Measurement Framework Steering Team Meeting #2 Summary

Monday, July 29th, 2019
1:00-4:00 PM
HIWAY Federal Credit Union, St. Paul, MN

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Participants

Steering Team:

- Bill Adams
- Graham Briggs
- Ellen De la torre
- Marie Dotseth
- Renee Frauendienst
- Courtney Jordan Baechler
- Lisa Juliar
- Scott Keefer
- Rahul Koranne
- Deb Krause

- Deatrick LaPointe
- Jennifer Lundblad
- Gretchen Musicant (phone)
- Sarah Reese (phone)
- Diane Rydrych
- David Satin
- Janet Silversmith
- Julie Sonier
- Marcus Thygeson
- Tyler Winkelman (phone)

- Pahoua Yang
- Maiyia Yang Kasouaher

MDH Project Staff:
Sarah Evans, Stefan Gildemeister (phone), David Hesse, Denise McCabe, Jeannette Raymond

Turnlane:
Alex Clark, Cassandra Canaday

Meeting Objectives

- More clearly define the Steering Team's role in Phase 2 of framework development and establish our approach to **decision-making;**

- Compare and discuss **existing framework models** to help us envision the type of model that will work best for Minnesota, and **identify desired elements** of a Minnesota measurement framework;

- Further refine our **framework definition building off of our June discussion and today's framework model discussion**; and

- Introduce the topic of **stewardship, or governance,** which will be the focus of our September meeting.
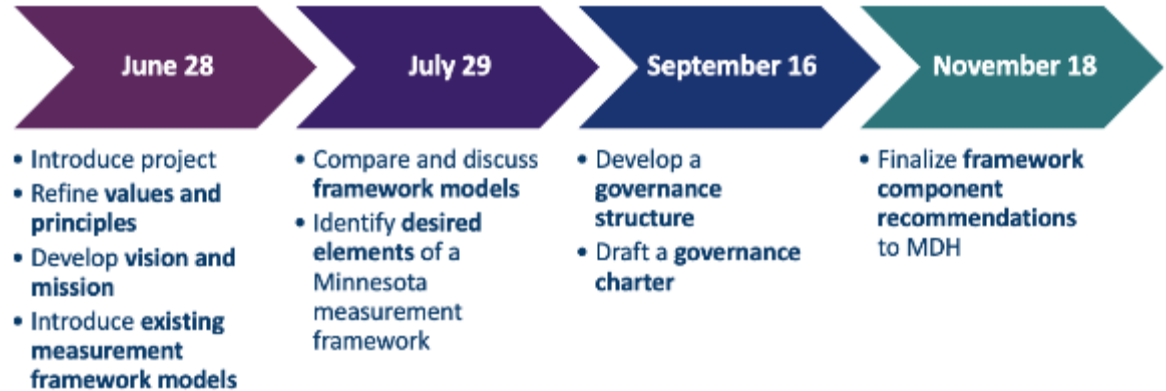
Experiential Goals

- Get to know each other

- Feel that the expertise and contributions each of us brings to this table are valued

- Feel excited about the opportunity the framework presents, and

- Share leadership

Welcome and Grounding

Co-chairs Jennifer Lundblad and Marie Dotseth welcomed participants by providing an overview of the meeting objectives and introducing the new facilitators for phase 2, Alex Clark and Cassandra Canaday of Turnlane.

Additionally, Jennifer reminded participants of the arc of the Steering Team's work throughout phase 2 (see right).

Arc of Work

June 28
- Introduce project
- Refine **values and principles**
- Develop **vision and mission**
- Introduce **existing measurement framework models**

July 29
- Compare and discuss **framework models**
- Identify **desired elements** of a Minnesota measurement framework

September 16
- Develop a **governance structure**
- Draft a **governance charter**

November 18
- Finalize **framework component recommendations** to MDH

Steering Team Agreements

Mindset
- Our work is on behalf of **Minnesota's citizens**, the ultimate stakeholders.
- We **test our assumptions and inferences**.
- We **respect** ourselves, each other, and the groups' process.

Verbalizing
- We encourage **constructive, adaptive thinking**.
- We are sensitive to the fact that **everyone deserves to be heard**.

Preparedness
- We **maximize our time** by coming to meetings having completed any homework assignments.
- We always **start meetings on time**.

Prior to discussion on core agenda topics, Alex Clark highlighted the Steering Team agreements, which are meant to guide the group's conduct during meetings (see left).

Alex also noted that, given the wealth of diverse perspectives and lived experiences, conflict and tension may arise within the Steering Team. Alex encouraged leaning into these moments rather than avoiding them, as they can help the group make progress.
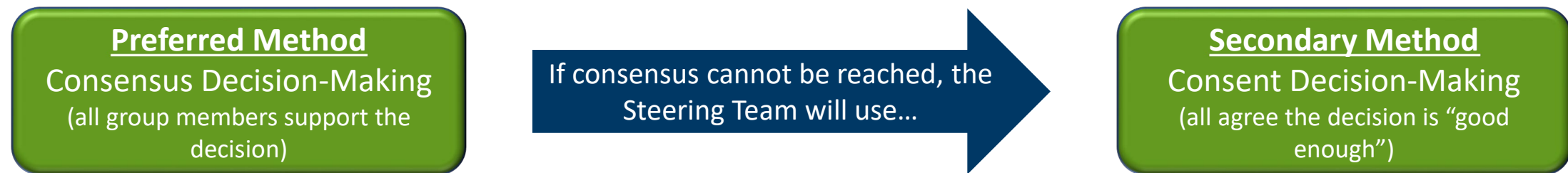
Steering Team's Role and How Decisions Will Be Made

The Role of the Steering Team

The group revisited their role and charge within the process of developing Minnesota's measurement framework.

