

Quality Framework Development Arc with Steering Team

The quality framework is intended to become guidance to the broader community that:

- Includes guiding principles for a system of health quality improvement and measurement;
- Articulates the value for statewide quality measurement across the spectrum of stakeholders;
- Responds to the legislatively-established criteria; and
- Establishes principles for ongoing framework evaluation, maintenance, and updates.

It is possible that the emerging quality framework vision may be more expansive than what can be covered during the project time period and that we need to develop a roadmap that lays out incremental steps that evolve quality measurement over a period of time to reach longer-term quality improvement goals.

March 12 meeting

Team fundamentals established

- Review Steering Team purpose, logistics, etc.
- Introduce members

Stakeholder engagement explained

- Introduce tentative stakeholder engagement and data collection plans

April 4 meeting

Identify what good we hope to see in Minnesota because of a new quality measurement system in regards to...

Improving disease management
Improving population health
Improving quality and patient safety
Reducing health care system costs
Reducing chronic disease

Reducing disparities
Reducing variation in outcomes
Promoting patient-centric care
(Other)

Draft potential principles* based on...

- “The good we hope to see” (above)

**Principle – a core assertion that serves as the foundation for a chain of reasoning*

Assist project team in preparing for broader stakeholder engagement

- Provide input on interview themes
- Suggest other stakeholder perspectives

May 1 meeting

Identify fundamental values critical to Minnesota's quality framework

- Generate tentative answers to: "What would Minnesotans say are the *fundamental values* critical to measuring our collective health?" (question may need fine-tuning)

Refine draft principles based on....

- Sample principles critical assessment
- Values discussion
- Group dialogue

Offer final input on stakeholder engagement

- Provide final input on interview guide
- Provide final input on target stakeholder list

May – Mid-June

Project team collects input from the broader stakeholder community

June 4 meeting

Begin framework development

- Begin to sketch out a framework based on sample review and any available stakeholder input
- Begin to sketch out implementation roadmap

July 2 meeting

Possible homework prior to July 2 meeting: stakeholder panel discussion webinar

Synthesize perspectives from stakeholder community

- Finalize draft values and principles based on stakeholder input
- Finalize draft framework
- Confirm content and process for public comment period on draft framework
- Continue to develop implementation roadmap (e.g. framework governance, principles for ongoing framework evaluation, maintenance, and updates)

Mid-July – mid-August

MDH holds a 30-day public comment period on the proposed framework and roadmap

- Project team compiles comments into useable form and recommendations for Steering Team

September 6

Make final values, principles, and framework adjustments based on public comment

Finalize implementation roadmap

September 30

MDH remits framework to Legislature

October

MDH begins implementing framework and roadmap

Quality Framework Steering Team Meeting Summary

MAD Draft 4/17/18

Meeting Date: April 4, 2018

Present

Steering Team: Kelly Fluharty, Monica Hurtado, Deatrick LaPointe, Kevin Larsen, Jennifer Lundblad, Ross Owen, Diane Rydrych, David Satin, Julie Sonier, Mark Sonneborn

MDH Staff: Marie Dotseth, Sarah Evans, Stefan Gildemeister, David Hesse, Denise McCabe

MAD Consultants: Lisa Anderson, Stacy Sjogren

Opening Activity

As they arrived, Stacy Sjogren instructed the Steering Team members to provide their thoughts on flip charts on how a system that focuses on quality measurement contributes to:

1. Improving disease management
2. Improving quality and patient safety
3. Improving population health
4. Promoting patient-centric care
5. Reducing chronic disease
6. Reducing disparities
7. Reducing health care system costs
8. Reducing variations in outcomes
9. Other

Welcome and Introductions

Stacy Sjogren from Management Analysis and Development (MAD) welcomed everyone to the meeting. Steering Team Co-Chairs Jennifer Lundblad and Diane Rydrych led introductions, starting with new members Deatrick LaPointe and Mark Sonneborn.

Marie Dotseth, Policy Advisor to the Commissioner of Health, provided opening remarks, highlighting how far Minnesota has come and that the definition of public health is the constant redefinition of what is unacceptable. She referred to quality measurement in this context as a new frontier.

Co-chairs reviewed roles of the Steering Team and the summary from the first Steering Team meeting. They shared highlights from the first meeting and invited Steering Team members to share what stood out to them. Steering Team members and MDH staff shared the following reflections:

- As a health care provider, what's our ideal state at the end of this? We have population health goals, we want to make the framework meaningful for all involved.
- What has been left out of federal quality measurement? Where does Minnesota need to fill in gaps?
- How far Minnesota has come in relation to the rest of the US and the need to keep being innovative.
- The composition of the Steering Team is impressive and includes a wide range of perspectives.
- We need to think about how we articulate the problem and invite more of a conversation around disparities and what will work for all populations. We need to change our approach and be less technocratic and make space for multiple conversations and be able to authentically listen. Be mindful of good practices.

Themes from Opening Activity

Stacy asked Steering Team members to review what they had posted in the opening activity and look for themes among all members' posts. The Steering Team offered and discussed the following themes:

- "Risk adjustment" permeates everything
- Measure subset of certain measures and aligning/ Connection to payment and incentivizing/ Measurement system can provide "signal strength"
- Comprehensive planning
 - Innovative actions
 - Challenges
 - Successes
- Aiming and measuring beyond provider (clinic) and what we currently measure
- Tracking disparities and social factors
- Involve patient voices and goals
- Including focus on improvement and goals
- Avoidable care
- Desire for benchmarking
- Importance of staging transition (knowledge of measures, time to make changes, etc.)
- Lower or minimize burden

Quality Framework Principles

Stacy reviewed the working together assumptions. Steering Team members added that the group should be able to express disagreement without feeling shy, ask for clarification when needed, and call out if plain language is needed.

Principles

Stacy reviewed the definition of principles and clarified a chain of reasoning to get from one point to the next. Principles should be sound enough to hang more reasoning on them and abstract enough to carry the weight to

handle what comes next. Principles stem from values, which are more general. Principles are universally accepted values.

The Steering Team identified the following candidate principles:

1. Variation is meaningful and should not be adjusted away
The system promotes justice/fairness for all parties
Should account for risk factors in order to measure more fairly
Be meaningful and benefit all Minnesotans regardless of geography, ethnicity, status, etc.
2. Different audiences (e.g. purchasers) need to be acknowledged. – should add value not be duplicative.
3. Framework needs to recognize there is more to health than health care
Should measure meaningful/impactful topics and be a parsimonious set
We need to prioritize – we can't solve all problems at once
We need to do what's most important, not what is easiest.
4. Useful for patient decision-making
Providers wanting measures for improvement
(this could all be linked to #2)
5. Hold ourselves accountable for positive health outcomes
Synthesize common values to create shared goals.
Cohesiveness between communities and systems
6. The system results in improving the quadruple aim (cost, provider satisfaction, patient satisfaction, population health quality)
Pay for performance
Public reporting
Internal improvement
7. The framework needs to be regularly monitored & updated, via an inclusive, transparent process, to make sure it's still meeting our goals.
 - This includes ongoing governance, which the Steering Team may need to address. A framework that is responsive to the needs of multiple audiences will need to be evaluated against its intent.
8. Measures need not be directly tied to financial incentives in order to drive health system improvement.

Stakeholder Conversations

Stefan Gildemeister reviewed the conversation outline for stakeholder engagement and asked the Steering Team for feedback. Feedback included:

- “How will you use information about the personal experience (individualistic vs. systematic) to inform the measures?”
- “Is the personal experience relevant?” There was a debate on this question where one member argued that the personal experience is not relevant, while another argued that the stories that motivate

organizations are valuable. A member of the project team stated that the intent of the personal experience questions are to encourage thinking beyond the interviewee's normal perspective.

- “How do we know if what we are hearing is representative of the experience? Do responses from individuals reflect their communities?”
- “How [do these personal experiences] translate into the health of the community?” It was also stated that there was no discussion thus far regarding community engagement, and that community engagement should be an ongoing process.
- Community engagement was added to the parking lot. The project team noted that there is more to explore regarding community engagement and that they planned to include it as a topic in future meetings.
- “We need to ask about their cultural and wellness perspectives and how both can be achieved.”
- “Perhaps there should be two sets of questions—one for those who work in health care and one for those who do not.”
- “Are we asking people about their experience in the health care system? Or about their lives?”

Next Steps

Stacy asked Steering Team members what reflections they had either on the conversation or the process. Comments included:

- Appreciation for the amount of commonality.
- There was a lot of information and knowledge squeezed into a small meeting.
- Appreciation for the interactive component and the different expertise.
- Given the level of engagement and depth of conversation, the agenda was too ambitious. We can work on that for subsequent meetings.

The next Steering Team meeting will be **Tuesday, May 1st from 2:00 to 4:00** at HIWAY Federal Credit Union.

