DEPARTMENT OF HEALTH

Measurement Framework Steering Team Meeting #3 Summary

Monday, September 16, 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
- Courtney Jordan Baechler
- Karolina Craft
- Ellen De la torre
- Marie Dotseth
- Lisa Juliar
- Scott Keefer
- Rahul Koranne
- Deb Krause
- Deatrick LaPointe
- Jennifer Lundblad
- Gretchen Musicant
- Sarah Reese (phone)
- Diane Rydrych
- David Satin
- Janet Silversmith
- Julie Sonier
- Tyler Winkelman
- Pahoua Yang (phone)
- Maiyia Yang Kasouaher

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

Turnlane:
Alex Clark, Cassandra Canaday

Meeting Objectives

- Refine the initial draft of the framework model design
- Discuss the work required to provide effective governance for this project moving forward
- Begin discussing an initial governance structure that will make decisions about framework implementation activities

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 Karolina Craft from the Department of Human Services. They also shared that Tuleah Palmer is unfortunately unable to participate on the Steering Team.

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

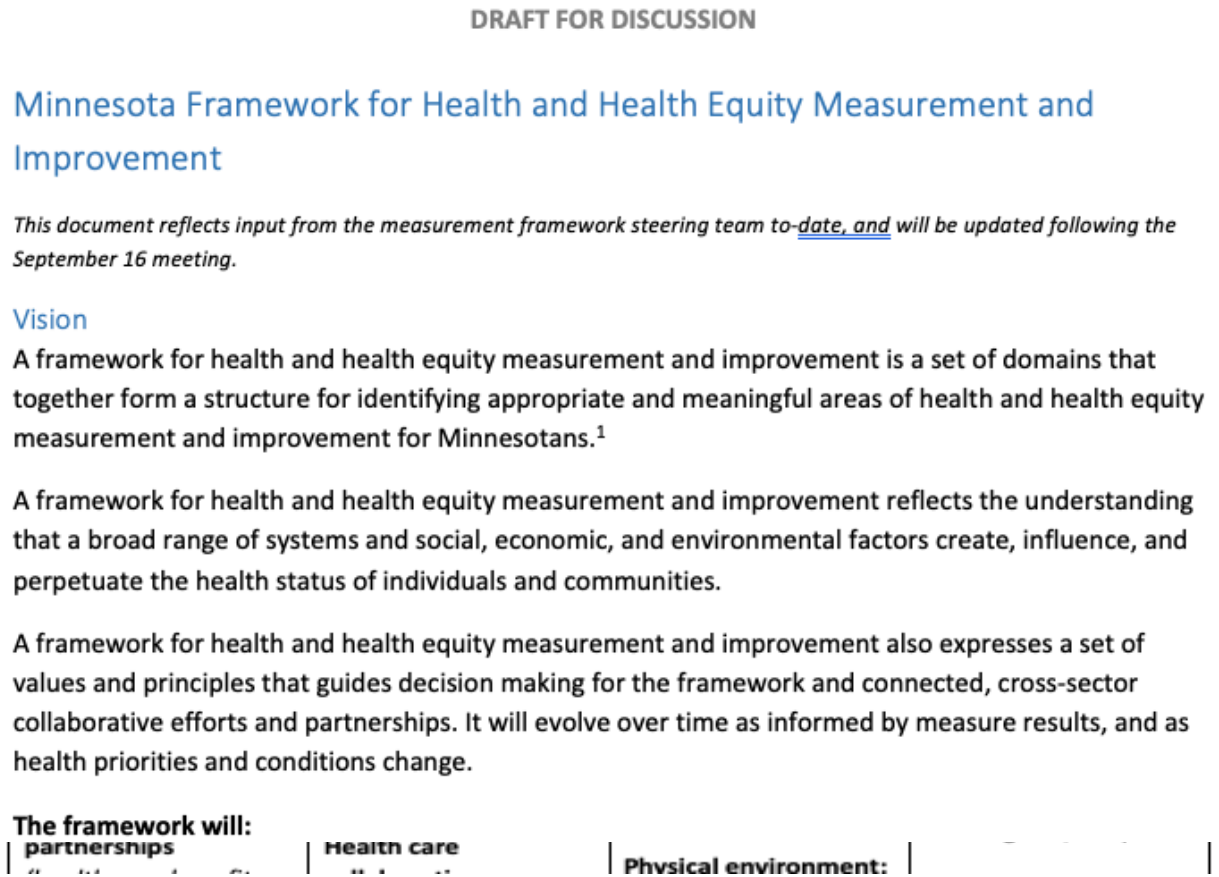
Steering Team Agreements

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).