> *The Steering Team serves in an advisory role and a consultative capacity to the state and to MDH in informing the development of the measurement framework.*

Decision-Making within the Steering Team

To ensure there are clear, common expectations for how the Steering Team will make decisions, Alex provided meeting participants with four potential group decision-making approaches to consider (see Appendix A). After small group discussions, the Steering Team agreed to the following approach. If the methods below fail, the Steering Team agreed to defer to MDH.

Preferred Method
Consensus Decision-Making
(all group members support the decision)

If consensus cannot be reached, the Steering Team will use…

Secondary Method
Consent Decision-Making
(all agree the decision is "good enough")

Learning from Other Measurement Frameworks

Meeting participants turned their attention toward the various frameworks that were reviewed by small groups following the June 28th meeting. One to two members from each small group provided a brief overview of their assigned framework, then answered clarifying questions to help Steering Team members understand the design and approach of each example (also see Appendix B).
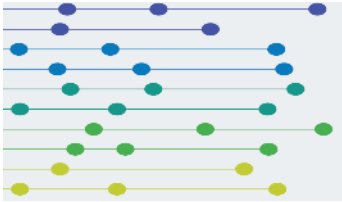
National Collaborative for Health Equity: The Health Opportunity and Equity (HOPE) Initiative

Maiyia Yang Kasouaher and Marcus Thygeson highlighted:
- Social and structural determinants focus, very little on health care
- Asset-based orientation
- Promotes cross-sector collaboration

Robert Wood Johnson Foundation (RWJF): Vision to Action Framework

Janet Silversmith highlighted:
- Very upstream measures
- Challenges status quo
- Poses a big gap between where MN is now
- Promotes cross-sector collaboration

Institute of Medicine: Core Metrics for Health and Health Care Progress

David Satin highlighted:
- Emphasis on health care measures, many on access and prevention
- Lacks focus on health equity
- Has experienced low levels of adoption

Centers for Medicare & Medicaid Services (CMS): Meaningful Measures

Julie Sonier highlighted:
- Emphasis on health care
- Lacks focus on equity
- Places patients at center
- Heavy on process measures
- Not very actionable

Desired Elements of Minnesota's Measurement Framework

Participants reviewed the analogy of a measurement framework as a tree – the definition and properties serving as the trunk, the domains as branches, and the measures as leaves. See Appendix C for further detail on how this analogy fosters common language for framework development.

Meeting participants then broke into small groups to discuss key questions about other measurement frameworks in order to identify what elements may be most suitable for Minnesota to consider.

Small groups shared perspectives and insights on these questions during debrief with all meeting attendees (see right for collective summary). Appendix D includes greater detail.

Small Group Discussion Questions

- Share with your group which **one element** across all frameworks stood out most to you.
- What elements of these frameworks do you see as a **good fit for Minnesota**?
- If you were designing a framework for Minnesota, what **three domains** would you choose? These do not have to be from the models the group reviewed.

Elements to Consider for Minnesota

Properties
+ Informs strategic investments
+ Fosters a culture of health
+ Scope includes social and structural det. of health
+ Promotes cross-sector collaboration
+ Incorporates an equity lens
+ Is asset-based, highly actionable, and process-focused
+ Utilizes evidence-based foundations
+ Includes the Triple aim
+ Clearly states goals
+ Focuses on community health and well-being

Structural Features
+ Goal-focused hierarchy
+ Inclusion of "drivers" of health
+ Visual Model
+ Equity goal charts
+ Modular "plug and play" design
+ "Poster child" measures supplemented by more specific ones
+ Equity as an encircling aspect
+ Equity is important, explicit, and embedded
+ Organization by strategies/levers of change

Domains
+ Rural Health
+ Access (broadly to include healthcare, supportive services, financial, etc.)
+ Telehealth
+ Cost or affordability (to people, families, and systems)
+ Policy
+ Clinical Outcomes
+ Context of community opportunity
+ Community features that affect health
+ Social det. of health
+ Advisory
+ Genetics

Continued Refinement of Our Framework Definition

Participants reviewed the latest iteration of the framework definition, which was revised based on Steering Team input during the June 28th meeting (see Appendix E for all detail). Several individuals suggested additional changes to further refine the Steering Team's working definition.

What is a measurement framework for health and health equity?

❖ A **set of domains** that together form a structure for identifying **appropriate and meaningful measures of health and health equity** for the **whole population** of Minnesota.

❖ Reflects the understanding that a broad range of **systems and social, economic, and environmental factors create, influence, and perpetuate the health status of individuals and communities.**

❖ Expresses a set of **values and principles** that guide **decision-making** for the framework and **connected collaborative efforts** to improve health and health equity.

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Steering Team Input
- To further enable a shared definition, further clarity is needed on how this framework will be utilized and by whom
- Definition could be strengthened by adding a bullet about the intention of experimenting and learning together instead of being overly prescriptive about health measurement

Parking Lot Questions for Additional Discussion
- Is it also intended to promote action across sectors?
- Who is reporting our to-be-determined measures (source of data)?
- What is the unit(s) of measurement and reporting accountability? Organization level? Community level?
- Will this be used to frame public communication about health improvement efforts?

Primer for Steering Team Governance Development

Alex Clark provided participants with a brief overview on the topic of governance and how the Steering Team's work during phase 2 will result in a governance approach for future phases of developing the measurement framework.

