

Measurement Framework

STEERING TEAM AGREEMENTS

Mindset

- Our work is on behalf of Minnesota's citizens, 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.

Measurement Framework Steering Team

ROSTER 2019

Members

Bill Adams, Community/patient member

Representing: Rural community and patient perspectives

Graham Briggs, Director of Public Health Services, Olmsted County Public Health

Representing: Public health perspective

Ellen De la torre, Chair, Rural Health Advisory Committee

Representing: Rural community and patient perspectives

Marie Dotseth, *Steering Team Co-Chair*, Assistant Commissioner, Minnesota Department of Health

Representing: Minnesota Department of Health

Renee Fraundienst, Public Health Division Director/Community Health Services Administrator, Stearns County Public Health

Representing: Public health perspective

Olivia Jefferson, Safety Net Programs Director, Greater Twin Cities United Way

Representing: Communities most impacted by health inequities perspective

Courtney Jordan Baechler, Assistant Commissioner, Minnesota Department of Health

Representing: Minnesota Department of Health

Lisa Juliar, Engagement Specialist/Patient Partner, Minnesota Alliance for Patient Safety

Representing: Communities and patients most impacted by health inequities perspectives

Maiyia Yang Kasouaher, Independent Research Consultant, SoLaHmo Partnership for Health and Wellness at Minnesota Community Care; Community Engagement Lead, Program in Health Disparities Research, University of Minnesota

Representing: Communities most impacted by health inequities perspective

Scott Keefer, Vice President, Public Affairs, Blue Cross and Blue Shield of Minnesota

Representing: Blue Cross Blue and Shield of Minnesota, and health plan perspectives

Rahul Koranne, Chief Medical Officer, Minnesota Hospital Association

Representing: Minnesota Hospital Association and health system perspectives

Deb Krause, Vice President, Minnesota Health Action Group

Representing: Minnesota Health Action Group and health care purchaser perspectives

Deatrick LaPointe, Independent Consultant

Representing: Digital health solutions to advance health equity

Jennifer Lundblad, *Steering Team Co-Chair*, President and Chief Executive Officer, Stratis Health

Representing: Stratis Health and health care quality improvement perspective

MEASUREMENT FRAMEWORK STEERING TEAM

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Representing: Public health perspective

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Representing: American Indian health perspective

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Representing: Public health perspective

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Representing: Minnesota Department of Health

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Representing: Health care and safety net provider perspectives

Janet Silversmith, Chief Executive Officer, Minnesota Medical Association
Representing: Minnesota Medical Association and health care provider perspectives

Julie Sonier, President, MN Community Measurement
Representing: MN Community Measurement and health care quality measurement
perspectives

Marcus Thygeson, Chief Health Officer, Bind On-Demand Health Insurance
Representing: Health plan perspective

Tyler Winkelman, Clinician-Investigator, Hennepin Healthcare
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A Measurement Framework for a Healthier Minnesota

PROJECT NARRATIVE

The urgency of our situation

Minnesota is a national leader on many fronts, with our exemplary public health system, our commitment to advance health equity, the quality of our health care, and the many ways communities across the state contribute to health and well-being.

Minnesota, however, also faces daunting challenges, especially persistent disparities in health outcomes that are rooted in inequities related to race, income, education, and geography. We have increasing chronic disease rates, rising health care costs, and economic and social forces that often work against our efforts to assure a healthy population.

Many people in Minnesota are working hard to improve health and wellbeing. But how can we know if our efforts are making a real difference? Do we measure what matters? Are we using the data we do collect to focus our actions on what will help Minnesotans be healthier? Do our measures let us know if we are doing the right things?

A meaningful measurement system

Measurement is a potentially powerful tool for identifying and addressing inequities in health status; assessing and improving the quality of health care; curbing costs; making systems transparent and accountable for health outcomes; and focusing action on the places where it can make a real difference.

The current consensus is that our measurement systems today do not provide us with the information essential to improving the health of the state. We need a new approach.

The Minnesota Department of Health (MDH) and stakeholders envision a new measurement framework that helps us set and achieve health improvement goals, and yet is broad enough to include key metrics in public and population health, measures of health care quality, and indicators of healthy system performance.

The design process

In 2018, stakeholders and MDH honed a set of values and principles to serve as a foundation for designing a new measurement framework for a healthier Minnesota. Those values include fairness, connection, rigor, innovation, transparency, and efficiency.

In 2019, MDH will continue to engage with stakeholders to develop a stewardship—or “governance”—structure that, in 2020 and beyond, will make important decisions with MDH about framework goals, priorities, measures, and activities. This new measurement framework

will emphasize the importance of being strategic in decision-making, and clear about the roles and responsibilities of communities, patients, public health and health care practitioners, organizations, and policy makers.

The opportunity

Our state has the opportunity to create a measurement framework capable of generating meaningful answers to the urgent questions we face about health in Minnesota. The goals of this effort are to imagine and design a framework that is flexible, expandable, and responsive to changing needs and priorities. Following the establishment of a stewardship structure, the framework development and implementation process will include organizing the measurement system around explicit health improvement goals. The design will reflect the evidence about what creates health and what has the potential to improve health. The responsibility for collecting measures will engage multiple sectors.

The benefits

As stakeholders come together to design a measurement framework for a healthier Minnesota, one that will lead to shared accountability and aligned action for meaningful and measurable health improvements, they will benefit in many ways:

- Having a say in the development and design of the framework means that **communities** and **patients** can assure that the measurement system reflects real needs and creates real opportunities for positive change.
- **Public health departments** can use the measures to inspire new and existing partnerships by aligning collaborative efforts that protect and improve the public's health.
- **Advocacy organizations** can lift-up meaningful information on health across the state to leverage resources and improve public policy for health.
- Meaningful and actionable data will allow **health care systems** and **practitioners** to monitor and make improvements in care quality, with confidence that a few, carefully selected measures reflect clearly defined system goals.
- **Health plans** and **purchasers** can use meaningful quality measures to support health through care coverage.

More information

For more information about this initiative and the results of the first phase of framework development, please visit the [Measurement Framework webpage](https://www.health.state.mn.us/data/hcquality/measfrmwk) (<https://www.health.state.mn.us/data/hcquality/measfrmwk>).

Measurement Framework Development: Progress and Remaining Work

Phase 1 Progress <i>March – September 2018</i> WE HAVE...	Phase 2 Expected Accomplishments <i>6-12 months</i> WE WILL...	Phase 3 Sample Implementation Activities <i>2020 and beyond</i> WE WILL...
Articulated values	<ul style="list-style-type: none"> ▪ Identify for whom measurement should matter ▪ Develop criteria for making measurement actionable ▪ Identify tensions 	<ul style="list-style-type: none"> ▪ Establish system goals, including improvement goals across clinical, population health, public health, and equity dimensions
Developed guiding principles	<ul style="list-style-type: none"> ▪ Propose approaches for identifying what measurement is most important ▪ Identify potentials for unintended consequences ▪ Establish system vision 	<ul style="list-style-type: none"> ▪ Make recommendations on how to resolve tensions between efficiency, simplicity and transparency
Used an intentional process to create values and principles, and include broad stakeholder input and community voice	<ul style="list-style-type: none"> ▪ Collect and incorporate additional recommendations from stakeholders ▪ Make recommendations on how to continue a transparent, inclusive process that includes broad stakeholder input and patient/community voice ▪ Draft a communications plan to disseminate information out to and receive feedback from stakeholders 	<ul style="list-style-type: none"> ▪ Set parameters for measurement, including measure selection criteria, specifying intended uses for measure data, conducting burden and benefit analyses ▪ Continue and potentially adjust a process for ongoing stakeholder input to inform measurement system activities
Determined that the stewardship process should be trusted, transparent, and able to include all perspectives	<ul style="list-style-type: none"> ▪ Develop models for organization structure that will assist MDH in implementation, identifying strengths, weaknesses, and resource needs for various approaches ▪ Determine the need and shape of organizational structure that will make decisions about implementation activities, improvement goals, workgroups, and recommendations to MDH and, as appropriate, the Legislature ▪ Clarify roles, responsibilities, and accountabilities among policy makers, patients, health care organizations and clinicians, and others 	<ul style="list-style-type: none"> ▪ Implement an approach to community and patient engagement at all levels of decision-making ▪ Stand-up a framework stewardship structure ▪ Develop processes for evaluating the measurement system as guided by the framework and evolving the system over time
Decided that: <ul style="list-style-type: none"> ▪ measurement is more than clinical care and ▪ the Quality Reporting System exists as a subset of the envisioned system and will evolve within it 	<ul style="list-style-type: none"> ▪ Name framework users and identify their needs ▪ Make recommendations to guide the measurement of health and health care, including how to measure on different levels and across systems of care, at the population/neighborhood level, and more. 	<ul style="list-style-type: none"> ▪ Respond to legislatively-mandated criteria, including alignment with other measurement initiatives
Decided that measurement must be subject to ongoing evaluation		<ul style="list-style-type: none"> ▪ Draft an evaluation plan

Note: The Quality Framework Steering Team developed this summary to identify Phase 1 accomplishments, and articulate Phases 2 and 3. The remaining work will evolve as we continue to develop the framework.
 Source: Adapted from “A Measurement Framework for a Healthier Minnesota”.

Measurement Framework Steering Team

MEETINGS AND OBJECTIVES

Meetings

Meeting 1

Date: June 28

Time: 9:00-12:00

Place: Orville L. Freeman Building, B144

Meeting 2

Date: July 29

Time: 1:00-4:00

Place: HIWAY Federal Credit Union, 840 Westminster Street, St. Paul, MN 55130

Meeting 3

Date: September 16

Time: 1:00-4:00

Place: HIWAY Federal Credit Union, 840 Westminster Street, St. Paul, MN 55130

Meeting 4

Date: November 18

Time: 1:00-4:00

Place: HIWAY Federal Credit Union, 840 Westminster Street, St. Paul, MN 55130

Telephone access

1-888-742-5095

933-209-2697#

Objectives

Meeting 1: June

- Introduce measurement framework project
- Develop framework mission and vision
- Refine values and principles
- Introduce existing measurement framework models

In-between meetings

- Undertake guided review of selected models

Meeting 2: July

- Compare and discuss framework models
- Identify desired features of a Minnesota measurement framework

In-between meetings

- Prepare for governance structure discussion

Meeting 3: September

- Develop a governance structure that will make decisions about framework implementation activities, improvement goals, workgroups, and recommendations for consideration by MDH and/or the Legislature
- Draft a governance charter

In-between meetings

- Prepare to finalize framework component recommendations to MDH

Meeting 4: November

- Finalize framework component recommendations to MDH: mission, vision, values and principles, model, measure criteria, and governance structure and charter

Figure 1. Emerging Health Quality Measurement Framework Values and Principles

VALUES

The Minnesota Quality Framework fosters:

1. Fairness and equity
2. Connection and collaboration
3. Measurement that matters
4. Actionable information
5. Improvement
6. Accuracy and rigor
7. Innovation
8. Transparency and simplicity
9. Efficiency

PRINCIPLES

1. Health is more than health care, and a measurement framework should recognize this by:
 - a. Linking up with overarching concepts of quality (e.g., safety);
 - b. Incorporating and appropriately accounting for provider, system, community, cultural, and patient factors that contribute to variation in quality measure results; and
 - c. Exploring 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 health outcomes, health care quality, health equity, patient experience, and population health, and reduction in costs for patients, health care providers, and purchasers.
3. Quality measurement should be patient-centered and produce information that is meaningful, fair, transparent, and actionable for different stakeholders (e.g., patients, health care providers, health plans) in different ways (e.g., decision-making, public reporting, internal improvement, value-based purchasing). Measures do not need to be used by all stakeholders for all purposes.
4. Quality measurement in Minnesota should be parsimonious, appropriately balance value for stakeholders with reporting burden, and not duplicate other efforts.
5. Minnesota must measure what is most important; a measurement framework should provide cohesiveness and alignment around what is important.
6. The quality framework should be regularly monitored and updated via an inclusive, transparent process to ensure it meets goals.

Measurement Framework Values and Principles

PHASE 1 STAKEHOLDER FEEDBACK

Suggested additional values and principles for consideration

Values

- **Access to health 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 measurement framework.
- **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.

Principles

- Add a corresponding principle to complement the “accuracy and rigor” value, e.g., “A measurement system should accurately assess the quality of services by health care providers.”

Measurement Framework: Values, Principles, Governance, Vision, and Mission

IDEAS FROM STEERING TEAM MEMBERS IN ABSENTIA

Values and principles

Clarifications

Clarify what we mean when we're talking about health equity and health.

Tensions

Tension between concepts of health and health care. It is important to be clear up front that this is a question of “both/and” – not “either/or”.

There is a lot of oversimplification of the debate about how much health care contributes to health versus other factors and little to no basis for the commonly cited figure of 10%.

The tensions of wanting a transparent and simple measurement framework, with the inherent complexity of measurement science. The framework will serve different stakeholders—make the “front of the house” simple and have the sophisticated econometrics in the “back of the house”.

Tension of innovation in measurement and alignment with existing measures. Innovation and minimizing burden in measurement do not need to be mutually exclusive.

Tension of structure and flexibility.

Tension of measuring in the middle and measuring at the tails.

Tension of big government versus small government approach.

Tension of standardization and recognizing reasonable variation.

Other

Unclear if order of values is intentional, but I like that “fairness and equity” come first. As a state, we have high quality health care, but our racial disparities are horrendous. Whatever we are currently measuring and incentivizing are not having any influence on disparities. Without fairness and equity being central to the values of a new measurement system, we won't make any headway.

Principle #6 is critical. “The quality framework should be regularly monitored and updated via an inclusive, transparent process to ensure it meets goals.” Ongoing monitoring can help us identify something that may become a problem and intervene before it gets to a worse level. Measurement cannot just be reactionary, must be proactive as well.

Need assurance that when we measure something, we are in fact measuring the thing that we think we are measuring.

Governance

A substantial investment in infrastructure and personnel are needed to make the measurement framework work. A paid central infrastructure team is crucial to ensure an ongoing feedback mechanism and the ability to respond quickly to new data. Communities most impacted by health disparities must be at the table, and must be financially compensated for their involvement and contributions; this cannot be a coalition of those with the most resources and most to lose in defending their turf. There would be a risk of this happening without a central body.

A governance structure gets at idea of evidence-based policy making. Ultimately, set a health goal, measure it, and if we're not hitting the target, we need to recalibrate. In order for all of this to happen, there needs to be very clear goals reliable measurement, and the will to make potentially radical changes if priorities are not met. There needs to be a real commitment to changing goals and measures which may seem daunting in a political process.

I've been a part of top-down groups, and consensus-seeking groups—both approaches provide ample opportunity for paralysis. It may be that a group is needed that picks an initial direction, decides on some things, and moved forward with the opportunity to revisit these initial decisions and make changes as needed. There should be a structure to provide feedback on a continuous loop that doesn't undo work or derail the work needs to be done.

The governance structure depends on how MDH plans to use the framework, and to what degree it includes specific measures and/or goals.

Even if MDH is in charge of the framework, there must be legislative buy-in and supporting resources to make the framework become a reality.

Vision and mission

Improvement and innovation in health

In order to be worthwhile, the framework must be used to drive strategic investments in health. Change won't happen without clear direction and resources to get there. An interesting question will be whether those investments will be public, private, or both.

Health care quality measures and quality improvement resources go hand-in-hand. The measurement framework will signal what we should all be working on.

This framework could have potential influence in other states, and initiatives in other states could inform our work. Every state having 50 ways of measuring health is interesting, but not efficient.

Set achievable health goals that are outcome-oriented. We are so heavy on process measures in health care, when the ultimate care objectives relate to quality of life. Innovation will come

by setting firm targets, and allowing organizations to try ways in which they think they will achieve that established goal.

Reward the achievement of meeting measure benchmarks and showing improvement.

A large investment in this framework is needed to achieve a large return.

Framework users

The framework will be helpful for us as a state to think about where we should head, where we fit-in, and what our part is to get all of us to achieve the bigger picture. When presented with various health frameworks, it's hard to see what our part could be in helping to achieve the bigger picture of health in the given framework even though we ourselves know what our part is. We know we can help create change from the bottom-up or the top-down. The framework can lay out, "here is where we're headed, and here's your part".

There is a role for community partners outside of the health care system. It is unlikely that a health system could achieve health improvements without partners. Incentivize cooperation and show collaborating in some way with organizations that is relevant to achieving the desired outcome.

Examples of health care system partners include jails, homeless shelters, mental health facilities, and counties. We could use the framework to think about the different services that patients are utilizing, and align these disparate lines of service into a more cohesive service line. This would force us to think more about what we're doing outside the walls of the hospital.

Patients are important and underused in terms of resources and users of measurement. There should be partnership with patient groups like the Minnesota Alliance for Patient Safety (MAPS).

Health systems and payers are involved in this work.

All major purchasers should see an incentive to invest in the measurement framework.

What is a measurement framework?

VISION AND MISSION

Definition: A structure that contains a set or sets of measures that will:

Be used by many to inform decision-making, action, and accountabilities to:

- Improve individual health outcomes
- Improve population health outcomes
- Reduce health inequities
- Improve health care quality and patient experience
- Reduce costs for patients, health care providers and purchasers
- Spur innovation (e.g., health equity advancement, healthy communities, patient engagement, value-based purchasing)
- Other

When measured over time, demonstrate improvement, opportunities for further action, or catch an eroding trend

- Some measures will be publicly reported
- Some efforts may use the framework structure to determine measures, but these may not be publicly reported

Measurement Framework

BENEFITS TO STAKEHOLDERS AND CALL TO ACTION

The contents of this document are excerpted from, “A Measurement Framework for a Healthier Minnesota”.

Benefits to Stakeholders

With a fully developed framework and implementation plan, and a system of measurement that better complements statewide health improvement goals, patients and communities, health care delivery organizations and providers, purchasers, and other key stakeholders will benefit in the following ways:

- **Patients and communities** will have a say in what aspects of care quality and health are measured and targeted for improvement, and be able to access measure results that can help identify opportunities and challenges and drive change.
- **Health care delivery organizations and providers** will have a parsimonious and meaningful set of actionable data to monitor and make improvements in care quality for their patient populations who experience health care along a continuum and across different providers, and more confidence that measures are chosen based on clearly-defined system goals.
- **Health plans and purchasers** will have meaningful quality metrics to aid in best supporting health through affordable coverage. The available data will represent a limited, parsimonious set of measures.
- **Public health and advocacy organizations** will have information on the health of populations that they can use to partner with community stakeholders to enhance the implementation and evaluation of health improvement policies, actions, and programs.
- **Quality improvement and measurement organizations** will bring their expertise to bear in stakeholder discussions, decisions, and the operationalization of what we should measure and how we should measure in our pursuit of statewide quality improvement goals and fostering improvement in the health and health care of Minnesotans.

Call to Action

Patients and communities

Continue to demand an explicit role in decision-making on measurement.

Health care delivery organizations and providers

Use your expertise to help identify measures that are meaningful to patients and operationally relevant and are worth the resource investment.

Employers

As the strongest stakeholder with substantial leverage, use your purchasing power to identify what metrics matter to your employees and your bottom-line, and change the system.

Health plans

As brokers for employers and consumers, help identify the parsimonious set of measures that help maintain and restore health, not just monitor the delivery of health care.

Public health

Use your unique understanding of the power of upstream interventions to challenge academia, funders and practice to create evidence on the link between investments and returns.

