Measurement Framework Steering Team
Meeting #2 Summary

Monday, July 29th, 2019
1:00-4:00 PM
HIWAY Federal Credit Union, St. Paul, MN

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS
**Participants**

**Steering Team:**
- Bill Adams
- Graham Briggs
- Ellen De la torre
- Marie Dotseth
- Renee Frauendienst
- Courtney Jordan Baechler
- Lisa Juliari
- Scott Keefer
- Rahul Koranne
- Deb Krause
- Deatrick LaPointe
- Jennifer Lundblad
- Gretchen Musicant (phone)
- Sarah Reese (phone)
- Diane Rydrych
- David Satin
- Janet Silversmith
- Julie Sonier
- Marcus Thygeson
- Tyler Winkelman (phone)
- Pahoua Yang
- Maiyia Yang Kasouaher

**MDH Project Staff:**
Sarah Evans, Stefan Gildemeister (phone), David Hesse, Denise McCabe, Jeannette Raymond

**Turnlane:**
Alex Clark, Cassandra Canaday
Meeting Objectives

- More clearly define the Steering Team’s role in Phase 2 of framework development and establish our approach to decision-making;
- Compare and discuss existing framework models to help us envision the type of model that will work best for Minnesota, and identify desired elements of a Minnesota measurement framework;
- Further refine our framework definition building off of our June discussion and today’s framework model discussion; and
- Introduce the topic of stewardship, or governance, which will be the focus of our September meeting.

Experiential Goals

- Get to know each other
- Feel that the expertise and contributions each of us brings to this table are valued
- Feel excited about the opportunity the framework presents, and
- Share leadership
Welcome and Grounding

Co-chairs Jennifer Lundblad and Marie Dotseth welcomed participants by providing an overview of the meeting objectives and introducing the new facilitators for phase 2, Alex Clark and Cassandra Canaday of Turnlane.

Additionally, Jennifer reminded participants of the arc of the Steering Team’s work throughout phase 2 (see right).

Steering Team Agreements

- 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 group’s process.
- We encourage constructive, adaptive thinking.
- We are sensitive to the fact that everyone deserves to be heard.
- We maximize our time by coming to meetings having completed any homework assignments.
- We always start meetings on time.

Prior to discussion on core agenda topics, Alex Clark highlighted the Steering Team agreements, which are meant to guide the group’s conduct during meetings (see left).

Alex also noted that, given the wealth of diverse perspectives and lived experiences, conflict and tension may arise within the Steering Team. Alex encouraged leaning into these moments rather than avoiding them, as they can help the group make progress.
The Role of the Steering Team
The group revisited their role and charge within the process of developing Minnesota’s measurement framework.

*The Steering Team serves in an advisory role and a consultative capacity to the state and to MDH in informing the development of the measurement framework.*

Decision-Making within the Steering Team
To ensure there are clear, common expectations for how the Steering Team will make decisions, Alex provided meeting participants with four potential group decision-making approaches to consider (see Appendix A). After small group discussions, the Steering Team agreed to the following approach. If the methods below fail, the Steering Team agreed to defer to MDH.

<table>
<thead>
<tr>
<th>Preferred Method</th>
<th>Secondary Method</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Consensus Decision-Making</strong>&lt;br&gt;(all group members support the decision)</td>
<td><strong>Consent Decision-Making</strong>&lt;br&gt;(all agree the decision is “good enough”)</td>
</tr>
</tbody>
</table>

If consensus cannot be reached, the Steering Team will use...
Meeting participants turned their attention toward the various frameworks that were reviewed by small groups following the June 28th meeting. One to two members from each small group provided a brief overview of their assigned framework, then answered clarifying questions to help Steering Team members understand the design and approach of each example (also see Appendix B).

### National Collaborative for Health Equity: The Health Opportunity and Equity (HOPE) Initiative

Maiyia Yang Kasouaher and Marcus Thygeson highlighted:
- Social and structural determinants focus, very little on health care
- Asset-based orientation
- Promotes cross-sector collaboration

### Robert Wood Johnson Foundation (RWJF): Vision to Action Framework

Janet Silversmith highlighted:
- Very upstream measures
- Challenges status quo
- Poses a big gap between where MN is now
- Promotes cross-sector collaboration

### Institute of Medicine: Core Metrics for Health and Health Care Progress

David Satin highlighted:
- Emphasis on health care measures, many on access and prevention
- Lacks focus on health equity
- Has experienced low levels of adoption

### Centers for Medicare & Medicaid Services (CMS): Meaningful Measures

Julie Sonier highlighted:
- Emphasis on health care
- Lacks focus on equity
- Places patients at center
- Heavy on process measures
- Not very actionable
Participants reviewed the analogy of a measurement framework as a tree – the definition and properties serving as the trunk, the domains as branches, and the measures as leaves. See Appendix C for further detail on how this analogy fosters common language for framework development.