Homework

- Please send any additional principles suggestions to Stacy by Friday, April 6th.
- The project team will compile principles and send them to the Steering Team with instructions for critical review.
- The Steering Team should review the Quality Framework Stakeholders document and send stakeholder perspective suggestions to Denise.
- Additional homework to come will be due April 24.

Public Comment

There was no public comment.

Adjourn

Summary of Steering Team Input on Current System

MAD Draft 4/23/2018

Aspects of current measurement system that are valuable

Most common responses:

- Minnesota has a multi-stakeholder system; many different stakeholders are involved.
- Minnesota is a leader.
- Standardized system helps community focus on quality improvement; having measures is important to improvement and the health of the population.

Mentioned once:

- Minnesota has created a measurement culture.
- Minnesota focuses on outcome rather than process.
- Minnesota Community Measurement capacity is powerful because it drives down into populations in a way that hasn't been done before.
- Current measurement system includes an annual system for revisiting measurement points.
- The current measurement system is broad, truly a statewide approach that allows comparison among clinics.
- Current process for developing measures is good.
- Data that includes demographic and geographic information is helpful.
- Hospital measures are well-aligned with federal measures.
- Quantitative measures for health care quality are important.
- Current system identifies that there's work to do in various racial and ethnic communities.

Aspects that are challenging

Most common responses:

- Reporting is burdensome - Some don't have adequate resources for all reporting – minimize administrative burden - align measures.

Mentioned once:

- SQ RMS is one of many (16) systems (MIPS, UCare Quality Measurement, to name a few).
- This generation's big challenge will be reconciling quantitative approach to quality improvement with providing clinical care.
- Tension between standardization nationally and local buy-in.

- Measurement system is regressive.
- Legislative input has limited SQRMS effectiveness because they haven't been interested in a multisector governance model.
- A lot of work goes into data collection and thinking about how data might be used and less about how we move collectively in response.
- Information is too technical for community use.
- Information is not easy to access.
- Implementation measures section has been a moving target.
- Assumes those who measure poorly can and will take steps to improve.
- There are gaps in health care literacy among patient groups, such as new Americans.

Considerations

Most common response:

- Need to consider relevance of measures to the consumer—use other consumer-based measures as examples. Start from consumer-focused perspective; focus on impact on patient care.

Mentioned once:

- This is a great opportunity to build the best of all systems.
- Measurement has proliferated but not evolved.
- Possibility for system of exception reporting like UK.
- Would like to see risk adjustment.
- Don't lose what has already been accomplished through SQRMS.
- Consider the role of the state in fostering innovation.
- There needs to be a combination of stakeholder accountability and sustainability.
- MDH should not be the sole owner of SQRMS.
- Consider culture of providers and health systems in MN; of urban, suburban, and rural populations.
- Providers are willing to do more measures, not just claims-based measures.
- Consider the relevance to improvement performance of the health system; create information that can be acted upon.
- Don't sacrifice what is important to patients in order to align with the federal system of measures.
- Need to have the right decision makers and stakeholders at the table.
- It may be helpful to have separate but related conversations about: population health (reducing disparities), providing transparent information – common set of facts, and what innovation is necessary to fill in gaps.
- There needs to be more demographic information.
- Communicate information in a way that makes sense for consumers.
- Include perspectives beyond those of experts in the medical field.
- Measure quality of care, not just patient health.

- Minnesota still needs to have its own system, but in the long term they can completely align with other systems.
- Minnesota should innovate on performing based on measures that exist and devote resources to performance. The framework should be about improving patient care
- This is not just an MDH project; this is everyone's project.
- Need to define MDH's role in a statewide measurement system.
- Don't let the perfect be the enemy of the good.
- It's important to have mixed-method approaches.
- Pay attention to progress in communities.

Questions/gaps in knowledge

Most questions related to or directly asked about scope. All questions were asked once except the direct ask about scope, which was asked twice.

- What is the scope of this framework development?
 - Specifically, how does MDH view the charge of the Steering Team?
 - Are we seeking alignment? Reducing the number of reports required?
 - What is the intended use of SQRMS? Single or multi-use? Multi-use is more robust but harder to figure out.
 - What is the governance of this going to look like? Public/private? Legislated?
 - What is the best scope of measurement?: Is it best aimed primarily at ambulatory or also extended to larger frame like hospital care, mental health care, etc.?
 - How will it be paid for?
 - Technical infrastructure: real time data? Claims and clinical? Where does the data sit and who has access? Patient level or aggregate?
- What types of changes would require legislative action? What types of changes does MDH have the authority to make?
- What stakeholders are driving the need for this framework? Who wins and who loses?
- Who is the roadmap for? Who is driving?
- What is the goal?
- Would like to know more about various federal programs and where they are headed, and how they might interact with Minnesota measurement systems.
- How will the framework going forward be a part of helping other systems grow and improve? When DHS pay attention, payer systems are involved so health insurance companies.

Success

All successes were mentioned once, but many relate to one another.

- The data shows patients live longer or live with less morbidity
- SQRMS is a model for other states and the federal government
- That whatever is developed is actionable and sustainable.
- Less burdensome (by 50%?) than current system

- Attempts made to create fairness of measurement funding
- System looks really different and is meaningful and value add
- Measures are the next iteration and not hospital or clinic specific but are patient-centered, meaningful, create accountability beyond hospital or clinic walls.
- We've preserved our focus on a robust outcome focused system that measures transparently.
- We don't recreate the wheel (not creating a new process that sits on top of existing process)
- That there are clear steps to follow to get to tangible change or improvement (spending less time doing collecting data).
- When it is actually implemented! Minnesota is great at coming up with frameworks and plans; not so great at following-through on commitment and action.
- People are paying attention to the product, and it's spurring conversation; people are engaged in the development of policy.
- Satisfied steering team members.
- MDH has used an authentic process, even if it means going past deadlines.
- Having some energy and excitement about a new effort to improvement in Minnesota.
- Agreement among and support from stakeholders.
- The framework is valuable in the community of stakeholders that will be using it.
- The recommendations could bring about unified, integrated investment in community and technology.

Overview

This Quality Framework Interview Guide will be used by MAD consultants in their conversations with other stakeholders.

As we've discussed, the Quality Framework is intended to become guidance to the broader community that:

- Includes guiding principles for a system of health quality improvement and measurement;
- Articulates the value of a statewide quality measurement across the spectrum of stakeholders;
- Establishes principles for ongoing framework evaluation, maintenance, and updates;
- Makes recommendations on the type and appropriate maximum number of measures and possibly includes policy recommendations; and
- Responds to the legislatively-established criteria of —
 - Articulating statewide quality improvement goals,
 - Fostering alignment with other measurement efforts,
 - Identifying the most important elements for assessing the quality of care,
 - Ensuring clinical relevance, and
 - Defining the roles of stakeholders.

MAD developed this stakeholder interview guide with an aim toward addressing all of these features of the Quality Framework. We included questions and ideas that arose from Steering Team meetings and interactions with members, discussions with MDH, and that other states used with stakeholders in their development of quality measurement systems.

Additionally, MAD developed the questions keeping in mind the different stakeholder groups that the legislation calls out: consumer/patients, community and advocacy organizations representing diverse communities and patients; health care providers whose quality is assessed, including providers who serve primarily socioeconomically complex patient populations; health plan companies; health care purchasers; community health boards; and quality improvement and measurement organizations.

MAD structured the interview questions around the "Stakeholder Conversation Outline" document that was presented to the Steering Team during the April 4 meeting. The main numbered questions within the "Discussion" section follow this outline.

We have **bolded** questions that we think should be asked during stakeholder interviews; unbolded questions are optional and will be explored as time and conversation permit. Questions that are most appropriate for health care industry stakeholders (i.e., providers, health plans, and quality measurement and improvement organizations) are *italicized*.

As you envision a statewide quality framework, think about whether these questions and their answers will provide sufficient information to move forward in developing a framework.

Stakeholder Conversation Questions

MAD Draft 4/16/18

Opening Conversation

Thank you for your time and for being willing to talk to us today about health care quality and measurement.

As consultants for the Minnesota Department of Health, we are asking for your input to inform a Minnesota Quality Framework. This framework will outline how Minnesota measures health care quality in the future. We will use your input, combined with input from other stakeholders, to draft a report of findings and recommendations to MDH to review as they develop the quality framework.

Your participation in this conversation is voluntary. The only consequence to you not participating is that we do not have your thoughts to include in our report to MDH. While we'd like to share what you say with MDH, Minnesota Statute 13.64 allows us to keep your viewpoints private. If, at any time, you would rather we not share what you say with MDH, please let us know, and we will keep that information private.

Thought Exercise

Before we begin, I'd like to take you through a thought exercise to get you thinking about how health care quality looks to an individual and how that translates up to the health care system level.