The governance approach the Steering Team develops will:

Delineate who is accountable for performing certain tasks	Identify the roles and responsibilities necessary to support framework development and implementation	Outline which roles hold decision-making ability and authority

Discussion

Participants shared that using a holistic definition of health and all the factors that determine health may require broader engagement from perspectives and sectors not currently represented within the Steering Team (e.g. transportation, law enforcement, etc). This specific topic will be revisited during the September meeting, which will include a more comprehensive discussion on governance.

Steering Team members will receive additional material on governance approaches for review ahead of the September 16th Meeting.

Public Comments, Meeting Close, and Next Steps

Public Comments
There were no comments from public observers.

Meeting Close
Alex Clark noted that action items from the meeting will be communicated via email. In addition to specific actions resulting from the July meeting, there will be required preparatory activities before the September 16th meeting.

Next Steps

- ❑ Provide input via the post-meeting survey (Steering Team members)

- ❑ Complete required review and preparation before the September 16th meeting (Steering Team members)

Group Decision-Making Approaches

Approach	Intent of Approach	Pros	Cons
Consensus Decision-Making	Consensus strives to incorporate everyone's perspectives, needs, and ultimately their permission.	• Satisfies all constituents • Fosters strong, united groups • Equalizes the distribution of power in a group • Constituents leave prepared to implement	• Requires a lot of time • Very challenging for groups with low trust or competing interests • Difficulty increases as group grows larger • Subject to compromises that may not serve the group well
Democratic Decision-Making	A group is presented with a series of options to vote on. The option with the most support is carried forward.	• Transparent process • Perceived as fair • People easily grasp where the process begins and ends (unlike consensus and consent)	• Vulnerable to groupthink or political campaigning • Majority feels little need to compromise with minority • Lack of ownership on implementing decisions - "I didn't vote for that!"
Consent Decision-Making	Consent means the absence of objections. Similar to consensus, consent invites group participation in the decision-making process but instead of granting each member the power to mold the proposal in pursuit of a compromise, consent urges the group to accept a "good enough" solution.	• Fast and consultative • Encourages iterative, "good enough" solutions • Doesn't require agreement • Promotes objective debate	• The decision-making process can be rushed toward a suboptimal solution • The process can feel unfamiliar and uncomfortable • Can ignore team cohesion in the decision-making process • Can be harmful if used on wide-impact, long-lasting decisions
Consultative Decision-Making	Consultative decision-making means asking for input from a set of individuals, but ultimately reserving the decision for one individual or group.	• Fast • Generates additional perspectives beyond decision-maker • Helps gauge how a decision will play out politically • Gives access to technical knowledge • Opportunity to influence key stakeholders	• People may feel excluded and unimportant • May result in limited buy-in and support • Creates the perception of politicking

Adapted from Nobl's "The Decider"

HOPE Initiative
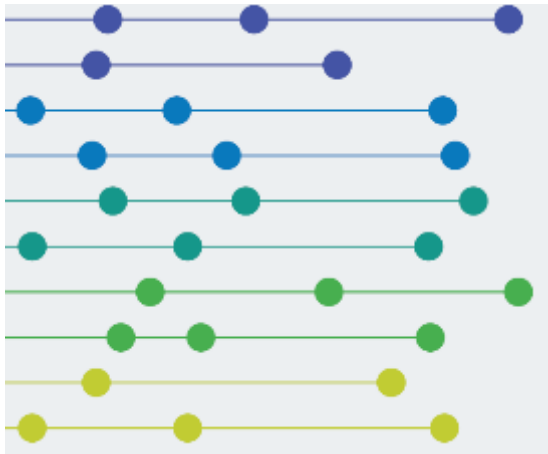
- Reviewers: Olivia Jefferson, Marcus Thygeson, Maiyia Yang Kasouaher

- Alignment: General alignment; little about health care in HOPE

- Desirable features: Asset-based approach, equity lens, social and structural determinants of health, culture of health

- Actionability: Fosters cross-sectoral collaborations

- Adoption: Consider adopting portions of HOPE and adding them to our existing measurement system

- Key question: How might **health care** see themselves in the HOPE framework?

RWJF Vision to Action

- <u>Reviewers:</u> Bill Adams, Courtney Jordan Baechler, Rahul Koranne, Janet Silversmith

- <u>Alignment:</u> General alignment; RWJF is action-oriented

- <u>Desirable features:</u> Action areas, drivers, measures

- <u>Actionability:</u> Fosters collaboration and partnership

- <u>Adoption:</u> Consider adopting RWJF with modifications

- <u>Key question:</u> Are we **tweakers** or **visionaries,** are we taking a **step** or making a **leap,** are we **evolutionary** or **revolutionary**?