Measurement and improvement experts

Help us break out of “what’s worked great.” Identify transformational efforts in measurement and improvement, the development of new data sources, and ways to leverage technology, learning collaboratives, and more.

Health information technology experts

Make progress in ensuring that quality measurement is timely and actionable for health care providers and others, without requiring substantial customization or manual curation of data by care organizations.

Government

Identify the role where you can make the greatest contribution to improvement and innovation—do not stagnate.

Existing Measurement Frameworks

GUIDED REVIEW

Instructions

- Before the July 29 meeting, review the framework model summaries in your binders with these questions in mind.
- **For those who have volunteered to conduct a critical review of a specific framework model**, please do so using this guide by July 15.
 - MDH will schedule small group discussions for each framework the week of July 15.
 - MDH will summarize the groups' feedback in writing the week of July 22.
 - Groups will present framework summaries to the steering team on July 29 with assistance from MDH staff.

Questions

1. How does the existing framework best align with Minnesota's priorities and our emerging vision and mission for a Minnesota measurement framework?
2. How does the existing framework align with the values and principles? Are there aspects of the framework that do not align?
3. Are there aspects of this framework that we would want to include in the Minnesota measurement framework? Are there things missing?
4. Are the measure categories/domains/action areas a good fit for the Minnesota measurement framework? Are any out of scope? Are any missing?
5. How could this framework be used to inform decision-making, action and accountabilities?
6. Would this framework initiate cross-sectoral approaches to improving health? If so, how?
7. Are you or your colleagues aware of anyone in Minnesota or another state that is actively using this framework? If so, please describe.

July 29 key discussion question

Is the existing framework one that you think Minnesota should adopt entirely, partially, or not at all, and why?

Supplemental resources

For additional information on the existing measurement frameworks, visit:

- [Robert Wood Johnson Foundation \(RWJF\) Building a Culture of Health](https://www.rwjf.org/en/cultureofhealth.html) (<https://www.rwjf.org/en/cultureofhealth.html>)

GUIDED REVIEW

- The Health Opportunity and Equity (HOPE) Initiative
(<http://www.nationalcollaborative.org/our-programs/hope-initiative-project>)
- Institute of Medicine Vital Signs: Core Metrics for Health and Health Care Progress
(<http://nationalacademies.org/HMD/reports/2015/vital-signs-core-metrics.aspx>)
- Centers for Medicare & Medicaid Services (CMS) Meaningful Measures
(<https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityInitiativesGenInfo/MMF/General-info-Sub-Page.html>)

Robert Wood Johnson Foundation (RWJF) VISION TO ACTION framework

IMPROVING AMERICA'S HEALTH BY WORKING TOGETHER AND MEASURING PROGRESS

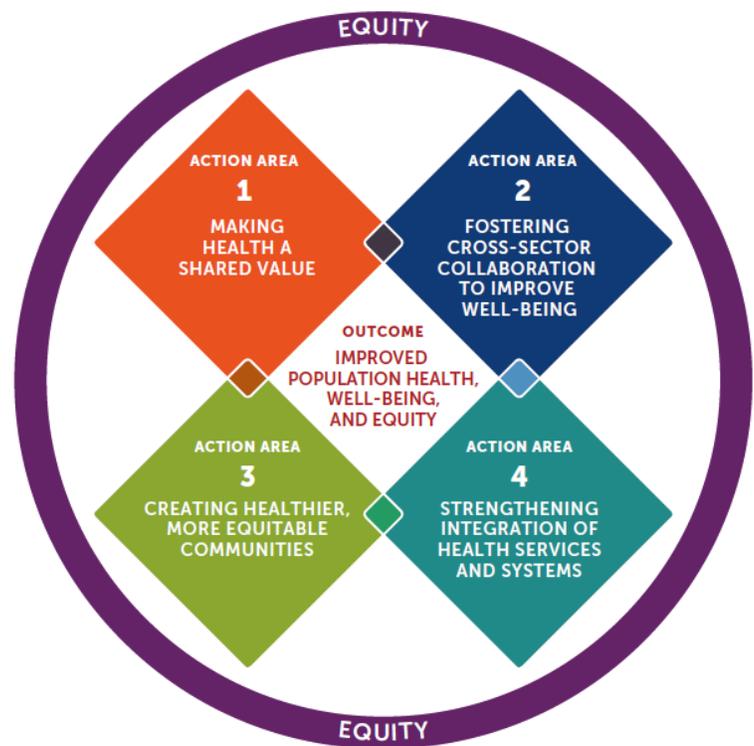
Building a national Culture of Health means creating a society that gives all individuals an equal opportunity to live the healthiest lives possible, whatever their ethnic, geographic, racial, socioeconomic, or physical circumstances happen to be.

The Action Framework reflects a vision of health and well-being as the sum of many parts, addressing the interdependence of social, economic, physical, environmental, and spiritual factors. It is intended to generate unprecedented collaboration and chart our nation's progress toward building a Culture of Health. Equity and opportunity are overarching themes of the entire Action Framework—not merely to highlight our nation's health disparities, but to move toward achieving health equity.

The Action Framework groups the many actors, and the many facets, of a Culture of Health into four Action Areas— each connected to and influenced by the others. These Action Areas are intended to focus efforts and mobilize an integrated course of action by many individuals, communities, and organizations.

Each Action Area contains a set of Drivers that indicate where our nation needs to accelerate change. The Drivers are the engine of the Action Framework, providing a set of long-term priorities both nationally and at the community level. The Action Areas and the Drivers are the essential, enduring structure of the Action Framework and will remain constant over time. Each Action Area is also accompanied by a set of national, evidence-based Measures, rigorously selected as points of assessment and engagement. By design, the Measures are not limited to traditional health indicators; instead, they encourage us to think of health in broader ways, incorporating all aspects of well-being. They are intended to serve as entry points for dialogue and action about health among a diverse group of stakeholders and across sectors.

The Measures will illustrate progress and will evolve over time to keep pace with changing conditions. The Measures highlight upstream factors that may not typically be associated with health care, and reflect actions that involve many more sectors and institutions than traditional health and health care services. Ambitious in scope, many of the Measures draw from existing sources, while others are based on new data gathered for this report.



ACTION AREA 1: MAKING HEALTH A SHARED VALUE

DRIVERS

1.1 MINDSET AND EXPECTATIONS

The views and expectations we have about health ultimately inform the decisions we make as individuals, families, businesses, communities, and as a nation. Do we understand that our health affects the health of others and vice versa? Do we expect health to be prioritized in our policies and consumer choices?

1.2 SENSE OF COMMUNITY

Research suggests that individuals who live in socially connected communities—with a sense of security, belonging, and trust—have better psychological, physical, and behavioral health, and are more likely to thrive. If people do not see their health as interdependent with others in their community, they are less inclined to engage in health-promoting behaviors or work together for positive health change.

1.3 CIVIC ENGAGEMENT

Civic engagement creates healthier communities by developing the knowledge and skills to improve the quality of life for all. Voting is a key component of a healthy society, yet many Americans do not vote regularly. Activities such as volunteering, community organizing, and participating in community groups demonstrate that residents care about the outcomes of their community and want to cultivate positive change. Moreover, communities with strong civic engagement are better able to respond and recover during an emergency. These Measures reflect whether Americans feel motivated and able to participate and make a difference.

MEASURES

Value on health interdependence

Percentage of people who are in strong agreement that their health is influenced by peers, neighborhood, and the broader community (7)

Value on well-being

Percentage of people who are interested in how their community invests in well-being, signaling a broader expectation for well-being (8)

Public discussion on health promotion and well-being

Proportion of tweets discussing health promotion and well-being to tweets discussing acute medical care (9)

Sense of community

Aggregate score on two subscales of the Sense of Community Index: emotional connection to community and sense of belonging to community (membership) (10)

Social support

Percentage of people noting they have adequate social support from partner, family, and friends (11)

Voter participation

Percentage of eligible voters who reported voting in general election (12)

Volunteer engagement

Percentage of adults and young people who reported volunteering (13)

ACTION AREA 2: FOSTERING CROSS-SECTOR COLLABORATION TO IMPROVE WELL-BEING

DRIVERS

2.1 NUMBER AND QUALITY OF PARTNERSHIPS

Research indicates that building relationships among partners is the most challenging aspect of creating change, and that leadership is particularly important for cross-sector synergy. (17) Other key factors include establishing a history of collaboration between organizations, ensuring participants have the resources they need, and building a sense of shared accountability. A Culture of Health calls for assessing the effectiveness of our partnerships and the integration of healthy practices in schools and workplaces—settings where well-being can flourish or falter.

2.2 INVESTMENT IN CROSS-SECTOR COLLABORATION (*need local measures*)

In addition to measuring the quality and quantity of cross-sector collaborations, it is important to track investments that support these partnerships. Corporate and federal contributions have the power to impact our nation’s health and well-being, both directly and indirectly.

2.3 POLICIES THAT SUPPORT COLLABORATION

Policies can play a key role in encouraging and maintaining collaboration across sectors, as well as creating incentives for different sectors to contribute what they can to the cause of improving our nation’s health. These Measures highlight policies that have the potential to catalyze widespread improvement in health and overall well-being.

MEASURES

Local health department collaboration

Percentage of local health departments that collaborated with community organizations in at least four public health program areas in the past year (18)

Opportunities to improve health for youth at schools

Annual number of school-based health centers that provide primary care (19)

Business support for workplace health promotion and Culture of Health

Index of employer health promotion and practices (by size of business) (20)

U.S. corporate giving

Annual dollar amount of U.S. corporate contributions to education (K–12 and higher education) and to community/economic development sectors (21)

Federal allocations for health investments related to nutrition and indoor and outdoor physical activity

Annual dollar amount of federal appropriation to select health initiatives

Community relations and policing

Percentage of full-time sworn personnel who have served as community policing or community relations officers, or were designated to engage regularly in community policing activities (22)

Youth exposure to advertising for healthy and unhealthy food and beverage products

Annual measure of children’s exposure to TV ads for unhealthy foods/beverages (23)

Climate adaptation and mitigation

Annual percentage of states with climate adaptation and mitigation action plans (24)

Health in all policies (support for working families)

Annual percentage of families with parents eligible for Family Medical Leave Act (FMLA) coverage who can also afford it (25)

ACTION AREA 3: CREATING HEALTHIER, MORE EQUITABLE COMMUNITIES

DRIVERS

3.1 BUILT ENVIRONMENT/PHYSICAL CONDITIONS

The built environment—or the physical space in which we live, learn, work, and play—is key to a community’s well-being. For example, sidewalks in good condition and active transport routes, such as bicycle lanes, are features of the physical environment that may provide greater access to exercise and healthy food options. However, to take advantage of these opportunities, it’s essential that we feel safe in our neighborhoods, parks, and schools.

3.2 SOCIAL AND ECONOMIC ENVIRONMENT

Our social environment, such as enduring racial and socioeconomic segregation, can also influence health and impact a community’s sense of trust and cohesion. In addition, research points to strong connections between our environment, economic vitality, and health. We know that children who attend preschool are more likely to stay in school, go on to hold jobs and earn more money—all of which are linked to better health. (33) Public libraries continue to serve as important hubs of enrichment and well-being—providing community connections and computer access, and links to civic engagement, health literacy, and resilience.

3.3 POLICY AND GOVERNANCE

This area spotlights policy aimed at creating healthy environments, with an emphasis on collaboration between residents and large institutions, both governmental and corporate. Too often, we see health-promoting initiatives fall short without the policy structures in place to sustain them.

MEASURES

Housing affordability

Percentage of families spending 50 percent or more of monthly income on housing costs for either rent or mortgage (30)

Access to healthy foods

Percentage of U.S. population with limited access to healthy foods (31)

Youth safety

Percentage of middle and high school students who reported feeling safe in their communities and schools (32)

Residential segregation

Evenness with which racial/ethnic groups are distributed across communities (index of dissimilarity, exposure to diversity) (34)

Early childhood education

Number of states where 60 percent or more 3- and 4-year-olds are enrolled in preschool (35)

Public libraries

Number of library outlets per 100,000 people (36)

Complete Streets policies

Number of jurisdictions with Complete Streets policies in place (37)

Adopting a Complete Streets policy means that every transportation project will make the street network better and safer for drivers, transit users, pedestrians, and bicyclists. These policies allow communities to direct their transportation planners and engineers to routinely design the entire right of way to enable safe access for all users, regardless of age, ability, or mode of transportation. (38)

Air quality

Percentage of population covered by comprehensive smoke-free indoor air laws (39)

4 ACTION AREA 4: STRENGTHENING INTEGRATION OF HEALTH SERVICES AND SYSTEMS

DRIVERS

4.1 ACCESS

Several factors influence access to health services, including the expansion of health insurance coverage. But access must be more than having insurance. It must be more broadly defined as being able to get comprehensive, continuous health services when needed and having the opportunity and tools to make healthier choices.

4.2 CONSUMER EXPERIENCE & QUALITY

When people don't feel connected to, or in control of, the full complement of medical and social services, they are more likely to delay or avoid care. In a Culture of Health, health care providers help patients thrive by planning for the care that's needed inside and outside the clinic. This means that all individuals are treated with dignity, and that cultural differences are honored and respected. Also, provider networks can improve the consumer experience by creating a coordinated health care system, with a network of doctors and hospitals sharing financial and medical responsibility for patients' health.

4.3 BALANCE AND INTEGRATION

A Culture of Health calls for better balance between prevention and acute/chronic care services, as well as the intentional integration of public health, social service, and health care systems. When these systems work in sync, we will see an improvement in the efficiency and quality of care delivered, leading to reduced hospital re-admissions, decreased health costs, and a more seamless health care experience. (49) In short, more people will get the preventive and social services they need early and avoid unnecessary medical care.

MEASURES

Access to comprehensive primary care*

Percentage of population (regardless of insurance) who utilize a comprehensive patient-centered primary care home health system (43)

Access to stable health insurance

Percentage of population, with stable health insurance, or no change in the source of health insurance (44)

Access to mental health services

Percentage of people who report having mental health or substance abuse problems, and who received treatment (45)

Routine dental care

Percentage of people who report a dental visit in the calendar year (46)

Consumer experience

Consumer Assessment of Healthcare Providers and Systems (CAHPS) summary measure of consumer experience across ambulatory, hospital, and home health care settings (47)

Population covered by an Accountable Care Organization (ACO) [or CCO]

Percentage of population whose health care provider is part of an ACO (48)

Electronic medical record linkages

Percentage of physicians who share data with other providers and hospitals, with the goal of encouraging integration, collaboration, and communication (50)

Hospital partnerships

Percentage of hospitals that have a collaboration or alliance with one or more organizations in each of these categories: local government, state agencies, and other community-based agencies (51)

Practice laws for nurse practitioners

Number of states that have laws and regulations that support full scope of practice for nurse practitioners (52)

Social spending relative to health expenditure

A ratio of annual social spending to annual health expenditures in the United States (53)

OUTCOME: IMPROVED POPULATION HEALTH, WELL-BEING, AND EQUITY

DRIVERS

O.1 ENHANCED INDIVIDUAL AND COMMUNITY WELL-BEING

The Culture of Health Action Framework emphasizes well-being, which can be evaluated by both subjective and objective data. Individual well-being can be defined as the extent to which people experience happiness and satisfaction, and are realizing their full potential. Key aspects of community well-being include community health, economic resilience, educational capacity, and environmental adaptation. By measuring well-being among individuals, communities, and care-givers, we gain a window into whether health has been woven into the fabric of our culture.

O.2 MANAGED CHRONIC DISEASE AND REDUCED TOXIC STRESS

A Culture of Health is intended to support a trajectory of well-being throughout the lifespan, addressing any health issues as early as possible. Today, more than half of all Americans suffer from one or more chronic diseases; by 2020, the number of those with chronic conditions is expected to grow to 157 million. There are significant disparities, with the burden of chronic conditions experienced disproportionately by low-income people and ethnic minorities.⁶⁰ In addition, a growing area of research has focused on the relationship between childhood trauma (such as domestic violence, substance abuse, and neglect) and the risk for physical and mental illness in adulthood. By measuring the prevalence of chronic disease and adverse child experiences (ACEs), we can gauge whether the health of the population is improving.

MEASURES

Well-being rating

Well-being rating in three areas: Health, Life Satisfaction, Work/Life Balance (58)

- *Health: Average life expectancy and percentage of population who report “good” or better health*
- *Life Satisfaction: Weighted sum of different response categories based on people’s rating of their current life relative to the best and worst possible lives for them on a scale from 0 to 10, using the Cantrell Ladder*
- *Work/Life Balance: Percentage of dependent employees whose usual hours of work per week are 50 hours or more, and average number of hours per day that full-time employed people spend on leisure and personal activities*

Caregiving burden

Average amount of out-of-pocket financial and emotional investment in caregiving, as reported by adults 18 years and older (59)

Adverse child experiences (ACEs)

Percentage of population, ages 0 to 17 years, with two or more reported ACEs, as reported by parents (61)

Disability associated with chronic conditions

Number of disability-adjusted life years (DALYs) for the top 10 U.S. chronic diseases (62)

O.3 REDUCED HEALTH CARE COSTS

It is well understood that health care costs are placing a significant burden on all sectors of American society, and that the United States spends more per capita on health care than other countries. Our nation has also seen the steepest increase in health care spending, even though our health outcomes have not markedly improved. As we measure overall health costs in relation to outcomes, we must also keep a close eye on how and when we spend. Progress will entail not only improving efficiency and avoiding unnecessary procedures, but managing issues early and preserving dignity across the lifespan.

