

# Minnesota Framework for Health and Health Equity Measurement and Improvement

*This document reflects input from the Steering Team and Model Workgroup to-date.*

## Context and Opportunity

Minnesota is a national leader on many fronts, with our exemplary public health system, our commitment to advance health equity<sup>1</sup>, the quality of our health care, and the many ways communities across the state contribute to physical and mental health<sup>2</sup> and well-being. Notably, for years we have measured and reported various aspects of clinical and hospital quality, and have collectively developed a standardized statewide approach to measurement.

Minnesota, however, also faces daunting challenges. We have increasing chronic disease rates, rising health care costs, an aging population, and economic and social conditions that often work against our efforts to assure a healthy population. We have persistent disparities in health outcomes that are rooted in inequities related to geography, housing, income, and education. We see gaps in health outcomes according to race, sexual orientation, gender identity, disability, other factors, and the intersectionality of these characteristics.<sup>3</sup> When compared to the rest of the country, our racial disparities stand out in particular. Data demonstrate that health outcomes in Minnesota are consistently worse for American Indians, African-Americans,

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

<sup>2</sup>Health has many meanings; people and communities may perceive health quite differently. Health sometimes is described as a condition in which someone or something is thriving or doing well. More than a condition of individuals, however, health means being in safe, stable, and nurturing environments and relationships, sharing in the shaping of society's structures, and experiencing with our families and communities our best possible physical, mental and social well-being. (Minnesota Department of Health. (2019). *Healthy Minnesota Partnership Emerging Narrative*. Saint Paul, MN).

<sup>3</sup>"Intersectionality" refers to the complex, cumulative way in which the effects of multiple forms of discrimination (such as racism, sexism, and classism) combine, overlap, or intersect especially in the experiences of marginalized individuals or groups.

and persons of Latinx, Asian Pacific Islander, Middle Eastern, and African descent than for those of European heritage.

Many communities, systems, and individuals in Minnesota are working hard to improve health and well-being; but it is difficult to know if these efforts are making a real difference. Measurement is a potentially powerful tool for identifying inequities in physical and mental health status; assessing the quality of health care and social services; and making systems transparent and accountable for health outcomes. However, the current consensus is that our measurement systems today do not help us use information in the right way and do not provide us with the information essential to improving the health of the state. We question whether we are measuring what matters and using the data we collect to focus our actions on what will improve health.

Our state has the opportunity to create a measurement framework that expands beyond health care and looks at health broadly, and is capable of truly driving health improvement and health equity advancement in Minnesota. This framework reflects the vision, values, and principles of and approach to health measurement that people across the state expressed in response to a request from the Minnesota Legislature to develop a measurement framework for a healthier Minnesota.

## Vision

To drive action to improve physical and mental health and well-being for all people in Minnesota, the health and health equity measurement and improvement framework will measure health outcomes and the conditions and factors that influence them, and provide information on the extent to which efforts to improve health and advance health equity are making a real difference in peoples' lives. The framework will engage a variety of partners and foster the cross-sector collaboration needed to better address Minnesota's health and well-being challenges.

## Using the Framework

People and organizations who use this framework may identify health priorities, develop equity targets, and select existing measures and develop new measures to achieve health and equity improvement goals across the measurement areas. The design of this framework intends to assist users in linking the quantitative and qualitative information produced across the measurement areas to form a more holistic picture of health and health inequities.<sup>4</sup> In effect, users will have the opportunities to attain and apply new knowledge to their efforts to improve

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<sup>4</sup>Quantitative and qualitative data are essential to understanding health outcomes and inequities. Quantitative data are those that express their results in numbers. They tell us the "who, what, where, when, how many, how much, or how often." Qualitative data yield results that cannot easily be measured by or translated into numbers. They tell us "the how and the why" and bring to life the "real" experiences of people. (Minnesota Department of Health. (2018). *HEDA: Conducting a Health Equity Data Analysis*. Saint Paul, MN).

health and advance health equity. Framework implementation will be iterative and the model will evolve based on what is learned.