Meeting participants then broke into small groups to discuss key questions about other measurement frameworks in order to identify what elements may be most suitable for Minnesota to consider.

Small groups shared perspectives and insights on these questions during debrief with all meeting attendees (see right for collective summary). Appendix D includes greater detail.

**Small Group Discussion Questions**

- Share with your group which **one element** across all frameworks stood out most to you.
- What elements of these frameworks do you see as a good fit for Minnesota?
- If you were designing a framework for Minnesota, what **three domains** would you choose? These do not have to be from the models the group reviewed.
Participants reviewed the latest iteration of the framework definition, which was revised based on Steering Team input during the June 28th meeting (see Appendix E for all detail). Several individuals suggested additional changes to further refine the Steering Team’s working definition.

**Steering Team Input**

- To further enable a shared definition, further clarity is needed on how this framework will be utilized and by whom.
- Definition could be strengthened by adding a bullet about the intention of experimenting and learning together instead of being overly prescriptive about health measurement.

**Parking Lot Questions for Additional Discussion**

- Is it also intended to promote action across sectors?
- Who is reporting our to-be-determined measures (source of data)?
- What is the unit(s) of measurement and reporting accountability? Organization level? Community level?
- Will this be used to frame public communication about health improvement efforts?
Alex Clark provided participants with a brief overview on the topic of governance and how the Steering Team’s work during phase 2 will result in a governance approach for future phases of developing the measurement framework.

The governance approach the Steering Team develops will:

- **Delineate who is accountable for performing certain tasks**
- **Identify the roles and responsibilities necessary to support framework development and implementation**
- **Outline which roles hold decision-making ability and authority**

**Discussion**

Participants shared that using a holistic definition of health and all the factors that determine health may require broader engagement from perspectives and sectors not currently represented within the Steering Team (e.g., transportation, law enforcement, etc). This specific topic will be revisited during the September meeting, which will include a more comprehensive discussion on governance.

Steering Team members will receive additional material on governance approaches for review ahead of the September 16th Meeting.
**Public Comments**
There were no comments from public observers.

**Meeting Close**
Alex Clark noted that action items from the meeting will be communicated via email. In addition to specific actions resulting from the July meeting, there will be required preparatory activities before the September 16th meeting.

**Next Steps**
- Provide input via the post-meeting survey (Steering Team members)
- Complete required review and preparation before the September 16th meeting (Steering Team members)
# Group Decision-Making Approaches

<table>
<thead>
<tr>
<th>Approach</th>
<th>Intent of Approach</th>
<th>Pros</th>
<th>Cons</th>
</tr>
</thead>
</table>
| Consensus         | Consensus strives to incorporate everyone’s perspectives, needs, and ultimately their permission. | • Satisfies all constituents  
• Fosters strong, united groups  
• Equalizes the distribution of power in a group  
• Constituents leave prepared to implement | • Requires a lot of time  
• Very challenging for groups with low trust or competing interests  
• Difficulty increases as group grows larger  
• Subject to compromises that may not serve the group well |
| Decision-Making   |                                                                                     |                                                                      |                                                                      |
| Democratic        | A group is presented with a series of options to vote on. The option with the most support is carried forward. | • Transparent process  
• Perceived as fair  
• People easily grasp where the process begins and ends (unlike consensus and consent) | • Vulnerable to groupthink or political campaigning  
• Majority feels little need to compromise with minority  
• Lack of ownership on implementing decisions - “I didn’t vote for that!” |
| Decision-Making   |                                                                                     |                                                                      |                                                                      |
| Consent           | Consent means the absence of objections. Similar to consensus, consent invites group participation in the decision-making process but instead of granting each member the power to mold the proposal in pursuit of a compromise, consent urges the group to accept a “good enough” solution. | • Fast and consultative  
• Encourages iterative, “good enough” solutions  
• Doesn’t require agreement  
• Promotes objective debate | • The decision-making process can be rushed toward a suboptimal solution  
• The process can feel unfamiliar and uncomfortable  
• Can ignore team cohesion in the decision-making process  
• Can be harmful if used on wide-impact, long-lasting decisions |
| Decision-Making   |                                                                                     |                                                                      |                                                                      |
| Consultative      | Consultative decision-making means asking for input from a set of individuals, but ultimately reserving the decision for one individual or group. | • Fast  
• Generates additional perspectives beyond decision-maker  
• Helps gauge how a decision will play out politically  
• Gives access to technical knowledge  
• Opportunity to influence key stakeholders | • People may feel excluded and unimportant  
• May result in limited buy-in and support  
• Creates the perception of politicking |
| Decision-Making   |                                                                                     |                                                                      |                                                                      |