Family health care cost

Average health care expenditure by family (63)

Potentially preventable hospitalization rates

Overall U.S. admission rates for chronic and acute conditions per 100,000 population, including:

- *Chronic: Diabetes with short-term complications; diabetes with long-term complications; uncontrolled diabetes without complications; diabetes with lower-extremity amputation; chronic obstructive pulmonary disease; asthma; hypertension; heart failure; angina without a cardiac procedure*
- *Acute: Dehydration; bacterial pneumonia; or urinary tract infection (64)*

Annual end-of-life care expenditures

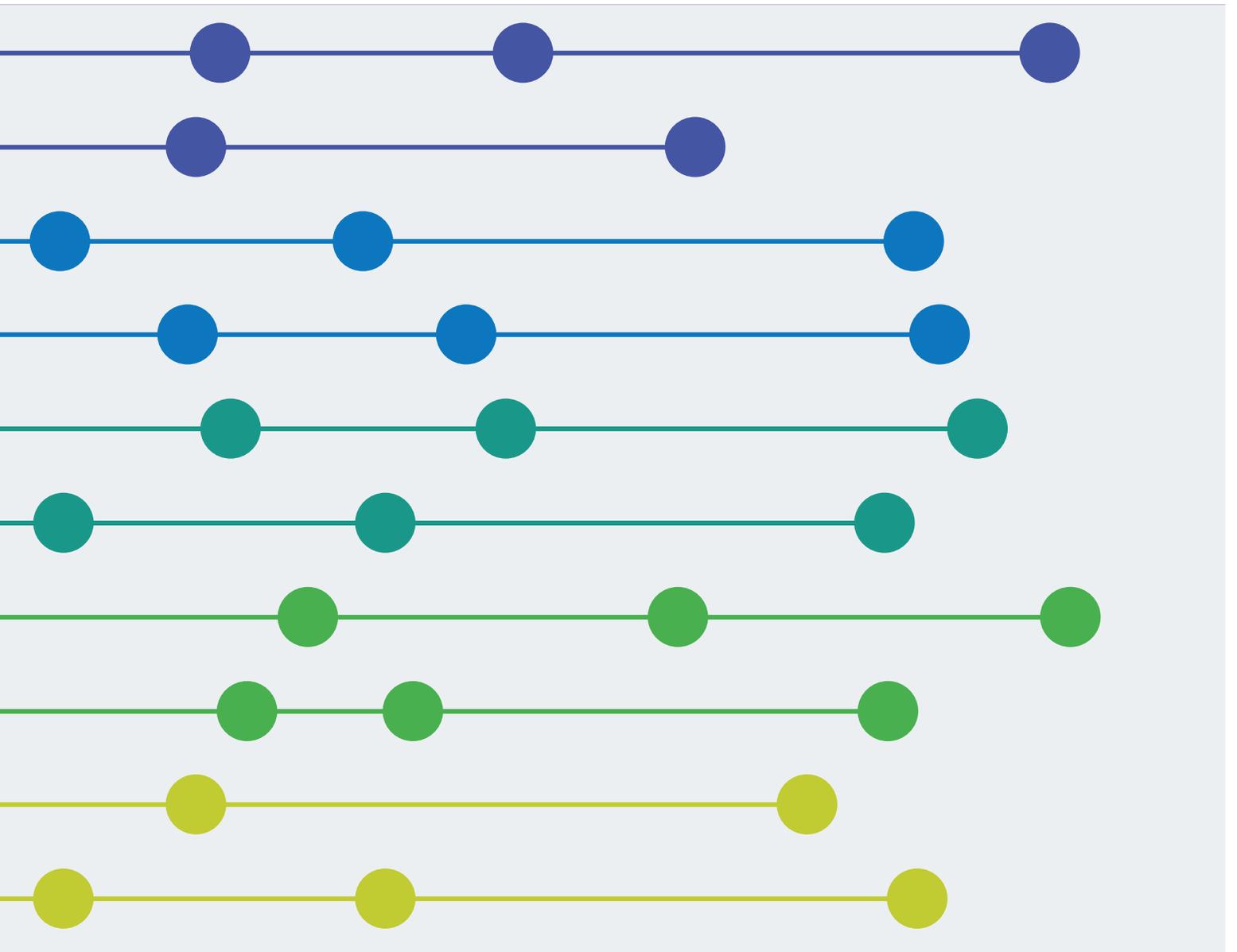
Annual average Medicare payment per decedent in the last year of life (65)

Advancing Health Opportunity and Equity Across the United States: A State-By-State Comparison

NATIONAL COLLABORATIVE FOR
HEALTH EQUITY

TEXAS HEALTH INSTITUTE

VIRGINIA COMMONWEALTH UNIVERSITY
CENTER ON SOCIETY AND HEALTH



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Introduction

Many circumstances in our homes, neighborhoods, schools, workplaces, and society at large affect whether we have a fair shot at living a healthy life. The opportunities for good health and well-being vary depending on our race or ethnicity, our level of education and income, and where we live, among other factors. But, it does not have to be this way. What drives health is more about the resources we have access to and the conditions in our neighborhoods, and less about medical care. Health behaviors like exercise and diet matter a lot, but our behaviors and even our ability to get quality health care depend on the opportunities and resources we can access. The good news is that we can create better opportunities for all Americans—especially for the most vulnerable among us—by expanding health equity. As Braveman (2017) states, “Health equity means that everyone has a fair and just opportunity to be as healthy as possible... measuring the gaps in health and in opportunities for optimal health is important not only to document progress but also to motivate action and indicate the kinds of actions to achieve greater equity.”

To expand opportunity, we must first understand where opportunity thrives, and for whom, and where we have gaps. The Health Opportunity and Equity (HOPE) Initiative offers a new way to measure our national and state-level progress toward expanding opportunity across all racial, ethnic, and socioeconomic groups. We do so by tracking 28 indicators that span the life course, including health outcomes and indicators related to opportunity such as socioeconomic factors, the physical and social environment, and access to health care. For each measure, we set benchmarks that are aspirational but achievable—based on populations and states that have already obtained the best outcomes. We intentionally set the HOPE Initiative’s measures at the national and state levels not only to track progress, but also because we understand the power held by states to create and further opportunities through policies that improve the lives of their residents.

Policies Can Create Opportunities for Better Health & Well-Being

Health and well-being are determined at multiple levels. On one level, people make individual choices about their health on a routine basis. This morning, you chose whether or not to eat breakfast; and, if you ate breakfast, you decided what and how much you ate. These types of daily decisions have a profound impact on individual health. Your personal health decisions, however, are not fully under your own control. Eating a banana for breakfast is a healthy choice but doing so presumes you have access to a store that sells produce and the money to purchase the banana. A human and historical chain affects the opportunity to make that decision—from the grocer, to the distributor, to the farmer, to the politicians setting trade policy, to the history and practices for cultivating the banana, among many others. For all too many, weak links or breaks in that chain greatly impede the opportunity to access affordable healthy food. This is just one, small example of the many systems that intersect beyond our individual choices that shape opportunities for health. And while the systems may be complex, they are malleable and we can construct them to reflect our values.

The opportunities to increase health and well-being are abundant. They exist in every place we live our lives—our homes, where our children go to school, where we work, where we shop, and where we socialize—as many of the social and economic factors that determine opportunities for health, and affect our quality of life, are interconnected. The factors that shape the stability of families, also determine educational attainment, employment, and retirement savings—and together shape the economic vitality and social well-being of neighborhoods across the nation. These circumstances and dynamics lead to one conclusion: good socioeconomic policy is good health policy. Improving educational opportunities is good health policy. Taking care of our environment is good health policy. And so on.

The Health Opportunity and Equity (HOPE) Initiative

Led by the National Collaborative for Health Equity (NCHE) and Texas Health Institute (THI), in partnership with Virginia Commonwealth University’s Center on Society and Health (VCU-CSH), and with support from the Robert Wood Johnson Foundation (RWJF), The Health Opportunity and Equity (HOPE) Initiative begins with a set of state and national metrics designed to spur action to improve health and well-being for all, regardless of race and ethnicity or socioeconomic status (SES). Key to HOPE is that we use measures that illuminate opportunities for everyone to flourish. Specifically, the indicators allow states to see where they are doing well and where they can do better on a broad range of factors that influence health and well-being. The indicators tracked by HOPE show us where babies are more likely to live past their first birthday, where residents can more easily access a doctor, where air quality is healthier, where young children are more likely to enroll in pre-k, or where housing is more affordable. We identify states with the best outcomes and ask, “What are they doing right, how did they get there, and how can it work in my

state?” Further, the data are broken down race, ethnicity, and socioeconomic status to help us better understand what it would take for members of all population groups to reach the benchmarks. Groups that have been systematically disadvantaged by racial discrimination or poverty—two key root causes of inequity (Braveman, 2017)—often have a greater distance to go, but these gaps differ by state suggesting policy and context matter.

What Is Unique About the HOPE Initiative?

HOPE is not the first or only national effort to furnish indicators on the determinants of health and equity. Other notable initiatives include *America’s Health Rankings*,¹ *County Health Rankings and Roadmaps*,² *Health of the States*,³ *National Equity Atlas*,⁴ and the *Opportunity Index*,⁵ among many others. What makes HOPE unique is that

HOPE Features

OPPORTUNITY FRAMING provides an asset-based orientation to replace measures that typically call attention to deficits rather than highlighting achievements or opportunities for improvement. We measure income, not poverty; employment, not unemployment; housing quality, not housing problems.

ASPIRATIONAL, YET ATTAINABLE GOALS for achieving equity across health and broader well-being indicators. We use “HOPE Goals” to set benchmarks that we know are reachable because they are based on actual rates we can observe among certain populations.

NATIONAL AND STATE DATA BY RACE, ETHNICITY, AND SOCIOECONOMIC STATUS, allowing for a deeper understanding of health equity and opportunity for specific population groups.

MEASURES OF PROGRESS, also referred to as “Distance to Goal,” for specific population groups. This tells states, and the nation, how far they must go to achieve the goal of greater equity in health outcomes and the determinants of health for their populations.

we have reoriented our focus from health inequities to a positive frame of opportunity, focusing whenever possible on assets rather than deficits. To make progress on health equity, we need to understand who is doing well and why. We have developed a new way for the nation and states to measure opportunities for better health and well-being, to learn from where population groups are doing well, and to take action based on metrics that are rooted in an opportunity framework. The HOPE Initiative intentionally presents data not only at the national level, to track the country's progress, but also for each state and the District of Columbia. This is because the opportunity landscape differs dramatically across the 50 states. And we stratify the data by race, ethnicity, and socio-economic status, allowing for a deeper understanding of how opportunity varies among subpopulations across the states. This kind of stratification of data in a nation-wide resource breaks new ground. Previous efforts have emphasized national averages to describe inequities among population groups. HOPE shows that the story varies considerably from one state to another.

It allows states to examine where they are in the progression toward equity, where they can celebrate wins, and where to look to other states for model solutions and policies to improve opportunities for health and well-being for all.

The Domains & Indicators of the HOPE Initiative

HOPE tracks 28 indicators of child and adult health outcomes and the key resources that produce opportunities for health and well-being. These outcomes and resources, which we call *domains*, include: health outcomes, socioeconomic factors, the social environment, the physical environment, and access to health care. For each indicator within a domain, we have calculated a national benchmark which we refer to as the HOPE Goal and ranked states on their performance related to the benchmark.⁶ National and state data are provided by race, ethnicity, and SES.

Measuring gaps in health and well-being is an important first step toward documenting progress and motivating action to achieve greater equity.

⁶ A technical summary on our methods is available at www.nationalcollaborative.org/our-programs/hope-initiative-project/

HEALTH OUTCOME INDICATORS

HOPE's six health and well-being indicators are intended to capture the overall physical and mental health of a population across the life cycle. These indicators measure the presence or absence of health and wellness, as well as mortality.

Adult Health Status	Portion of adults who say their health is very good or excellent
Mental Health Status	Portion of adults who say their mental health was not good for 14 or more days in the past 30 days
Child Health Status	Portion of children whose parents rate their health as very good or excellent
Premature Mortality	Number of annual deaths due to any cause per 100,000 population age 25-64
Infant Mortality	Number of infants who die before their first birthday annually per 1,000 live births
Low Birth Weight	Portion of infants weighing less than 2,500 grams at birth

SOCIOECONOMIC INDICATORS

The six socioeconomic factors tracked by HOPE reflect systemic circumstances that promote or constrain opportunities to enjoy good health. These indicators broadly measure financial, educational, and occupational conditions influencing the standard of health people and households can achieve.

Livable Income	Portion of people living in households with income greater than 250% FPL
Affordable Housing	Portion of households spending no more than 30% of monthly household income on housing and related expenses
Post-secondary Education	Portion of adults with at least some college education after graduating from high school
Connected Youth	Portion of young people age 16-24 enrolled in school or working, including military enlistment
Preschool Enrollment	Portion of children age 3-4 enrolled in preschool
Employment	Portion of people in the labor force who are employed

SOCIAL ENVIRONMENT INDICATORS

HOPE's five social environment indicators measure elements of one's social surroundings with implications for health, such as living in an environment without concentrated poverty or violence. Differences in social conditions between groups often reflect historical practices or policies that privileged certain people over others and contribute today to limited health opportunity among socially disadvantaged groups. Here, the surrogate measure for safety is low crime rates.

Low Poverty Concentration	Portion of people in neighborhoods with less than 20% of residents living in poverty
Low Murder Rate	Portion of people living in counties with fewer than 5.1 murders per 100,000 population annually
Low Assault Rate	Portion of people living in counties with fewer than 283 reported cases of aggravated assault per 100,000 population annually
Low Rape Rate	Portion of people living in counties with fewer than 36.9 reported cases of rape per 100,000 population annually
Low Robbery Rate	Portion of people living in counties with fewer than 52.1 reported cases of robbery per 100,000 population annually

PHYSICAL ENVIRONMENT INDICATORS

HOPE identified five physical environment indicators to measure dimensions of health opportunity embedded in people’s physical surroundings. Together, these indicators are meant to capture the physical conditions that either promote or discourage health and wellbeing in the places where people live, work, play, and perform activities of daily living.

Home Ownership	Portion of households living in a home they own
Housing Quality	Portion of households living in homes with no severe housing problems (i.e., homes that have complete kitchens, functioning plumbing, and are not overcrowded or severely cost-burdened)
Air Quality—Particulate Matter	Portion of people living in counties with average daily density of fine particulate matter (PM _{2.5}) below 12 micrograms per cubic meter
Low Liquor Store Density	Portion of people living in counties with fewer than 1.736 liquor stores per 10,000 population
Food Security	Portion of people living in census tracts that are not food deserts (i.e., census tracts not designated low income and low food access)

ACCESS TO HEALTH CARE INDICATORS

HOPE’s six measures of access to health care are intended to capture conditions to ensure that people can engage with clinical services when needed. Accessible and affordable health care are essential to protect people’s opportunities to maintain the highest possible standard of health across the lifespan.

Access to Primary Care	Portion of people living in counties with a population-to-primary care physician ratio of less than 2,000:1
Access to Psychiatric Care	Portion of people living in counties with a population-to-psychiatrist ratio of less than 30,000:1
Health Insurance Coverage	Portion of people under age 65 with any kind of health insurance
Affordable Health Care	Portion of adults who did not delay or forego any medical care they needed due to cost in the past year
Usual Source of Care	Portion of adults who have someone they consider their personal health care provider
Colorectal Cancer Screening	Portion of adults age 50–75 receiving recommended colorectal cancer screenings

Key HOPE Findings: What Did We Learn?

Detailed charts and data on all of HOPE's measures can be found in *The HOPE Initiative: Data Chartbook* and an in-depth description of our methods can be found in *The HOPE Initiative: Technical Summary*.⁷ Several key takeaways emerged from our analysis revealing how the 50 states and District of Columbia vary in terms of health and the domains that shape health. First, we learned that the racial and ethnic disparities we see nationally hide important differences that exist across the states. As shown in Figure 1, the health status described by whites, Blacks, and other populations of color are not uniform across the country. For example, some minorities in the healthiest states—particularly those with less diversity, such as New England or the Northern Great Plains states—report better health status than do whites in other states such as West Virginia.

Second, we observed—as many others have—that the relationship between socioeconomic status and health operates as a gradient; that is, health improves progressively with greater levels of education or income. Many reports have documented this gradient in national data, but we also observed it in each state as well as variation in the size of the gradient by state. Figure 2, for example, shows that despite some variation between states on their performance in comparison to the HOPE benchmark, higher levels of educational attainment are associated with higher percentages of home ownership.

National data show that these gradients also exist within racial and ethnic groups; for example, Blacks, whites, and other racial groups with advanced degrees on average have better health than members of their racial group with less education. However, we find that education or income do not confer equal benefits to all racial and ethnic minorities, as the health profiles of the most educated people of color often resemble those of whites with less education. In Figure 4, using the health care affordability indicator, we see that Hispanics with some college education face

a greater distance to reach the HOPE goal than do whites with less than a high school degree.

Third, the HOPE Goals help us to better understand the degree of equity within and across states. Using the example of adult health status in Figure 3, the HOPE rankings show that among four southern states, Virginia is closest to the HOPE Goal at 18th, North Carolina is a bit further back at 33rd, and Alabama and Mississippi are among the farthest at 46th and 47th respectively. Despite Mississippi being relatively far from the Goal at 47th, race and ethnicity groups within the state rate themselves on health similarly, whereas, in North Carolina the degree of inequity between groups or the opportunity gap is much wider.

Finally, we have much to learn from bright spots—that is, states that are positive outliers and exhibit surprising data. While infant mortality among U.S. Blacks nationally, for example, is much higher than among whites, infant mortality in Washington State is lower among Blacks (7.1 per 1,000 live births) than among whites in Alabama (7.3), Hispanics in South Dakota (8.6), and Asian and Pacific Islanders in Utah (7.6). We have much to learn from these unexpected findings. These kinds of positive outliers raise questions about which contextual factors at the state level are driving outcomes that are different from national trends. Where we find these bright spots, we should scrutinize the social, economic and environmental conditions in that particular state because they can offer important clues for policy change.

Taken all together, these findings show that higher levels of socioeconomic status are associated with better health and opportunity, but the protective effects of SES do not fully apply to all populations or facilitate health to the same degree in all states. That is, the health of Americans is shaped not only by their personal characteristics and lifestyles but also by the places in which they live.

⁷ Available at www.nationalcollaborative.org/our-programs/hope-initiative-project/