Draft framework model development process and design

Jeannette Raymond provided an overview of the draft model design and the process for its development. Of particular note, this initial draft model was informed by Steering Team input from the June and July meetings.

Additionally, the Steering Team was provided with examples of how the framework model might function with two distinct health priority areas – infant mortality and mental health; Jeannette walked the Steering Team through the infant mortality example. See Appendices A and B for the draft framework model design and the examples, respectively.



DRAFT FOR DISCUSSION

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:

partnerships | Health care | Physical environment:

Draft framework model design refinement

Through small and large group discussion, the group shared their initial reactions, thoughts, and reflections on the draft framework model. Many noted that this model is different than they had envisioned and that it takes steps in the right direction. Several noted that after reviewing this draft, they'd had an "aha!" moment that created a sense of clarity

The following provides a synthesis of group input. See Appendix C for more detail on input gathered.

Small Group Discussion Questions

- Does this design help stakeholders envision the work that's needed to improve health in Minnesota moving forward?
- Does it help identify which stakeholder partners are needed to make progress?
- What might prevent this framework from working? What do we need to do to make this work?
- What, if anything, would you change about the design (What would you add? What would you remove?)?

What Resonates

- Enables priority setting
- Promotes a vision of cross-sector collaboration
- Creates space for various stakeholders and may foster bipartisanship

What to Change

- More explicitly capture health equity focus
- Reinforces some of what is already done
- Create greater clarity on how this leads to collaboration
- Complexity and potential to overwhelm
- Ensure differing communities' needs can be accounted for
- Integrate community and individual voices

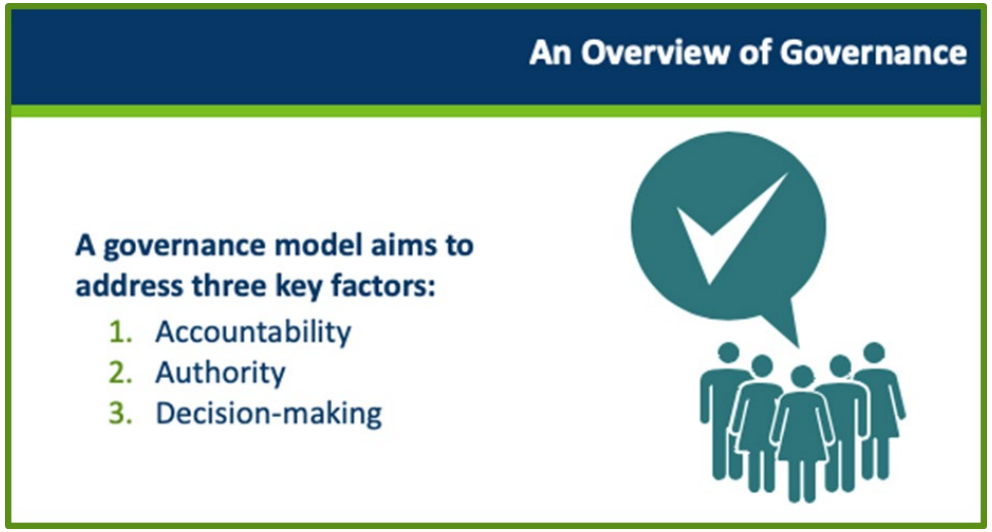
Barriers to Acknowledge & Address

- Lack of evidence
- Failure to incentivize (creating an unfunded mandate)
- Partisanship
- Lack of buy-in from stakeholders
- Lack of progress tracking and accountability
- Some may see framework as too prescriptive or irrelevant

Next Step: A work group (Karolina, David, Marie, and any other volunteers) will form and meet to further develop the draft framework model before the November meeting

Governance Overview

Alex Clark provided participants with a brief overview on the topic of governance, which was intended to inform the Steering Team's subsequent discussions and development of a governance approach for future phases of work on the framework model.



Our selected governance approach will:

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

Alex noted some of the responsibilities the governance body could hold and decisions they may be responsible for making (see Appendix D for further detail), and then provided examples of how consideration of the following core characteristics could impact the governance model:

- How the solution will be used and by whom
- Charge
- Accountability
- Authority
- Flexibility
- Representation
- Participation and Engagement

Governance Discussion

What is the work of this governance body?