People and organizations may use the framework to:

- Spark a broad change movement at multiple levels (including, but not limited to communities, organizations, coalitions, the state) by holistically measuring health and health factors;
- Advance equity and reduce disparities;
- Measure, track, and report progress and performance in order to identify unmet needs and focus areas for improvement efforts;
- Incentivize action, investment, engagement, and accountability; and
- Establish goals for performance and improvement.

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

- Collaborations and coalitions;
- Communities and advocates;
- Public health organizations and researchers;
- Nonprofit and philanthropic organizations;
- Health care and social service providers;
- Purchasers of health care, including health plans, employers, and individuals;
- Payers of social services;
- Employers;
- State and local government, including the Minnesota Department of Health, the Minnesota Department of Human Services, counties, and municipalities; and
- Elected officials and policymakers.

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

- As people or organizations who will or might use the framework;
- As people, representatives of communities and organizations, and experts who may inform the ongoing maintenance and evolution of the framework model; and
- As members of the governance body that the Minnesota Department of Health convenes to implement and evolve this framework.

## Values and Principles

These values and principles will guide decision making for the framework and could guide associated collaborative efforts and partnerships. The values are qualities that are fundamental to how health will be measured, and the principles are core assertions that will serve as the foundation for decision making.

### Values

1. **Equity.** The framework intentionally advances equity through the measurement of social, cultural, and structural conditions that create health.
2. **Fairness, accuracy, and rigor.** The framework will foster fair, accurate, and robust quantitative and qualitative measurement of the people, systems, and conditions that contribute to health outcomes.
3. **Connection, collaboration and inclusivity.** The framework will be used to connect interested parties on an ongoing basis, and foster authentic cross-sector collaboration and communication especially with communities most impacted by health disparities. Authentically collaborating and communicating with communities involves the intentional process of co-creating solutions to inequities in partnership with people who best know—through their own experiences—the pathways and barriers to health.
4. **Measurement for improvement.** The framework recognizes that measures hold different meaning for different people, and that quantitative and qualitative measure data have the power to transform communities. Health data also have the potential to harm communities, and awareness and caution are needed to avoid the negative, unintended consequences of measurement. The framework will elevate measurement that is meaningful to health care and social service recipients, and produce understandable and actionable information for framework users, systems, and communities to improve health. It will measure assets as well as identify gaps and challenges.
5. **Transparency and simplicity.** Information about the framework, priorities, and measures will be easily accessible and understandable for various audiences.
6. **Accountability.** The framework acknowledges that policies, systems, and social, cultural, and structural factors influence health outcomes. Users of the framework will clarify the roles, responsibilities, and accountabilities among interested parties to shape measurement and drive health improvements.
7. **Dynamic and responsive.** The framework will respond to the health needs and priorities of interested parties, including communities most impacted by health disparities, through ongoing learning, evaluation, and evolution that enables the framework to proactively adapt to changing needs and priorities. The framework will promote innovation, and encourage flexibility and experimentation to cultivate new ideas in measurement and health improvement (for example, including the patient and beneficiary voice in measurement, leveraging technology, and developing collaborations).

## Principles

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

## Health Priorities, Equity Targets, and Measurement Areas

The framework for health and health equity measurement includes four measurement areas: policy environment; social, cultural and structural; health care and social services; and outcomes. These measurement areas provide a robust view of the broad range of conditions and factors that influence health and health outcomes, opportunities to identify what is and is not working to improve people's health, and where disparate health outcomes may be reduced or eliminated.

- The **policy environment** area measures national, state, local, and other policies related to advancing or constraining our ability to achieve health.
- The **social, cultural, and structural** area measures such conditions and factors that influence health.

- The **health care and social services** area measures access, affordability, quality, safety, and expectations and experiences of services.
- The **outcomes** area measures health and well-being outcomes.

The table below shows the four measurement areas and provides illustrative examples of subareas and measures that could be tracked for a given health priority and equity targets. Measures will have various data sources, and will be reported and analyzed at different geographies for populations of interest. Some measures may be linked to state and federal health improvement initiatives and reporting requirements. Framework users may select existing measures and they may develop new measures to meet their needs.