FIGURE 1

ADULT HEALTH STATUS

By Race and Ethnicity

- White
- Black
- Hispanic
- Asian/PI
- AI/AN
- Multiracial

Percent of Adults with Very Good or Excellent Health

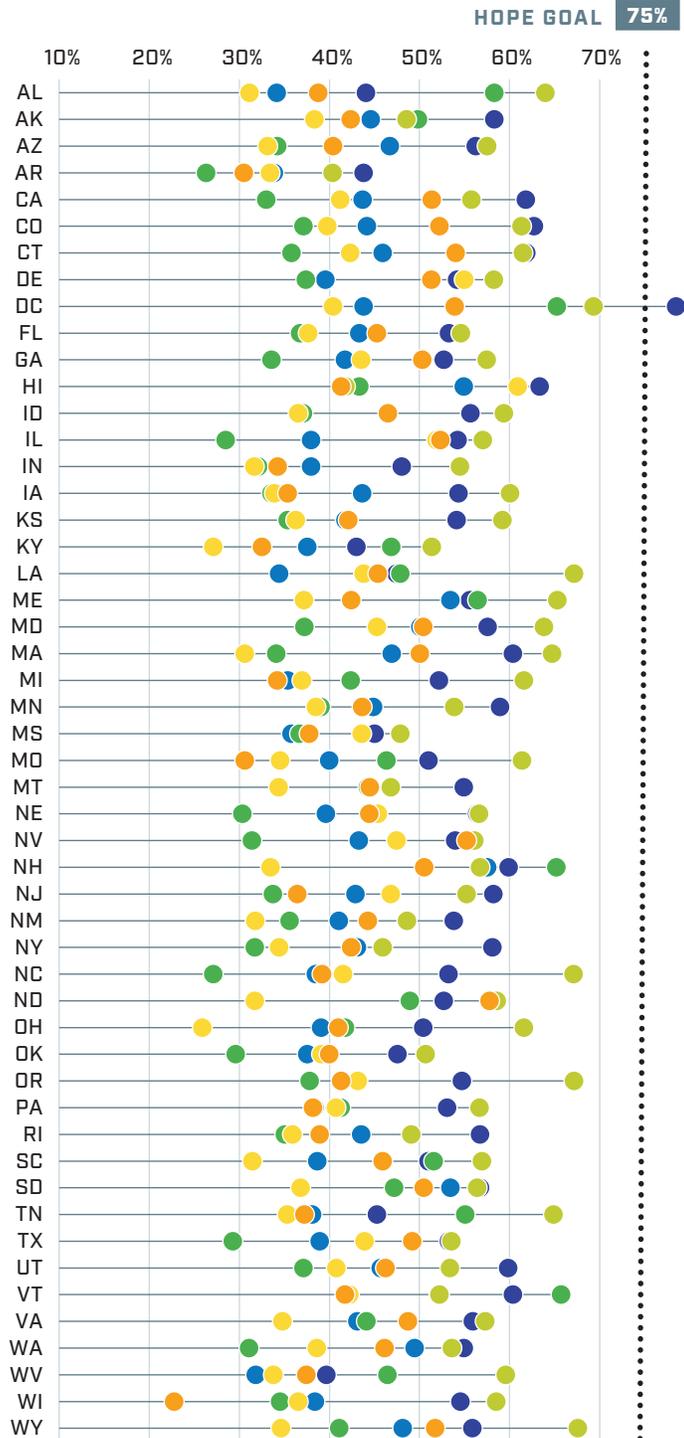


FIGURE 2

HOME OWNERSHIP

By Education Attainment

- Less than HS
- HS Grad
- Some College
- College Grad

Percent of Households Owning Homes



FIGURE 3
DEMONSTRATING THE DEGREE OF EQUITY WITHIN AND BETWEEN STATES USING HEALTH STATUS

By Race and Ethnicity for AL, MS, NC & VA

- White ● Black ● Hispanic
- Asian/PI ● AI/AN ● Multiracial

Percent of Adults with Very Good or Excellent Health

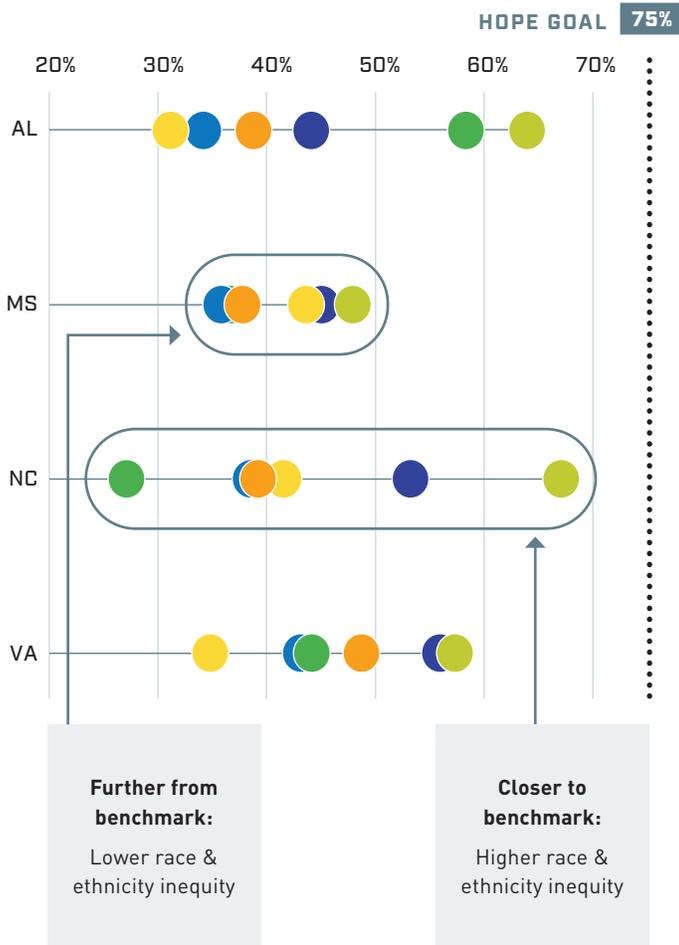
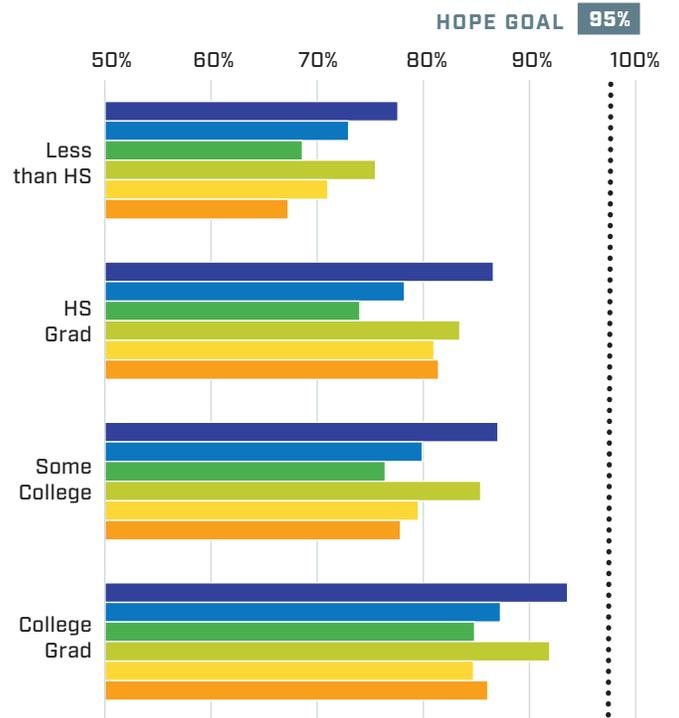


FIGURE 4
AFFORDABLE HEALTH CARE: NATIONAL PROGRESS TOWARD HOPE GOAL
By Race, Ethnicity, and Education

- White ■ Black ■ Hispanic
- Asian/PI ■ AI/AN ■ Multiracial

Percent with Affordable Health Care



How Can I Use HOPE's Measures?

HOPE's measures forge the way for states and the nation to:

- Identify each state's areas of strength and of greatest need
- Learn from states that are leading on our measures of equity and opportunity
- Assess policy priorities and potential health impacts that may be linked to opportunity status within each state
- Identify key drivers of health opportunity and equity
- Use data in conversations within states and communities to understand what is happening and what is working well
- Understand the degree of equity within a state and compared to other states against a national benchmark

The policies of states and communities affect the environment and socioeconomic circumstances in which residents live and contribute to divisions in access to opportunities to thrive.

Research has documented evidence of equity-focused policies that have proven effective in enhancing health opportunities for all. For example, with its long history of work to achieve universal coverage, Massachusetts ranks at or near the top on many HOPE measures of health and well-being, as well as health care access. Notably, all income and racial and ethnic groups in the state possess high rates of health insurance coverage and primary care access. Thus, equitable state level policies across the multiple sectors that shape health are a promising point of intervention. What can we learn about the context and potential policies and investments that are producing the outcomes we seek? We believe these kinds of data offer promising clues about what works for improving opportunity and equity.

Future HOPE research will delve more deeply into "positive outliers" to identify common characteristics and strategies. We will also conduct more analyses to examine how states in different regions of the country, or those with similar demographic profiles, fare on HOPE measures, again to identify important commonalities that can assist others in furthering construct programs and policies.

EVERY STATE CAN DO SOMETHING TO IMPROVE THE HEALTH AND WELL-BEING OF ITS RESIDENTS. A review of state policies can offer important clues for strategies that could be helpful for states that want to close opportunity gaps. In so doing, our team recognizes the rich and growing literature documenting promising strategies to expand opportunity, health and well-being. While an exhaustive review of this literature is not possible here, below we cite examples from this body of research, with the goal of informing discussions and actions among state policymakers and identifying research questions that HOPE will address in future work.

Socioeconomic Factors

States can expand economic opportunities, particularly for low-income families and communities, through a combination of macroeconomic, labor market, housing, and education policies, among other strategies to boost family incomes and economic security. State tax policy, for example, can help low-income families retain more of their income and encourage savings. Several states have implemented earned income tax credit (EITC), Child Tax Credit (CTC), and/or Child and Dependent Care Credit (CDCTC) policies, which provide a tax refund to eligible low-income families.⁸ These policies have been shown to increase employment and income, especially for single mothers, and improve health and access to health care among poor working families (Centers for Disease Control and Prevention, 2014). Such policies are also associated with improvements in child health, including reductions in infant mortality (Arno et al., 2009; Marr et al., 2013) and low birth weight (Strully et al., 2010).

Similarly, there is robust evidence that high-quality early childhood education improves children's educational attainment, as well as health and well-being, across a range of measures. Children who attend high-quality preschool programs are less likely to show behavioral problems, score higher on standardized tests, and achieve higher levels of education relative to children who do not attend pre-kindergarten programs (Barnett et al., 2017). In addition, they are more likely to be employed as adults, and have greater adult earnings (Ruhm & Walfoegel, 2011).

Several states that perform well on HOPE measures of child health, such as Minnesota, Oregon, and Washington, rank high in ratings of quality and accessibility of state-funded pre-k programs.

State policies can also influence family earnings. Slightly less than half (49%) of salaried workers in the United States earn the federal minimum wage, and three-fourths (76%) of these are 20 years or older (Bureau of Labor Statistics, 2013). But in many communities the federal minimum wage

is insufficient to meet needs, especially among families with children. Researchers have developed a “living wage” calculation that takes into consideration regional and community variation in costs related to housing, health care, transportation, food, and child care (Glasmeier, 2004), and some states have enacted minimum wage laws that require employers to pay wages higher than the federal minimum wage (U.S. Department of Labor, 2018).

Many of that states that have the greatest distance to HOPE Goals on socioeconomic factors (e.g., Southeastern) use the federal minimum wage standard while states that are closest to the respective goals (e.g., Northeastern and Pacific Northwest) have set state minimum wages higher than the federal requirement.

Social Environment

A large body of research finds that aspects of the social environment—in particular, neighborhood poverty concentration—powerfully shape opportunities for health and well-being. Children living in high-poverty neighborhoods face greater risk for exposure to adverse childhood experiences such as violence, have less access to healthy food, face greater environmental health risks, and are too often educated in poorly-resourced schools (Kramer & Hogue, 2009; Williams, Priest & Anderson, 2016; Acevedo-Garcia et al., 2014). Policies that encourage mixed-income housing developments—where affordable housing is included with market-rate housing—have resulted in multiple benefits for families with low incomes (Joseph, Chaskin & Webber, 2007). And, the recently-concluded Moving to Opportunity study, a longitudinal, randomized control trial involving over 4,600 low-income families, found that families in an experimental condition who used housing vouchers to move from high- to low-poverty neighborhoods earned higher incomes and experienced lower levels of psychological distress, severe obesity, and diabetes relative to a control group that received no assistance to move to low-poverty neighborhoods (Chetty, Hendren & Katz, 2016).

While housing policy is primarily established by local jurisdictions, states can incentivize inclusionary zoning and the use of portable housing vouchers to combat high levels of neighborhood poverty concentration.

States such as California, Colorado, and Washington have used policy incentives like inclusionary zoning and housing vouchers and by comparison perform much closer to the HOPE Goal of ensuring that no resident lives in a community with high levels of poverty concentration.

Physical Environment

Recognizing that home ownership is key to building wealth and economic opportunity, as well as promoting stable families and communities, many states have implemented policies to assist low- and moderate-income families to purchase homes. These strategies include providing down payment assistance through grants, second mortgages, or premium bonds; direct lending to first-time home buyers; and homeownership counseling.

West Virginia, a relatively poor state, offers all three sources of homeownership support, and is ranked second among all states on HOPE's measure of home ownership. Minnesota and Michigan—ranked 3rd and 4th respectively—offer both down payment assistance and counseling. California and New York are ranked the lowest—49th and 50th—are among the most expensive states to own a home and only offer down payment assistance.

States are also increasingly implementing policy strategies to improve access to healthy food retail, particularly in low-income communities. One of the first such initiatives was launched in the Commonwealth of Pennsylvania in 2004. The Pennsylvania Fresh Food Financing Initiative (FFFI) was designed to attract supermarkets and grocery stores to underserved urban and rural communities, with the goals of stimulating investment of private capital and removing financial obstacles for supermarkets to establish in “food deserts.” The program also sought to reduce the

incidence of diet-related diseases, while creating good-paying jobs for community residents. Preliminary evidence suggests that the initiative is meeting its goals: by 2010, FFFI approved 88 grocery retail projects for funding, which created more than 5,000 jobs and increased health food access to nearly 500,000 Pennsylvania residents. And while many factors influence diet-related health outcomes, researchers found an unprecedented 5% decline in rates of childhood obesity in Philadelphia where the first FFFI funds were implemented (Harries et al., 2014). The success of this effort stimulated creation of the federal Healthy Food Financing Initiative in 2011.

The states that are closest to the HOPE goal of ensuring that 97% of residents live in communities with healthy food retail—including California, New York, New Jersey, Massachusetts, and Pennsylvania—all had adopted fresh food financing programs by 2015 (Opportunity Finance Network, 2015).

Access to health care

States have important opportunities to improve health insurance coverage through Medicaid and the Child Health Insurance Program, as well as other efforts to incentivize private insurance markets. To the extent that states equitably approach the HOPE insurance coverage goal, they will also reduce geographic barriers to care and induce health care providers and institutions to locate in medically underserved communities. But many states—particularly those in the Deep South and Mountain West that elected not to expand the Medicaid program through the Affordable Care Act—remain far from the goal. The federal government remains the primary force determining health care provider supply and distribution, through designating and funding federally-qualified health centers and supporting health care provider training and service programs such as the National Health Service Corps, but states can also create programs and incentives to align health care resources with community need. For example, 34 states have established Certificate of Need (CON) laws to regulate the citing and construction of new health care facilities, but these tools are rarely applied with equity as a guiding principle (National Conference of State Legislatures, 2016).

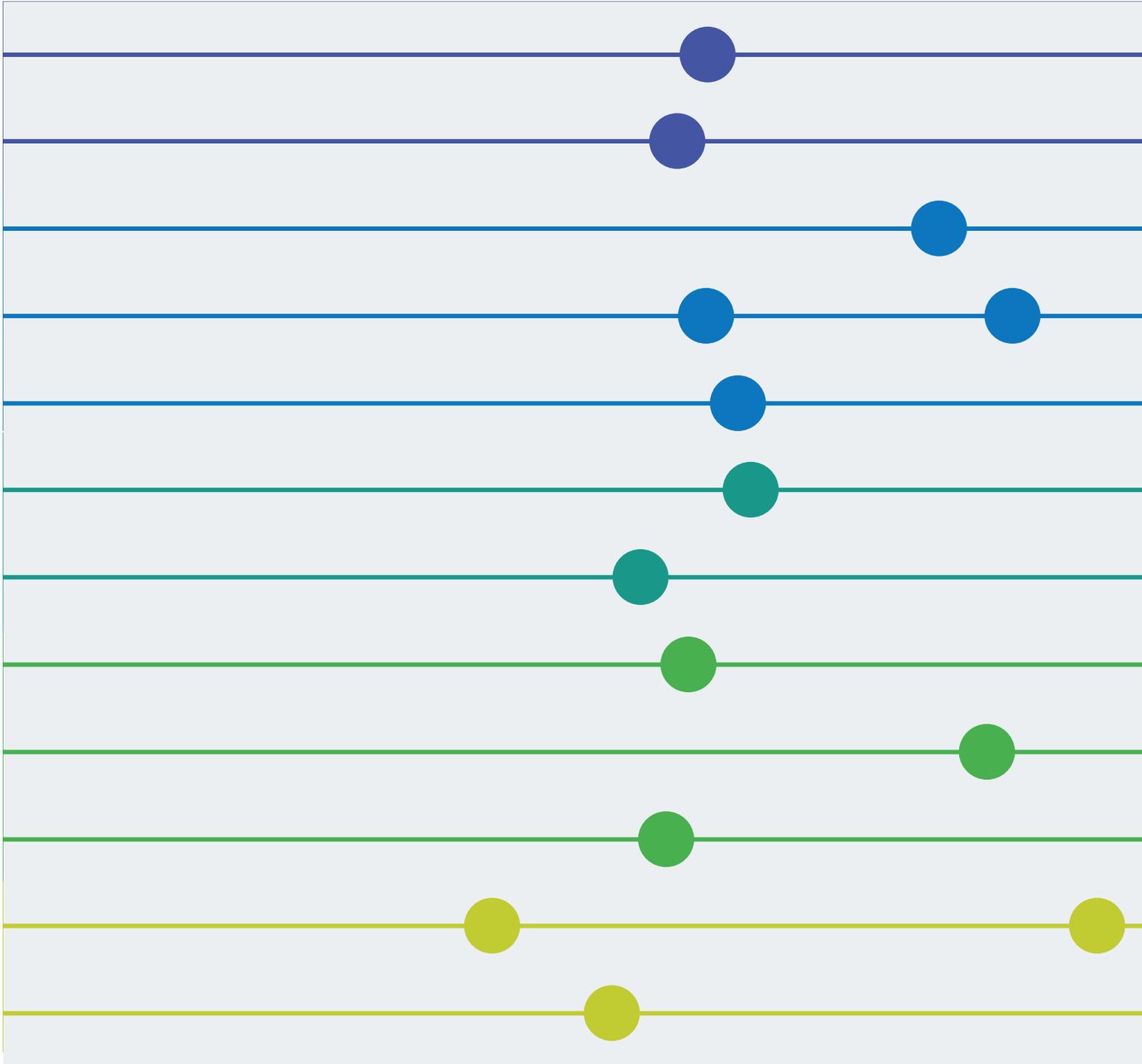
Conclusion

The HOPE Initiative envisions a nation where state and national policymaking prioritizes health, equity, and opportunity for all, with a particular focus on low-income families, people of color, and others who face currently face the widest gaps in opportunity and health. Ultimately, the goal of our work is to promote a Culture of Health that embraces fair and just opportunities to access needed

resources, provides metrics that society can use to track progress, enables forecasting of likely outcomes of state-level policy solutions, and promotes wise, strategic investments in remedying the root causes of inequities. It's in our national interest to nurture the resources that enhance all facets of a good life—for all.

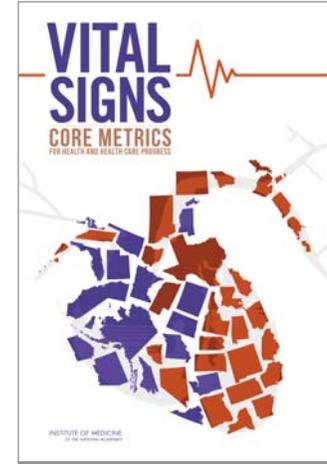
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Vital Signs

Core Metrics for Health and Health Care Progress



Thousands of measures are in use today to assess health and health care in the United States. Although many of these measures provide useful information, their sheer number, as well as their lack of focus, consistency, and organization, limits their overall effectiveness in improving performance of the health system. To achieve better health at lower cost, all stakeholders—including health professionals, payers, policy makers, and members of the public—must be alert to which measures matter most. What are the core measures that will yield the clearest understanding and focus on better health and well-being for Americans?

With support from the Blue Shield of California Foundation, the California Healthcare Foundation, and the Robert Wood Johnson Foundation, the Institute of Medicine (IOM) convened a committee to identify core measures for health and health care. In *Vital Signs: Core Metrics for Health and Health Care Progress*, the committee uses a four-domain framework—healthy people, care quality, lower cost, and engaged people—to propose a streamlined set of 15 standardized measures, with recommendations for their application at every level and across sectors. Ultimately, the committee concludes that this streamlined set of measures could provide consistent benchmarks for health progress across the nation and improve system performance in the highest-priority areas.

A streamlined set of measures could provide consistent benchmarks for health progress across the nation and improve system performance in the highest-priority areas.

The Measurement Landscape

Health measurements are requested or required by many organizations for many purposes, including efforts to track population, community, and individual health; assessments of health care quality and patient experience; transparency monitoring; public reporting and benchmarking; system or professional performance requirements; and funder reporting. Many of these measures are very similar, with only slight variations in terminology and methodology. However, their differences are often significant enough to prevent direct comparisons across states, institutions, and individuals. In addition, many measures focus on narrow or technical aspects of health care processes, rather than on overall health system perfor-

mance and health outcomes. According to the committee, the growing number of clinical measures, even those that provide valuable information, draws attention to narrow, specific elements and away from system capacity and effectiveness.