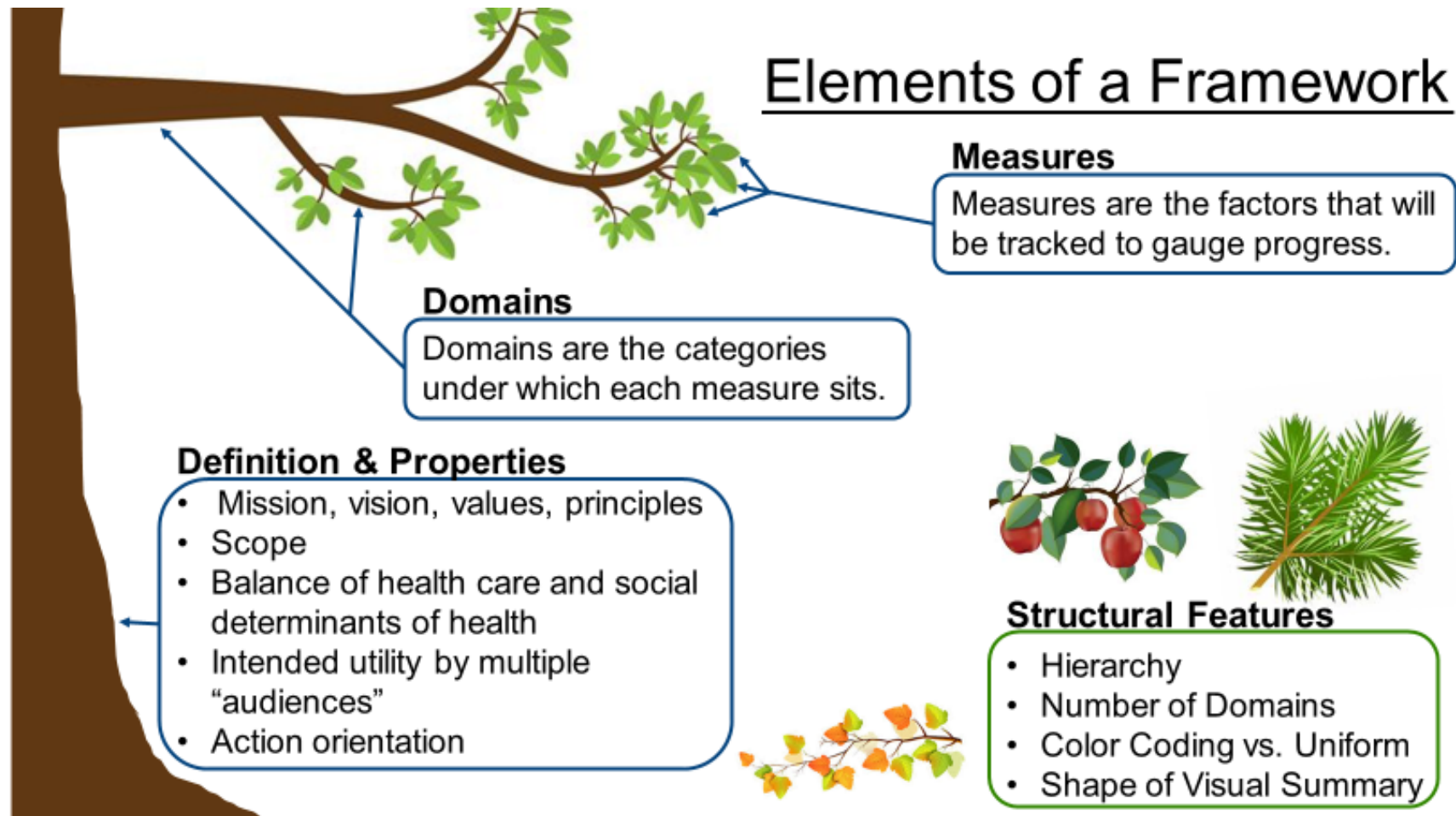# IOM Vital Signs: Core Metrics for Health and Health Care Progress

- **Reviewers:** David Satin, Marcus Thygeson, Tyler Winkelman

- **Alignment:** General alignment; IOM does not emphasize health equity, and connection and collaboration

- **Desirable features:** Core measure set, triple aim

- **Actionability:** Fosters cross-sectoral collaborations and partnerships

- **Adoption:** Consider adopting the IOM framework with modifications

- **Key question:** How would **funding** be leveraged to encourage cross-sectoral approaches?

CMS Meaningful Measures

- <u>Reviewers:</u> Scott Keefer, Julie Sonier

- <u>Alignment:</u> General alignment; CMS does not emphasize health equity, and connection and collaboration and is focused on health care

- <u>Desirable features:</u> Strategic goals, cross-cutting criteria, overarching measurement categories, visual model

- <u>Actionability:</u> Informs strategic investments, not a useful model for cross-sectoral collaborations

- <u>Adoption:</u> The Minnesota framework should be informed by the best of the measurement frameworks under review

- <u>Key question:</u> What is the **there** we are trying to get to, **how** do we get from here to there, and **what** will it take to get there?

Thinking of Framework Development as a Tree

Elements of a Framework

Measures
Measures are the factors that will be tracked to gauge progress.

Domains
Domains are the categories under which each measure sits.

Definition & Properties
- Mission, vision, values, principles
- Scope
- Balance of health care and social determinants of health
- Intended utility by multiple "audiences"
- Action orientation

Structural Features
- Hierarchy
- Number of Domains
- Color Coding vs. Uniform
- Shape of Visual Summary

Small Group Discussions

Small Group Discussion Questions

- Share with your group which **one element** across all frameworks stood out most to you.
  Major Themes:
  - Cross-sector collaboration
  - Framework scopes that recognize that health is broader than health care
  - Evidence based
  - Clear hierarchies
  - Recognition of health equity and disparity at some level
  - Focus on community health and well-being
  - Some significant parties are missing from the table

- What elements of these frameworks do you see as a **good fit for Minnesota**?
  Major Themes:
  - Leveraging existing efforts, data, and evidence base
  - A focus on equity
  - Actionability and accountability
  - Relevant, tailored measures that take context into account
  - Comprehensive balance between health care, social determinants/upstream factors, equity, policy
  - Emphasis on healthy communities

- If you were designing a framework for Minnesota, what **three domains** would you choose? These do not have to be from the models the group reviewed.
  Major Themes:
  - Community and Community Health
  - Policy
  - Cross-sector collaboration
  - Community Partnerships and Engagement
  - Access
  - Advisory
  - Clinical Outcomes
  - Cost or Affordability
  - Individual Outcomes
  - Patient Experience
  - Healthcare System Performance
  - Social Determinants of Health
  - Equity
  - Rural Health
  - Disparities
  - Socio-economic factors

Large Group Discussion

Large Group Discussion

- Which **one element** across all frameworks stood out most to you as a **good fit for Minnesota**?