Meeting participants separated into trios and pairs to discuss the two most foundational governance considerations:

- How the Solution Will be Used and by Whom
- The Charge

After a period of discussion, trios and pairs presented brief reports on their group's conversations to the larger group. See Appendix E for a detailed summary of this discussion.

How the solution will be used and by whom

The Framework and How It Will Be Used

+ Spark a broad change movement
+ Enable increased equity and reduction of disparities
+ Track and measure progress and performance
+ Incentivize action, investment, and engagement

Who Will Use the Framework

+ MDH and DHS
+ Health care and social service providers
+ Payers of services
+ Politicians and policymakers
+ Communities and advocates

The Charge of this Governance Body

The Core Function of this Governance Body

+ Design, development and maintenance of the framework
+ Identify threats and emerging issues
+ Advise the MDH Commissioner
+ Continuously refine and rethink the model

The Buckets of Work and Focus Areas

+ Set guidelines and principles
+ Oversee topic area work subgroups/work groups
+ Provide knowledge and insight

Next Step: A work group (Gretchen, Julie, Jennifer, and any other volunteers) will form and meet to further develop the governance approach before the November meeting

Public Comments, Meeting Close, and Next Steps

Public Comments
There were no comments from public observers.

Next Steps

- ❑ Provide input via the post-meeting survey (Steering Team members)
- ❑ Work group formation for phase 2 components:
  - ❑ Next iteration of the draft framework model (Karolina, David, Marie, and any other volunteers)
  - ❑ Continued development of the governance approach (Gretchen, Julie, Jennifer, and any other volunteers)

Appendix A

Draft Framework Model Design

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)* **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)*	**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.)

Appendix B

Draft Framework Model Examples

Infant Mortality Measurement Example
(attached under separate cover)

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	**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**	**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	**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)

Mental Health Measurement Example
(attached under separate cover)

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	**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	**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**	**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)

Appendix C

Framework Model Small Group Discussions

- Does this design help stakeholders envision the work that's needed to improve health in Minnesota moving forward?

  Comments and Themes:
  - Generally, yes, but it needs revision

- Does this framework design help identify which stakeholder partners are needed to make progress?

  Comments and Themes:
  - It lacks integration of citizens' voices—the input of those impacted by it
  - The governance model can help with identification of stakeholder partners
  - Perhaps it should offer explicit examples
  - Yes, it could encourage discussion
  - Perhaps, but it's important to note that stakeholders of governance and implementation may differ

- What might prevent this framework from working? What do we need to do to make this work?

  Comments and Themes:
  - Lack of evidence base and transparency around evidence
  - Measuring things that don't matter
  - Failure to incentivize action (unfunded mandate)
  - Partisanship and politics
  - Policy may not act like other domains—measurement/tracking is different + more political, so evidence base more critical
  - People not seeing themselves and their role within it
  - Strained inter-stakeholder relationships and lack of trust
  - It needs to provide room for growth, change, experimentation, and adaptation
  - Underlying issues are hard to measure (e.g., racism)
  - Lack of buy-in from key stakeholders
  - Lack of organizational alignment/coordination of initiatives
  - No accountability requirement, tracking, or enforcement
  - These complex problems may not be able to be solved by a framework alone
  - It may be too prescriptive and/or otherwise irrelevant for some stakeholders, communities, and cultures,
  - Factors and appropriate priorities may vary between communities and at state level
  - It may be too complex or unclear
  - Not keeping relevant: need to determine how priority selection will work & be responsive to arising issues

Appendix C

Framework Model Small Group Discussions (cont.)

- What, if anything, would you change about the design (What would you add? What would you remove?)?