### Measurement Areas

Health priority and equity advancement targets			
<p><b>Policy environment</b></p> <ul style="list-style-type: none"> <li>▪ <b>Federal</b> <i>(Medicaid, Affordable Care Act, Americans with Disabilities Act, pollution control standards, earned income tax credits)</i></li> <li>▪ <b>State</b> <i>(paid parental leave, minimum wage, pollution control standards)</i></li> <li>▪ <b>Local</b> <i>(paid parental leave, indoor air, dementia/aging-friendly communities)</i></li> <li>▪ <b>Other</b> <i>(corporate, policies of paid parental leave, paid sick leave)</i></li> </ul>	<p><b>Social, cultural, and structural</b></p> <ul style="list-style-type: none"> <li>▪ <b>Public engagement and belonging</b> <i>(social isolation, sense of community)</i></li> <li>▪ <b>Social environment</b> <i>(racism and exposure to racism, safety, poverty)</i></li> <li>▪ <b>Socio-economic</b> <i>(housing, education income, employment)</i></li> <li>▪ <b>Physical, natural and built environment</b> <i>(walkability, transportation, housing, access to healthy food, parks and recreation utilization water quality, air quality, accessibility)</i></li> <li>▪ <b>Community partnerships</b> <i>(health care benefit agenda, local health initiatives)</i></li> <li>▪ <b>Cultural factors</b> <i>(food beliefs and diet, gender roles and relationships, spirituality)</i></li> <li>▪ <b>Access to information</b> <i>(freedom of information)</i></li> </ul>	<p><b>Health care and social services</b></p> <ul style="list-style-type: none"> <li>▪ <b>Access to services</b> <i>(health care, mental health, dental, health insurance, housing assistance, SNAP benefits)</i></li> <li>▪ <b>Affordability of services</b> <i>(health care, mental health, dental, health insurance)</i></li> <li>▪ <b>Health care collaboration</b> <i>(health care use of framework)</i></li> <li>▪ <b>Social service collaboration</b> <i>(social service use of framework)</i></li> <li>▪ <b>Quality of services</b> <i>(health care, mental health, dental, health insurance, housing assistance, SNAP benefits)</i></li> <li>▪ <b>Patient/recipient/beneficiary experience of services</b> <i>(patient experience survey, expectations of services)</i></li> </ul>	<p><b>Outcomes</b></p> <ul style="list-style-type: none"> <li>▪ <b>Physical, mental, and social health and well-being</b> <i>(mental health status, functional status, mortality, birth weight, chronic condition rates, education, employment)</i></li> </ul>

DRAFT FOR DISCUSSION

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*To obtain this information in a different format, call: 651-201-3550.*

# Measurement Framework Model: Updates

*This document describes the revisions MDH staff made in response to the feedback the Steering Team provided during the November meeting. Staff also made some revisions to streamline content.*

## Overall

- Specified that health includes physical and mental health.
- Context and Opportunity
- Defined health and health equity in footnotes.
- Added aging to “daunting challenges”.
- Added that we have an opportunity to advance health equity through action.
- Added that we do not make the best use of the health measure information we have.
- Added emphasis that the new measurement framework helps us shift from a narrow focus on health care measurement to health measurement broadly.

## Using the Framework

- Moved this section earlier in the document.
- Defined quantitative and qualitative data in footnote.
- Transferred content from the governance charter to clarify framework uses, users, and types of collaboration.
- Added purchasers as users.
- Added that the implementation process will be iterative and users can link the information produced across the measurement area to form a more holistic picture of health and inequities.
- Clarified that framework users may choose to use existing measures or develop new ones.

## Values and Principles

- Added an introductory statement to explain what these are.
- Revised the “responsiveness” value to “dynamic and responsive.”
- Revised Principle 5 (formerly 1) to continue to expand the scope beyond health care and added a reference to “unconscious bias”.

## Health Priorities, Equity Targets, and Measurement Areas

### Social, cultural and structural measurement area

- Changed name from “drivers of health”.
- Added “racism and exposure to racism,” “transportation,” and “housing” examples to the “physical, natural and built environment” subarea.
- Added “socio-economic” subarea.

### Health care and social services measurement area

- Added “expectations of services” to the “patient/recipient/beneficiary experience of services” subarea.