The necessity to collect, analyze, and store data for such a large number of measures also imposes a significant burden on providers, organizations, and the health care system as a whole. Preliminary research commissioned by the committee finds that the growth in measurement and reporting activities results in considerable expense and requires substantial time commitments—without a matching return on investment. The establishment of a core set of measures could improve efficiency and ensure a focus on the most important health outcomes.

The Core Measure Set

To select a core measure set, the committee first considers each candidate measure’s importance for health, likelihood to contribute to progress, understandability, technical integrity, potential to have broader system impact, and utility at multiple levels. Next, in considering how the measures should

operate as a set, the committee selects 15 measures that together have systemic reach, are outcomes-oriented, are meaningful at the personal level, are representative of concerns facing the U.S. health system, and have use at many levels. The core measures proposed by the committee are as follows:

- 1. Life expectancy:** Life expectancy is a validated, readily available, and easily understandable measure for a critical health concept. Because life expectancy depends on a full range of individual and community influences on health—from cancer to homicide—it represents an inclusive, high-level measure for health.
- 2. Well-being:** Well-being captures the subjective dimensions of health related to quality of life. Furthermore, levels of well-being often predict utilization of and satisfaction with health care. Self-reported well-being is a reliable indicator.
- 3. Overweight and obesity:** More than two-thirds of Americans are overweight or obese, a fact that has causes and consequences that extend beyond the health system—including socioeconomic, cultural, political, and lifestyle factors.

BOX Core Measure Set with Related Priority Measures

 <p>1. Life expectancy Infant mortality Maternal mortality Violence and injury mortality</p>	 <p>7. Preventive services Influenza immunization Colorectal cancer screening Breast cancer screening</p>	 <p>11. Care match with patient goals Patient experience Shared decision making End-of-life/advanced care planning</p>
 <p>2. Well-being Multiple chronic conditions Depression</p>	 <p>8. Care access Usual source of care Delay of needed care</p>	 <p>12. Personal spending burden Health care-related bankruptcies</p>
 <p>3. Overweight and obesity Activity levels Healthy eating patterns</p>	 <p>9. Patient safety Wrong-site surgery Pressure ulcers Medication reconciliation</p>	 <p>13. Population spending burden Total cost of care Health care spending growth</p>
 <p>4. Addictive behavior Tobacco use Drug dependence/illicit use Alcohol dependence/misuse</p>	 <p>10. Evidence-based care Cardiovascular risk reduction Hypertension control Diabetes control composite Heart attack therapy protocol Stroke therapy protocol Unnecessary care composite</p>	 <p>14. Individual engagement Involvement in health initiatives</p>
 <p>5. Unintended pregnancy Contraceptive use</p>		 <p>15. Community engagement Availability of healthy food Walkability Community health benefit agenda</p>
 <p>6. Healthy communities Childhood poverty rate Childhood asthma Air quality index Drinking water quality index</p>		

The necessity to collect, analyze, and store data for such a large number of measures imposes a significant burden on providers, organizations, and the health care system as a whole.

4. Addictive behavior: Addiction, including to nicotine, alcohol, and other drugs, is prevalent in the United States, representing a complex challenge for the health system, communities, and families. Every year, substance abuse and addiction cost the country more than \$500 billion.

5. Unintended pregnancy: Unintended pregnancy, a significant challenge for both individual and community health, is a measure that aggregates a variety of social, behavioral, cultural, and health factors—particularly women’s knowledge about and access to tools for family planning.

6. Healthy communities: Individual health is a function of a wide range of socioeconomic and community factors, from infrastructure to social connections. Community health includes critical elements of health that fall outside the care system, such as housing, employment, and environmental factors.

7. Preventive services: Preventive services (for example, screening for hearing loss or counseling for tobacco cessation) present a valuable opportunity for both improving health and reducing costs.

8. Care access: A person’s ability to access care when needed is a critical precondition for a high-quality health system. Factors that could hamper access to care include lack of health insurance, clinician shortages, lack of transportation, cultural and linguistic barriers, and physical limitations.

9. Patient safety: Avoiding harm is among the principal responsibilities of the health care system, yet adverse outcomes are common. Ensuring patient safety will require a culture that prioritizes and assesses safety through a reliable index of organizational results.

10. Evidence-based care: Ensuring that patients receive care supported by scientific evidence for appropriateness and effectiveness is a central challenge for the health care system. Currently, an estimated one-third of U.S. health care expenditures

do not contribute to improving health. Aggregating carefully selected and standardized clinical measures can provide a reliable composite index of system performance.

11. Care match with patient goals: Systematically assessing each patient’s individual goals and perspectives ensures that the health care system is focusing on the aspects of care that matter most to patients.

12. Personal spending burden: Care that is too expensive can limit access to care, lead people to avoid care, or prevent them from spending money in other areas of value to them—with far-reaching economic impacts.

13. Population spending burden: Health care spending consumes a large portion of the U.S. gross domestic product, dwarfing the health care spending of other nations. This burden can be measured at national, state, local, and institutional levels.

14. Individual engagement: Given the effects of personal choices on health, as well as the increasing use of personal health devices, it is critical for individuals to be aware of their options and responsibilities in caring for their own health and that of their families and communities.

15. Community engagement: Across the United States, communities have and utilize different levels of resources to support efforts to maintain and improve individual and family health—for example, addiction treatment programs, emergency medical facilities, and opportunities for social engagement.

The committee recognizes that these 15 measures will not be sufficient to meet every interest for each organization, nor are there established methods for measurement in each area. To begin to accommodate these challenges, the committee identifies 39 additional priority measures that can act as surrogates while refinement is under way (see Box).



Committee on Core Metrics for Better Health at Lower Cost

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Refinement of the measures and methodology will require leadership from stakeholders across sectors.

Implementation of the Core Measures

Successful implementation of the core measures will depend on their relevance, reliability, and utility to stakeholders. Implementation challenges include multiple competing priorities for stakeholders, the sizable degree of change proposed, and the slow pace of change overall in the health system. Progress can be accelerated by ensuring that the core measurement set is applied by, and adds value to, existing measurement activities. The committee stresses that leadership will be required at nearly every level of the health system. CEOs of health care organizations, payers and employers, standards organizations, and public health agencies will have important roles in the uptake, use, and maintenance of the core measures as practical tools. The committee recommends that the Secretary of the Department of Health and Human Services, with support from the Executive Office of the President, lead the effort to refine, standardize, and implement core measures throughout the nation.

Conclusion

The set of core measures proposed by the committee is a tool for enhancing the efficiency and effectiveness of measurement. Ultimately, widespread application of a limited set of standardized measures could not only reduce the burden of unnecessary measurement but also align the incentives and actions of multiple organizations at multiple levels. *Vital Signs* lays the groundwork for the adoption of core measures that, if systematically applied, could yield better health at lower cost for all Americans. 



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Overview of the CMS Meaningful Measures Initiative

Launched in 2017, CMS's new comprehensive "[Meaningful Measures](#)" initiative identifies high priority areas for quality measurement and improvement to improve outcomes for patients, their families, and providers while also reducing burden on clinicians and providers.

The Meaningful Measures initiative draws on prior measure work performed by the Health Care Payment Learning and Action Network, National Quality Forum, and National Academies of Medicine. It includes perspectives from patient representatives and additional experts such as the Core Quality Measures Collaborative, and many other external stakeholders.

Principles for Identifying Meaningful Measures

Meaningful Measures will move payment toward value by focusing everyone's efforts on the same quality areas and advancing specificity by identifying measures that:

- Are patient-centered and meaningful to patients, clinicians, and providers
- Address high-impact measure areas that safeguard public health
- Are outcome-based where possible
- Minimize level of burden for providers
- Create significant opportunity for improvement
- Address measure needs for population based payment through alternative payment models
- Align across programs

Rethinking Our Approach to Meaningful Outcomes

The Meaningful Measures Framework builds upon multiple concepts that defined **high impact areas** for quality measurement and quality improvement. We refer to these high impact areas as "Meaningful Measure Areas" (see Meaningful Measures graphic below). These Meaningful Measure areas:

- Offer more granular details in terms of what measurement areas to focus on
- Use a new approach to development and implementation of meaningful quality measures while reducing the burden of quality reporting on all clinicians and providers

Mapping It Out—The Framework

The following Meaningful Measures Framework shows how at CMS the **patient is always at the center of everything we do. Our strategic goals surround the patient:**

1. Improve the CMS customer experience
2. Usher in an era of state flexibility and local leadership
3. Support innovative approaches to improve quality, accessibility, and affordability
4. Empower patients and doctors to make decisions about their health care



Meaningful Measures Framework



- **Promote Effective Communication & Coordination of Care**
 Meaningful Measure Areas:
 - Medication Management
 - Admissions and Readmissions to Hospitals
 - Transfer of Health Information and Interoperability
- **Promote Effective Prevention & Treatment of Chronic Disease**
 Meaningful Measure Areas:
 - Preventive Care
 - Management of Chronic Conditions
 - Prevention, Treatment, and Management of Mental Health
 - Prevention and Treatment of Opioid and Substance Use Disorders
 - Risk Adjusted Mortality
- **Work with Communities to Promote Best Practices of Healthy Living**
 Meaningful Measure Areas:
 - Equity of Care
 - Community Engagement
- **Make Care Affordable**
 Meaningful Measure Areas:
 - Appropriate Use of Healthcare
 - Patient-focused Episode of Care
 - Risk Adjusted Total Cost of Care
- **Make Care Safer by Reducing Harm Caused in the Delivery of Care**
 Meaningful Measure Areas:
 - Healthcare-associated Infections
 - Preventable Healthcare Harm
- **Strengthen Person & Family Engagement as Partners in their Care**
 Meaningful Measure Areas:
 - Care is Personalized and Aligned with Patient's Goals
 - End of Life Care according to Preferences
 - Patient's Experience of Care
 - Patient Reported Functional Outcomes

The **four CMS strategic goals** are encircled by **six cross-cutting criteria** that are applied to any Meaningful Measure area:

1. Eliminating disparities
2. Tracking to measurable outcomes and impact
3. Safeguarding public health
4. Achieving cost savings
5. Improving access for rural communities
6. Reducing burden

The Meaningful Measures Framework aligns CMS measure work with the **six overarching quality categories**, which also serve to organize the **19 Meaningful Measure areas** into specific quality domains. These six quality categories are:

1. Promote Effective Communication and Coordination of Care
2. Strengthen Person and Family Engagement as Partners in their Care
3. Promote Effective Prevention & Treatment of Chronic Disease
4. Work with Communities to Promote Best Practices of Healthy Living
5. Make Care Affordable
6. Make Care Safer by Reducing Harm Caused in the Delivery of Care



Meaningful Measures Framework Example

The following is an illustrative example of how the overarching domains, goals, criteria, and measures are interrelated in the Meaningful Measures Framework. The quality category of “Promote Effective Prevention and Treatment of Chronic Disease” includes five Meaningful Measure areas as listed in the above Framework including the Prevention and Treatment of Opioid and Substance Use Disorders. The opioid crisis has been declared a public health emergency and therefore it has been recognized as a high priority focus area for measurement.



Next Steps

There are three dimensions to the implementation of Meaningful Measure areas:

1. Conduct thorough review of existing measures and remove ones that don't meet criteria;
2. Analyze measure sets to identify gaps based on the Meaningful Measures Framework; focus any new measures on filling these gaps and moving from lower value process measures towards higher value measures such as outcome measures; and
3. Work with clinicians, providers, registries, EHR vendors and other federal stakeholders to advance measurement systems to lower burden particularly around the area of reporting.

Additionally, there will be ongoing efforts to receive stakeholder input to further improve the Meaningful Measures Framework, work across CMS components to implement the Framework, and evaluate current measure sets to inform measure development.

For More Information

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





A Measurement Framework for a Healthier Minnesota

REPORT TO THE MINNESOTA LEGISLATURE

February 2019

A Measurement Framework for a Healthier Minnesota

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Upon request, this material will be made available in an alternative format such as large print, Braille or audio recording. Printed on recycled paper.

As requested by Minnesota Statute 3.197: This report cost approximately \$293,107 to prepare, including staff time, printing and mailing expenses.



Protecting, Maintaining and Improving the Health of All Minnesotans

February 27, 2019

The Honorable Jim Abeler
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The Honorable Michelle Benson
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To the Honorable Chairs and Ranking Members:

As a national leader in the measurement of health care quality, Minnesota pioneered efforts to measure and report on clinical quality and established a standardized quality measurement system that has

measured clinic and hospital quality over the past nine years. In 2017, the Minnesota Legislature directed MDH to develop a quality measurement framework with stakeholder input, recognizing the need for Minnesota to critically assess the value and impact of its current measurement system amidst a much-evolved local and national measurement landscape.

This report presents results from the foundational first phase of our work toward completing a quality measurement framework. We had rich conversations with a wide range of stakeholders that helped lay the groundwork for a new vision of quality measurement for Minnesota. There is widespread enthusiasm for evolving our current quality measurement system and creating a stronger focus on improvement, as well as for widening the scope of measurement beyond health care to health broadly. This report contains findings from the first phase of framework development and a roadmap intended to guide the remaining work and its implementation.

Along with our partners, we are eager to continue our work toward a fully developed measurement framework. We see a valuable opportunity for Minnesota to take the lead on developing and implementing an evolved system of quality measurement; one that, among other aspects, engages community members in the process, is guided by a set of values and principles, and is subject to ongoing evaluation.

We look forward to carrying out the second phase of quality framework development during 2019, after which we will provide an update to the Legislature. If you have questions or concerns regarding this project, please contact me at 651-201-5810 or jan.malcolm@state.mn.us, or Stefan Gildemeister, the State Health Economist, at 651-201-3554 or stefan.gildemeister@state.mn.us.

Sincerely,

Jan K. Malcolm
Commissioner of Health

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Executive Summary

In 2009, the Commissioner of Health established a standardized set of quality measures for health care providers across the state that built on existing voluntary measurement efforts. The standardized quality measure set is called the Statewide Quality Reporting and Measurement System (Quality Reporting System). Quality measurement is a valuable tool that health care delivery organizations, providers, purchasers, and others use to drive improvements in health care quality, curb costs, and bring accountability and transparency to patient outcomes. However, there is still a lot about quality measurement and its impact that is uncertain, and much has changed in health care delivery and payment since the Quality Reporting System began.

Acknowledging the need for Minnesota to critically assess the impact and effectiveness of its current measurement system, the Minnesota Legislature directed the Minnesota Department of Health (MDH) to develop a quality measurement framework in consultation with a broad group of stakeholders. This opportunity allows the state to imagine and design a system of measurement that is responsive to lessons learned from prior experience and to define the value of a Minnesota system within an evolved local and national measurement landscape.

Over the past nine months, MDH conducted the following activities to inform the development of the quality measurement framework:

- We performed an environmental scan of quality measurement efforts in other states, and;
- We conducted a robust, “community-owned” stakeholder engagement process that included working with a steering team, holding individual and small group interviews with stakeholders (including representatives of communities disproportionately impacted by health disparities), and engaging with a workgroup of partners across state government.

Key Findings

In this first phase of framework development, stakeholder conversations generated the following findings about the bigger picture of what we measure in Minnesota and why, and how different stakeholders can contribute to a new measurement framework for a healthier Minnesota.

- **There is strong enthusiasm in Minnesota for evolving health quality measurement and creating a stronger focus on improvement.** Stakeholders showed much enthusiasm for the topic of health quality measurement and for a system that can help us set and achieve improvement goals. They exhibited a keen interest in building upon collective experience to develop a new quality measurement framework to foster a healthier Minnesota.
- **Measurement for a healthier Minnesota should focus on more than health care.** Stakeholders emphasized that the quality framework and measurement system that flows from it should go beyond clinical care to track key metrics in public and population health, as well as health system performance.

- **The framework must be nimble and adaptable.** Some stability is important to track progress and allow for quality improvement activities, and it is also important to have a system that evolves over time as priorities change and in response to ongoing evaluation about what does and does not work.
- **There is strong agreement among diverse stakeholders about the values and principles that should underpin the measurement framework.** There was consensus on key elements, such as fostering ongoing communication and collaboration among stakeholders, measuring what matters, and making information actionable to different stakeholders.
- **Minnesota’s health care quality measurement and reporting efforts exist within a larger context.** Minnesota’s system must be attentive to other programs to avoid duplication, reduce data collection and reporting burden, and assure Minnesota’s state-focused system is meaningful and adds value.
- **There is work remaining to refine the initial set of values and principles.** Before we can translate these values and principles into specific recommendations for changes to the Quality Reporting System, we need to work through some trade-offs and offer additional clarity.
- **Communities disproportionately impacted by disparities must have a strong role in defining health and health quality, and deciding how quality is measured.** All stakeholder groups thought the framework should intentionally and authentically advance health equity. Community members said that ongoing community engagement and leadership will be key to the full development, implementation, maintenance, and evolution of the measurement framework and system, and that the goal of this authentic engagement is to work *with* communities, not for or on behalf of them. Community members and others emphasized that the authentic approach MDH took to community engagement for this first phase of framework development was transformational and nation-leading.
- **The successful implementation of a measurement framework for a healthier Minnesota requires a robust, inclusive stewardship process with clear roles and accountability.** Stakeholders strongly felt that a stewardship process for the ongoing development and implementation of the health quality measurement framework must be trusted, transparent, and able to include all perspectives.

Roadmap to Completing Framework Development

Together with a broad range of stakeholders, MDH has laid a solid foundation for developing a measurement framework for a healthier Minnesota that MDH and partners will begin implementing in 2020. Additional work is needed to finish developing the framework, and some of these next steps will continue to evolve. MDH developed a roadmap to complete the framework during 2019, and critical components include:

- Leading an ongoing and inclusive stakeholder engagement process to gather additional input to help shape the framework, establish bi-directional communication with stakeholders, and continually inform best practices for a transparent and inclusive process;
- Finalizing certain framework components, such as naming framework users and identifying their needs, and identifying principles and characteristics of an evaluation plan;
- Determining how best to leverage existing efforts in the community;
- Articulating an effective stewardship structure; and

- Developing an implementation blueprint that specifies actions for MDH and key partners across professional organizations, communities, and others.

Conclusions

Across the board, stakeholders are excited to create a new framework for health quality measurement and improvement, and firmly believe that Minnesota should continue to be a leader and innovator in this space. Nevertheless, change is hard, and difficult conversations and decisions lie ahead as we determine quality improvement priorities, identify accountability paths, select measures, and allocate resources.

We had many questions going into this framework development process around alignment, improvement goals, use of measures, and more, and we are on the road to building a measurement framework that will help us to answer these and other fundamental questions. Building from the foundation that we collectively established this year, we are committed to developing the health quality measurement framework in consultation with stakeholders during 2019. We will provide the full framework to the Minnesota Legislature by the end of 2019, and will begin implementing the framework in 2020.

Introduction

The concept of measuring the performance of systems or activities with the goal of improving is embedded in all aspects of our economic and social fabric. It can be found in the development of processes that ensure air travel is safe, in comparisons of consumer experience with everything from restaurants to smartphones, in the monitoring of air and water quality, and assessing the effectiveness of policy interventions, such as seat belt laws.