What the group liked and would keep

- Ability to set priorities
- Helps envision cross-sector collaborations
- Getting domains and subdomains is key to the process
- This can be bipartisan

What the group didn't like and would change

- Seems to reinforce what we already do
- It's very complex and possibly overwhelming—should simplify
- Need to have a balanced (not excessive) number of measures
- Ways to collaborate need to be more clear
- Community vs. state-level: what's the distinction? (consider metric approach)
- Doesn't allow for adaptation to varying community needs
- Add to design: high-level dashboard
- Clarify how data sharing standards would be created/upheld
- Consider how to promote community collaboration vs. competition
- Model requires us to get clear on who this engages/involves
- Needs to incorporate health equity more actively and explicitly
- Design doesn't clearly reflect goal
- Are these indicators deep enough?
- How can it balance patient voice with evidence base?
- Prioritize areas in need of collaborative effort
- Measure outcomes, not processes –don't be too prescriptive
- Conditions and outcomes are different, and should maybe be tracked/measured separately
- Need to include community/citizen voices more intentionally and explicitly

Appendix D

Governance Body Responsibilities

Our governance body will have a number of responsibilities. Some of the responsibilities they could have and decisions they could be asked to make might include:

- Deciding on priority areas for measurement
- Selecting and/or revising domains and sub-domains
- Choosing appropriate measures and/or updating them as needed
- Identifying the need for new work groups
- Helping to form and oversee work groups

Appendix E

Governance Trio Discussions

- What is the solution we are creating and how will it be used?

Comments and Themes:

- Tracking and measuring progress and performance
- Incentivizing action, investment, and engagement
- A tool for reducing disparities and increasing equity
- A broader change movement
- Facilitating improvement vs just reporting
- Fostering collaboration
- Innovation/experimentation
- Setting priorities and goals for the state
- Driving investment of time, money, and other resources
- Requiring accountability and ownership
- Holistic view of what drives health
- Values should tie to the solution
- Different stakeholders, users, and impacted persons would likely use it in different ways

- Who will use it, and therefore, who needs to be involved in our governance model?

Comments and Themes:

- Not only the people who use it should be involved in governance—those who would be affected despite not being core users should be included too
- Should clarify/specify benefits to users
- *Define* who must use framework & *consider* who should use it
- MDH
- DHS
- Possibly employers, if it's clear enough how they would use it
- Health care system/providers
- Social service organizations
- Payers/plans
- Politicians and policymakers
- Researchers and experts
- Communities and advocates
- Investors

Appendix E

Governance Trio Discussions (cont.)

- What is the core function of this governance body?

  Comments and Themes:
  - Establishment of the framework (e.g., identifying priorities, articulating domains, selecting measures)
  - Maintenance and updating the framework
  - Identifying emerging needs, threats, and other issues
  - Advisory to MDH commissioner
  - Revise and rethink the model, ensure sustainability through continued relevance
  - Set parameters (e.g. evidence, actionability)
  - Promote equity and ensuring that all community perspectives and experiences are informing process
  - Maintain transparency
  - Consider/implement incentives required to assume organizations will utilize this
  - Create reporting cadence to track progress and promote accountability
  - Make actionable recommendations for change

- What are buckets of work and focus areas necessary to perform this function?

  Comments and Themes:
  - Oversee topic area subgroups/workgroups
  - Oversee administrative needs
  - Set guidelines/principles
  - Provide knowledge/wisdom/advice

- Additional notes and discussion:
  - The governance body needs to be structured in a manner that allows it to evolve as needed to address new issues and include new relevant perspectives
  - The main governance body doesn't have to do or know everything, work groups can be relied on for expertise
  - The goal is for the governance body to lead and take some ownership of this work
  - The governance body and processes will need to be structured in a way that minimizes the potential for governance body membership to bias governance body decisions (e.g., possibly priority areas)
  - MDH should uphold leadership and authority

Minnesota Framework for Health and Health Equity Measurement and Improvement

This document reflects input from the framework model workgroup to-date.

Context and Opportunity

Minnesota is a national leader on many fronts, with our exemplary public health system, our commitment to advance health equity, the quality of our health care, and the many ways communities across the state contribute to health and well-being. Notably, for years we have measured and reported various aspects of clinical and hospital quality, and have collectively developed a standardized statewide approach to measurement.

Minnesota, however, also faces daunting challenges. We have increasing chronic disease rates, rising health care costs, and economic and social conditions that often work against our efforts to assure a healthy population. We have persistent disparities in health outcomes that are rooted in inequities related to geography, housing, income, and education. We see gaps in health outcomes according to sexual orientation, gender identity, disability, race, other factors, and the intersectionality of these characteristics.[1] When compared to the rest of the country, our racial disparities stand out in particular. Data demonstrate that health outcomes in Minnesota are consistently worse for American Indians, African-Americans, and persons of Latinx, Asian Pacific Islander, Middle Eastern, and African descent than for those of European heritage.

