

# Quality Framework: Community Stakeholder Input

MDH Draft 8/8/18

## Process

From June 15 through August 3, MDH conducted interviews with representatives of communities that are disproportionately impacted by health disparities. Deatrick LaPointe facilitated three small group discussions and MDH staff followed-up with community representatives who were unable to attend those meetings and wanted to provide input. In conducting these interviews, Deatrick and MDH staff used the interview guide, and values and principles developed in collaboration with the Steering Team.

## Key findings

### Values and principles

#### *Existing values and principles*

- Values should be defined. Words have different meaning to different people.
- **Connection and collaboration** – There should be two-way communication between communities and health care system, not just one way from the health care system to patients and communities. The health care system should leverage the assets of the community to advance health, and not solely focus on deficits. Don't turn to the community only when something is needed from them; this feels transactional, not authentic.
- **Actionable information** – It is important to provide Information and education to communities. Information can empower patients and their families, and advance health literacy.
- **Principle #3** – It is important that the quality measurement system is actionable for different stakeholders.

#### *New values*

- **Access to care** – Health care is affordable, culturally responsive, non-discriminatory.
- **Accountability** – The health care system is accountable to patients. Those who use quality measure data are also accountable to patients. Balance the power dynamic between patients and communities, and the health care system.
- **Cultural responsiveness** – Health care staff should have a baseline of training in providing culturally responsive care (this includes care for LGBTQ and HIV+ patients). Patients should be able to find such qualified health care professionals through a directory. The health care system should espouse cultural humility.
- **Inclusivity** – The current health care system was created by some people for some people and is one-size-fits-all; the framework should promote a health care system that is not oppressive and views a person as a whole which includes the social determinants of health.
- **Racial and cultural equity** – Be intentional about advancing racial and cultural equity through the quality measurement framework.

## Framework scope

The quality measurement framework and measurement system should:

- Include more than health care quality measurement, and within health care quality measurement, it should measure more than clinic and hospital quality.
- Be living, flexible, and fluid, and adaptive to changing needs.
- Take a whole person approach and the context in which they live. This includes prevention, wellness, mental health, spiritual well-being, connectedness, belonging, and the social determinants of health.
- Focus on systemic barriers that keep communities from being healthy.

#### Health equity

- A shared statement or definition of health equity is needed for the framework to enable the achievement of health equity gains.
- If the system could identify where communities are and are not doing well on quality measures, it could better identify significant health disparities and inequities. The system could then ask if the right types of measures are being used to assess community health and if the measurements need to be adjusted.

#### Data

- Data should be aggregated or segmented using information about the social determinants of health.
- It is important for patients and communities to know how quality measure data is used, results should be shared with communities, and data must be available for use by communities.
- The measurement system should include qualitative information that can be used along with quantitative data as an input into measuring community health and for communities and partners to develop interventions.
- Track qualitative data within communities to understand narratives of health equity and assess gaps in services, existing health disparities, understand how social determinants of health impact overall health of Minnesotans.
- Equal access to health education and resources through community-based care coordinators and mobile applications that could be developed, downloaded on data phones, and utilized with community members/patients. Ideas were generated for an app that could help with mental health concerns and link patients with health resources in their respective communities. Some community members expressed interest in giving patient experience feedback through an app that could be linked with their primary health care clinics and hospitals.

#### Measures

- Preventive care
- Patient experience
- Patient trust in provider or health care system

#### Implementation, maintenance, evolution

- Implementation, maintenance, and evolution of how data informs strategic advancement of health care is critical for innovation and sustainability.
- The framework should be implemented and experimented with iteratively or as a pilot before rolling it out statewide—this approach will lead to evaluation and evolution.

- Evaluate the impact; see what, if any, change occurred.
- Ongoing community conversations with intergenerational representation will be important.
- Continue to identify and fill-in gaps about health quality through conversations with communities.
- The framework needs a process to keep it relevant. One option would be to convene an ongoing steering team with more community member representation allowing for better community feedback.
- Communities need a better idea of how outcomes of measurement are being used and how high quality health care services are incentivized overall and for patients and providers with the biggest barriers.
- When the framework is complete, MDH should share the story of this process back with the community. Think of how many doors this could open—the interest in how MDH collects data can generate more community interest and involvement. Keep the conversation loop with communities open.