Think about the last time you sought health care services for you or a family member. This can be in any kind of setting—for example, a clinic, behavioral health provider, outpatient surgery. Think about how helpful the professional staff were or were not. Think about how informed or uninformed you felt after your appointment. Think about whether you got information that would help you maintain or improve your health, and how you've used that information since.

In keeping with the information theme, think about the questions the professional staff (e.g., doctor, nurse, care coordinator, front desk staff) asked you and how they documented that information. Think about any surveys you've received that ask about your care. Think about where that information goes, how it's compiled with information from thousands of other patients—information about people that are healthy and people with many different kinds of health concerns—and what power and potential that information has.

Finally, let's think briefly about what it means to improve health care for all Minnesotans and all those who have a role in improving health. Think about what else affects a person's health.

Our discussion today will be about information and how information can contribute to the improvement of the health of all Minnesotans.

Introduction

Reflection on a recent personal experience with the health care system, including what worked well and what didn't, and what could have been better.

- 1. What assets does your organization or community bring to health and wellness?**

Discussion

2. **What role does health care play in maintaining health?**
 - a. **[Consumer/patient stakeholders only:] From a cultural perspective, how does your community define health? How is that related to wellness?**
 - b. **Tell me about the impacts of the current health care system on your (community/patients/beneficiaries/employees).**

3. **If you were to imagine a different health care system/experience, what characteristics would it have with regard to the quality of care? How would this be different than what exists today?**

4. **What does high quality health care mean for you?**
 - a. **What health care outcomes are most important to you? (If they are unsure how to answer, offer examples: goals around quality improvement, population health, health equity goals, cost reduction, disease burden.)**
 - b. **What do you believe Minnesota's top three health care quality improvement priorities should be and why?**
 - i. **For the priorities you've stated, what do you think it would take to increase quality in those areas?**
 - ii. **How can increasing quality in those areas improve health care outcomes?**
 - c. **What factors should we consider when thinking about patients, cultures, providers, and health care systems, and their relationship to care quality and health outcomes?**
 - i. **How can we obtain information or data on these factors?**
 - ii. **How could Minnesota measure care that is delivered beyond hospitals and clinics?**
 - d. **What, if anything, is important about improving care outcomes that is not currently being measured? Where are the gaps?**
 - e. **How should data be used in quality measurement and improvement? (If they are unsure how to answer, offer examples: Examples include internal quality improvement, public reporting, and pay-for-performance, or are different measures better suited to different functions? Should all measures be used for all purposes?)**
 - i. ***Where or who should the data come from?***
 - ii. **What, if anything, should Minnesota keep in mind as it collects and analyzes data for health care quality improvement?**
 - iii. ***How do we measure other settings or across settings along the care continuum?***

- f. How should we decide what to start or stop measuring?
 - i. *What, if anything, do you think we could stop measuring?*

5. What would it take for us to consistently have high quality health care and know we do? Who would do what?

- a. What could a quality framework accomplish or change?
 - i. Whose experience could change and how?
- b. How can the quality framework best serve all stakeholder groups?
- c. **What strengths do different partners in quality measurement and improvement bring to the table?**
 - i. **Health care industry (providers, health plans, quality measurement organizations, quality improvement organizations)**
 - ii. **Patients, consumers, and communities**
 - iii. **Purchasers/employers**
 - iv. **Public sector**
- d. **What factors should be considered to determine the right number of measures to include in a statewide quality measurement system?**

6. How well do you think these values and principles for a quality framework can help create the health care system evolution you imagine? (Show the emerging values and principles from the Steering Team that were shared in advance and ask for interviewees' reactions and additions.)

- a. **What, if any, guiding values and principles would you suggest adding to achieve quality improvement?**
- b. What should we consider as we collectively develop the goals of the statewide quality framework?
 - i. What goals would you suggest the state adopt for the statewide quality framework?
 - ii. How do we successfully achieve them?
- c. Who should the end user(s) of a statewide quality measurement system be?
- d. **In what ways can quality measurement help to advance health equity? In what ways is it limited?**
- e. **What, if any, examples do you have of health care quality measurement systems that do a good job?**
 - i. **How can Minnesota quality measurement align with what they are doing well?**

7. **How can we keep a quality framework and the system of measurement that flows from it relevant over time; how do we evolve?**
 - a. What will it take to implement a statewide quality framework?
 - b. How should the quality measurement and improvement system be maintained, evolved, and evaluated over time?**
 - i. Who is responsible for it?
 - c. *How do we avoid duplication or replication of other quality measurement initiatives?*
 - d. *How can we increase the efficiency of quality measure reporting?*
 - e. *How could emerging information, research, or best practices be incorporated into the system's operation or use?*
 - i. *How do we find efficiencies and integrate them into the system?*

Conclusion questions, envisioning the future

8. What is the one thing you would like to see MDH do with respect to quality measurement?
9. **If you could have anything you wanted, what would you want health care quality measurement in Minnesota to look like in five years?**
10. **Is there anything else you'd like to share?**

Thank you for your input. We'll incorporate it into our report for MDH. MDH intends to release a draft framework for public comment in late summer and present the framework to the legislature by September 30th. You can stay informed by visiting their project website (<http://www.health.state.mn.us/healthreform/measurement/measfrmwk>) and subscribing to Statewide Quality Reporting and Measurement System announcements through GovDelivery.

Quality Framework Stakeholders

Key informant interviews and small group discussions

The project team will reach out to the stakeholders listed below to schedule key informant interviews and small group discussions. The project team will add others to this list during April through consideration and exploration of suggestions from the Steering Team, Internal Workgroup, and others.

Consumer, community and advocacy organizations representing diverse communities and patients

- Health Equity Advisory and Leadership (HEAL) Council
- Quality Measurement Enhancement Project (QMEP) Community Engagement Team
- Somali, Latino and Hmong Partnership for Health and Wellness (SoLaHmo)
- Voices for Racial Justice and health equity champions

Preliminary

- American Association of Retired Persons Minnesota
- American Cancer Society
- Eliminating Health Disparities Initiative grantees
- Minnesota American Lung Association
- Minnesota Board on Aging
- Minnesota State Councils
 - Council on Asian Pacific Minnesotans
 - Minnesota Council on Latino Affairs
 - Council for Minnesotans of African Heritage
 - Minnesota Indian Affairs Council
 - Minnesota State Council on Disability
- Patient Family Action Committees

Health care providers whose quality is assessed, and who serve primarily socioeconomically complex patient populations

- Minnesota Academy of Family Practice (MAFP)
- Minnesota Association of Community Health Centers (MNACHC) and some members
- Minnesota Association of Community Mental Health Programs (MNACMHP) and some members
- Minnesota Hospital Association (MHA)
- Minnesota Medical Association (MMA) physician workgroup for quality measurement project
- Safety Net Coalition (SNC)
- Small and large providers across Minnesota (clinics, hospitals)
 - University of Minnesota Physicians
 - Winona Health
 - Others

Health care purchasers

- Hennepin Health
- Minnesota Department of Human Services (DHS)
- Minnesota Health Action Group (MNHAG)
- Minnesota Management and Budget State Employee Group Insurance Program (SEGIP)

Health information technology

- Minnesota e-Health Advisory Committee

Health plan companies

- Minnesota Council of Health Plans (MCHP) and some members

Public health/Community health boards

- Some members of State Community Health Services Advisory Committee (SCHSAC)

Quality improvement organizations

- Institute for Clinical Systems Improvement (ICSI)
- Stratis Health

Quality measurement organizations

- MN Community Measurement

Questions

1. Recognizing that we will use a multi-pronged approach to obtaining broad stakeholder feedback (e.g., interviews, surveys, public comment periods), what, if any, perspectives are missing from this list of stakeholders with which to hold in-person key informant interviews and small group discussions?
2. Some entities have offered to pull together small groups of stakeholders for these conversations (e.g., QMEP, MMA, and MHA). Are there other opportunities to create other small group discussions or listening sessions, particularly for consumers, patients, and community and advocacy organizations?

Quality Framework Steering Team

April 4, 2018 Meeting Output

MAD Draft 4/5/2018

How could a system that focuses on quality measurement contribute to...