Many communities, systems, and individuals in Minnesota are working hard to improve health and well-being; but it is difficult to know if these efforts are making a real difference. The current consensus is that our measurement systems today do not provide us with the information essential to improving the health of the state. We need a new approach.

Measurement is a potentially powerful tool for identifying inequities in health status; assessing the quality of health care and social services; and making systems transparent and accountable for health outcomes. However, do we measure what matters? Are we using the data we collect to focus our actions on what will improve health? Do our measures let us know if we are doing the right things?

Our state has the opportunity to create a measurement framework capable of generating meaningful answers to the urgent questions we face about health in Minnesota. This framework reflects the vision, values, and principles of and approach to health measurement that people across the state expressed in response to a request from the Minnesota Legislature to develop a measurement framework for a healthier Minnesota.

[1] "Intersectionality" refers to the complex, cumulative way in which the effects of multiple forms of discrimination (such as racism, sexism, and classism) combine, overlap, or intersect especially in the experiences of marginalized individuals or groups.

Vision

To drive action to improve health and well-being for all people in Minnesota, the measurement framework will measure across the areas of policy, drivers of health, health care and social services, and outcomes, and provide information on the extent to which efforts to improve health and advance health equity are making a real difference in peoples' lives. The measurement framework will engage a variety of partners and foster the cross-sector collaboration needed to better address Minnesota's health and well-being challenges.

Values and Principles

These values and principles will guide decision making for the measurement framework and could guide associated collaborative efforts and partnerships.

Values

1. **Equity.** The framework intentionally advances equity through the measurement of social, cultural, and structural conditions that create health. 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.
2. **Fairness, accuracy, and rigor.** The framework will foster fair, accurate, and robust qualitative and quantitative measurement of the people, systems, and conditions that contribute to health outcomes.
3. **Connection, collaboration and inclusivity.** The framework will be used to connect interested parties on an ongoing basis, and foster authentic cross-sector collaboration and communication especially with communities most impacted by health disparities. Authentically collaborating and communicating with communities involves the intentional process of co-creating solutions to inequities in partnership with people who best know—through their own experiences—the pathways and barriers to health.
4. **Measurement for improvement.** The framework recognizes that measures hold different meaning for different people, and that qualitative and quantitative measure data have the power to transform communities. Health data also has the potential to harm communities, and awareness and caution are needed to avoid the negative, unintended consequences of measurement. The framework will elevate measurement that is meaningful to both the recipients of health care and social services, and produces understandable and actionable information for framework users, systems, and communities to improve health. It will measure assets as well as identify gaps and challenges.
5. **Innovation.** The framework will promote flexibility and experimentation to cultivate new ideas in measurement and health improvement (for example, including the patient and beneficiary voice in measurement, leveraging technology, developing collaborations). Such innovation can lead to meaningful and efficient measurement, and help evolve the framework over time.

6. **Transparency and simplicity.** Information about the framework, priorities, and measures will be easily accessible and understandable for various audiences.
7. **Accountability.** The framework acknowledges that policies, systems, and social, cultural, and structural factors influence health outcomes. The framework will clarify the roles, responsibilities, and accountabilities among interested parties to shape measurement and drive health improvements.
8. **Responsiveness.** The framework will respond to the health needs and priorities of interested parties, including communities most impacted by health disparities, through ongoing learning, evaluation, and evolution that enables the framework to adapt to changing needs and priorities.

Principles

1. Health care is a subset of the factors that influence our health, and the framework will recognize this by:
    a. Incorporating and appropriately accounting for factors related to systems, communities, cultures, and individuals that contribute to variation in health measure results and disparities;
    b. Fostering a culture of health equity that includes identifying and dismantling inequitable structures through measurement;
    c. Exploring factors at different aggregations (e.g., geographies and populations) and across the continuum of health care and social service systems; and
    d. Adhering to a collaborative, community-wide effort at all stages of implementation.
2. The framework will foster improvement in health outcomes, health equity, population health, accessibility, health care quality, health care safety, and patient experience, and reduction in health care costs for patients, health care providers, and health care purchasers.
3. Health measurement will elevate the voice of recipients of health care and social services, and produce information that is meaningful, fair, and transparent. Measures will be actionable for different framework users in different ways, and they do not need to be used by everyone for all purposes.
4. Health measurement in Minnesota will appropriately balance value with reporting burden, and not duplicate other efforts.
5. Minnesota must measure what is most important, not what is easiest. The framework will provide cohesiveness and alignment around what is important.
6. The framework will be regularly monitored and updated using an inclusive, transparent process to ensure it meets goals.