### Other considerations

- Because of the anti-immigration sentiment in the nation, people from immigrant communities (as well as communities of color and other ethnic communities) are under a lot of stress and mental health concerns are strong. People’s sense of belonging to communities is being diminished and exacerbating anxiety. There is high distrust of the health care system and people are not seeking services for themselves or their families.
- There is a strong desire by communities to avoid the health care system altogether due to all of the barriers: it is costly, there is a lack of provision of culturally responsive care leading to distrust, there is a lack of services in rural Minnesota, and the system was not designed by or for communities that are disproportionately impacted by disparities. Therefore, a health quality framework that includes more than health care is desirable.
- From the patient perspective, high quality health care is excellent customer service: providers communicate at the patient’s level (not talking above or around the patient), show respect for the patient as a human being, and provide connections (i.e., specialist referrals) to resources to help care for the whole person.
- There is a scarcity of services in rural Minnesota as compared to the metro area, e.g., resources, specialized services, providers, dental care, and mental health providers.
- What weight is being applied to patient and community input to balance the power dynamic of stakeholder input into this framework (i.e., balancing the power that providers and insurers hold in the health system and in the development of this framework)?
- Patients are the experts—turn to them for solutions in addressing health disparities, and identifying gaps and how to close them.
- Public events were recommended to promote health literacy to learn more about how the health systems work and understand the importance of health care prevention and intervention services.

- Allow patients to give feedback about their experience in the health care system through electronic online portals to assess qualitative and quantitative data to continuously improve health care services.
- Health equity is not defined and is lacking quantitative and qualitative data to support what it means from a community and health systems stakeholder perspective. Metrics and strategic solutions to advance equality of health for all Minnesotans can be a consideration for the Quality Framework.
- Consider collecting qualitative data as a holistic approach to understand social determinants of health from a patients' perspective in regards to: prevention, intervention, wellness, mental health, spiritual well-being, connectedness, and sense of belonging within their experience of the health care system.
- Focus on data that matters to the patient experience, quality and access to health care, standardization of health care.
- Identify systematic barriers that keep communities from being healthy and discover technological solutions for health equity.
- It is important for the best interests of the State of Minnesota that this framework gets it right—that means the framework will have pertinence, it will support the state's economic interests, it will be patient-centered, and it will make use of community resources.

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# Key Findings from Health Industry Stakeholder Input

MAD Draft 7/26/18

## Methods

From May 15 to June 27, 2018, Management Analysis and Development (MAD) conducted 14 small group and key informant interviews using the interview guide developed in collaboration with the Minnesota Department of Health and the Steering Team. Analysis involved the development of a qualitative coding structure based on legislative requirements and MDH assessment of what should be accomplished through stakeholder input. The following stakeholder groups were represented in interviews:

- Providers, including those of socioeconomically complex patient populations
- Associations and patient advocacy groups
- Public health
- Health plans
- Purchasers
- Quality improvement organizations
- Quality measurement organizations

## Key findings

### Values and principles

Most groups said the draft values and principles were good at a high level but were very general and would benefit from further definition around ownership or perspective (e.g., to whom? for whom?).

- Providers, associations and patient advocacy groups, public health, health plans, purchasers, and quality improvement organizations said values and principles were good at a high level.
- Providers, associations and patient advocacy groups, public health, health plans, purchasers, and quality measurement organizations said values and principles were very general.
- Providers, public health, purchasers, and quality measurement organizations said values and principles need more definition around ownership or perspective.

- Specific feedback about values and principles across stakeholders included:
  - Values: Expand on cost and affordability for people not currently seeking care.
  - Principles:
    - 1: Unclear whether it is referring to the system of health or the health care system; should include examples of health outside the health care system.
    - 2: The principle is good but very broad. It assumes measurement fosters improvement. Include provider experience (e.g., retention) with health equity and patient experience.
    - 3: Lots of general support. Unclear whether it is referring to the system of health or the health care system. Perhaps there could be a stronger stance or guidelines on how measures should be used.
    - 4: Unclear whether it is referring to the system of health or the health care system. “Duplicating efforts” may need to be further defined to clarify whether alignment is considered duplication. Also, to whom quality measurement should be actionable needs further definition.
    - 5: The term “important” has different meanings for different people.
    - 6: Will need to keep in mind cost and affordability as value is assessed. Add something about community engagement. “Inclusive” should mean inclusive of people beyond the typical data users. Measurement should include things that the public thinks reflect quality.