1...improving disease management

- Design non-regressive measures (e.g. A1C, 13-14, 12-13, 11-12...) pay more for improvements in sickest patients
- Highlight social needs beyond health
- Create measures consistent with MIPS
- Allow for low-burden exception reporting
- Reward case-finding (e.g. PAP smear \geq 5 years) out of compliance with guidelines
- By giving clinicians and patients a shared dashboard for making joint decisions (ala the Swedish Rheumatology registry)
- Improving quality and patient safety

2...improving population health

- By identifying trends in chronic disease and the factors that contribute – able to identify and prioritize interventions
- Move some measurement efforts out of clinical care and into public health schools, etc.
- Align system goal/metrics with statewide public health targets
- Focus on high-prevalence, high-impact conditions
- Utilize technological applications to leverage social networking/media to impact social community engagement. I.e. survey monkey...
- Community based participate action research – approaches for establishing comprehensive strategic approaches for discovering barriers, innovations, successes, and challenges of health care
- Focus on measures with significant room for improvement (not “topped out”) and variations across providers
- Expand units of measurement to community/region
- Design non-regressive measures (e.g. A1C, 13-14, 12-13, 11-12...) pay more for improvements in sickest patients
- Systems improvement: Educating community-based organizations of health literacy and health equity quality of life standards
- Create measures consistent with MIPS
- Allow for low-burden exception reporting
- Reward case-finding (e.g. PAP smear \geq 5 years) out of compliance with guidelines
- By routinely measuring in a patient and family centric way, the system will capture not just scientifically important information, but also things important to patients and families – such as

satisfaction, treatment burden, self-empowerment etc. (see the work of the HIV/AIDS and Ryan White programs on the HIV Measure Cascade)

3...improving quality and patient safety

- Set improvement goals – and share what works to reach them
- Incorporate data into contract incentives to drive improvement. Align across payers to get maximum “signal strength”
- Focus resource and effort on priority health issues (fits many categories)
- Measure quality of life at the person level
- By focusing attention of leaders on quality and safety by reporting quality and safety measures.
- Design non-regressive measures (e.g. A1C, 13-14, 12-13, 11-12...) pay more for improvements in sickest patients
- Systems improvement: Educating community-based organizations of health literacy and health equity quality of life standards
- Create measures consistent with MIPS
- Allow for low-burden exception reporting
- Reward case-finding (e.g. PAP smear \geq 5 years) out of compliance with guidelines

4...reducing health care system costs

- By helping to avoid costly and avoidable complications
- Also look at what shouldn't happen, not just what should
- Create a true efficacy cost/outcome risk adjusted measure
- Have measures that cross settings – more about populations, not providers (fits in many categories)
- Emphasizes preventive coordinated care that is efficiently delivered
- Move some measurement efforts out of clinical care and into public health schools, etc.
- Design non-regressive measures (e.g. A1C, 13-14, 12-13, 11-12...) pay more for improvements in sickest patients
- Systems improvement: Educating community-based organizations of health literacy and health equity quality of life standards
- Allow for low-burden exception reporting
- Reward case-finding (e.g. PAP smear \geq 5 years) out of compliance with guidelines
- A system that routinely and consistently measures health care delivery costs will allow cost comparison and value based purchasing (ala the Health Partners total cost of care measure)
- A system that measures and allows consumers to see which providers recommend more care and services than guidelines recommend (e.g. the Choosing Wisely Program)
- A system with patient level identification would allow real time or near real time understanding of where there may be duplication in services (e.g. the CQM systems in the Tulsa HIE (MyHealth) and the Michigan HIE (MiHin))

5...reducing chronic disease

- By identifying trends in chronic disease and the factors that contribute – able to identify and prioritize interventions
- Move some measurement efforts out of clinical care and into public health, schools, etc.

- Focus on measures with significant room for improvement (not “topped out”) and variations across providers
- Create measures consistent with MIPS
- Reward case-finding (e.g. PAP smear \geq 5 years) out of compliance with guidelines

6...reducing disparities

- Risk adjust for medical and social complexity (having a measure of social complexity adds to #2)
- Allow for low-burden exception reporting
- Focus on measures with significant room for improvement (not “topped out”) and variations across providers
- Design non-regressive measures (e.g. A1C, 13-14, 12-13, 11-12...) pay more for improvements in sickest patients
- Promote patient-defined measures of quality
- Begin to measure social factors as a more comprehensive picture of health
- Identifying disparities can point toward the need for new types of innovations (e.g. payment, covered services) that will target disparities.
- By helping to identify disparities and track progress over time toward eliminating them
- Reward case-finding (e.g. PAP smear \geq 5 years) out of compliance with guidelines
- By consistently measuring and reporting key areas of diversity, such as geography, age, ethnicity, language etc., a system can give insight into where Minnesota can make investments in supporting people and communities to improve health outcomes in important areas (see the system built by Harborview Medical Center in Seattle)

7...reducing variation in outcomes

- Create measures consistent with MIPS
- Focus on measures with significant room for improvement (not “topped out”) and variations across providers
- Help providers understand how they compare to others and prioritize improvement efforts
- Highlighting differences by geography/region
- Identify high-variation in performance on specific measures
- Allow for low-burden exception reporting
- Reward case-finding (e.g. PAP smear \geq 5 years) out of compliance with guidelines
- Comparisons across providers with appropriate risk adjustment will allow providers to identify when they are an outlier and ideally be paired with a high performer to learn tools and methods for improvement (e.g. many of the surgical registries – like IRIS)

8...promoting patient-centric care

- Promote patient-defined measures of quality
- Bring patient voices strongly into governance/direction setting as peers
- By reporting patient reported outcomes (PROs), reflecting patient perspective on care, quality, and outcomes.
- Transparent and timely reporting of results that are meaningful to patients
- Incorporate patient perspectives and focus on outcomes

- Systems improvement: Educating community-based organizations of health literacy and health equity quality of life standards
- Identify high-variation in performance on specific measures
- Allow for low-burden exception reporting

9...other

- Perhaps look at emergency care for non-emergent reasons – or similar – avoidable costs
- Align all 16 MN P\$P/Measurement programs to increase participation (works for most)
- Look to other countries (UK, Canada, Australia, New Zealand, Singapore, etc.) for P4P ideas.
- Driving innovation:
 - In measurement
 - Health care delivery
 - Health care payment
- Measure either fewer key items or have additional measures zero burden (and possibly formative)
- Look to other groups working on a similar project: NQF, IOM, Starfield III, (family medicine)

Themes and observations that emerged from previous exercise

- “Risk adjustment” permeates everything
- Measure subset of certain measures and aligning
- Connection to payment and incentivizing
- Measurement system can provide “signal strength”
- Comprehensive planning
 - Innovative actions
 - Challenges
 - Successes
- Aiming and measuring beyond provider (clinic) and what we currently measure
- Tracking disparities and social factors
- Involve patient voices and goals
- Including focus on improvement and goals
- Avoidable care
- Desire for benchmarking
- Importance of staging transition (knowledge of measures, time to make changes, etc.)
- Lower or minimize burden

What are some candidate principles?

Principle – a core assertion that serves as the foundation for a chain of reasoning.

1. Variation is meaningful and should not be adjusted away
The system promotes justice/fairness for all parties
Should account for risk factors in order to measure more fairly
Be meaningful and benefit all Minnesotans regardless of geography, ethnicity, status, etc.
2. Different audiences (e.g. purchasers) need to be acknowledged. – should add value not be duplicative.
3. Framework needs to recognize there is more to health than healthcare
Should measure meaningful/impactful topics and be a parsimonious set
We need to prioritize – we can't solve all problems at once
We need to do what's most important, not what is easiest.
4. Useful for patient decision-making
Providers wanting measures for improvement
(this could all be linked to #2)
5. Hold ourselves accountable for positive health outcomes
Synthesize common values to create shared goals.
Cohesiveness between communities and systems
6. The system results in improving the quadruple aim (cost, provider satisfaction, patient satisfaction, population health quality)
Pay for performance
Public reporting
Internal improvement
7. The framework needs to be regularly monitored & updated, via an inclusive, transparent process, to make sure it's still meeting our goals. *(Diane's explanation: I'm trying to get at ongoing governance, which is an issue I think this group will need to touch on at some point – if we're going to set goals, and develop a framework that is responsive to the needs of multiple audiences, we can't just do it and consider it done. We need to have a process for overseeing it in the future, and assessing whether it's doing what we intend.)*
8. Measures need not be directly tied to financial incentives in order to drive health system improvement.

Data Conversation Outline feedback

What's missing?

- Personal experiences take individualistic view vs system
- How to apply individualistic questions to health industry organizations
- Engagement and how to ensure individuals are speaking about groups and not themselves
- Cultural perspective of healthcare and wellness and what aspects help you feel you are achieving that?
- Separate sets of questions tailored to different groups of stakeholders
- Asking about experiences in healthcare system or whole life?

Parking Lot

- Further intentional conversation about community engagement throughout process.

Meeting reflections

- Lots of commonality but differences exist, too
- A lot of information and knowledge to squeeze – process-wise, hard to translate
- Agenda was too ambitious

Draft Quality Framework Principles

1. Health is more than health care, and a measurement framework should recognize this by linking up with overarching concepts of quality (e.g., safety), incorporate the idea that non-clinical factors and social determinants are important (e.g., race, housing status, food insecurity), and explore 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 patient satisfaction, provider satisfaction, and population health, and reduction in costs for patients, providers, and purchasers.
3. 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.
4. Quality measurement in Minnesota should be parsimonious, add value for stakeholders, and not duplicate other efforts.
5. Quality measurement should produce information that is meaningful, fair, transparent, and actionable for different stakeholders.
6. It is important to understand the underlying provider, system, community, cultural, and patient factors that contribute to variation in quality measure results, and to account for these appropriately in a measurement system. However, variation is meaningful and should not be entirely adjusted away.
7. Measures should be useful for different stakeholders (e.g., patients, providers, purchasers) in different ways (e.g., decision-making, public reporting, internal improvement, pay-for-performance). Measures do not need to be used by all stakeholders for all purposes.
8. The quality framework should be regularly monitored and updated via an inclusive, transparent process to ensure it meets goals.