  Major Themes:
  - Health is more than health care
  - Health equity—it's its own domain but also underlies all other domains, needs to be both explicit and embedded
  - Cross-sector collaboration and accountability
  - Working with communities and focusing on their health and well-being

  - Agile/adaptable model and orientation
  - Rigorous evidence-base
  - Actionability
  - Cost and affordability as part of access—should focus particularly on the cost of care for patients/individuals/ families

- If you were designing a framework for Minnesota, what **key domains** would you choose?

  Major Themes:
  - Access to health care (possibly including tech, telehealth, interoperability, affordability/financial access)
  - Advisory
  - Clinical outcomes
  - Affordability
  - Community-level factors

  - Individual-level/patient-reported outcomes
  - System performance and affordability
  - Policy

What is a Measurement Framework for Health & Health Equity?

❖ A **set of domains** that together form a structure for identifying **appropriate and meaningful measures of health and health equity** for the **whole population** of Minnesota.

❖ Reflects the understanding that a broad range of **systems and social, economic, and environmental factors create, influence, and perpetuate the health status of individuals and communities**.

❖ Expresses a set of **values and principles** that guide **decision-making** for the framework and **connected collaborative efforts** to improve health and health equity.

What is a Measurement Framework for Health & Health Equity?

The measurement framework will:

- Clearly frame the **range of factors** that need to be addressed to **"move the needle"** on health outcomes

- Be informed by those experiencing the **most negative health outcomes**, and reflect the **lived experience of people**

- Uncover factors that **historically have been obscured or ignored**

- Enable the establishment of **health improvement goals**

- Inform **decision-making, action and accountability** to drive:
  - Allocation of resources and strategic investments
  - Intentional action (working on the right things)
  - New and expanded partnerships, collaboration, and other alignment of efforts
  - Innovation

What is a Measurement Framework for Health & Health Equity?

The measurement framework will:

- Demonstrate improvement or catch eroding trends for:
  - Social, economic, and environmental factors that impact health
  - Population health outcomes
  - Health inequities
  - Health care delivery and other systems
- Frame public communication about health improvement efforts
  - With easy to understand graphic depiction

Survey Results

The following synthesizes input from 12 Steering Team members who provided feedback on Meeting #2 (July 29th) via an online survey conducted by Turnlane.

All responses to questions below are on a scale from 1 – 5 with 1 being "Strongly Disagree" and 5 being "Strongly Agree".

The materials provided… helped me feel prepared to participate in discussion	I felt that my perspectives were heard in this meeting	I had adequate opportunities to voice my input in this meeting	I feel like I understand the goals of this project	I feel like I understand my role in this project
Average **4.3** out of **5**	**Average** **4.0** out of **5**	**Average** **4.2** out of **5**	**Average** **3.9** out of **5**	**Average** **3.8** out of **5**

Themes and Suggestions

*"At the beginning, we were talking about principles and decision making. **This was frustrating** to me and others - here we are in our second of three meetings, and these are such basic things. **How will we get to the desired outcomes?"***
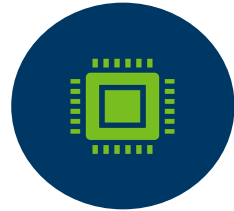
Fix technology issues— they're distracting and frustrating

Use clear, consistent language and modeling

Use a physical "parking lot" for ideas to keep discussions relevant

It is still unclear to many what we are trying to accomplish.

Keep discussion on track by using frequent grounding, consistent reminders of our goals, and stricter limits on people taking up too much time

Minnesota Framework for Health and Health Equity Measurement and Improvement

This document reflects input from the measurement framework steering team to-date, and will be updated following the September 16 meeting.

Vision

A framework for health and health equity measurement and improvement is a set of domains that together form a structure for identifying appropriate and meaningful areas of health and health equity measurement and improvement for Minnesotans.[1]

A framework for health and health equity measurement and improvement reflects the understanding that a broad range of systems and social, economic, and environmental factors create, influence, and perpetuate the health status of individuals and communities.

A framework for health and health equity measurement and improvement also expresses a set of values and principles that guides decision making for the framework and connected, cross-sector collaborative efforts and partnerships. It will evolve over time as informed by measure results, and as health priorities and conditions change.

The framework will:
- Clearly frame the range of factors that need to be addressed to "move the needle" on health outcomes
- Be informed by those experiencing the most negative health outcomes, and reflect the lived experience of people
- Uncover factors that historically have been obscured or ignored
- Enable the establishment of health improvement goals
- Inform decision-making, action and accountability to drive:
  - Allocation of resources and strategic investments
  - Intentional action (working on the right things)
  - New and expanded partnerships, collaboration, and other alignment of efforts
  - Innovation

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[1]Health equity is a state of affairs where everyone has what they need to be healthy and no one is prevented from being as healthy as they can be by unjust or unfair barriers. We can only achieve health equity when all children get a loving and healthy start; when we can all get a good education and good jobs; when we can all take part in the decisions that shape our communities; and when we all have good living conditions. When some of our populations are not as healthy as they could be, it is typically because of inequities in these conditions. Inequities in health outcomes can only be eliminated when each of us has the opportunity to realize our health potential—the highest level of health possible for us—without limits imposed by structural inequities. (Minnesota Department of Health. (2017). *2017 Minnesota Statewide Health Assessment*. Produced in collaboration with the Healthy Minnesota Partnership. St. Paul, MN).