Items identified as missing or understated in current values and principles (in order of the number of interviews from most to least):

- Purpose or goal of the framework (identified by providers, associations and patient advocacy groups, quality improvement organizations, quality measurement organizations)
- Equity and fairness, specifically measuring the social determinants of health (SDOH) (identified by providers, associations and patient advocacy groups, public health, quality improvement organizations)
- Cost, affordability, and burden containment (identified by providers, public health)
- Access to health care (identified by providers, associations and patient advocacy groups, and public health)
- Ongoing maintenance and how measures will be added, modified, and removed (identified by providers, quality improvement organizations)

## Principles of framework stewardship

One conversation mentioned the need for ongoing governance. Nearly all groups mentioned the need to involve stakeholders on an ongoing basis.

## Framework components/actions

Many respondents, generally provider groups, health plans, and quality improvement organizations, noted that SQRMS has tried to be all things to all people, and a framework should provide a more focused approach.

- Associations and patient advocacy groups and some provider groups mentioned that some groups, namely patients or consumers, are not included in the reference, “all things to all people.”

Most respondent groups were in favor of alignment with other health care quality measures and measurement systems (generally unspecified) to reduce measurement burden and increase consistency in reporting. No one voiced opposition except to caution that it might cause backslide in patient impact or that full alignment alone may reduce the visibility and impact of SQRMS on advancing medical care.

- Providers, associations and patient advocacy groups, health plans, purchasers, quality improvement organizations, and quality measurement organizations talked about aligning with other measurement systems.
- Providers, associations and patient advocacy groups, quality improvement organizations, and quality measurement organizations talked about measurement burden.
- Providers, health plans, and quality improvement organizations expressed caution that full alignment might cause Minnesota to backslide on some measures and no longer be setting the national standard.

## Framework priorities

Respondent groups identified characteristics they thought aligned with a high quality health care system, and they thought measurement could contribute to these characteristics. At a high level, possible statewide goals or priorities respondents cited most often were:

- Caring for the whole person, incorporating SDOH and other context, patient-centered (mentioned in discussions across all stakeholder groups)
- Providing care that is effective; achieves intended results (mentioned across all stakeholder groups)
- Care that is affordable, though not specific to whom (mentioned across all stakeholder groups)
- Improving access to care (providers, associations and patient advocacy groups, public health, purchasers, and quality measurement organizations)
- Creating a system that is fair and equitable (providers, associations and patient advocacy groups, public health, health plans, quality improvement organizations, and quality measurement organizations)

- Providing preventive care (providers, associations and patient advocacy groups, public health, health plans, quality improvement organizations, and quality measurement organizations)

## Health equity

There was universal interest in knowing more about SDOH. Specifically, respondent groups noted the need to measure SDOH and use them to set the context for measurement and disaggregate measure data. Groups provided the following suggestions regarding health equity and quality measurement:

- Use the National Quality Forum Roadmap to Health Equity for examples of equity measures (providers, associations and patient advocacy groups)
- Use measures to identify disparities and target resources to address disparities (providers, associations and patient advocacy groups, public health)
- Payer data could provide additional information on access and affordability (providers)
- Include people with disabilities; be intentional about how various disabilities are defined (associations and patient advocacy groups)

A few groups (providers and quality improvement organizations) cautioned that health equity may be too big to achieve through measurement alone and that negativity around measurement burden could impact health equity efforts if they were tied to measurement. A few groups (providers and public health) also cautioned that not measuring the right things or disproportionately targeting solutions to the least disadvantaged groups could have the unintentional effect of making disparities worse.

## Measurement areas

Most groups also expressed interest in population health, though some (providers, health plans, and quality improvement organizations) were cautious that providers would be held accountable for aspects of health that are out of their control and were interested in measuring population health across settings. Suggestions for which settings to measure varied widely and included behavioral health, dental, ambulatory care (e.g., primary care), aspects of both ambulatory and in-patient care (e.g., care integration and coordination), post-acute and long-term care, public health, and pharmacies.