Minnesota Quality Framework Steering Team Sample Framework Survey Results

MAD Draft 4/25/2018

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Summary

This section provides an overview of how Steering Team members responded to questions about whether the Steering Team and MDH should adopt, adapt, use elements from, or not use the sample frameworks and a high level synthesis of the strengths and elements to use from each sample framework.

Overall, eight of the ten Steering Team members completed the survey, and one additional member responded to the first question regarding the Agency for Healthcare Research and Quality National Quality Strategy.

Results of how to use each Sample Framework

Figure 1 below demonstrates how the Steering Team members responded to a question asked of each sample framework: Is there a way we can use this sample as part of Minnesota's Quality Framework? Members most commonly said that there were useable elements from the sample frameworks. Members agreed that at least one element (or more) could be used from the Minnesota Health Information Technology (MN HIT) Trailblazers Draft Principles for the Minnesota Statewide Quality Improvement Roadmap and the Agency for Healthcare Research and Quality National Quality Strategy. Less popular samples included the National Committee on Vital and Health Statistics (NCVHS) Measurement Framework for Community Health and Well-Being, V4 and the Institute for Improvement (IHI) Triple Aim, though half of members found at least one usable element in each sample.

Figure 1: Steering Team member ratings for use of Sample Frameworks



Strengths and elements to use from Sample Frameworks

Agency for Healthcare Research and Quality National Quality Strategy has a useful structure and addresses the social determinants of health.

Centers for Medicare & Medicaid Services (CMS) Meaningful Measures are consistent with the Draft Principles and provide an opportunity to examine where the two align and how they are different.

Healthcare Association of New York State (HANYS) Quality Institute: Measures that Matter includes a call to action for stakeholders and the following language, which resonated with a few Steering Team members:

- *Measures will reflect “clinical reality” by accurately measuring the intended target, and be actionable by providers who can use the data to implement evidence-based practices to improve care.*
- *The data acquisition and reporting process will “no longer [distract] from the process of care nor [require] extra effort” and will be embedded seamlessly in integrated, interoperable electronic health records (EHRs), allowing for more comprehensive measurement.*

Institute for Healthcare Improvement (IHI) Triple Aim is good at a high level but too broad for Minnesota’s Quality Framework.

Institute of Medicine (IOM) Six Domains of Health Care Quality is “tried and true” and “classic” but perhaps too broad for the Minnesota Quality Framework. Specific language to use might include overuse/underuse/misuse concepts and the sixth domain:

Equitable: Providing care that does not vary in quality because of personal characteristics such as gender, ethnicity, geographic location, and socioeconomic status.

Institute of Medicine Vital Signs: Core Metrics for Health and Health Care Progress is well-thought-out and particularly helpful in the context of population and community measures. The following may be particularly useful:

Healthy communities

- High-quality care
- Preventive services
- Care access
- Patient safety
- Evidence-based care
- Care match with patient goals

Minnesota Health Information Technology (HIT) Trailblazers: Draft Principles for the Minnesota Statewide Quality Improvement Roadmap aligns with the current Draft Principles. Members cited nearly all HIT Principles, especially 3, 4, and 5, as similar to current Draft Principles. Members also liked that HIT Principles address how measure data would be collected.

National Committee on Vital and Health Statistics (NCVHS) Measurement Framework for Community Health and Well-Being, V4 is comprehensive and has a good community focus. Specific language to use might include:

Provide each sector the opportunity to see how they are achieving outcomes critical to their performance and achieving collective impact on the health of their population and well-being of their community.

National Quality Forum's (NQF) Health Equity Roadmap: Four I's for Health Equity addresses disparities and could be added to the framework.

Feedback by Sample Framework

How to read this section

This section provides all of the Steering Team feedback for each sample. The section uses the following structure for each sample framework:

- Sample framework language
- Graph of responses from Steering Team members
- Synthesis of Steering Team comments
- List of all Steering Team comments

Items that are **highlighted** reflect suggested edits additions or deletions from the Steering Team.

Finally, MAD uses the following conventions to talk about proportions of respondents:

- All /everyone
- Almost all /almost everyone
- Many (more than half)
- Some (less than half but more than several—somewhere in the area of 1/3)
- Several (more than a few, less than some)
- A few (two or more)

Agency for Healthcare Research and Quality National Quality Strategy

Achieving Aims

The National Quality Strategy pursues three broad aims. These aims will be used to guide and assess local, State, and national efforts to improve health and the quality of health care.

1. **Better Care:** Improve the overall quality, by making health care more patient-centered, reliable, accessible, and safe.
2. **Healthy People/Healthy Communities:** Improve the health of the U.S. population by supporting proven interventions to address behavioral, social and, environmental determinants of health in addition to delivering higher-quality care.

3. Affordable Care: Reduce the cost of quality health care for individuals, families, employers, and government.

Setting Priorities

To advance these aims, the National Quality Strategy focuses on six priorities:

1. Making care safer by reducing harm caused in the delivery of care.
2. Ensuring that each person and family is engaged as partners in their care.
3. Promoting effective communication and coordination of care.
4. Promoting the most effective prevention and treatment practices for the leading causes of mortality, starting with cardiovascular disease.
5. Working with communities to promote wide use of best practices to enable healthy living.
6. Making quality care more affordable for individuals, families, employers, and governments by developing and spreading new health care delivery models.

Using Levers

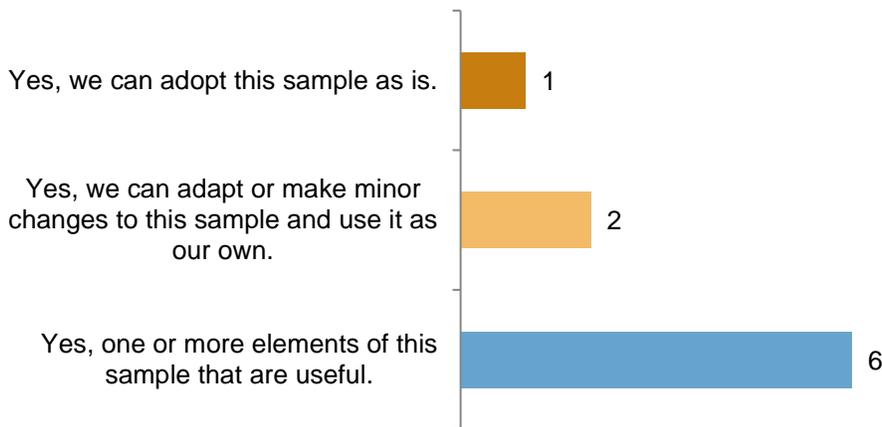
The nine National Quality Strategy levers below represent core business functions, resources, and/or actions that stakeholders can use to align to the Strategy. In many cases, stakeholders may already be using these levers but haven't connected these activities to NQS alignment.

1. Measurement and Feedback: Provide performance feedback to plans and providers to improve care
2. Public Reporting: Compare treatment results, costs, and patient experience for consumers
3. Learning and Technical Assistance: Foster learning environments that offer training, resources, tools, and guidance to help organizations achieve quality improvement goals
4. Certification, Accreditation, and Regulation: Adopt or adhere to approaches to meet safety and quality standards
5. Consumer Incentives and Benefit Designs: Help consumers adopt healthy behaviors and make informed decisions
6. Payment: Reward and incentivize providers to deliver high-quality, patient-centered care
7. Health Information Technology: Improve communication, transparency, and efficiency for better coordinated health and health care, including the deployment of qualitative data analysis software in systems/communities
8. Innovation and Diffusion: Foster innovation in health care quality improvement and facilitate rapid adoption within and across organizations and communities
9. Workforce Development: Investing in people to prepare the next generation of health care professionals and support lifelong learning for providers

Source: https://www.ahrq.gov/sites/default/files/wysiwyg/nqsfactsheet_2017.pdf

Year: 2017

Figure 2: Steering Team rating of use of AHRQ National Quality Strategy



Generally, Steering Team members liked the structure of this framework, including the use of levers, but not all members agreed. A few members mentioned the need to address social determinants of health. Those who were less in favor of this framework found it too broad or not simple enough for SQRMS.