- Demonstrate improvement or catch eroding trends for:
  - Social, economic, and environmental factors that impact health
  - Population health outcomes
  - Health inequities
  - Health care delivery and other systems
  - With easy to understand graphic depiction

Values and Principles

Values
1. Fairness and equity
2. Connection and collaboration
3. Measurement that matters
4. Actionable information
5. Improvement
6. Accuracy and rigor
7. Innovation
8. Transparency and simplicity
9. Efficiency

Principles
1. Health is more than health care, and a measurement framework should recognize this by:

   a. Linking up with overarching concepts of quality (e.g., safety);

   b. Incorporating and appropriately accounting for provider, system, community, cultural, and patient factors that contribute to variation in quality measure results; and

   c. Exploring factors at the population/neighborhood level and across systems of care (e.g., ambulatory, long term, behavioral).

2. A measurement system should seek to measurably foster improvement in health outcomes, health care quality, health equity, patient experience, and population health, and reduction in costs for patients, providers, and purchasers.

3. Quality measurement should be patient-centered and produce information that is meaningful, fair, transparent, and actionable for different stakeholders (e.g., patients, providers, health plans) in different ways (e.g., decision-making, public reporting, internal improvement, value-based purchasing). Measures do not need to be used by all stakeholders for all purposes.

4. Quality measurement in Minnesota should be parsimonious, appropriately balance value for stakeholders with reporting burden, and not duplicate other efforts.

5. Minnesota must measure what is most important, not what is easiest. A measurement framework should provide "signal strength"—cohesiveness and alignment around what is important.

6. The quality framework should be regularly monitored and updated via an inclusive, transparent process to ensure it meets goals.

Domains

There are four emerging domains of health and health equity measurement and improvement areas:

- The **community conditions and outcomes** domain contains geographic-specific and population-specific indicators that are actionable for organizations that work on behalf of specific communities.
- The **health care and social services** domain contains indicators associated with access, affordability, quality and expectations of services.
- The **statewide conditions and outcomes** domain contains high-level social and structural indicators to assist in placing other indicators into the broader context of what creates health.
- The **policy environment** domain contains health care policy, economic policy and other policy indicators related to health priorities that impact statewide conditions and outcomes.

Using these four domains for any identified health and health equity measurement and improvement priority will allow for the identification of existing measures and measure gaps. Framework health priorities will be determined through the governance process with community input.

Health priority			
Community conditions and outcomes	**Health care and social services**	**Statewide conditions and outcomes**	**Policy environment**
Public engagement and belonging *(social isolation, sense of community, etc.)* **Environment** *(walkability, access to healthy food, parks and recreation utilization, etc.)* **Community partnerships** *(health care benefit agenda, local health initiatives)*	**Access to services** *(health care, mental health, dental, health insurance, housing assistance, SNAP benefits)* **Affordability of services** *(health care, mental health, dental, health insurance)* **Health care collaboration** *(health care use of framework)*	**Health outcomes** *(mental health status, functional status, mortality, birth weight)* **Socio-economic** *(housing, education, income)* **Social environment conditions** *(safety, poverty)* **Physical environment; natural and built environment** *(water, air, housing quality)*	**Policies that advance or constrain our ability to achieve health** *(minimum wage, paid parental leave)* - Statewide policy indicators - Localized policy indicators - Other (corporate, religious, etc.)

Health priority			
Community conditions and outcomes	**Health care and social services**	**Statewide conditions and outcomes**	**Policy environment**
	Social service collaboration *(social service use of framework)* **Quality of services** *(health care, mental health, dental, health insurance, housing service, SNAP benefits)* **Patient/recipient/ beneficiary experience of services** *(patient experience survey)*		

Infant Mortality Measurement Example

The following health priority and measures serve as an example of how the draft framework model may look when implemented. Measures were selected from a variety of sources including Minnesota state agency indicators and existing frameworks reviewed by the Steering Team (HOPE, RWJF and IOM).