## Implementation, maintenance, and evaluation

In terms of ongoing maintenance and evaluation of the framework, several groups cited a tension between needing a framework that is nimble and can quickly adapt to innovation or research and the need for consistent measurement to develop historic data and reduce measurement burden. A few cautioned that there should be monitoring to ensure measures are used for their intended purpose and avoid unintended consequences.

- Providers and public health said some things should be kept constant to develop historic data and reduce burden.



- Providers, purchasers, and quality improvement organizations said the framework and measurement system should be monitored to ensure their relevance and identify opportunities to advance.
- Providers, public health, and quality improvement organizations said the framework and measurement system needs to be agile, nimble, and fluid.
- Providers and quality measurement organizations said the framework should undergo periodic review, perhaps annual or every three years.
- Providers, purchasers, quality improvement organizations, and quality measurement organizations said stakeholder feedback should be included in the evaluation of the framework.

## Keys to success or barriers/challenges to implementation

Nearly all stakeholder groups (providers, associations and patient advocacy groups, public health, purchasers, quality improvement organizations, and quality measurement organizations) said it would be important to continue gathering input from stakeholders, including those not involved in health care, such as patients and the public.

Nearly all stakeholder groups (providers, public health, health plans, purchasers, quality improvement organizations, and quality measurement organizations) cited the need for innovation and advancement in technology resources in order to create an efficient system of measurement. Such a system could allow for more streamlined data entry, extraction, reporting, and sharing.

- Providers, public health, purchasers, quality improvement organizations, and quality measurement organizations cited or described challenges with electronic medical records, including limited fields to enter data and that they vary widely across health systems.
- Providers, public health, health plans, purchasers, quality improvement organizations, and quality measurement organizations cited and described challenges with the current measurement and reporting infrastructure.
- Providers, public health, and quality improvement organizations mentioned desire to increase the ability to share data and challenges associated with data sharing.
- Public health and quality measurement organizations cited challenges specific to certain types of data, such as units of measure (e.g., the patient, the provider, the clinic, etc.) and people that do not access health care.

## Other considerations

Groups generally favored a broader scope of health versus focusing on health care alone for the framework. Purchasers said they liked the current focus on health care, though they also suggested expansions beyond current settings.

Most groups, including providers, health plans, purchasers, quality improvement organizations, and quality measurement organizations provided input on how measurement is connected to improvement. Collectively, they said measurement alone does not necessarily lead to quality improvement.

- Stakeholders (providers, quality improvement organizations, and quality measurement organizations) cited additional resources, such as payment models, dedication of internal resources, or providers dedicating time and effort to improvement as ways that measures can inform and drive quality improvement.
  - Providers, health plans, and quality improvement organizations suggested to the extent that measures influence payment structures, measures should be aligned with intended areas of quality improvement.

# Quality Framework: Internal Workgroup Input

MDH Draft 7/3/18

## Process

From March 26 through June 18, MDH convened three meetings of its internal workgroup that includes representation from the Minnesota Department of Health, Minnesota Department of Human Services, and Minnesota Management and Budget.

## Key findings

### Values and principles

- Values should be defined.
- Add a value of “Responsiveness”. The framework should respond to the needs identified by the community, and other external and internal stakeholders. Engaging in ongoing conversations with external and internal stakeholders is one way to implement the value of responsiveness.
- Equity is not clearly reflected in the principles.
- Consider including a principle to reflect the “accuracy and rigor” value, e.g., “A measurement system should accurately assess the quality of services by health care providers”
- It can be assumed that the current system probably strives toward these values. Now that federal measurement has made advances, are there places where certain areas or values are not covered? Are there gaps or areas we can work on as a state?

### Framework characteristics

- Include more than health care quality measurement in the framework. Within health care quality measurement, the framework should measure more than clinic and hospital quality, and it can measure clinic and hospital quality differently than it does now. There should be a way for the state to signal the new things that need attention without losing what already exists.
- With respect to the diagram, a vision statement is needed and there should be an “act/use” element (measurement occurs, then the data are used which helps inform measurement system and framework evaluation and evolution).
- Visualize the framework as a multi-dimensional web so that the framework can be actionable for different stakeholders.
- Build-in stakeholder feedback loops at multiple points, wherever data is involved.