Comments:

- Strategies of health equity framework should include community-based accountable care organizations
- Like the identification of levers that suggest action in response to measurement
- 6 priorities provide a helpful focus for measuring and improving
- The overall aims are very useful. "Setting priorities" and "using levers" are too broad for SQRMS—perhaps more applicable to the federal government
- Priorities concept (practical naming)
- The levers could be helpful for articulating the different audiences/purposes of a measurement framework
- This three part structure is interesting, and could be useful for our framework.
- Need to consider social determinants.
- Well-thought out framework, but perhaps not simple enough
- Aim #2 is extremely broad - we should discuss how our work relates (or doesn't) to social determinants

Centers for Medicare & Medicaid Services (CMS) Meaningful Measures

Cross Cutting Connections

Meaningful Measures will move payment toward value through focusing everyone's efforts on the same quality areas and lend specificity, with the following principles for identifying measures that:

1. Address high impact measure areas that safeguard public health
2. Patient-centered and meaningful to patients

3. Outcome-based where possible
4. Fulfill requirements in programs' statutes
5. Minimize level of burden for providers
6. Significant opportunity for improvement
7. Address measure needs for population based payment through alternative payment models
8. Align across programs and/or with other payers (Medicaid, commercial payers)

Meaningful Measure Areas

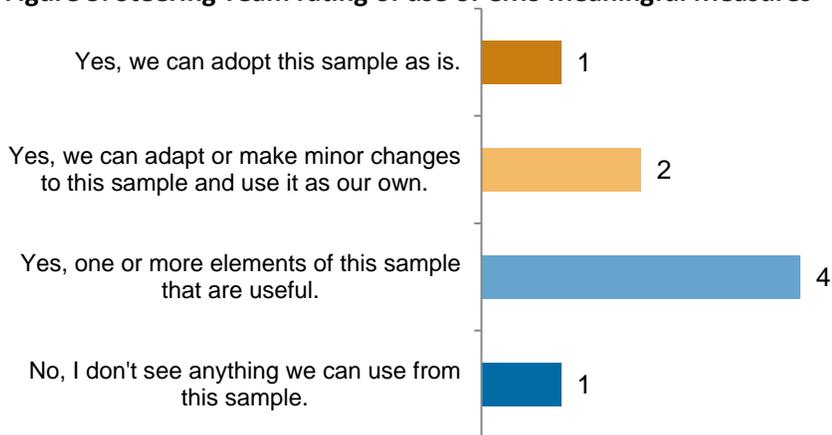
The Meaningful Measure Areas serve as the connectors between CMS goals and individual measures/initiatives that demonstrate how high quality outcomes for our beneficiaries are being achieved. They are concrete quality topics, which reflect core issues that are most vital to high quality care and better patient outcomes.

1. Eliminate disparities
2. Track to measurable outcomes and impact
- ~~3. Safeguard public health~~
4. Achieve cost savings; make care affordable
- ~~5. Improve access for rural communities~~
6. Reduce burden
7. Promote effective communication and coordination of care; strengthen person and family engagement as partners in their care
8. Promote effective prevention and treatment of chronic disease; work with communities to promote best practices of healthy living
- ~~9. Work with communities to promote best practices of healthy living~~
- ~~10. Make care affordable~~
- ~~11. Strengthen person and family engagement as partners in their care~~
12. Improve quality and make care safer by reducing harm caused in the delivery of care

Source: <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityInitiativesGenInfo/CMS-Quality-Strategy.html>

Year: 2017

Figure 3: Steering Team rating of use of CMS Meaningful Measures



Steering Team members observed alignment between CMS Meaningful Measures and the Draft Principles, but either favored the draft principles, perceived too much overlap between the two, or expressed concern that the CMS Meaningful Measures scope is too broad and could use specificity.

Comments:

- The one thing I like about this is how concise and clear it is.
- All areas are consistent with Steering Team discussion
- The principles we have drafted are more descriptive and compelling than the CMS framework
- Overall I think this framework is elegant but needs more specificity
- Most elements are useful but some go beyond scope of SQRMS
- The "Cross Cutting Connections" get at our concept of parsimony
- The Meaningful Measure Areas are useful because they are framed as the outcomes desired
- The "Meaningful Measure Areas" are more specific than SQRMs would accommodate perhaps
- The mention of the need to align with program requirements
- What belongs in SQRMS vs. CMS?
- I like call-out of rural areas - could add underserved communities. Good domains for measures.
- Include a technological platform to connect clinical meaningful measures with psychosocial variables
- Mobile apps are technological pathways to connect systems with communities

Healthcare Association of New York State (HANY) Quality Institute: Measures that Matter

HANY envisions a future where quality measurement supports providers' efforts to improve quality and patient safety:

1. Measures will reflect "clinical reality" by accurately measuring the intended target, and be actionable by providers who can use the data to implement evidence-based practices to improve care.
2. The number of reported measures required of providers by payers (government and commercial) and other entities will be parsimonious, align with one another using standardized definitions, and represent only the most important health priorities.

3. The data acquisition and reporting process will “no longer [distract] from the process of care nor [require] extra effort” and will be embedded seamlessly in integrated, interoperable electronic health records (EHRs), allowing for more comprehensive measurement.
4. Providers will focus their quality and patient safety efforts on their most serious safety concerns, and prioritize time and resources to improve care with a goal of zero harm.

HANYS’ call to action urges all stakeholders to:

1. Streamline—commit to the minimum number of measures needed to evaluate healthcare quality.
2. Align—with national, standardized, evidence-based measures.
3. Focus—on those select few representative measures that target the most vital aspects of care, are meaningful and actionable, are tailored to the organization’s patient population, and offer opportunities to directly and positively impact patient outcomes.
4. Collaborate—with key healthcare stakeholders to coordinate quality and patient safety efforts.

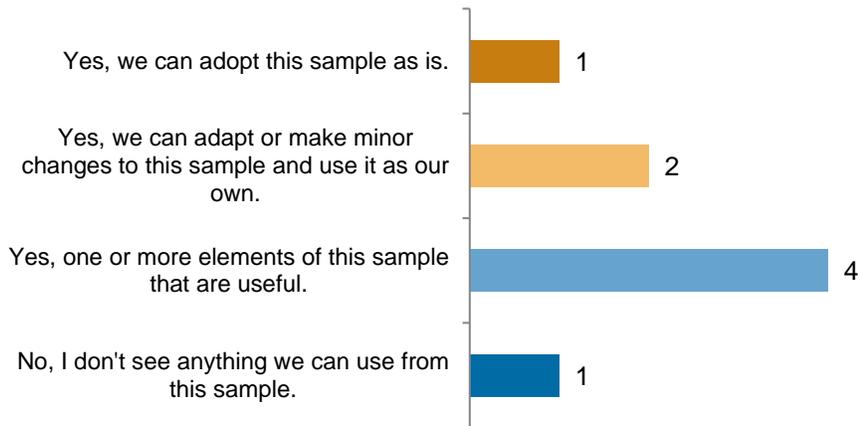
EHRs should be part of the solution.

Source:

https://www.hanys.org/quality/clinical_operational_oversight/measures_that_matter/docs/mtm_report.pdf

Year: 2016

Figure 4: Steering Team rating of use of HANYS Quality Institute: Measures that Matter



Steering Team members were split in their impressions of the HANYS principles, with nearly half saying that they either align with the Draft Principles or that they are interested in the approach. The other half of members found the HANYS approach to be too narrowly focused or too focused on providers. A few members expressed interest in mentioning EHRs and how they can be used.

Comments:

- This seems like it characterizes our aspirations well
- The HANYS principles line up well with our draft principles. #3 is an important addition.
- This is fantastic, I love the focus. The top 4 statements are very good - #1 especially resonates
- Interesting approach to a call to action for stakeholders. Can we test this idea in our outreach?
- Patients advisory boards as stakeholders can provide quality health equity standards/metrics

- This is not a very patient-centered approach - mostly from provider perspective
- Seems to focus on providers as only users/audience.
- This is too narrow an approach and doesn't speak to the opportunity or possibility we envision.
- The notions of safety as a priority is good (but hard to get right) and “clinical reality” is a goal
- Emphasis on evidence-based measures, parsimony is useful
- I like explicit focus on EHRs/interoperability/seamless data collection
- EHR can utilize comprehensive algorithms to align with state standards of health equity

Institute for Healthcare Improvement (IHI) Triple Aim

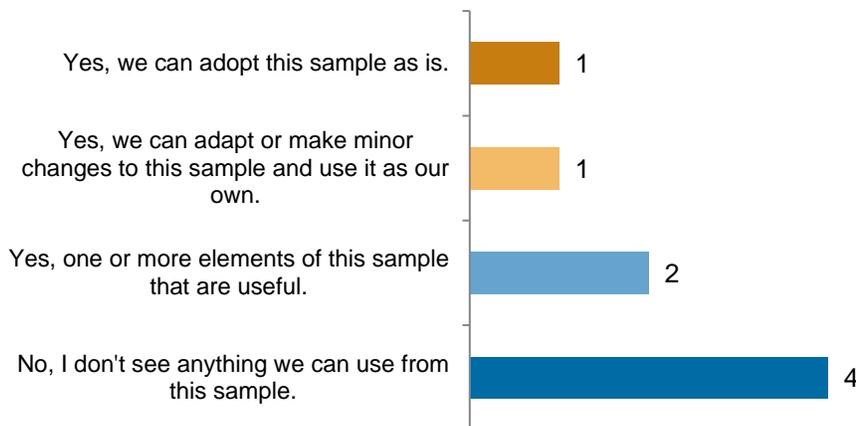
The IHI Triple Aim is a framework developed by the Institute for Healthcare Improvement that describes an approach to optimizing health system performance. It is IHI’s belief that new designs must be developed to simultaneously pursue three dimensions, which we call the “Triple Aim”:

1. Improving the patient experience of care
2. Improving the health of populations
3. Reducing the per capita cost of health care

Source: <http://www.ihl.org/Engage/Initiatives/TripleAim/Pages/default.aspx>

Year: 2008

Figure 5: Steering Team rating of use of IHI Triple Aim



Overall, Steering Team members were fairly united in responding that Triple Aim is a high level, widely-accepted framework but on its own is not sufficient for Minnesota’s Quality Framework.