Community conditions and outcomes	Health care and social services	Statewide conditions and outcomes	Policy environment
Public engagement and belonging • **Sense of community** (sense of community index) • **Social support** (Percentage of people noting that they have adequate social support from partner, family and friends) • **Voter participation** (Percentage of eligible voters who reported voting in the general election) **Environment** • **Availability of healthy food** • **Walkability** **Community partnerships** • **Community health benefit agenda** • **Hospital partnerships** (Percentage of hospitals that have a collaboration or alliance with one or more organizations in each of these categories: local government, state agencies, other community-based agencies) • **Health care provider organizations and obstetricians use framework** to implement disparity reduction interventions,	**Access to services** • **Access to primary care** (Portion of people living in counties with a population-to-primary care physician ratio of less than 2,000:1) • **Access to mental health services** (Percentage of people who report having mental health or substance abuse problems, and who received treatment) • **Medicaid enrollment for women of childbearing age** **Affordability of services** • **Affordable health care** (Portion of adults who did not delay or forgo any medical care they needed due to cost in the past year) • **Health insurance coverage** (Portion of people under age 65 with any kind of health insurance) **Quality of services** • **Measure of comprehensive, culturally appropriate, coordinated health care** women receive during preconception, pregnancy and post-partum periods	**Health outcomes** • **Infant mortality** (# of infants who die before their 1st birthday annually per 1,000 live births) • **Rate of pre-term births** • **Rate of Sudden Unexpected Infant Deaths** • **Rate of pregnancies that are planned** • **Rate of teen pregnancies** **Socio-economic** • **Affordable housing** (Portion of households spending no more than 30% of monthly household income on housing and related expenses) • **Post-secondary education** (Portion of adults with at least some college education after graduating from high school) • **Connected youth** (Portion of young people age 16-24 enrolled in school or working, including military enlistment) • **Employment** (Portion of people in the labor force who are employed) **Social environment conditions** • **Low poverty concentration** (Portion of people in neighborhoods	**Statewide policy indicators** • **Support for working families** (Annual percentage of families with parents eligible for Family Medical Leave Act coverage who can also afford it) • **Targeted care for those at greatest risk** (state coverage of enhanced prenatal care interventions for women enrolled in Medicaid or the Children's Health Insurance Program who are at risk for a preterm birth) • **Safe sleep** (state promotion of interventions to improve infant safe sleep practices, including public education campaigns) • **Smoking cessation** (state coverage and provision of smoking cessation for pregnant women and cigarette taxation)

Community conditions and outcomes	Health care and social services	Statewide conditions and outcomes	Policy environment
like providing culturally competent care • **Community-based organizations use framework** to inform community interventions, like safe sleep education, and track progress	**Patient/recipient/ beneficiary experience of services** • **Measure of comprehensive, culturally appropriate, coordinated health care** women receive during preconception, pregnancy and post-partum periods	with less than 20% of residents living in poverty) • **Low rape rate** (Portion of people living in counties with fewer than 36.9 reported cases of rape per 100,000 population annually) **Physical environment; natural and built environment** • **Housing quality** (Portion of households living in homes with no severe housing problems) • **Air Quality—Particulate Matter** (Portion of people living in countries with average daily density of fine particulate matter below 12 micrograms per cubic meter)	

Mental Health Measurement Example

The following health priority and measures serve as an example of how the draft framework model may look when implemented. Measures were selected from a variety of sources including Minnesota state agency indicators and existing frameworks reviewed by the Steering Team (HOPE, RWJF and IOM).

Community conditions and outcomes	Health care and social services	Statewide conditions and outcomes	Policy environment
Public engagement and belonging • **Belonging in school** (Percentage of 9th graders bullied or harassed once a week or more) • **High School Dropout Rate** • **Ratio of school counselors to student population** • **Sense of community** (Aggregate score on two subscales of the Sense of Community Index: emotional connection to community and sense of belonging to community) **Environment** • **Availability of healthy food** • **Walkability** • **Regional park availability usage** **Community partnerships** • **Hospital partnerships** (Percentage of hospitals that have a collaboration or alliance with one or more organizations in each of these categories: local government, state agencies, other community-based agencies) • **Student Mental Health Referrals** (% of students with behavioral	**Access to services** • **Access to Psychiatric Care** (Portion of people living in counties with a population-to-psychiatrist ratio of less than 30,000:1) • **Access to Mental Health services** (Percentage of people who report having mental health or substance abuse problems, who received treatment) • **Access to Paid Family and Sick Leave** (Percentage of Minnesota employees with paid leave or family leave or sick leave benefits) • **Access to Mental and Emotional Health services** (The percentage of 11th grade students who received mental or emotional health treatment in the past year) **Affordability of services** • **Affordable mental health care** (Portion of adults who did not delay or forgo any mental health care they needed due to cost in the past year) **Quality of services** • **Depression Remission at Six Months** (Percentage of patients 18 years of age or older with Major Depression or Dysthymia	**Health outcomes** • **Mental Health Status** (Portion of adults who say their mental health was not good for 14 or more days in the past 30 days) • **Suicide deaths** **Socio-economic** • **Livable income** (Portion of people living in households with income greater than 250% of the federal poverty level) • **Post-secondary education** (Portion of adults with at least some college after graduating from high school) • **Connected Youth** (Portion of young people age 16-24 enrolled in school or working, including military enlistment) • **Employment** (Portion of people in the labor force who are employed) **Social environment conditions** • **Low poverty concentration** (Portion of people in neighborhoods with less than 20% of residents living in poverty) • **Low murder rate** (Portion of people living in counties with fewer	**Statewide policy indicators** • **Support for working families** (Annual percentage of families with parents eligible for Family Medical Leave Act coverage who can also afford it) **Localized policy indicators** • **Jurisdictional policy on welcoming/belonging** (e.g. immigrant friendly communities) • **Dementia or aging friendly communities** • **Comprehensive policy plans** (e.g. that include transportation, housing, or other indicators)

