures
- Further evaluate the HCH benchmarking process

HCH employed the next steps:

- **Clinic Benchmarking Survey**: The HCH program conducted a survey with the objective of understanding the value of HCH Benchmarking to clinic stakeholders. The benchmarking survey was sent to all HCH certified clinic organizations from December 17, 2018 to January 18, 2019.
- **Brainstorming Session with Program Innovation and Measurement and Evaluation Workgroups:** To enhance understanding of the survey findings, HCH facilitated a brainstorming session on February 27, 2019, with 21 participants from the HCH Measurement and Evaluation and the HCH Program Innovation Workgroups.

Clinic Benchmarking Survey

The HCH program conducted a survey to understand the value of HCH Benchmarking to clinic stakeholders. The HCH Clinic Benchmarking Survey was developed and sent to 65 organizations. 35 responses were received from 34 organizations. The results indicated that 46% (16) certified clinic organizations use the HCH benchmarking portal and 54% (19) do not use the portal for quality improvement purposes.

Table 1: Organization Demographics

Respondent Summary	#
HCH organizations surveyed	65
Organizations responding	34 (52%)
Total number of responses collected	35
Primarily Urban Clinic respondents	14 (40%)
Primarily Rural Clinic respondents	16 (46%)
Organization has both Urban and Rural Clinics	5 (14%)

The majority, 82% (9), of respondents reported using the benchmark portal for HCH recertification requirements; other uses included internal performance measurement and operational changes. Specific examples included setting annual internal goals, contracting, employee development, care improvement, updating workflows and change monitoring.

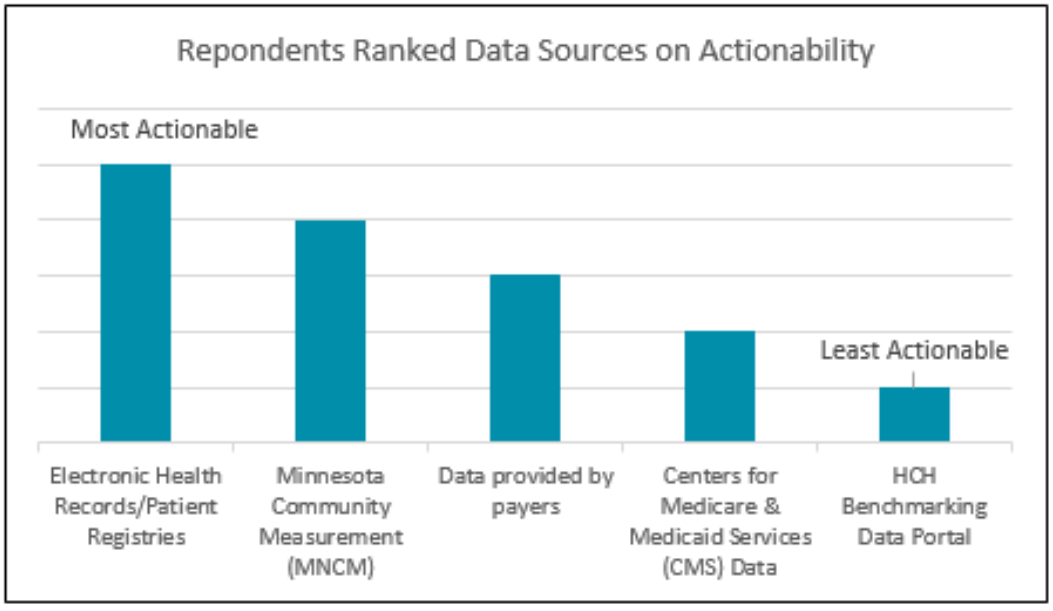
Table 2: Portal Usage

Use of Portal for QI	#	%
Number of respondents who reported they **use portal** for QI	16	46%
Number of respondents who reported they **do not use portal** for QI	19	54%
Types of Use*	**#**	**%**
HCH recertification	**9**	**82%**
Internal performance measurement processes	5	46%
Operational changes (workflows, procedures, protocols, etc.)	4	36%
Other	1	9%

*only 11 of the 16 respondents, who reported using the portal for QI, responded to questions about how they use the portal data.

The majority of respondents reported using the portal for HCH recertification, 64% (7) respondents reported the data as somewhat meaningful to demonstrate improvement in patient outcomes but in comparison to other available data, the HCH benchmarking data had little practical value in ongoing decision making and planning.

Figure 1: Data Actionability Rankings



Value to Clinics

Recommendations from Portal Users:

- Make the portal simpler to use
- Use plain language
- Provide real-time data

Non-Portal Users Reported:

Respondents that reported not using the HCH Benchmark Data Port for QI provided the following reasons.

