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

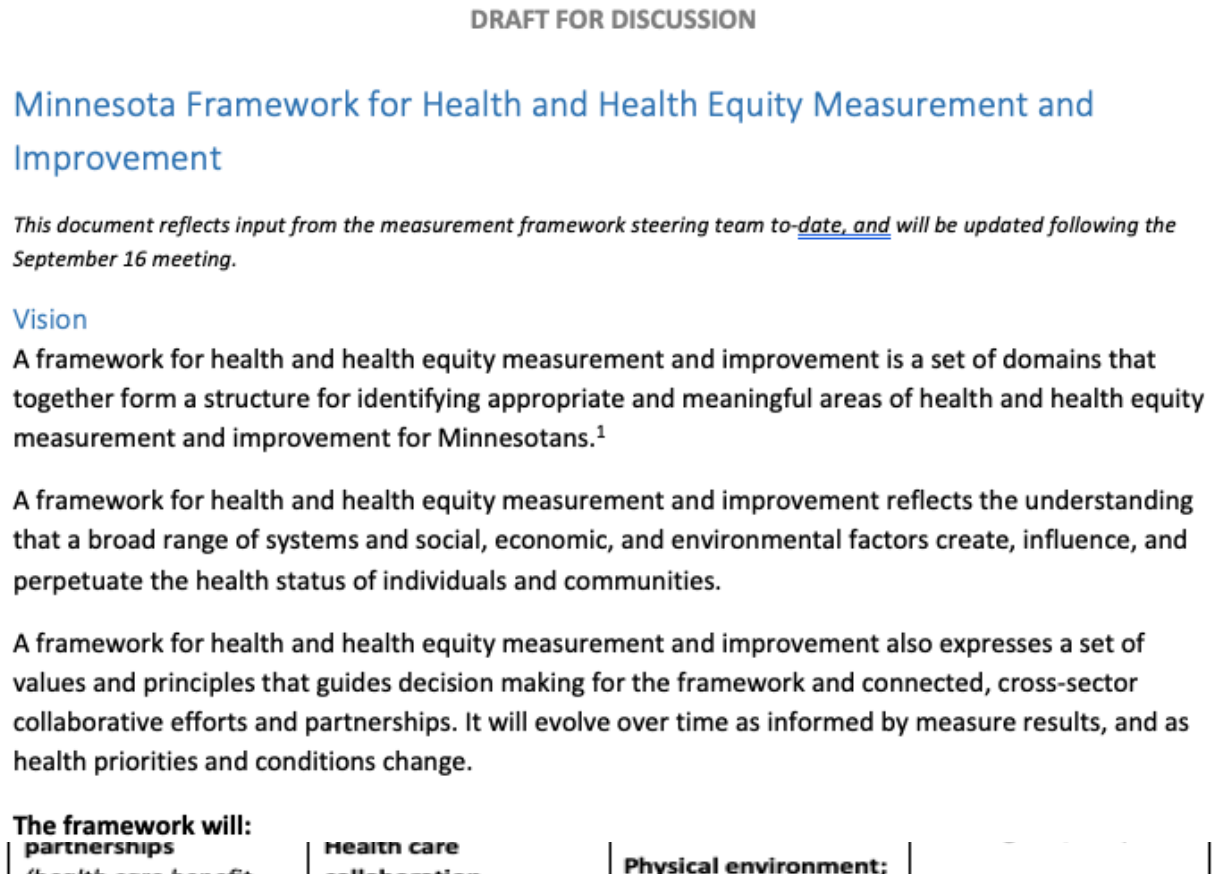
Steering Team Agreements

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

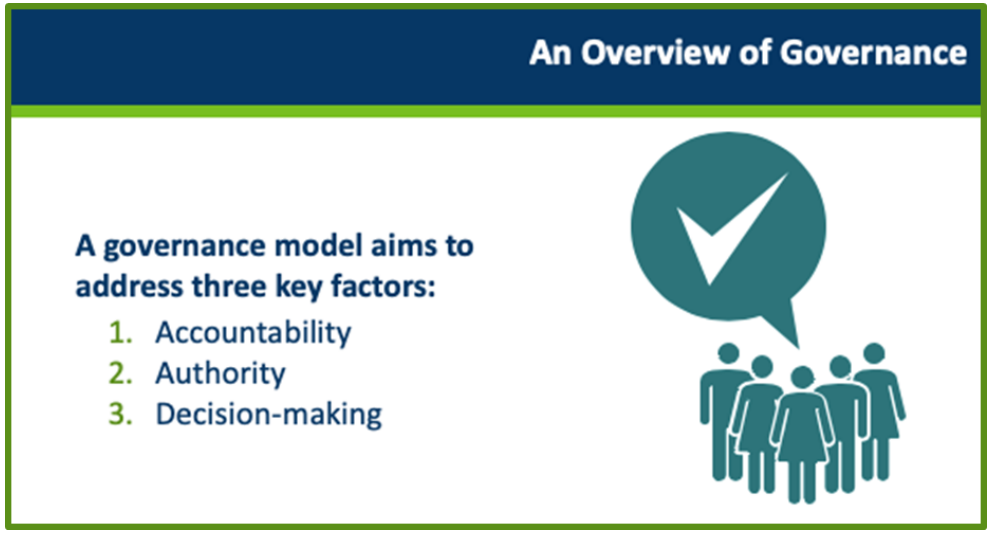
Barriers to Acknowledge & Address

- 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