Community conditions and outcomes	Health care and social services	Statewide conditions and outcomes	Policy environment
infractions referred to mental health services versus law enforcement) **Localized health outcome indicators** • **Ex:** Stearns county is using population health data from CentraCare to drive health improvement efforts	seen in a physician clinic who reached remission within six months) • **Adolescent Mental Health and/or Depression Screening** (Percentage of patients 12-17 years of age seen in a physician clinic who were screened for mental health and/or depression) **Patient/recipient/ beneficiary experience of services** • **Adverse child experiences** (Percentage of population, ages 0 to 17 years, with two or more reported adverse childhood experiences, as reported by parents) • **Self-reported well-being** • **Disability associated with mental and behavioral disorders** (Number of disability-adjusted life years for mental and behavioral disorders)	than 5.1 murders per 100,000 population annually) • **Low assault rate** (Portion of people living in counties with fewer than 36.9 reported cases of aggravated assault) **Physical environment; natural and built environment** • **Housing quality** (Portion of households living in homes with no severe housing problems) • **Air Quality—Particulate Matter** (Portion of people living in counties with average daily density of fine particulate matter below 12 micrograms per cubic meter) • **Low Liquor Store Density** (Portion of people living in counties with fewer than 1.736 liquor stores per 10,000 population) • **Food Security** (Portion of people living in census tracts that are not food deserts; i.e. census tracts not designated low income and low food access)	

_____ Measurement Example

(insert health priority)

To help you envision how the draft framework model may look when implemented from your or your organization's perspective, select your own example of a health priority and brainstorm possible measures below.

Community conditions and outcomes	Health care and social services	Statewide conditions and outcomes	Policy environment
Public engagement and belonging *(social isolation, sense of community, etc.)* • • • • **Environment** *(walkability, access to healthy food, parks and recreation utilization, etc.)* • • • • **Community partnerships** *(health care benefit agenda, local health initiatives)* • • •	**Access to services** *(health care, mental health, dental, health insurance, housing assistance, SNAP benefits)* • • • • **Affordability of services** *(health care, mental health, dental, health insurance)* • • • **Health care collaboration** *(health care use of framework)* • • •	**Health outcomes** *(mental health status, functional status, mortality, birth weight)* • • • • **Socio-economic** *(housing, education, income)* • • • **Social environment conditions** *(safety, poverty)* • • •	**Statewide policy indicators** • • • • **Localized policy indicators** • • • • **Other policy indicators** • • •

Community conditions and outcomes	Health care and social services	Statewide conditions and outcomes	Policy environment
	Social service collaboration *(social service use of framework)* • • • • **Quality of services** *(health care, mental health, dental, health insurance, housing assistance, SNAP benefits)* • • • • **Patient/recipient/ beneficiary experience of services** *(patient experience survey)* • • • •	**Physical environment; natural and built environment** *(water, air, housing quality)* • • • •	

The Basics of Governance: An Overview

A governance model aims to address three key factors: 1) accountability, 2) authority, and 3) decision-making.

Our selected governance model will:
- Identify what groups, sub-groups, roles, and responsibilities are necessary to support the development and implementation of Minnesota's measurement framework,
- Delineate who is accountable for performing certain tasks, and
- Outline which roles hold decision-making ability and authority.

This includes clarifying roles, responsibilities, and accountabilities among communities and patients, health care organizations and clinicians, public health practitioners, the State (MDH and DHS), policy makers, and potentially others.

Key Considerations

The following examples are intended to highlight various characteristics and priorities which can affect governance structure design. These are not intended to present either/or dichotomies nor provide specific prescriptive advice. Rather, there are possibilities that serve to spark thinking on governance structure design. In some cases, it may be possible for both examples to be relevant and/or accurate.

How the solution will be used and by whom

The work product that this governance body will oversee and manage (the measurement framework) is a primary consideration in how to design the most appropriate governance approach.

Examples: The governance structure most suitable for the group might look different if …

The framework will solely be used for the purposes of state reporting on the health of Minnesota	The framework will be used to foster a shared approach and collaborative efforts that drive health improvement across various organizations and sectors

The Charge

The work that will be asked of this governance body and others involved should be a primary consideration in designing the most effective governance model.

Examples: The governance structure most suitable for the group might look different if …

The group is charged with providing input on framework measures and framework updates as needed	The group is charged with promoting stakeholder adoption of the framework and increasing its use

Accountability

The governance approach should clearly indicate who on the governance body (and work groups) will be held accountable for what and by whom, and how the governance structure upholds these accountabilities.

Examples: The governance structure most suitable for the group might look different if …

Just one stakeholder or organization is to be held accountable	Many or all stakeholders are to be held accountable

Authority

The level of influence and authority each member has in decisions should be stated clearly in governance roles and responsibilities. Increasing individual-level authority could improve engagement and equity but will also increase the time required to make decisions.

Examples: The governance structure most suitable for the group might look different if …

Decisions are intended to be centrally determined by a few people	Decisions are intended to be de-centralized with all members weighing in on most decisions

Flexibility

The speed with which decisions will need to be made should be considered in the governance model design.

Examples: The governance structure most suitable for the group might look different if …

Work needs to be delivered on in a fast, rapid-response fashion	Work can be done and decisions can be made at a more moderate, tempered pace

Representation

The desired breadth of representation (from organizations, sectors, and communities) is a primary consideration in how to design the most appropriate governance approach.

Examples: The governance structure most suitable for the group might look different if …

It's acceptable to gather input primarily from those willing and able to provide it in a timely fashion	Input from *all sectors* that influence health (e.g. transportation, housing, etc.) is desired

Participation and Engagement

The required level of participation, engagement, and time commitment of each governance body member will result in differing levels of buy-in and ownership, which should be reflected in the governance model design.

Examples: The governance structure most suitable for the group might look different if …

The intent is that members will take a more advisory role in informing MDH's focus areas (a less significant level of participation and engagement)	The intent is that members will take ownership and buy in to the process to the extent that they bring the framework to their organization (a more significant level of participation and engagement)