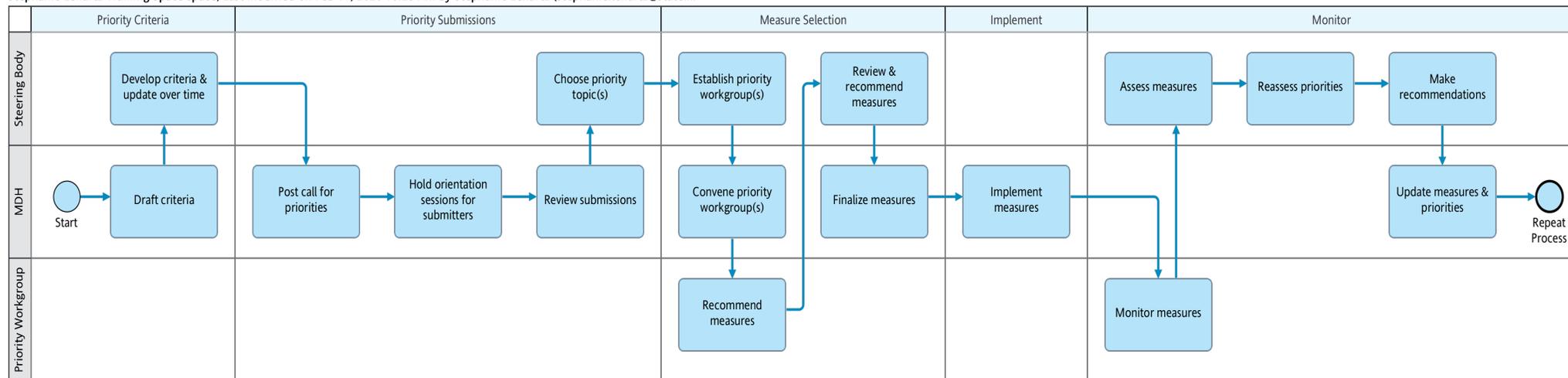
## MODEL UPDATES

### **Outcomes measurement area**

- Changed “health and well-being” subarea name to “physical, mental, and social health and well-being”.

# Statewide Priority Selection and Implementation Process

Measurement Framework Implementation (ID: 209e398157) <https://us001.blueworkslive.com/scr/processes/209e398157>  
 Stephanie Lenartz Training Space space, Last modified on Feb 11, 2020 10:28 AM by Stephanie Lenartz (stephanie.lenartz@state....)



# Minnesota Framework for Health and Health Equity Measurement and Improvement Steering Body Charter

UPDATED 02/05/2020

## Vision

To drive action to improve physical and mental health and well-being for all people in Minnesota, the health and health equity measurement and improvement framework will measure health outcomes and the conditions and factors that influence them, and provide information on the extent to which efforts to improve health and advance health equity are making a real difference in peoples' lives. The framework will engage a variety of partners and foster the cross-sector collaboration needed to better address Minnesota's health and well-being challenges.

## Overview

The Steering Body is a group of cross-sector, cross-community stakeholders who play a critical advisory role in the development and implementation of the Minnesota Framework for Health and Health Equity Measurement and Improvement (measurement framework model). This group will provide insight, advice, and recommendations to MDH on various aspects of the measurement framework model and its ongoing evolution.

## Charge

The charge of this Steering Body is to oversee the ongoing implementation, evaluation, and maintenance and improvement of the health and health equity measurement and improvement framework. The Steering Body will provide knowledge and insight, and promote equity and inclusion.

Responsibilities of those serving on the Steering Body include, but are not limited to, the following:

### Implementation:

- **Priorities:** Assist with the Priority Submission Process by developing criteria for selection, reviewing and considering all health priority submissions, and selecting health priorities for recommendation to the Commissioner.
- **Measures:** Identify and recommend health and health equity improvement measures by establishing workgroups and leveraging workgroup input on measure identification and selection, developing criteria for choosing measures, and monitoring and interpreting measure effectiveness. Once measures have been selected, the Steering Body will also be responsible for suggesting goals and targets for health and health equity improvement.

- **Communication, Promotion, and Use:** The Steering Body will oversee, approve and participate in plans for communicating and disseminating the framework. Members will share their learnings about use of the framework for health improvement efforts of their own organization and partnerships. In addition, the Steering Body will report on progress made by those utilizing the measurement framework.