Performance measurement in health care has been around since the 1960s in different forms, but it has evolved and been implemented unevenly across the delivery system. Even though the payoffs are still not fully understood, today, quality measurement is a valuable tool that is used by health care delivery organizations, providers, purchasers, and others to drive improvements in health care quality, curb costs, and bring accountability and transparency to patient outcomes.

With health care quality measurement in Minnesota going back to the early 2000s, the state has led the nation in many efforts to measure and report on various aspects of clinical and hospital quality, beginning with a voluntary statewide reporting system that began in 2002.

In more recent years, there has been a greater focus at the national level on quality measurement through, for example, the Centers for Medicare & Medicaid Services' (CMS) Quality Payment Program, the National Committee for Quality Assurance health plan accreditation, and the Health Resources & Services Administration's Health Center Program. Some of this work has been innovative and transformative, but aspects of it have contributed to what some observers term a "measurement tsunami." Other initiatives feel more like stagnation or reversal to states like Minnesota, who have led for years in the health care measurement space.

Although Minnesota has had a standardized statewide approach to physician clinic and hospital quality measurement for nine years and nation-leading measurement experience that pre-dates this system, there are aspects about quality measurement and its impact that are uncertain, lack complete evidence or were developed without effectively considering the views from communities that experience disparities. For example,

- Should quality measures be linked to explicit goals around quality improvement, and to what extent should expectations around population health, health equity, cost, and disease burden matter?
- Should all statewide measures be used in quality improvement, public reporting, and pay-for-performance, or are different measures better suited to different functions?
- Should we measure performance in other settings or across settings along the care continuum, and if so, how?
- Who are the potential users of the information, and what role can they play in helping to transform health and health care?
- To what extent do patients and their caregivers find the things that are important to them represented by the current measurement and reporting system?
- What should a state's role be in quality measurement, as national initiatives take on a greater footprint? Where can states add value?

It is a timely next step for Minnesota to acquire a deeper understanding of statewide quality measurement. Much has changed in health care delivery and payment since the Quality Reporting System was first implemented, and collectively, we have learned more about the strengths and limitations of quality measurement in general and our statewide system in particular. But the fact that Minnesota’s current measurement system does not allow us to answer these questions means that it is not as effective as it could be in promoting high-quality health care across the spectrum of settings—and that some participants in the system, like providers and patients—feel like their needs could be better met. Now, **our state has the opportunity to imagine and design a measurement system that addresses some of the lessons of the first years and critically considers improvement goals** as part of the equation.

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

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

In this update to the Minnesota Legislature, MDH is providing an overview of the current state of quality measurement in the state. We then describe the approach taken over nine months to address the legislative requirement. After presenting the findings from this initial work, we sketch out a roadmap towards completing the development of a measurement framework and offer conclusions for consideration by the Legislature.

Background

Quality Measurement in Minnesota

Minnesota clinics, hospitals, and health plans have a rich history of health care quality measurement through initiatives such as the Minnesota Health Data Institute; collaboratives, such as the Institute for Clinical Systems Improvement; adoption of the National Committee on Quality Assurance’s Health Care Effectiveness Data and Information Set (HEDIS); purchasing initiatives such as the Buyers Health Care Action Group (now the Minnesota Health Action Group); and voluntary data submission of Minnesota-grown outpatient measures through MN Community Measurement (MNCM). The Minnesota Hospital Association and Stratis Health have long supported hospital quality measurement and improvement activities for federal and state initiatives.

Prior to the passage of state health reform in 2008, payers were using a disparate set of health care quality measures to assess provider performance, resulting in substantial reporting burden and inconsistencies in reporting. To better coordinate measurement activities, establish a common set of

metrics, and encourage public reporting of results to increase accountability and improve care, the Minnesota Council of Health Plans established the Minnesota Community Measurement Project in 2002.¹ The project issued its first performance report on Optimal Diabetes Care in 2003, and its first report on medical group performance in 2004.

In 2005, Minnesota health plans and the Minnesota Medical Association established MNMCM as an independent nonprofit organization to better coordinate quality measurement activities including data collection, data validation, and measure development. Over the years, more medical groups submitted quality measure data to MNMCM, and health care organizations—including medical groups, health plans, state agencies, and business collaboratives—increasingly used the quality measures for quality improvement activities and pay-for-performance programs.

Minnesota Statewide Quality Reporting and Measurement System

Enacted in 2008, Minnesota’s health reform law requires the Commissioner of Health to establish a standardized set of quality measures for health care providers across the state.² The goal is to create a more uniform approach to quality measurement to enhance market transparency and drive health care quality improvement through an evolving measurement and public reporting strategy. This standardized quality measure set, which built on the earlier voluntary efforts and made data submission by health care providers mandatory, is called the Minnesota Statewide Quality Reporting and Measurement System (Quality Reporting System). Physician clinics and hospitals are required to report quality measures annually. Ambulatory surgical centers reported three quality measures between 2011 and 2013.

At this point, nearly 900 clinics report on 10 quality metrics; similarly, 133 hospitals report on a number of hospital measures (Appendix A). Physician clinics report patient socio-demographic information including gender, health insurance type, age, and ZIP Code, and for selected measures since 2017, race, ethnicity, preferred language, and country of origin. The hospital measures are highly aligned with federal requirements and reporting systems. MDH updates the measure set on an annual basis, and contracts with MNMCM to obtain physician clinic quality measure data.³

Payers may use Quality Reporting System measures for performance-based contracting or pay for performance initiatives. Consumers may use available data, reported on MNMCM’s MNHealthScores website, to choose a clinic or at least understand relative performance. Health care delivery organizations and providers may use their data for quality improvement initiatives and benchmarking.

¹MN Community Measurement (MNCM), mncm.org.

²Minnesota Statutes, Section 62U.02.

³To identify a qualified vendor, MDH conducted two competitive procurement processes in 2008 and 2013.

Some Challenges

As noted in the introduction, there are a range of questions about how the current measurement strategy, even if narrowly focused on clinical performance, fits within an effective, modern approach to health and health care improvement. The following challenges are voiced most often by a range of stakeholders:

Reporting burden. The Quality Reporting System was set up as a standardized tool for measuring and reporting on clinical performance measures. The intention was to limit the volume of measures and the administrative effort by health care providers to collect and report data consistent with measure specifications, and to create a standard set of measures that would be used across payer organizations. Much has worked well in this regard:

- We have a single standardized set of measures for all physician clinics and hospitals, and commercial health plans, the Department of Human Services, and other health care purchasers use the measures;
- Health care providers have been highly involved in decisions about measurement and public reporting; and
- Minnesota has evolved beyond measuring processes to measuring outcomes.

However, the Quality Reporting System does not exist in isolation and the overall burden of quality measurement that serves multiple local and federal payers, and health care providers' internal quality improvement efforts, is high and increasing. For example, private and public payers can calculate quality measures from health care claims, and use those measures in contracts with health care providers. In addition, payers may use any measure endorsed by the National Quality Forum for performance measurement. Therefore, even though MDH specifies a small number of provider-reported measures under Minnesota's statewide system, providers may still be held accountable for their performance on hundreds of quality measures by numerous private and public payers. Finally, although most health care providers in our state have implemented electronic health record systems, Minnesota has yet to reach the ideal of real-time electronic measurement that could help limit some of the existing resource-intensive manual data abstraction.

Static and narrow measurement landscape. The Quality Reporting System has not been paired with an explicit quality improvement strategy or related goals. As a result, we at MDH do not have firm criteria for adding and removing measures, and we do not have a good sense for whether measures are impactful or when they cease to hold value. We tend to measure care for common conditions and procedures, not for patients who have more complex health problems or unique circumstances. Additionally, for most patients, their experience of health care crosses health care delivery organizations and providers, conditions, and systems; our measurement, however, rarely reflects this lived experience. This lack of measurement along and across the care continuum is in part due to our primary motivation for measurement—provider accountability—and it is also about the ease of measurement—it can be easier to measure a primary care visit versus a care experience that includes a hospital stay plus follow-up with specialty and primary care. As a result, measurement of care quality generally fails to measure some key aspects of system performance that matter to many patients:

- How care was transitioned;
- Whether the provider delivered safe care;
- The extent to which culturally-competent care was provided;
- How neighborhood and cultural factors were taken into consideration (in care delivery or measurement); and more.

Approach to Developing A Minnesota Measurement Framework

The legislative direction to develop a quality measurement framework, as noted above, intersects with significant rethinking of measurement activities at the federal government, by national measurement organizations and health care payers, and within state governments. In its challenge to tie a measurement framework to health improvement goals, the legislative direction also aligns with discussions in Minnesota over the past few years about preventing potential unintended consequences of quality measurement for safety net providers, acknowledging the potential for measurement to improve health inequities, and being responsive to the factors in health care delivery patients ultimately care about (Appendix B).

To take advantage of this environment and the existing critical thinking, MDH conducted an environmental scan of activities related to measurement questions, which can be found in Appendix C. We approached developing a framework as a community-owned process, by working with stakeholders in three ways.

1. **Steering team:** We convened a 10-member steering team including state and national experts on quality measurement and improvement, care delivery, policy, and authentic community engagement (Appendix D).
2. **Interactions with many more Minnesotans:** We held 19 small group and key informant interviews with 106 participants 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; public health organizations; e-health practitioners; and quality improvement and measurement organizations.
3. **Administration workgroup:** We convened a workgroup of representatives from MDH, the Department of Human Services, and the State Employee Group Insurance Program within Minnesota Management and Budget who have expertise in health care delivery and purchasing, health information technology, population health, and health equity.

The findings in this status report flow from the stakeholder engagement process. Appendix E includes more information on our approach to stakeholder consultation.

Findings

We knew that the next step of measurement for a healthier Minnesota—to develop a measurement framework—would be a significant undertaking, yet there is widespread enthusiasm for this opportunity to be transformational with a refreshed approach to statewide health improvement and measurement. Our environmental scan showed that no other states have developed and implemented a health quality measurement framework like the one the Legislature envisioned. Adding to the challenge, stakeholders correctly pointed out that measurement for a healthier Minnesota includes more than clinical care, and that we are operating within an intricate measurement ecosystem that includes priorities and measures from individual health care systems, health plans, and the federal government—systems and activities that do not “talk to each other.”

We have begun a needed conversation about the bigger picture of what we measure in Minnesota and why, and the contributions of different stakeholders to help us achieve a new measurement framework for a healthy Minnesota. This conversation is taking place in two phases, with the first representing our work to date.

What We Learned in Phase One

There is strong enthusiasm in Minnesota for evolving health quality measurement and creating a stronger focus on improvement. To begin developing a quality measurement framework, we asked stakeholders foundational questions about the role that health care plays in maintaining health and what high quality health care means. This approach allowed stakeholders to think critically about the current measurement system and what it has accomplished. When we entered into these discussions, we did not know how interested stakeholders would be in the framework considering the vast array of health and health care issues and priorities faced by the health care industry, communities and patients, and others. We soon learned that there was much enthusiasm across stakeholder groups for the topic of health quality measurement and for a system that is organized around explicit improvement goals.

Measurement for a healthier Minnesota must focus on more than just health care. Over the course of these conversations, stakeholders across the board, whether they were patients, representatives of local communities, or health care providers, emphasized that the quality framework and measurement system that flow from it should go beyond clinical care. Such a measurement system should be designed around evidence about what creates health and has the potential to improve health. As such, stakeholders found that a measurement framework needed to include measuring clinical quality of care, and also track key metrics in public and population health, as well as health system performance.

The framework must be nimble and adaptable. While some stability in measurement over time is important to track progress and to allow health care delivery organizations and providers time to develop and implement improvement practices, it is also important that the framework be nimble and adaptable. Stakeholders imagined a measurement ecosystem in which the health quality measurement framework evolves over time as priorities change and in response to ongoing evaluation about what does and does not work and the extent to which goals are met.

There is strong agreement among diverse stakeholders about the values and principles that should underpin the measurement framework. During the five-month discussions with stakeholders, we had the chance to hone a set of values and principles that are fundamental to how we might wish to measure to improve Minnesotans' health (see Figure #1). There was strong consensus on key elements, such as fostering ongoing communication and collaboration among stakeholders, measuring what matters, and making information actionable to different stakeholders, though stakeholders began from a diverse set of starting points. This agreement was shared widely as we tested the values and principles with additional groups, including a workgroup of clinician members of the Minnesota Medical Association who were working in a parallel process on a strategic plan for measurement that improves state and federal alignment, prioritizes statewide mandatory measurement, and expands physician leadership in the measurement agenda.

Minnesota's health care quality measurement and reporting efforts exist within a larger context. Many other quality measurement and reporting efforts exist; and in particular, federal government quality measurement and reporting has expanded and matured significantly in recent years. Stakeholders agree that there needs to be a clear sense of why a Minnesota-specific measurement system is not only needed but desirable. Minnesota's system must be attentive to other measurement efforts to minimize data collection and reporting burden, avoid duplication, and assure Minnesota's state-focused system adds value. Stakeholders believe, if this careful balance could be achieved anywhere, it would be in Minnesota, where we are accustomed to innovate and lead in this area.

Figure 1. Emerging Health Quality Measurement Framework Values and Principles

VALUES

The Minnesota Quality Measurement Framework fosters:

1. Fairness and equity
2. Connection and collaboration
3. Measurement that matters
4. Actionable information
5. Improvement
6. Accuracy and rigor
7. Innovation
8. Transparency and simplicity
9. Efficiency

PRINCIPLES

1. Health is more than health care, and a measurement framework should recognize this by:
 - a. Linking up with overarching concepts of quality (e.g., safety);
 - b. Incorporating and appropriately accounting for provider, system, community, cultural, and patient factors that contribute to variation in quality measure results; and
 - c. Exploring 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 health outcomes, health care quality, health equity, patient experience, and population health, and reduction in costs for patients, health care providers, and purchasers.
3. Quality measurement should be patient-centered and produce information that is meaningful, fair, transparent, and actionable for different stakeholders (e.g., patients, health care providers, health plans) in different ways (e.g., decision-making, public reporting, internal improvement, value-based purchasing). Measures do not need to be used by all stakeholders for all purposes.
4. Quality measurement in Minnesota should be parsimonious, appropriately balance value for stakeholders with reporting burden, and not duplicate other efforts.
5. Minnesota must measure what is most important; a measurement framework should provide cohesiveness and alignment around what is important.
6. The quality framework should be regularly monitored and updated via an inclusive, transparent process to ensure it meets goals.

There is work remaining to refine the initial set of values and principles. By their nature, values and principles represent high-level consensus. But before we can translate these values and principles into specific recommendations for changes to the Quality Reporting System or the formation of a broader measurement framework, we need to work through some trade-offs and offer additional clarity. For example, broadening the measurement scope to include factors at the population/neighborhood level and across systems of care may be in conflict with the goal of a parsimonious measure set.⁴ Further, the third value articulates the expectation that “measurement matters.” A framework will benefit from additional clarity about for whom measurement should matter in cases where measurement may not matter universally.

Communities disproportionately impacted by disparities must have a strong role in defining health and health quality, and deciding how quality is measured. All stakeholder groups thought the health quality measurement framework should intentionally and authentically advance health equity, considering the significant disparities that exist across our state. The framework and measurement system should drive towards improvements in health outcomes statewide for vulnerable populations, including, but not limited to, the old and the young, Minnesotans from different cultural and economic backgrounds, and persons with disabilities. Community members who we spoke with emphasized that patients are the experts about the disparities that affect them, and we should turn to them to help identify gaps in equitable health outcomes, priorities, and solutions to close the gaps. Community members and others emphasized that the authentic approach we took to community engagement for this first phase of framework development is transformational and nation-leading. They said that ongoing community engagement and leadership will be key to the full development, implementation, maintenance, and evolution of the measurement framework and system, and that the goal of this authentic engagement is to work *with* communities, not for or on behalf of them.

The successful implementation of a measurement framework for a healthier Minnesota requires a robust, inclusive stewardship process with clear roles and accountability. Stakeholders strongly felt that a stewardship process for the ongoing development and implementation of the health quality measurement framework must be trusted, transparent, and able to include all perspectives. Envisioned outcomes include:

- Effective management of personal and system power dynamics to ensure all voices are heard, values and principles are followed, and transparency and collaboration are upheld;
- Provision of technical assistance; and
- A living measurement system that adapts to what is and is not working well.

⁴According to the National Quality Forum, a not-for-profit organization that works to improve health care, being parsimonious with measures means using only as many measures as necessary to meet a program’s goals—no more, no less.

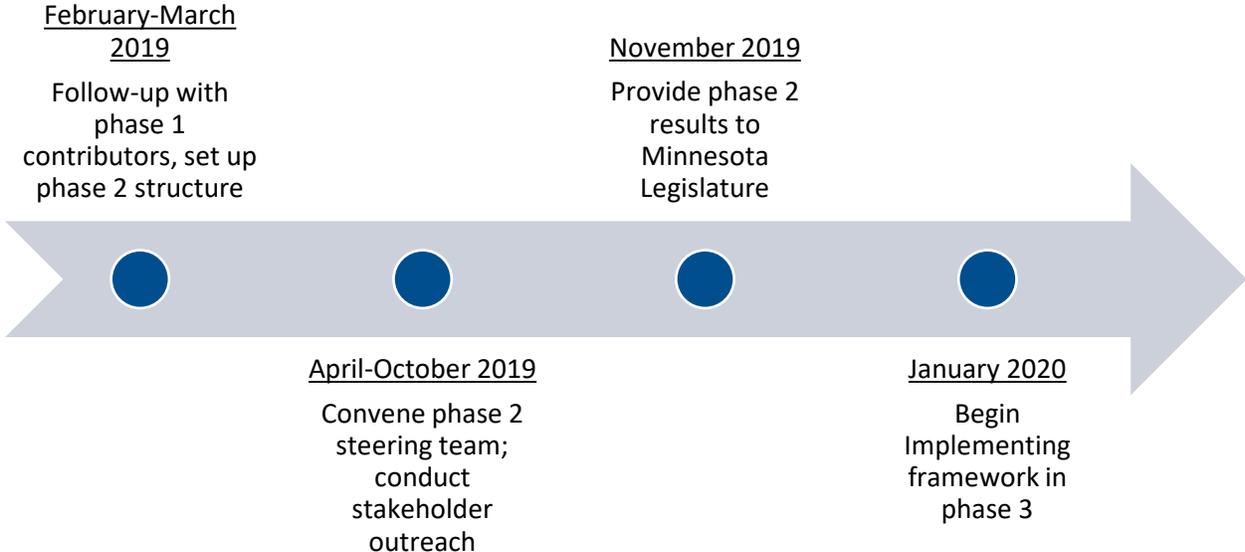
A Roadmap for Completing the Development of the Measurement Framework

Together with a broad range of stakeholders, MDH has laid a solid foundation for developing a measurement framework for a healthier Minnesota. We realized it was important to take the time to get input from a broad range of perspectives, which is why we are extending the framework development timeline to two years to maintain this intentional, inclusive, and thoughtful approach. We expect to begin implementing aspects of the framework in 2020 as directed. Critical and evolving components of the work MDH will conduct in 2019 include:

- Leading an ongoing and inclusive stakeholder engagement process to gather additional input to help shape the framework, establish bi-directional communication with stakeholders, and continually inform best practices for a transparent and inclusive process;
- Finalizing certain framework components, such as naming framework users and identifying their needs, and identifying principles and characteristics of an evaluation plan;
- Determining how best to leverage existing efforts in the community;
- Articulating an effective stewardship structure; and
- Developing an implementation blueprint that specifies actions for MDH and key partners across professional organizations, communities, and others.