### Health equity

- Quality measurement can help advance health equity by:
  - Measuring disparities (e.g. health literacy);
  - Translating data more effectively to both patients and providers;
  - Advancing population health by translating data to community health;

- Providing data analytics and technical assistance to communities; and
- Increasing responsiveness and utility to communities and stakeholders.
- The framework should include a clear statement of how it can serve individual communities.
- The framework and/or measurement system should provide information to health care providers about the value of the demographic information that is in a patient’s medical record which providers can use to advance health equity.

### Measures

- Population health
- Prevention
- Patient experience

### Stakeholder roles

- The framework is a multi-dimensional web that is actionable for different stakeholders. Not all stakeholders necessarily need to be involved in each part, and MDH could be the minder of the web to keep track of the big picture, and identify and communicate gaps.
- MDH should provide technical assistance and capacity building to data users (e.g., community groups, patient advocacy organizations, researchers, providers).
  - Communicating data in ways patients and providers can understand is such a huge challenge; we get hung-up on using technical correct language instead of plain language.
- Programs within MDH should figure out how to plug into the framework in terms of where programs are interacting with communities and providers.

### Implementation, maintenance, evolution

- In order to evolve, we need to be responsive, know that the data is used and is meaningful, and have a method for gap recognition. We need to think more about the methods of data collection, extraction, and aggregation—advancements that allow us to be more responsive and actionable in areas that need improvement.
- Engage in ongoing stakeholder conversations. Keep an open less-structured process so everyone can participate. This approach fosters implementation of the values “innovation” and “responsiveness”.

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# Quality Framework Stakeholder Panel Summary

**Date:** July 31, 2018

**Moderator:** Stefan Gildemeister, State Health Economist, Minnesota Department of Health (MDH)

**Panelists:**

- **Debra Burns**, Director of the Centers for Health Equity and Community Health, MDH
- **Dr. Rodney Christensen**, Vice President for Medical Operations in the Network Division, Allina Health; Representative of the Minnesota Medical Association's (MMA) Physician-Consensus Measures of Performance to Advance Quality and Safety Work Group
- **Dr. Kevin Larsen**, Enterprise Lean and Health IT Advisor, Centers for Medicare & Medicaid Services
- **Maiyia Yang, PhD**, Researcher at SoLaHmo Partnership for Health and Wellness

## Welcome

Mr. Gildemeister welcomed everyone to the call, introduced panelists, and explained that the session's intent was to:

- Provide space for additional discussion on input from various stakeholders in the development of the framework, and
- Allow panelists to share their own perspectives more broadly on the topic of health quality measurement.

## Discussion

**1. What is your connection to health quality measurement, what related initiatives have you been a part of, and what are the areas of alignment and difference with the quality measurement framework we are collectively developing for Minnesota?**

- **Ms. Burns:** Public health professional without explicit expertise in health care quality measurement, but involved in related conversations regarding how to align quality initiatives across public health, population health and the health care system to develop common direction and goals. Involved with National Quality Forum population health framework that developed a guide for health care organizations. Worked with Institute for Clinical Systems Improvement on global health measures. There is a need for alignment across all sectors that seek to improve health. This framework effort can help us move toward that.
- **Dr. Christensen:** Family physician with experience in clinics to foster improved performance on quality measures (state, national, internal priority measures).

- In Minnesota we deliver better care because we have pushed ourselves as a state and system to measure, benchmark, and be transparent. There is also tremendous waste in how we do quality measurement which diverts us from delivering improvements. As a state, we need to move toward measuring quality improvement topics that lead to better outcomes (i.e. functional outcomes, efficient care, equitable care) and matter to the population at the clinic, state or community level. We should use benchmarking to help ourselves improve and give people, patients, and buyers the ability to compare the quality of care we deliver.
- In terms of the MMA workgroup, we want to ensure that chosen measures have been proven valuable. There is tension with parsimony, because every measure has support. Additionally, there is lots of enthusiasm about population level measures, though they need clear purpose and accountability.
- **Ms. Yang:** Researcher with the Quality Measurement Enhancement Project; brings community perspective to the table.
  - As part of the Quality Measurement Enhancement Project, we held community listening sessions and asked community members to prioritize what quality primary care looks like. Quality health care is a concept that everyone wants, but there are different cultural definitions and social justice components. We should engage communities throughout the framework process.
- **Dr. Larsen:** Federal perspective from work with Centers for Medicare & Medicaid; experience helping to run the quality program for Meaningful Use. For Meaningful Use, we had lots of the same conversations you are having now for the framework.
  - Measurement is difficult and expensive; we want it to be cheap and easy. How does cheap and easy look in comparison to difficult and expensive?
  - How do we think about quality measurement at different levels (e.g., state, clinics, teams, consumers, etc.)? The challenge that Minnesota, other states and federal agencies are experiencing is to build a system for all levels at the same time, where perspectives are different. The National Committee for Quality Assurance is working on how to collect data, in a tech-enabled world, that makes sense for various levels of the system (physicians to health plans).
  - In this framework conversation, figuring out how to prioritize and connect different levels and purposes of measurement is key and important.