Comments:

- Community Needs Assessment (CHN), Align TX plans with CHN recommendations, Improve health outcomes
 - Health system improvement metrics/performance/reimbursement can be health outcome based
- Already one of our principles along with provider experience/satisfaction

- This was part of the earlier AHRQ framework. Need more than this to guide our work
- This is a universally-supported framework, but is not sufficient for this work.
- It is the high level frame we are all working toward, but not specific enough for our task at hand.
- Is basis for many frameworks but by itself is not specific enough to provide meaningful guidance
- We already refer to triple aim, it's seen as a guiding framework.

Institute of Medicine (IOM) Six Domains of Health Care Quality

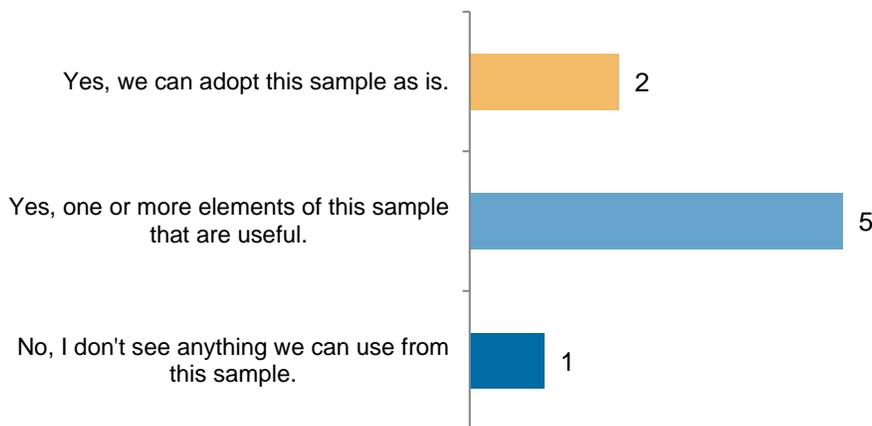
The IOM put forth the following six aims for the health care system:

1. Safe: Avoiding harm to patients from the care that is intended to help them.
2. Effective: Providing services based on scientific knowledge to all who could benefit and refraining from providing services to those not likely to benefit (avoiding underuse and misuse, respectively).
3. Patient-centered: Providing care that is respectful of and responsive to individual patient preferences, needs, and values and ensuring that patient values guide all clinical decisions.
4. Timely: Reducing waits and sometimes harmful delays for both those who receive and those who give care.
5. Efficient: Avoiding waste, including waste of equipment, supplies, ideas, and energy.
6. Equitable: Providing care that does not vary in quality because of personal characteristics such as gender, ethnicity, geographic location, and socioeconomic status.

Source: <https://www.ahrq.gov/professionals/quality-patient-safety/talkingquality/create/sixdomains.html>

Year: 2008

Figure 6: Steering Team rating of use of IOM Six Domains of Health Care Quality



Most Steering Team members addressed the value of this sample. A few mentioned, though, that the sample is not really a framework. A few suggested found ways it could be improved, such as adding more detail or including a health and community focus.

Comments:

- A classic. Complete and correct
- This model is aligned with MN health care services goals and objectives
- Tried and true. Need more detail than this, however.
- While more than 15 years old, these aims remain the vision of what we want our health system to be.
 - But the IOM aims were written with a health care, not a health and community focus
- Great goals but not much guidance here that would be helpful in choosing measures
 - Great framework for thinking about quality but it is not a measurement framework
- Specific mention of overuse/underuse/misuse is helpful. Also timeliness
 - Not really framework principles, but could guide measure selection.
- I'd like to see language similar to #6 woven into our framework.
- This is oriented toward traits of a health system, not measurement approaches.

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

To achieve better health at lower cost, all stakeholders—including health professionals, payers, policy makers, communities, and members of the public—must focus on what matters most.

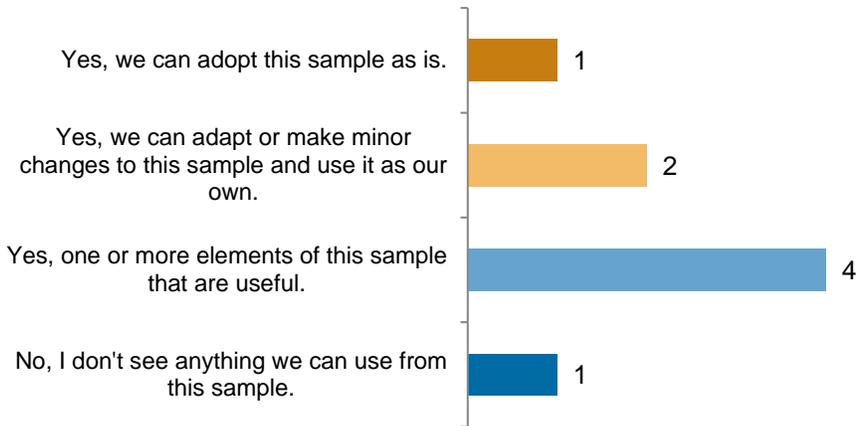
Goals and measure areas:

1. Healthier people
 - Life expectancy
 - Well-being
 - Overweight and obesity
 - Addictive behavior
 - Unintended pregnancy
2. Healthy communities
 - High-quality care
 - Preventive services
 - Care access
 - Patient safety
 - Evidence-based care
 - Care match with patient goals
3. Affordable care
 - Personal spending burden
 - Population spending burden
4. Engaged people
 - Individual engagement
 - Community engagement

Source: <http://nationalacademies.org/hmd/reports/2015/vital-signs-core-metrics.aspx>

Year: 2015

Figure 7: Steering Team rating of use of IOM Vital Signs: Core Metrics for Health and Health Care Progress



Steering Team members were rather split on how or whether to use anything from this sample, with a few responding that this was a good example of an overall framework and others responding that the scope or perspective of the framework was not quite consistent with what the Minnesota Quality Framework should be.

Comments:

- Hard to do completely but a good overall framework of priority
- An excellent example of a well thought out framework.
- Nice framework but its scope is well beyond what we can/should measure in SQRMS
- Domain #2 is most closely matched to what we need for health care measurement/SQRMS
- This might guide our selection of measures within the framework, but not an articulation of principles
- Nice broad list of domains, like community and population measures to get beyond clinic walls.
- Add framework for health equity accountability based on annual community health needs assessments
- Not everything here is under the control of the provider community (e.g. unintended pregnancy)
- Better for measuring states against other states, not provider vs. provider

Minnesota Health Information Technology (HIT) Trailblazers: Draft Principles for the Minnesota Statewide Quality Improvement Roadmap

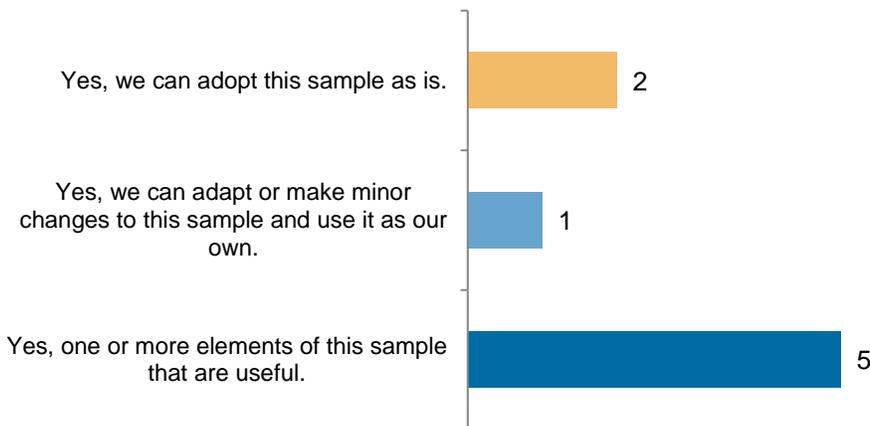
Several years ago, MDH, in collaboration with stakeholders, developed principles of a statewide quality improvement roadmap for a federal initiative called the “HIT Trailblazer Project”.