MDH expects to provide a full framework and implementation blueprint to the legislature in 2019, and will begin framework implementation in 2020. See Figure 2 for a timeline of framework development milestones.

Figure 2. Measurement Framework Development Timeline



Continue Stakeholder Engagement

Hearing from a wide range of stakeholders, including those who often don't have the opportunity to help shape how we think about health and health care, has been critical to the process of moving towards developing a measurement framework. It has produced a sense of shared ownership across the spectrum of perspectives, resulted in powerful consensus over the direction towards shaping a framework, and confirmed the important role of community members in this work.

We will maintain an ongoing and inclusive stakeholder engagement process to further develop the health quality measurement framework by:

- **Maintaining a steering team.** Given the focus on developing transformative processes and structures, we plan on adding health plan, health care purchaser, and public health representatives to the steering team, along with other members as needed. We will convene this expanded team in early 2019. The charge of this group will be to continue to develop framework components, articulate a stewardship process, and create an implementation blueprint.
- **Collecting and incorporating additional suggestions from stakeholders.** We will meet with stakeholders who provided input into this first phase of framework development to share results and begin work on the second phase. We will issue a broad invitation to stakeholders to participate in a survey about the results of the first phase and components of the next phase. Additionally, as we make progress further developing the framework in the second phase, we will work with the steering team to identify where input from the broader stakeholder community is needed and determine how to best engage authentically with stakeholders, especially patients and community members.

Develop Framework Components

In consultation with stakeholders, we will further develop framework components by:

- **Refining and defining values and principles.** As noted, the current set of values and principles in some cases may require adding further precision and in other cases explicitly resolving tensions between conflicting goals. Discussions with the steering team and other stakeholders will help prioritize and delegate decision-making, where appropriate, to the implementation phase.

Call to Action

- **Patients and communities:** Continue to demand an explicit role in decision-making on measurement.
- **Health care delivery organizations and providers:** Use your expertise to help identify measures that are meaningful to patients and operationally relevant and are worth the resource investment.
- **Employers:** As the strongest stakeholder with substantial leverage, use your purchasing power to identify what metrics matter to your employees and your bottom-line, and change the system.
- **Health plans:** As brokers for employers and consumers, help identify the parsimonious set of measures that help maintain and restore health, not just monitor the delivery of health care.

- **Naming framework users and identifying their needs.** In the first phase of framework development, we acknowledged that there would be multiple users of the measurement system. In the second phase, we will look to define who they are; what matters to them; what measurement is already occurring by local health care delivery organizations and providers, health plans, quality measurement organizations, and CMS; and what gaps in priority measurement exist.
- **Proposing approaches for identifying what measurement is most important, how to make it actionable, how to resolve trade-offs, and how to identify the potential for unintended consequences.** Not only is it important to identify users and determine what measurement is important to them, a complete framework will require an approach, including a set of criteria, for resolving potential tradeoffs between users, what is important to them and the burden measurement creates. Similarly, with the focus on actionable change, a framework will need to include a process for determining the potential for unintended consequences and how to address them.
- **Proposing recommendations to guide innovation in measurement of health and health care.** A critically important recommendation from the process in the first phase of framework development concerned the challenge to MDH that the framework accommodate robust opportunities for innovation in measurement and improvement priorities, measurement methods, and measure data sources. A complete framework should encourage measurement across the spectrum of health and health care, and sites of service; accommodate different models for measurement and reporting; expand our approach to what data to use for measurement; and whether to measure across broad populations and aspects of measurement or more narrowly.
- **Identifying principles and characteristics of an evaluation plan.** One of the most powerful observations during the discussions in the first phase of framework development concerned the expectation that a measurement system should never be static. It should be accountable to established goals through ongoing evaluation and be nimble enough to adjust. How to structure such a plan, embed it into measurement up-front, and finance it, will be a key discussion point during the remaining work of framework development.
- **Operationalizing health equity.** One goal of the framework will be to contribute to meaningfully improve outcomes for Minnesotans who disproportionately experience health disparities. As such, the framework will need to be aware of the features of measurement systems—in the clinical space and beyond—that may cause or exacerbate inequities in the delivery and in opportunities to have good health, and articulate strategies for addressing these structural barriers.

Call to Action

- **Public health:** Use your unique understanding of the power of upstream interventions to challenge academia, funders and practice to create evidence on the link between investments and returns.

- **Measurement and improvement experts:** Help us break out of “what’s worked great.” Identify transformational efforts in measurement and improvement, the development of new data sources, and ways to leverage technology, learning collaboratives, and more.

- **Health information technology experts:** Make progress in ensuring that quality measurement is timely and actionable for health care providers and others, without requiring substantial customization or manual curation of data by care organizations.

- **Government:** Identify the role where you can make the greatest contribution to improvement and innovation—do not stagnate.

Develop a Model for Framework Stewardship

In order for the framework to be more than a set of aspirational goals, it has to include an effective and inclusive mechanism for stewardship and processes that will guide MDH's implementation and operationalization of key decisions.

While MDH is ultimately responsible for implementing, maintaining, and evolving the framework, and is accountable to the Legislature, a successful implementation of this measurement framework will depend on strong collaboration and partnership with stakeholders across the state and a range of organizations who bring their insights and talents with the aim of transforming health measurement in our state.

Guided by stakeholders during phase 2 of shaping the measurement framework, MDH will develop one or more models of multi-stakeholder stewardship—in which it will also be a participant—and will consider the strengths, weaknesses, and resource needs of various stewardship approaches. Together we will consider the need and shape for a stewardship body that will function in a strategic decision-making capacity to prioritize and plan implementation activities, develop improvement goals, establish workgroups as needed, and make recommendations to MDH and, as appropriate, the Legislature. In our discussions with stakeholders in the development of a stewardship model, we will work to clarify roles, responsibilities, and accountabilities among patients and communities, health care organizations and clinicians, public health practitioners, and policy makers.

Create an Implementation Blueprint

Finally, in consultation with stakeholders, we will develop a framework implementation blueprint that articulates timelines and milestones, as well as recommendations with supporting actions, resources, and considerations (such as statutory authority). Implementation activities that we will describe in the blueprint and that will be developed in phase 2 of this process include, for example, establishing the vision and goals of the measurement system, articulating an approach to community and patient engagement at all levels of decision-making, and developing a process for evaluating the measurement system.

Figure 3. Measurement Framework Development: Progress and Remaining Work

<p>Phase 1 Progress March – September 2018 WE HAVE...</p>	<p>Phase 2 Expected Accomplishments 6-12 months WE WILL...</p>	<p>Phase 3 Sample Implementation Activities 2020 and beyond WE WILL...</p>
<p>Articulated values</p>	<ul style="list-style-type: none"> ▪ Identify for whom measurement should matter ▪ Develop criteria for making measurement actionable ▪ Make recommendations on how to resolve tensions between efficiency, simplicity and transparency 	<ul style="list-style-type: none"> ▪ Establish system vision and goals, including improvement goals across clinical, population health, public health, and equity dimensions
<p>Developed guiding principles</p>	<ul style="list-style-type: none"> ▪ Propose approaches for identifying what measurement is most important ▪ Identify potentials for unintended consequences 	<ul style="list-style-type: none"> ▪ Set parameters for measurement, including measure selection criteria, specifying intended uses for measure data, conducting burden and benefit analyses
<p>Used an intentional process to create values and principles, and include broad stakeholder input and community voice</p>	<ul style="list-style-type: none"> ▪ Collect and incorporate additional recommendations from stakeholders ▪ Make recommendations on how to continue a transparent, inclusive process that includes broad stakeholder input and patient/community voice ▪ Draft a communications plan to disseminate information out to and receive feedback from stakeholders 	<ul style="list-style-type: none"> ▪ Continue and potentially adjust a process for ongoing stakeholder input to inform measurement system activities
<p>Determined that the stewardship process should be trusted, transparent, and able to include all perspectives</p>	<ul style="list-style-type: none"> ▪ Develop models for organization structure that will assist MDH in implementation, identifying strengths, weaknesses, and resource needs for various approaches ▪ Determine the need and shape of organizational structure that will make decisions about implementation activities, improvement goals, workgroups, and recommendations to MDH and, as appropriate, the Legislature ▪ Clarify roles, responsibilities, and accountabilities among policy makers, patients, health care organizations and clinicians, and others 	<ul style="list-style-type: none"> ▪ Implement an approach to community and patient engagement at all levels of decision-making ▪ Stand-up a framework stewardship structure ▪ Develop processes for evaluating the measurement system as guided by the framework and evolving the system over time
<p>Decided that:</p> <ul style="list-style-type: none"> ▪ measurement is more than clinical care and ▪ the Quality Reporting System exists as a subset of the envisioned system and will evolve within it 	<ul style="list-style-type: none"> ▪ Name framework users and identify their needs ▪ Make recommendations to guide the measurement of health and health care, including how to measure on different levels and across systems of care, at the population/neighborhood level, and more. 	<ul style="list-style-type: none"> ▪ Respond to legislatively-mandated criteria, including alignment with other measurement initiatives
<p>Decided that measurement must be subject to ongoing evaluation</p>	<ul style="list-style-type: none"> ▪ Draft an evaluation plan 	

Note: The Quality Framework Steering Team developed this summary to identify Phase 1 accomplishments, and articulate Phases 2 and 3. The remaining work will evolve as we continue to develop the framework.

Conclusions

The Legislature's charge to MDH, to develop a framework that will guide how we measure and improve the quality of health and health care in Minnesota, has led to transformative discussions on what we measure, why we measure, and how we can best drive improvement in health and health outcomes. Across the board, stakeholders are excited to create a new framework for health quality measurement and improvement, and firmly believe that Minnesota should continue to be a leader and innovator in this space. Nevertheless, change is hard, and difficult conversations and decisions lie ahead as we determine quality improvement priorities, identify accountability paths, select measures, and allocate resources.

At the end of our first phase of this potentially nation-leading work, we are on the road to building a measurement framework that will help us improve clinical quality, health equity, and population health. With a fully developed framework and implementation plan, and a system of measurement that better complements statewide health improvement goals, patients and communities, health care delivery organizations and providers, purchasers, and other key stakeholders will benefit in the following ways:

- **Patients and communities** will have a say in what aspects of care quality and health are measured and targeted for improvement, and be able to access measure results that can help identify opportunities and challenges and drive change.
- **Health care delivery organizations and providers** will have a parsimonious and meaningful set of actionable data to monitor and make improvements in care quality for their patient populations who experience health care along a continuum and across different providers, and more confidence that measures are chosen based on clearly-defined system goals.
- **Health plans and purchasers** will have meaningful quality metrics to aid in best supporting health through affordable coverage. The available data will represent a limited, parsimonious set of measures.
- **Public health and advocacy organizations** will have information on the health of populations that they can use to partner with community stakeholders to enhance the implementation and evaluation of health improvement policies, actions, and programs.
- **Quality improvement and measurement organizations** will bring their expertise to bear in stakeholder discussions, decisions, and the operationalization of what we should measure and how we should measure in our pursuit of statewide quality improvement goals and fostering improvement in the health and health care of Minnesotans.

Building from the foundation that we collectively established this year, we will continue developing the health quality measurement framework in consultation with stakeholders during 2019. We will provide the full framework to the Minnesota Legislature by the end of 2019, and will begin implementing the framework in 2020.

Acknowledgements

We would like to acknowledge the valuable contributions made to this project by members of the external steering team, community members and representatives, patients and advocates, health industry stakeholders, members of a workgroup that comprised stakeholders across government agencies, Management Analysis and Development and community consultants, and members of MDH's project team. The support, dedication, and collaboration displayed by project partners was essential in setting the foundation for continued work to develop and implement a quality measurement framework for all Minnesotans.

Appendix A. Minnesota Statewide Quality Reporting and Measurement System Measures

Table A-1. Quality Reporting System Measures

Provider Type	Measures
Physician Clinic	<ul style="list-style-type: none"> ▪ Adolescent Mental Health and/or Depression Screening ▪ Asthma Education and Self-Management – Adult and Child ▪ Colorectal Cancer Screening ▪ Depression Remission at 6 Months ▪ Health Information Technology Survey ▪ Optimal Asthma Control – Adult and Child ▪ Optimal Diabetes Care ▪ Optimal Vascular Care ▪ Spinal Surgery: Lumbar Discectomy/Laminotomy ▪ Spinal Surgery: Lumbar Spinal Fusion ▪ Total Knee Replacement
Prospective Payment System Hospital	<ul style="list-style-type: none"> ▪ Hospital Acquired Condition Reduction Program Score ▪ Hospital Readmissions Reduction Program Excess Readmission Score ▪ Hospital Value-Based Purchasing Total Performance Score
Critical Access Hospital	<ul style="list-style-type: none"> ▪ Admit Decision Time to ED Departure Time for Admitted Patients – Overall Rate ▪ Elective Delivery ▪ Influenza Vaccination Coverage Among Healthcare Personnel (HCP) ▪ Fibrinolytic Therapy Received within 30 Minutes ▪ Median Time to Transfer to Another Facility for Acute Coronary Intervention – Overall Rate ▪ Median Time from ED Arrival to ED Departure for Discharged ED Patients ▪ ED-Patient Left without Being Seen ▪ Head CT or MRI Scan Results for Acute Ischemic Stroke or Hemorrhagic Stroke Patients Who Received Head CT or MRI Scan Interpretation within 45 Minutes of Arrival ▪ Catheter Associated Urinary Tract Infection (CAUTI) ▪ Emergency Department Transfer Communication Composite
Prospective Payment System and Critical Access Hospitals	<ul style="list-style-type: none"> ▪ Death Rate among Surgical Inpatients with Serious Treatable Complications ▪ Emergency Department Stroke Registry Indicators: Door-to-Imaging Initiated Time and Time to Intravenous Thrombolytic Therapy ▪ Health Information Technology Hospital Survey ▪ Mortality for Selected Conditions Composite ▪ Patient Safety and Adverse Events Composite

Source: Quality Reporting System, 2019.

MDH required physician clinics to report the Clinician & Group Consumer Assessment of Healthcare Providers and Systems survey every other year from 2013 through 2017, and hospitals to annually report the Hospital Consumer Assessment of Healthcare Providers and Systems survey from 2011 to 2017. A change implemented by the 2017 Legislature restricts MDH from requiring physician clinics and hospitals to use a vendor to administer or collect data to meet reporting requirements. Since working with a vendor certified by the

Centers for Medicare & Medicaid Services (CMS) represents documented best practices, aligns with CMS requirements, and is consistent with MDH's approach over seven years, the Department discontinued the patient experience of care survey for physician clinics and hospitals.

From 2011 through 2013, MDH required ambulatory surgical centers to report three measures: Prophylactic Intravenous Antibiotic Timing, Hospital Transfer/Admission, and Appropriate Surgical Site Hair Removal. In 2014, MDH suspended the reporting of these measures because they were topped out.

Appendix B. Department of Health: 2017 Minnesota Laws

Minnesota Laws 2017, Chapter 6, Article 4, Section 3

Payment Restructuring; Quality Incentive Payments.

Subdivision 1.

(b) By June 30, 2018, the commissioner shall develop a measurement framework that identifies the most important elements for assessing the quality of care, articulates statewide quality improvement goals, ensures clinical relevance, fosters alignment with other measurement efforts, and defines the roles of stakeholders. By December 15, 2018, the commissioner shall use the framework to update the statewide measures used to assess the quality of health care services offered by health care providers, including health care providers certified as health care homes under section 256B.0751. No more than six statewide measures shall be required for single-specialty physician practices and no more than ten statewide measures shall be required for multispecialty physician practices. Measures in addition to the six statewide measures for single-specialty practices and the ten statewide measures for multispecialty practices may be included for a physician practice if derived from administrative claims data. Care infrastructure measures collected according to section 62J.495 shall not be counted toward the maximum number of measures specified in this paragraph. The commissioner shall develop the framework in consultation with stakeholders that include consumer, community, and advocacy organizations representing diverse communities and patients; health plan companies; health care providers whose quality is assessed, including providers who serve primarily socioeconomically complex patient populations; health care purchasers; community health boards; and quality improvement and measurement organizations. The commissioner, in consultation with stakeholders, shall review the framework at least once every three years. The commissioner shall also submit a report to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services policy and finance by September 30, 2018, summarizing the development of the measurement framework and making recommendations on the type and appropriate maximum number of measures in the statewide measures set for implementation on January 1, 2020.

Appendix C. Environmental Scan of Measurement Systems in Other States

To inform the health quality measurement framework development process, MDH requested assistance from the State Innovation Model (SIM) for an environmental scan of measurement efforts in other states.⁵ Minnesota's SIM grant sought to support community partnerships and collaboratives, such as Accountable Communities for Health and Integrated Health Partnerships, which connect health care with broader concepts of health, including social determinants of health. The SIM project highlighted the inability of existing measures to effectively capture the quality of care provided by collaboratives and other efforts that span the health care continuum. The environmental scan provided an opportunity to consider alternative measurement frameworks and quality measures, and bring a broader perspective to measurement in Minnesota. The State Health Access Data Assistance Center (SHADAC) conducted the scan.⁶

Methods

The environmental scan focused on states that were involved with SIM and had undertaken quality measurement efforts. States of interest that emerged were:

- SIM Round One Model Test Awardees of Arkansas, Maine, Massachusetts, Oregon, Vermont;
- SIM Round Two Model Test Awardees of Colorado, Connecticut, Delaware, Idaho, Iowa, Michigan, New York, Ohio, Rhode Island, Tennessee, Washington; and
- SIM model design awardees of California, Maryland, and Wisconsin.

The environmental scan explored measurement efforts in these states to determine whether the states had a core set of health care quality measures and what was being measured. In addition, the scan reviewed how measure sets were developed, how measures were selected, and the stakeholders that participated in the selection process, and whether the measures or objectives aligned with other quality measurement programs.

Results

Many states have made some efforts to move towards a standard set of health care measures, but most have not yet progressed to the implementation of an actual standardized measure set as exists in Minnesota since 2009. Our experience with developing it and the standardized measurement set in-and-of-itself continues to

⁵The SIM initiative provided federal grants to states to design and test innovative health care delivery and payment systems. In 2013, Minnesota received a SIM testing grant of over \$45 million to use across a four and a half year period ending December 2017.

⁶SHADAC is a multidisciplinary health policy research center affiliated with the University of Minnesota School of Public Health. Since 2012, SHADAC has been part of a team providing consultation and technical assistance to states and territories that received SIM grants.

make Minnesota a leader in measuring health care quality. Massachusetts is the only other state with a Minnesota-style standardized measure set for all health care provider facilities in the state. Several other states developed measurement systems for more targeted applications. For example:

- Maine and Vermont created measure sets for accountable care organization payment models;
- Oregon has a measure set designed to align metrics for state health programs; and
- Connecticut, Rhode Island, and Washington also developed measure sets primarily for aligning quality measurement across commercial and public payers.

The motivations, goals, and approaches used to develop measure sets varied greatly across states. In Oregon, Washington and Massachusetts, the state legislature initiated measure set development. In Maine, Vermont, Connecticut and Rhode Island, SIM work groups led the efforts on behalf of their respective administration. Most states planned to use their measure sets primarily for payment purposes, and some were concerned with both payment and generally measuring and reporting on quality. Vermont and Connecticut both selected separate measure sets for payment and reporting. Both of these states also incorporated some elements of population health and health disparities into their measurement. Vermont’s measure set includes social determinants of health, such as unemployment and education, and Connecticut used a “health equity value” during the measure selection process.