**2. What excites you about a statewide health quality measurement framework? What opportunities are there for you and your colleagues or communities? How might you/your organization/your members/your community use this framework? How could it be more useful to you?**

- **Dr. Christensen:** (1) Opportunity to measure in a way that causes us to think differently about the care we provide. A focus on larger, global functional outcome measures for people and populations that would force us to think more creatively about where we're not providing care. (2) Better aligning measures with outcomes that are useful to the intended audience.

- **Ms. Burns:** (1) The process being used in this framework development is a good, deliberate and stakeholder-focused approach. There are a lot of exciting opportunities presented in the values and principles; e.g., equity, connection and collaboration, actionable information, health is more than health care. Opportunity to think about measures (population health, social determinants of health, prevention) that have a broader impact on people's health. (2) There is an opportunity to think about aligning efforts on the part of many different kinds of sectors that are broader than health care measurements that would be in the quality measurement framework.
- **Ms. Yang:** (1) Opportunity to change how communities are engaged in the process. The community can provide input on defining and measuring quality, and evaluation and implementation policies that come out of the framework. (2) Opportunity to acknowledge and address social determinants of health and historical trauma, and to pay for services in those contexts. Space for positive change to help communities across Minnesota.

### 3. What concerns you about this new framework? What barriers do you anticipate?

- **Ms. Burns:** Cost and complexity. We want to keep a reasonable number of measures but also include those that relate to social determinants of health, prevention and other activities. We don't have an overall umbrella of measures or goals tied to measures that multiple groups have agreed upon to track quality and progress. It's impossible to do everything, so prioritization is key. We need to create a high level agreement under which measures can fall out.
- **Dr. Christensen:** We need to be held to a high level of evidence before endorsing a measure (i.e., it needs to be worth it). It's a continual learning process and it's hard to get consensus on what the evidence shows. In order to move to broader, more important measures, we need to have the guts to stop measuring what isn't working. We've experienced tremendous resistance to stopping measures.
- **Ms. Yang:** (1) Aligning and synchronizing perspectives of stakeholders and communities is a potential challenge. If the framework truly wants authentic community engagement, a potential barrier is not having community buy-in if community members do not see or experience the proposed change. (2) Concern about how individual physicians are being reimbursed based on quality measurements. (3) Concern that policies created from the framework may be misinterpreted to perpetuate structural inequities. It will be important to create a place in the process to reflect and improve on those potential negative consequences and also include the patient voice.

### 4. Dr. Larsen, you have seen a number of statewide quality measurement systems in various states of development and implementation. What lessons can we learn from other states as we develop our quality measurement framework in Minnesota, and what pitfalls should we avoid?

- Minnesota has been a leader, so the risk is to align with national measurement efforts that would lead to regression. Work on things like PHQ-9 and D5 have been groundbreaking and lead the country. Even though they're imperfect, we can learn from them. Minnesota also lead the charge for patient reported outcomes. Few states have

the kind of deliberation and broad stakeholder engagement and commitment to measurement that Minnesota has.

- Minnesota can learn from Oregon and Michigan. Oregon has a standing committee that continually reviews and thinks about measurement. Michigan took more of a business-oriented approach—health plans, payers, and others say what they are willing to pay for in a given year and this helps drive the measurement agenda.
- It's very expensive to create evidence for measurement and then create measurement. If the bar for evidence is high, the price tag will be high, and you will get few measures. Evidence created using scientific research investment often focuses on the majority and the middle. If what we care about is the minority and the edges (rare condition, population, age, etc.) we won't have a lot of evidence or pre-existing measurement.
- Open question—do we believe if we move the middle, everyone will move with it, or, do we work in the middle and at the edges?