**Evaluation:**

- Review the measurement framework on an ongoing basis to ensure that it is up-to-date and evolves to reflect changes in evidence, the political environment, and the status of health and health equity in Minnesota.
- Inform a plan for external evaluation of the measurement framework.

**Maintenance and Improvement:**

- Review the results of external evaluations of the framework and lead associated improvement efforts.
- Ensure that, to the extent possible, the framework effectively leverages a solid evidence base, emerging research, and relevant expertise.
- Update and/or maintain the framework as needed.

## Roles and Responsibilities of MDH

MDH is accountable for the continued development and implementation of the framework. Roles MDH may assume include, but are not limited to, the following:

- Partner and co-creator in the continued development of the measurement framework model;
- Leader in broad implementation of the framework;
- Framework user to guide and prioritize the work of MDH;
- Regulator for any measures mandated through the Statewide Quality Reporting and Measurement System; and
- Member(s) of Steering Body.

**Responsibilities:**

- Host and convene all Steering Body meetings (including any workgroups that emerge);
- Provide orientation to members of the Steering Body and its workgroups;
- Provide appropriate resources and staff support (e.g., project management support, technical assistance, research, etc.);
- Host training opportunities for Steering Body members to build skills and capacity in data, measurement, community engagement, presenting complex data and measurement concepts to general audiences;
- Respect and honor the Steering Body's recommendations and advice to the fullest extent possible;

- Create connections to other groups, projects, and coalitions that relate to and enhance the measurement framework model.

## Membership

### Representation

Members of this Steering Body will be selected to represent particular perspectives and communities, including various stakeholder types, specific communities most impacted by disparities, and different levels of the public sector. Steering Body members are expected to speak from a community perspective, authentically connect with members of communities most impacted, and engage those who are translating information to action.

### Desired skills and experience

Those serving on this Steering Body and its subcommittees are to reflect the communities and people who will use the framework and will be impacted by its implementation. Given that priorities for measurement will change over time, the members of the Steering Body and those consulted are expected to change in order to reflect the diversity of those touched by and knowledgeable of the priorities.

This group should include some individuals with experience and/or expertise in data, measurement, evaluation, and/or evidence.

### Conflicts of interest

All Steering Body members are required to report any potential conflicts of interest at the outset of their term, at which point MDH will review them and determine what, if any, steps are required to address such conflicts. Additionally, Steering Body members are expected to report any potential conflicts of interest that arise during their term.

### Expectations

All members are expected to:

- Participate fully in Steering Body meetings, review and prepare meeting materials ahead of time, be prepared to contribute clear focused ideas for discussion, and participate in follow-up as needed;
  - Attend at least 75% of Steering Body meetings (either in-person or remotely);
  - If unable to participate in meetings or activities, Steering Body members are to ensure a designated alternate attends and/or provide written or verbal comments to the co-chairs in advance of any meeting;
- Participate in workgroups;
- Bring the perspective(s) of those they are representing to all discussions and recommendations, as well as additional constructive perspectives; and

## STEERING BODY CHARTER

- Uphold the agreements in Appendix 1 or as modified.

Participation on the Steering Body will require a substantive time commitment. Details of this commitment will be forthcoming based on the phase 3 process design and arc of work.

### Terms

- Once Steering Body members are selected, they will be expected to serve a term of two years, with an option to extend. An individual may serve no more than two consecutive terms.
- Representatives' term completion dates will be staggered to promote continuity and facilitate effective orientation of new members.

### Structure

- Broad Steering Body.
- Workgroups are subcommittees of the broader Steering Body that are open to non-Steering Body members and are responsible for guiding specific work as needed.
- Consultative experts may be invited and/or groups may be formed to bring in expert voices on particular topics or objectives. Community voices and perspectives will be considered experts in the needs and interests of the communities they represent and will be included in this Steering Body accordingly.
- Meeting will be open to all and attendees will have an opportunity to participate in all or parts of the meeting.

### Timeline

- Meeting frequency will be revisited following initial implementation of the framework.

### MDH contacts

TBA

## Appendix 1. Steering Body Agreements

### Mindset

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

### Verbalizing

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

### Preparedness

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

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