Nearly all of these states had a work group or committee of stakeholders that played a role in selecting measures. These groups were frequently established by legislation and/or gubernatorial appointments. Typical representatives included state agencies, payers, consumers, and health research and measurement experts. Several states also included health care providers and community partners. One state, Washington, also included representatives from federally recognized tribes. These work groups typically set measure selection criteria and determined priority areas or topics for measurement, but did not manage measure data or decide how data should be applied or reported. Their responsibilities were generally separate from measure development efforts, and many states prohibited the groups from creating or selecting untested measures. Several states regularly reassessed their work group membership, as well as their measures and measurement priority areas as needs and priorities changed.

Appendix D. Steering Team

Table D-1. Steering Team Members

Expertise	Perspective	Team Member
Rural health care provider serving socioeconomically complex patient populations	Quality improvement and measurement; care delivery; integrated health partnership	Kelly Fluharty, Winona Health
Health equity, authentic community engagement	Diverse communities, patients, and consumers	Monica Hurtado, Voices for Racial Justice Maiyia Yang, West Side Community Health Services (alternate)
Health equity, authentic community engagement	Diverse communities, patients, and consumers	Deatrick LaPointe, Independent Consultant
Health information technology (HIT), quality measurement, care provider	Leveraging HIT; quality improvement and measurement; care delivery; health care policy	Kevin Larsen, MD, Center for Medicare & Medicaid Innovation
Quality improvement organization	Quality improvement and measurement	Jennifer Lundblad, Stratis Health; *Co-chair
Health care purchaser	Care quality and value; Medicaid	Ross Owen, Hennepin Health
Minnesota Department of Health	Health care policy	Diane Rydrych, MDH; *Co-chair
Urban health care provider serving socioeconomically complex patient populations	Quality improvement and measurement; care delivery; measurement science	David Satin, MD, University of Minnesota and University of Minnesota Physicians
Quality measurement organization	Quality measurement and reporting; historical perspective on measurement in MN	Julie Sonier, MN Community Measurement
Hospital health care provider	Quality improvement and measurement; care delivery	Mark Sonneborn, Minnesota Hospital Association

Appendix E. Stakeholder Engagement Methodology

To begin developing the quality measurement framework in collaboration with stakeholders, we took a mixed-mode approach to stakeholder engagement to inform and guide the process. We:

- Convened a **10-member steering team** including state and national experts on quality measurement and improvement, care delivery, policy, and authentic community engagement.
- Held **19 small group and key informant interviews** with 106 participants representing diverse communities and patients; health care delivery organizations and providers whose quality is assessed, including providers who serve primarily socioeconomically complex patient populations; health plan companies; health care purchasers; public health organizations; e-health practitioners; and quality improvement and measurement organizations.
- Convened a **workgroup** of representatives from the Minnesota Department of Health (MDH), the Department of Human Services, and the State Employee Group Insurance Program within Minnesota Management and Budget who have expertise in health care delivery and purchasing, health information technology, population health, and health equity.

Steering Team

We convened a 10-member steering team that represented a broad cross-section of stakeholders including local and national experts on quality measurement and improvement, care delivery, policy, health equity, and health information technology. See Appendix D for a list of steering team members. Members functioned as representatives of their perspectives and personal expertise, rather than their organizations, to encourage broad-based thinking and creativity in the development of the quality measurement framework.

The steering team met monthly for seven intensive sessions facilitated by Management Analysis and Development (MAD) consultants from March 12 to September 6, 2018. As an advisory body to MDH, the steering team's role was to:

- Assist with the identification, articulation, and prioritization of framework objectives;
- Advise on the key topics and questions to use in outreach with a broader stakeholder audience;
- Think through the right perspectives and people to include in the stakeholder consultation;
- Synthesize input from the broader stakeholder community to contextualize and articulate themes, and help build a roadmap towards a Minnesota quality framework; and
- Discuss ideas for ongoing framework evaluation, maintenance, and updates.

During the course of their work, the steering team accomplished the following activities:

- Defined Quality Framework values and principles;
- Critically analyzed the content of other local and national quality frameworks;
- Co-created the interview guide for key informant and small group interviews;
- Identified stakeholders to interview;
- Synthesized interview themes;
- Added definition to framework scope, characteristics and stewardship; and

- Refined the scope of work that will happen in the second phase of the project to complete framework development.

Each steering team meeting reserved 10 minutes for the public to provide comments on the quality measurement framework.

For additional information on steering team meetings, including meeting materials and summaries, please visit [Quality Framework](https://www.health.state.mn.us/data/hcquality/measfrmwk) (<https://www.health.state.mn.us/data/hcquality/measfrmwk>).

Key Informant and Small Group Interviews

From May through August, the project team and one other facilitator conducted 19 small group and key informant interviews across the stakeholder groups identified in statute. We selected interviewees based on their alignment with the stakeholder groups in the statute, familiarity with quality measurement, and input from the steering team. The names and organizations of the 106 individuals interviewed are listed in table E-1.

The project team developed the interview guide through a collaborative effort with feedback from the steering team. We developed a catalog of potential questions that would inform legislative requirements, including those it identified in the environmental scan of measurement initiatives in other states, and MAD consultants refined the questions based on qualitative data collection best practices. The project team further refined the interview guide based on feedback from the steering team. See Figure E-1 for the interview guide.

The project team arranged the interviews and facilitated discussions. Interviews were semi-structured, allowing facilitators to ask follow-up questions and pursue relevant topics as they arose. In conducting these interviews, project staff used the interview guide, and the values and principles developed in collaboration with the Steering Team. Interview modes and durations varied based on interviewee availability, with the preferred method being 90-minute in-person interviews. In many cases, some or all interviewees in a group participated by conference or video call. Facilitation techniques to ensure equal input among all interviewees were applied during the interviews.

MAD consultants conducted 15 interviews with patient advocacy groups, health care delivery organizations and providers whose quality is assessed, health care purchasers, health plan companies, public health practitioners, and quality improvement and measurement organizations. The consultants conducted qualitative analysis and synthesized results.

MDH staff conducted three small group interviews with representatives of communities that are disproportionately impacted by health disparities, one key informant interview with a community representative, and one small group interview with e-health stakeholders. Deatrick LaPointe, an independent consultant skilled in trauma-informed approaches to community engagement, facilitated small group discussions with community representatives, and MDH staff followed-up with two individuals who were unable to attend a community meeting and wanted to provide input.

Community representative small group interviewees included:

- Interested members of MDH’s Health Equity Advisory and Leadership Council⁷;
- Health equity champions convened by Voices for Racial Justice⁸; and
- Community representatives convened by West Side Community Health Services’ Somali, Latino and Hmong Partnership for Health and Wellness (SoLaHmo)⁹.

Stakeholder Panel

In July, we convened a stakeholder panel to inform the work of the steering team that included representatives from public health, physicians, the world of health information technology, as well as various communities from local and national contexts. See table E-2 for a list of panelists. The panel provided space for additional discussion on input from various stakeholders in the development of the framework and allowed panelists to share their own perspectives more broadly on the topic of health quality measurement. This session was also open for public observation.

Panelists discussed their connections to health quality measurement, including their involvement in related initiatives, what excites them about a statewide quality measurement framework, and what concerns they have about a new framework. Additionally, one panelist shared insight from the national perspective on measurement success in other states and measurement considerations for Minnesota, given its national position as a leader in the field.

Administration Workgroup

We convened a workgroup of leaders and representatives from MDH, the Minnesota Department of Human Services, and Minnesota Management and Budget’s State Employee Group Insurance Program. Members offered expertise in population health, measurement science, health equity, community engagement, health policy, health care delivery, health care purchasing, program evaluation, health information technology and quality improvement. See table E-3 for a list of workgroup members. We convened the workgroup four times over the course of the project.

⁷MDH created the HEAL Council as part of a broader effort by the agency to address Minnesota’s disparities in health status—particularly those persistent disparities across various ethnic, racial and regional groups. The HEAL Council represents the voices of many communities most severely impacted by health inequities across the state, including racial and ethnic minority groups, rural Minnesotans, Minnesotans with disabilities, American Indians, LGBTQ community members, refugees and immigrants.

⁸Voices for Racial Justice is a Minnesota organization that works with communities of color and American Indians on issues of equity and inclusiveness. Voices for Racial Justice has worked with MDH on Quality Reporting System projects in which they engaged with members of communities disproportionately impacted by health inequities and community-based organizations to develop findings and recommendations on data-related topics.

⁹SoLaHmo is a community-based participatory action research group and community-driven program of West Side Community Health Services. In partnership with the Minnesota Health Care Safety Net Coalition’s Quality Measurement Enhancement Project (QMEP), SoLaHmo researched community leader perspectives on primary health care quality.

The workgroup’s role was to:

- Provide input on quality improvement topics to explore with stakeholders;
- Help identify stakeholders throughout the state to engage with on the project;
- Provide feedback on the themes that emerged from discussions with stakeholders; and
- Provide feedback on elements the draft framework that MDH developed with stakeholder input.

Participants

Table E-1. Interview Participants

Interview	Date	Stakeholder group	Interviewees
Consumer, community and advocacy organizations representing diverse communities and patients			
1	June 15	MDH Health Equity Advisory and Leadership Council Subgroup	<ul style="list-style-type: none"> ▪ Abiola Abu-Bakr, Minnesota Black Nurses Association ▪ Joann Usher, JustUs Health
2	June 20	Patient advocacy representatives	<ul style="list-style-type: none"> ▪ Matt Flory, American Cancer Society ▪ Jill Heins-Nesvold, American Lung Association ▪ Amanda Jansen, ClearWay Minnesota ▪ Mary Olsen Baker, Minnesota Department of Human Services and Minnesota Board on Aging ▪ Joan Willshire, Minnesota Council on Disability
3	June 27	Health equity champions convened by Voices for Racial Justice	<ul style="list-style-type: none"> ▪ Huda Ahmed, Grassroots Solutions ▪ Julia Freeman, Voices for Racial Justice ▪ Monica Hurtado, Voices for Racial Justice ▪ Roxana Linares, Centro Tyrone Guzman ▪ Rosa Tock, Minnesota Council on Latino Affairs ▪ Vang Xor Xiong, Asian American Organizing Project
4	June 28	Community representatives convened by West Side Community Health Services’ Somali, Latino and Hmong Partnership for Health and Wellness (SoLaHmo)	<ul style="list-style-type: none"> ▪ Pilar de la Parra, West Side Community Health Services ▪ Hsajune Dyan, St. Paul Public Schools ▪ Cindy Kaigama, Healing Virtue, LLC* ▪ Abelardo Mena, Student ▪ Ana Rodriguez, Student ▪ Isolina Soto, West Side Community Health Services ▪ Marcela Soto, West Side Community Health Services ▪ Demetria Turnage, Minnesota CarePartner* ▪ Bai Vue, Student ▪ Song Xiong, West Side Community Health Services

			<i>*Ms. Kaigama and Ms. Turnage were unable to participate in the small group discussion; MDH staff interviewed them individually via telephone.</i>
5	August 3	Community representative	<ul style="list-style-type: none"> Pahoua Yang, Amherst H. Wilder Foundation
Health care organizations and clinicians whose quality is assessed, including organizations and clinics who serve primarily socioeconomically complex patient populations			
6	May 15	Health Care Homes Measurement and Evaluation Workgroup	<ul style="list-style-type: none"> Corinne Abdou, Wayzata Children’s Clinic Miranda Cantine, Ortonville Area Health Services Karolina Craft, Minnesota Department of Human Services Susan Gentilli, Allina Health Michele Gustafsson, Entira Family Clinics Peter Harper, MD, MPH, University of Minnesota Family Medicine Nathan Hunkins, Bluestone Physician Services Dan Schletty, Riverwood Healthcare Center Erica Schuler, Ridgeview Medical Center Nathan Shippee, University of Minnesota School of Public Health
7	May 22	Safety Net Coalition representatives	<ul style="list-style-type: none"> Jinny Palen, Minnesota Association of Community Mental Health Programs Michael Scandrett, MS Strategies Jonathan Watson, Minnesota Association of Community Health Centers Stacie Weeks, Hennepin County Medical Center Sarah Wovcha, Children’s Dental Services
8	May 23	Critical access hospital representatives convened by the Minnesota Hospital Association	<ul style="list-style-type: none"> Brad Alm, Lakeview Hospital Kelly Chase, Cuyuna Regional Medical Center Greg Larson, Mille Lacs Health System Trina Lower, Mercy Hospital Darlene Mechtenberg, Murray County Medical Center Jeremy Morgan, Sanford Health Janelle Rauchman, River’s Edge Hospital & Clinic Laura Scott, Sanford Health Cheryl Simpson, Sanford Health Jodi Ulmen, Madelia Community Hospital & Clinic Cheryl Vershelde, Avera Marshall Regional Medical Center Jennifer Wiik, Sanford Health

			<ul style="list-style-type: none"> ▪ Deb Wynia, Sanford Health
9	June 11	Minnesota Academy of Family Physicians staff	<ul style="list-style-type: none"> ▪ Maria Huntley
10	June 26	Minnesota Medical Association's Physician-Consensus Measures of Performance to Advance Quality and Safety Workgroup	<ul style="list-style-type: none"> ▪ Rodney Christensen, MD, Allina Health ▪ Kathleen A. Culhane-Pera, MD, MA, East Side Family Clinic ▪ Viorel Florea, MD, PhD, University of Minnesota Medical School and Minneapolis Veterans Affairs Health Care System ▪ Brian Graham, MD, PhD, Hennepin Healthcare ▪ Beth Helgerson, MD, Tri-County Health Care ▪ Laura Saliterman, MD, South Lake Pediatrics* ▪ Janet Silversmith, Minnesota Medical Association ▪ Rebecca Thomas, MD, MHS, University of Minnesota ▪ Douglas Wood, MD, Mayo Clinic Health System* <p><i>*Dr. Saliterman and Dr. Wood were unable to participate in the small group discussion; MDH staff interviewed them individually via telephone.</i></p>
Health care purchasers			
11	June 7	Minnesota Health Action Group members	<ul style="list-style-type: none"> ▪ Four members who chose to participate anonymously
12	June 27	Health care purchaser representatives	<ul style="list-style-type: none"> ▪ Bentley Graves, Minnesota Chamber of Commerce ▪ Lucas Nesse, Minnesota Business Partnership
e-Health			
13	August 21	Minnesota e-Health Advisory Committee subgroup	<ul style="list-style-type: none"> ▪ Sunny Ainley, Normandale Community College ▪ Kevin Peterson, MD, University of Minnesota ▪ Jonathan Shoemaker, Allina Health ▪ Sonja Short, MD, Fairview Health Systems
Health plan companies			

14	June 7	Health plan representatives convened by the Minnesota Council of Health Plans	<ul style="list-style-type: none"> ▪ Beth Averbeck, MD, HealthPartners ▪ Stacy Ballard, MD, Medica ▪ Annette Baumann, Hennepin Health ▪ Cara Broich, Medica ▪ Dennis Cross, HealthPartners ▪ Charles Fazio, MD, HealthPartners ▪ Greg Hanley, UCare ▪ Thomas Kottke, MD, MSPH, HealthPartners ▪ Larry Lee, MD, UCare ▪ Allison Lorenzen, HealthPartners ▪ John Moon, UCare ▪ Stephanie Schwartz, UCare ▪ Daniel Trajano, MD, MBA, Blue Cross and Blue Shield of Minnesota
Public health practitioners			
15	June 18	Statewide Health Improvement Partnership Evaluation Steering Group subgroup	<ul style="list-style-type: none"> ▪ Jamie Bachaus, Scott County Public Health ▪ Julie Hatch, Olmsted County Public Health Services ▪ David Johnson, Hennepin County ▪ LaReesa Sandretsky, Healthy Northland
16	June 21	Regional Public Health Association Chairs subgroup	<ul style="list-style-type: none"> ▪ Joanne Erspamer, Carlton County Public Health and Human Services ▪ Gretchen Musicant, Minneapolis Health Department ▪ Brenda Pohlman, Fillmore County Public Health ▪ Sarah Reese, Polk County Public Health ▪ Sandy Tubbs, Horizon Public Health
Quality improvement organizations			
17	June 20	Institute for Clinical Systems Improvement staff	<ul style="list-style-type: none"> ▪ Jodie Dvorkin, MD, MPH ▪ Senka Hadzix ▪ Audrey Hansen ▪ Tani Hemmila ▪ Sarah Horst ▪ Jeyn Monkman ▪ Claire Neely, MD
18	June 27	Stratis Health staff	<ul style="list-style-type: none"> ▪ Sarah Brinkman ▪ Candy Hanson ▪ Betsy Jeppesen
Quality measurement organizations			

19	July 25	MN Community Measurement	<ul style="list-style-type: none"> ▪ Liz Cinqueonce ▪ Julie Sonier
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Table E-2. Stakeholder Panelists

Panelist	
Debra Burns	Acting Assistant Commissioner, MDH
Rodney Christensen, MD	Vice President for Medical Operations in the Network Division, Allina Health; Representative of the Minnesota Medical Association’s Physician-Consensus Measures of Performance to Advance Quality and Safety Work Group
Kevin Larsen, MD	Enterprise Lean and Health IT Advisor, Centers for Medicare & Medicaid Services
Maiyia Yang	Researcher at West Side Community Health Services

Table E-3. Workgroup Members

Agency	Program	Representative(s)
Minnesota Department of Health	Centers for Health Equity and Community Health	<ul style="list-style-type: none"> ▪ Sara Chute ▪ Dan Fernandez-Baca
	Community & Family Health	<ul style="list-style-type: none"> ▪ Janet Olstad ▪ Dawn Reckinger ▪ Virginia Zawistowski
	Health Care Homes	<ul style="list-style-type: none"> ▪ Chris Dobbe ▪ Bonnie LaPlante
	Health Promotion & Chronic Disease	<ul style="list-style-type: none"> ▪ James Peacock
	Health Regulation Division	<ul style="list-style-type: none"> ▪ Martha Burton Santibanez
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Interview Guide

Figure E-1. Quality Measurement Framework Interview Guide

Introduction

1. What relationship does your organization or community have with health and wellness?
 - a. What connection does your organization have to health care quality measurement and/or improvement?

Discussion

2. What role does health care play in maintaining health?
3. What does high quality health care mean for you?
 - a. How could a statewide quality measurement system contribute to achieving that?
 - b. What do you believe Minnesota's top three health care quality improvement priorities should be and why?
4. How well do you think the attached values and principles for a quality framework can help advance high quality health care?
 - a. What, if any, guiding values and principles would you suggest adding to achieve quality improvement?
 - b. Would they help create the system you would imagine?
 - c. To what extent does our current measurement system reflect those values and principles? Where are the gaps or opportunities?
 - d. What would it take to get there?
5. In what ways can quality measurement help to advance health equity?
6. What would it take for us to consistently have high quality health care and know we do? Who would do what?
 - a. What strengths do different partners in quality measurement and improvement bring to the table?
 - b. What factors should be considered to determine the right measures to include in a statewide quality measurement system?
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. How, if at all, should the quality measurement and improvement system be maintained, evolved, and evaluated over time?

Conclusion questions, envisioning the future

8. What advice do you have for MDH as we move forward in developing a roadmap to implement the quality measurement framework? What should we keep in mind? What are the next steps?
9. Is there anything else you'd like to share?