1. The improvement of health and health care for Minnesota citizens and communities is the central focus of the statewide quality improvement roadmap
2. Collaboration across patients, providers, settings of care, payers, and the public and private sector is necessary for achieving statewide quality improvement
3. To achieve real improvement, all stakeholders (e.g. consumers, practitioners, practices, hospitals, payers, community) must have access to data/information that is timely, actionable, and appropriate to the stakeholder for use in decision making
4. Quality measures, their reporting, and feedback of information should be focused on delivering the highest value, with the least possible administrative burden; and must be aligned across care settings and integrated into workflows, so that a patient’s entire care team can be aware of and accountable for care delivery performance, and fully able to evaluate clinical outcomes
5. Quality measurement programs, whether in the public or private sector, should rely on an aligned, parsimonious core set of measures that are meaningful, valid, standardized to the extent possible, and tied to priorities
6. Standardizing electronic clinical data and using health IT for quality measurement and reporting is essential for providers, state and federal government officials, and other stakeholders to improve quality and support value-based payment of health care services
7. New infrastructure should consider how to leverage existing assets, but also take into account new initiatives in progress and technologies under development
8. Public reporting of quality data must be timely, focused on delivering information that is meaningful to patients and usable to inform health care decisions

Source: Minnesota Department of Health

Year: 2013

Figure 8: Steering Team rating of use of MN HIT Trailblazers: Draft Principles for the Minnesota Statewide Quality Improvement Roadmap



In general, these principles received the most support from the Steering Team. The team collectively identified nearly all principles as aligning with the Draft Principles. A few members provided insights and suggestions for implementation. None of the members offered critical feedback.

Comments:

- Looks good; Seems like we're a ways away from realizing the aspirational EHR/HIE goals we had 5 years ago
- I like that it addresses how measures are collected and the operational realities/implications
- Aligned with our draft measures, and perhaps a crosswalk would tell us what we might be missing.
- [Use] #3, #5, #8. First half of #4 (workflow piece is outside scope).
- Pretty close to our principles. #7 is worth discussing as a potential addition.
- 2 - 5 and 8 have language that seems to align with the direction that we are going in.
- Implement model with updated HIT platforms & leverage social media to create positive health impact

National Committee on Vital and Health Statistics (NCVHS) Measurement Framework for Community Health and Well-Being, V4

The purpose of this Framework is to:

1. Strengthen multi-sectoral health and well-being improvement efforts at the local level.
2. Help HHS, other federal agencies and private-sector partners identify and close gaps in the accessibility of data at a sub-county level.
3. Offer communities a blueprint of the key issue areas—domains and subdomains—to stimulate and inform dialogue across sectors on barriers, opportunities, and approaches for improvement.
4. Promote public-private collaboration that builds on the successes of numerous metrics efforts already in development and/or in use

This Framework is designed to:

1. Offer communities a flexible tool designed to promote multi-sectoral engagement with the ability to choose indicators that are locally relevant and accessible.
2. Focus on (upstream and downstream) determinants of health through the lenses of both equity and life-course perspectives.
3. Provide each sector the opportunity to see how they are achieving outcomes critical to their performance *and* achieving collective impact on the health of their population and well-being of their community.
4. Complement existing framework efforts by seeking opportunities to inform and be informed by other efforts with similar aims, and avoiding defining a single set of metrics/ to be used by all communities.

The intent for this Framework is to accommodate two complementary objectives:

1. A parsimonious multi-sectoral core set of indicators that will:
 - Guide federal and state policy and resource allocation, and
 - Allow communities to benchmark themselves against peers and identify best practices.
2. A flexible set of multi-sectoral indicators to strengthen health and well-being efforts at the local level, from which communities can choose to use.

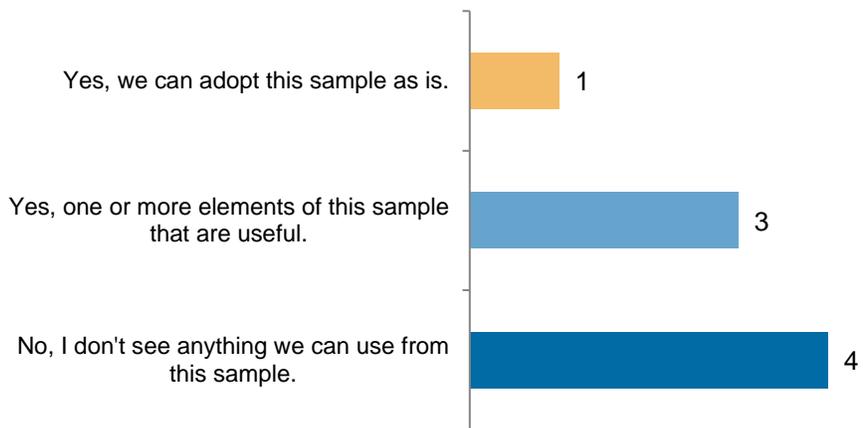
Domains:

1. Community vitality
2. Demographics
3. Economy
4. Education
5. Environment
6. Food and agriculture
7. Health
8. Housing
9. Public Safety
10. Transportation

Source: <https://www.ncvhs.hhs.gov/wp-content/uploads/2013/12/NCVHS-Measurement-Framework-V4-Jan-12-2017-for-posting-FINAL.pdf>

Year: 2017

Figure 9: Steering Team rating of use of NCVHS Measurement Framework for Community Health and Well-Being



Some Steering Team members said they liked specific elements of this framework, but several said it was too broad or outside the scope of SQRMS.

Comments:

- Model is comprehensive & can be designed with specific strategies to advance local community needs
- Nice clarity of purpose, goals, and intent -we could do better at articulating in our current work.
- Good community coordination ideas
- #3 in the second section could be helpful language.
- Seems like this is outside the scope of SQRMS, not actionable by providers
- It does not clearly articulate goals or priorities - too wordy and descriptive
- It is too vague (no criteria for choosing measures) and far too broad for SQRMS.
- May be too broad/ambitious for where we are right now - more of a long term vision?
- Designing this model on a technological platform to analyze data could accelerate aptitude

National Quality Forum’s (NQF) Health Equity Roadmap: Four I's for Health Equity

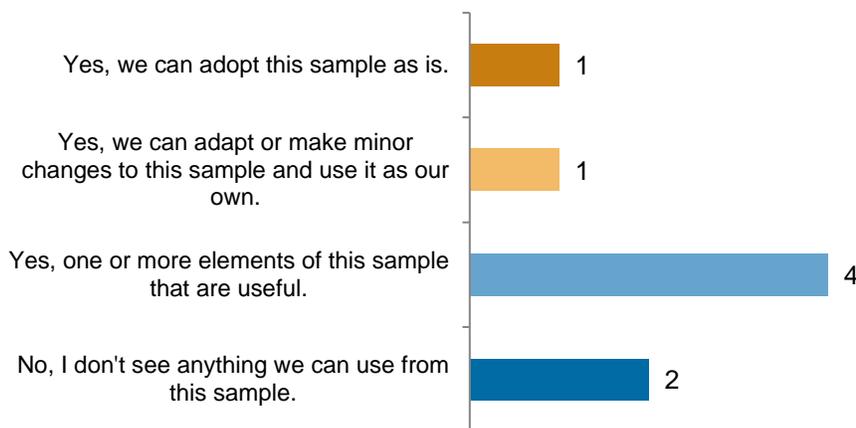
NQF created a roadmap for the U.S. healthcare system (i.e., providers and payers) to reduce health and healthcare disparities through performance measurement and associated policy levers. The roadmap lays out four actions:

1. Identify and prioritize reducing health disparities
2. Implement evidence-based interventions and community-based participatory action research to reduce disparities
3. Invest in the development and use of health equity performance measures
4. Incentivize the reduction of health disparities and achievement of health equity

Source: https://www.qualityforum.org/NQFs_Roadmap_to_Health_Equity.aspx

Year: 2017

Figure 10: Steering Team rating of use of NQF Health Equity Roadmap: Four I's for Health Equity



Steering Team members generally expressed that, at a high level, this sample framework is good, but some members mentioned that it is not the right level of information for Minnesota’s Quality Framework.

Comments:

- A good disparities expansion section
- It points to action and rolls up to a stated macro-level goal
- Too narrow to address SQRMS
- No clear single objective to SQRMS
- Our principles don't yet acknowledge need to prioritize areas with link to known interventions
- Very concise, but capture a very comprehensive set of concepts.
- Very important, but a roadmap is different than a framework. Maybe useful in framework implementation