Health Priorities, Equity Targets, and Measurement Areas

The framework for health and health equity measurement includes four measurement areas: policy environment, drivers of health, health care and social services, and outcomes. These measurement areas provide a robust view of the broad range of conditions and factors that influence health and

health outcomes, opportunities to identify what is and is not working to improve people's health, and where disparate health outcomes may be reduced or eliminated.

- The **policy environment** area measures national, state, local, and other policies related to advancing or constraining our ability to achieve health.
- The **drivers of health** area measures social, cultural, and structural factors that create health across different geographies and populations of interest.
- The **health care and social services** area measures access, affordability, quality, safety, and expectations and experiences of services.
- The **outcomes** area measures health and well-being, and socio-economic outcomes across different geographies and populations of interest.

Health priority and equity advancement targets			
Policy environment	**Drivers of health**	**Health care and social services**	**Outcomes**
Federal *(Medicaid, Affordable Care Act, Americans with Disabilities Act, pollution control standards, earned income tax credits)* **State** *(paid parental leave, minimum wage, pollution control standards)* **Local** *(paid parental leave, indoor air, dementia/aging-friendly communities)* **Other** *(corporate, policies of paid parental leave, paid sick leave)*	**Public engagement and belonging** *(social isolation, sense of community)* **Social environment** *(safety, poverty)* **Physical environment; natural and built environment** *(walkability, access to healthy food, parks and recreation utilization water quality, air quality, accessibility)* **Community partnerships** *(health care benefit agenda, local health initiatives)* **Cultural factors**	**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)* **Social service collaboration** *(social service use of framework)* **Quality of services**	**Health and well-being** *(mental health status, functional status, mortality, birth weight, chronic condition rates)* **Socio-economic** *(housing, education, income, employment*)

Health priority and equity advancement targets			
Policy environment	**Drivers of health**	**Health care and social services**	**Outcomes**
	(food beliefs and diet, gender roles and relationships, spirituality)	*(health care, mental health, dental, health insurance, housing assistance, SNAP benefits)* **Patient/recipient/ beneficiary experience of services** *(patient experience survey)*	

Using the Framework

People and organizations who use this measurement framework may identify health priorities, develop equity targets, and select measures to achieve health and equity improvement goals across the four measurement areas.

To foster innovation and change in health improvement, this framework encourages cross-sector collaboration and engagement, and new or enhanced partnerships. Potential framework users include and are not limited to:

- State and local government, including state agencies, counties, and municipalities;
- Health care and social service providers and payers;
- Communities and advocates;
- Public health organizations and researchers;
- Collaborations and coalitions;
- Nonprofit and philanthropic organizations; and
- Politicians and policymakers.

Measures in the policy environment and drivers of health areas can be used to monitor the conditions and factors that affect health. Measures in the health care and social services, and outcomes areas can be used to highlight the roles and responsibilities that different parties have in improving health. The measurement areas also allow for the identification of existing measures and measure gaps.

Minnesota Measurement Framework Governance Charter

Purpose

Minnesota is a national leader on many fronts, with our exemplary public health system, our commitment to advancing health equity, the quality of our health care, and the many ways communities across the state contribute to health and well-being. However, Minnesota also faces daunting challenges, especially persistent disparities in health outcomes that are rooted in inequities related to race, income, education, disability, and geography. Many communities, systems, and individuals in Minnesota are working hard to improve health and well-being; but it is difficult to know if these efforts are making a real difference. The purpose of this governance body is to create and maintain a measurement framework capable of generating meaningful answers to the urgent questions we face about health in Minnesota.

Statutory Authorization

In 2017, in acknowledgment of the need for an improved health measurement system, the Minnesota Legislature directed MDH to develop—in consultation with a broad group of stakeholders—a quality measurement framework by 2020 that:

- Articulates statewide quality improvement goals;
- Fosters alignment with other measurement efforts;
- Identifies the most important elements for assessing the quality of care;
- Ensures clinical relevance; and
- Defines the roles of stakeholders.