- **Portal Data Not Timely**
  - When portal data is released
  - Organizations have access to more timely data
  - EMR provides real-time data
- **Other Data Sources Available**
  - ACO membership
  - Electronic medical records
  - MNCM portal or mnhealthscores.org
  - Internal reports
  - Federally Qualified Health Centers use UDS [Uniform Data Systems]
- **Awareness**
  - Was not aware of the portal
  - New to HCH, learning to navigate the program
  - Do not use the portal but will now consider using the portal
- **Portal Data Capability**
  - Other platforms better serve QI
  - Pay for performance contracts determine goals/benchmarks
  - Other data can be stratified at the provider level
  - Internal data used for a standardized approach for reporting quality outcomes
  - Qualify for only 1 HCH measure
  - Comparisons are difficult when the patient demographics are unknown
  - Difficult to navigate

Recommendations on how the HCH benchmarking process could be more meaningful and actionable:

- Allow comparison with similar clinics (same demographics)
- Integrate HCH benchmarking portal with the MNCM measures portal or with large electronic health record (EHRs) systems, such as EPIC
- Provide summary reports of all the benchmark measures together and where clinics fall in comparison to state/HCH averages
- Provide training on how to navigate and use the portal
- Make the portal more user-friendly, easier to navigate
- Include the [benchmarking] process in the certification application as a basic requirement
- Use real-time data to measure performance on HCH action plans
- Research best-practices nationally

Benchmarking Brainstorming Session

HCH facilitated a brainstorming session on February 27, 2019, with 21 participants from the HCH Measurement and Evaluation and the HCH Program Innovation Workgroups to react to survey results and the HCH benchmarking process.

Members were asked to respond to the following questions:

1. What are your thoughts on the survey results? Any surprises? What jumped out at you and why?
    a. What do you agree or disagree with? What do you want to know more about?
2. What would make the benchmarking process more useful and valuable for clinics?
    a. Relevant, actionable, easier to navigate, other?
3. Are there good alternatives for HCH to track QI for benchmarking purposes?
    a. Manageable for clinics
    b. HCH gets what they need
    c. A value to clinics

Brainstorming Summary

Participants appreciated that urban and rural clinics participated in the survey at a similar rate. They agreed that the majority of certified clinics use the HCH benchmarking portal data for recertification purposes. The group did question why clinics would use the benchmarking portal data for operational and internal performance improvement when EHR data is more current. There was further agreement that smaller clinics and medical groups may use the portal more if they have less capacity and resources for internal data analytics.

Benchmarking has a role in measuring progress over time but this is only an element of what clinics need for measurement and evaluation, and does not necessarily drive ongoing QI. Payer data was viewed as more of a driver of QI, and participants were surprised that it was not rated higher in data actionability. Clinics are interested in finding a middle ground where they and the HCH program both have the data needed for the recertification process, while improving benchmarking data so that it is more relevant as we move more into the value-based care environment.

There is tension between meeting HCH requirements and the many other reporting requirements for clinics, hence finding alignment across programs would be helpful to the clinics. The clinic profile data in the HCH Benchmarking Data Portal is onerous to maintain, especially for large systems. Clinics would like to better understand how the HCH program uses the profile data in the Portal.

Recommendations include:

- Investigate the difference between clinics on use of the benchmarking portal
- Provide benchmarking reports to clinics soon after the information is released from MNCM
- Incorporate real-time, more actionable data into the HCH benchmarking process

- Provide clinic the ability to compare their performance to that of "like" clinics
- Provide learning and tools on QI, benchmarking and the portal
- Consider how the data could be useful to patients
- Align and standardize benchmarking with other performance measures
- Evaluate the importance of benchmarking role in HCH
- Consider the needs of various types of clinic populations (e.g. FQHCs)

Recommendations specific to the HCH Benchmarking Data Portal:

- Change the HCH Portal to meet the needs of clinics using the feedback from the Benchmarking Survey and Brainstorming Session
- Provide more training on QI measurement in the MDH Learning Management System
- Focus less on annual benchmarking and more on QI implementation for recertification
- Include more internal clinic data for quantitative measurement of improvement for recertification
- Eliminate the HCH Portal and use data directly from MNCM for HCH recertification

III. Conclusions

The 2008 legislation, that established HCH, required benchmarking to be part of the clinic recertification process and the HCH benchmarking data portal was implemented using measures from SQRMS. The SQRMS data is uploaded to the HCH benchmarking data portal, providing convenient benchmarks for the process and a good source of measures for clinics to meet the QI requirement of HCH certification.

Since 2010 when the first clinic was certified, clinics have increased their data analytics capacity and have access to many other data sources. Both the brainstorming session participants and survey responses confirm that the primary use of the current HCH benchmarking data portal is the recertification process. However, 46% (16) of survey respondents reported using it for quality improvement, which was a surprise to the brainstorming session participants. The use of the benchmarking data portal may be more useful to smaller clinics with limited capacity, and this independent third party validation facet may make it more valuable than internal data.

The Health Care Homes program is legislatively mandated to have a benchmarking process, and based on this feedback it would seem that it is a good time to revisit the benchmarking process to make improvements. It is possible that HCH could still use MNCM data for benchmarking without it being uploaded to the HCH benchmark data portal, but the question remains if MNCM the best source of data to use for the HCH benchmarking process. Clinics are required to report data to many different agencies, and aligning HCH benchmarks with data already being submitted would reduce burden on clinics. Further investigation is needed to understand available data sources, if these sources could be used in a standardized benchmarking process across all clinics, and if this would ease clinic burden.