## Steering Team Questions

**Jennifer Lundblad: I was struck by a number of panelists speaking directly or indirectly about a measurement system in Minnesota trying to be all things to all people. Any advice or elaboration on how to be inclusive and comprehensive but also targeted and actionable, and how to balance the tension?**

- **Dr. Christensen:** One approach is to use patient-reported outcome questions where anyone could participate, and parse it by social determinants of health (e.g., age, race).
  - **Dr. Larsen:** “Healthy Days” measure. In the last 30 days, how many days were healthy? The question is defined by the person and takes their context into account.
- **Dr. Larsen:** Articulate the tension that you have and build tests around that tension. For example, if you want a measure that includes a lot of people, meeting the needs of diverse voices, have that as a goal. Test and try.
- **Dr. Christensen:** Everyone would like to address equity issues and the social determinants of health. A barrier is the reluctance to get that social determinant of health data that's needed to address it. We need to persuade individuals and communities to provide that information on the basis that it will be used for good.



## Framework Development: Progress and Remaining Work

Goal: A system of measurement that fosters improvement in health outcomes, health care quality, health equity, patient experience, and population health, and reduces costs for patients, providers, and purchasers

Phase 1 Progress <i>March – August 2018</i>	Phase 2 Remaining Work <i>6-12 months</i>	Framework Implementation Steps <i>2020 and beyond</i>
We have articulated <b>values</b>	<ul style="list-style-type: none"> <li>• Incorporate <b>additional recommendations</b> from stakeholders</li> <li>• Identify <b>for whom</b> measurement should matter</li> <li>• Develop criteria for making measurement <b>actionable</b></li> <li>• Articulate thoughts on how to resolve tensions between <b>efficiency, simplicity and transparency</b></li> </ul>	<ul style="list-style-type: none"> <li>• Stand-up framework stewardship structure</li> <li>• Implement approach to community and patient engagement at all levels of decision-making</li> <li>• Specify improvement goals across clinical, population health, public health, and equity dimensions</li> </ul>
We have developed <b>guiding principles</b>	<ul style="list-style-type: none"> <li>• Explore approaches for identifying what measurement is <b>most important</b></li> <li>• Identify <b>potentials for unintended consequences</b></li> </ul>	<ul style="list-style-type: none"> <li>• Identify measurement domains, including by capturing overarching concepts</li> </ul>
We have decided that measurement is <b>more than clinical care</b>	<ul style="list-style-type: none"> <li>• <b>Name the clients</b> of the framework and identify their needs</li> </ul>	<ul style="list-style-type: none"> <li>• Select measures and specify the uses</li> <li>• Explicitly consider the potential for winners/losers with measurement</li> </ul>
We have decided that measurement must be subject to <b>ongoing evaluation</b>	<ul style="list-style-type: none"> <li>• Articulate the <b>structure and components</b> of an evaluation plan</li> </ul>	<ul style="list-style-type: none"> <li>• Identify measurement frequency and method</li> <li>• Report out measure results, after aligning with intended uses and making necessary adjustments</li> </ul>
We have determined that the <b>stewardship process</b> should be trusted, transparent, and able to include all perspectives	<ul style="list-style-type: none"> <li>• Discuss a possible <b>structure for framework stewardship</b> and resource needs</li> <li>• Identify <b>accountability</b> paths for framework implementation</li> <li>• Articulate a draft roadmap for implementation under <b>political, operational, system power, and resource realities</b></li> <li>• Consider which <b>roles</b> should be outside stewardship, i.e. be independent of it (e.g., evaluation?)</li> </ul>	<ul style="list-style-type: none"> <li>• Develop process for acting on measurement results to advance quality improvement (e.g., resources, training, roles, etc.)</li> <li>• Establish process for assessing measurement impact (e.g., data, window of measurement, criteria) and alignment with our vision</li> <li>• Evolve measures (e.g., criteria for removing measures and new measurement)</li> </ul>