Overview

The framework model will be used to:

- Spark a broad change movement at multiple levels (including, but not limited to community, institution, state) by holistically measuring health & health factors
- Advance equity and reduce disparities
- Track and measure progress and performance in order to identify unmet needs and focus areas for improvement efforts
- Incentivize action, investment, engagement, and accountability
- Establish goals for performance and improvement

There are three primary ways people might collaborate and contribute to this effort:

1. As members of the governance body
2. As experts and representatives of communities who may inform the development and implementation of the framework model
3. As people or organizations who will or might use the framework

People and groups who may fall into one of these three categories may include:

- State and local government, including MDH, DHS, counties, and municipalities
- Health care and social service providers
- Payers of services
- Politicians and policymakers
- Communities and advocates
- Public health organizations and researchers
- Collaborations/coalitions
- Nonprofit and philanthropic organizations

Charge of the Governance Body

The function of this governance body is to:

- Advise MDH on topics related to the ongoing implementation, monitoring, communication/ outreach, and evaluation of the measurement framework. This may include the following responsibilities:
  - Make recommendations regarding health priorities and specific measures within the framework
  - Identify emerging health issues that are revealed through framework use
  - Identify and resolve issues with framework implementation
  - Refine, rethink, and update the framework model as needed
  - Report on progress made by those utilizing the framework

The core focus areas of this governance body are to:

- Set guidelines and principles
- Recommend framework measures and health priorities
- Promote equity and inclusion
- Oversee topic area work subgroups/work groups
- Provide knowledge and insight
- Promote use of the framework by generating buy-in and engagement among potential users
- Ensure framework leverages evidence base and emerging research and expertise
- Evaluation of the measurement framework
- Plan implementation steps

Accountability

- MDH is ultimately accountable for the development and implementation of the framework. Roles MDH may assume include, but are not limited to, the following:
  - Partner and co-creator in designing and developing the measurement framework model
  - Host and convener for all governance body meetings (including any subgroups that emerge)

    - "Super user" of the framework to guide and prioritize the work of MDH
    - Regulator solely for any mandated measures
    - Leader in broad implementation of the framework
    - Resource provider (project management support, technical assistance, research, etc.)
- The governance body is accountable to MDH for carrying out a process that aligns with the core charge and focus areas of the governance body, including but not limited to:
    - Developing a process for selecting health priorities
    - Creating an accountability process within each domain or health priority
- The measurement framework will include some measures for which the state mandates reporting and it will also include some measures that for which reporting will be voluntary. MDH will promote engagement from users who report on both mandated and voluntary measures.

Proposed Membership

Representation

Those serving on this governance body are to reflect the communities and people who will use the measurement framework and will be impacted by its implementation.

A list of specific communities, perspectives, organizations, and sectors to be represented on the governance body could be developed and added to this section if desired.

Given that health priorities for measurement will change over time, this governance body and those consulted in the development and implementation process will need to change in order to reflect the diversity of those touched by and knowledgeable on this effort.

Size of Governance Body

The number of individuals serving on the governance body are to be determined.

Expectations of Members

- *Term length to be decided*; term may be extended if necessary
- Participate fully in governance body meetings, preparation, and follow-up as needed
- Those serving on the governance body will uphold the Agreements that have been previously established. *These will be included in an appendix.*
- If unable to participate in meetings or activities, governance body members are to ensure a designated alternate attends and/or provide written or verbal comments to the co-chairs in advance of any meeting
- Bring the perspective(s) of the category/group being represented to all discussions and recommendations, as well as additional perspectives that are constructive

- Review/prepare meeting materials ahead of time and be prepared to contribute clear, focused ideas for discussion
- *A conflict of interest (COI) statement could be developed and added to this section if desired.*

Proposed Timeline

To be determined

Structure

1. Broad Governance Body
2. Executive Committee (may or may not include co-chairs)
3. Work groups—subcommittees of the broader governance body responsible for guiding specific work as needed.
4. Consultative Groups may be formed and maintained to bring in expert voices on particular topics or objectives. Community voices and perspectives will be considered experts in the needs and interests of the communities they represent and will be included in this governance body accordingly.

Authority

To be developed: this section will contain guidance regarding the types of decisions the governance body will have authority to make vs. those MDH will make.

Decision-Making and Voting Mechanism

The Governance Body will make decisions based on consensus when feasible. When consensus cannot be reached, a consent-based approach will be used.

MDH Contacts

To be developed