*Adapted from Nobl’s “The Decider”*
Reviewers: Olivia Jefferson, Marcus Thygeson, Maiyia Yang Kasouaher

Alignment: General alignment; little about health care in HOPE

Desirable features: Asset-based approach, equity lens, social and structural determinants of health, culture of health

Actionability: Fosters cross-sectoral collaborations

Adoption: Consider adopting portions of HOPE and adding them to our existing measurement system

Key question: How might health care see themselves in the HOPE framework?
Reviewers: Bill Adams, Courtney Jordan Baechler, Rahul Koranne, Janet Silversmith

Alignment: General alignment; RWJF is action-oriented

Desirable features: Action areas, drivers, measures

Actionability: Fosters collaboration and partnership

Adoption: Consider adopting RWJF with modifications

Key question: Are we **tweakers** or **visionaries**, are we taking a **step** or making a **leap**, are we **evolutionary** or **revolutionary**?
Reviewers: David Satin, Marcus Thygeson, Tyler Winkelman

Alignment: General alignment; IOM does not emphasize health equity, and connection and collaboration

Desirable features: Core measure set, triple aim

Actionability: Fosters cross-sectoral collaborations and partnerships

Adoption: Consider adopting the IOM framework with modifications

Key question: How would funding be leveraged to encourage cross-sectoral approaches?
Reviewers: Scott Keefer, Julie Sonier
Alignment: General alignment; CMS does not emphasize health equity, and connection and collaboration and is focused on health care
Desirable features: Strategic goals, cross-cutting criteria, overarching measurement categories, visual model
Actionability: Informs strategic investments, not a useful model for cross-sectoral collaborations
Adoption: The Minnesota framework should be informed by the best of the measurement frameworks under review
Key question: What is the there we are trying to get to, how do we get from here to there, and what will it take to get there?
Thinking of Framework Development as a Tree

**Elements of a Framework**

- **Domains**
  - Domains are the categories under which each measure sits.

- **Measures**
  - Measures are the factors that will be tracked to gauge progress.

**Definition & Properties**

- Mission, vision, values, principles
- Scope
- Balance of health care and social determinants of health
- Intended utility by multiple “audiences”
- Action orientation

**Structural Features**

- Hierarchy
- Number of Domains
- Color Coding vs. Uniform
- Shape of Visual Summary
Small Group Discussion Questions

- Share with your group which **one element** across all frameworks stood out most to you.
  - **Major Themes:**
    - Cross-sector collaboration
    - Framework scopes that recognize that health is broader than health care
    - Evidence based
    - Clear hierarchies
    - Recognition of health equity and disparity at some level
    - Focus on community health and well-being
    - Some significant parties are missing from the table

- What elements of these frameworks do you see as a **good fit for Minnesota**?
  - **Major Themes:**
    - Leveraging existing efforts, data, and evidence base
    - A focus on equity
    - Actionability and accountability
    - Relevant, tailored measures that take context into account
    - Comprehensive balance between health care, social determinants/upstream factors, equity, policy
    - Emphasis on healthy communities

- If you were designing a framework for Minnesota, what **three domains** would you choose? These do not have to be from the models the group reviewed.
  - **Major Themes:**
    - Community and Community Health
    - Policy
    - Cross-sector collaboration
    - Community Partnerships and Engagement
    - Access
    - Advisory
    - Clinical Outcomes
    - Cost or Affordability
    - Individual Outcomes
    - Patient Experience
    - Healthcare System Performance
    - Social Determinants of Health
    - Equity
    - Rural Health
    - Disparities
    - Socio-economic factors
Large Group Discussion

Which **one element** across all frameworks stood out most to you as a **good fit for Minnesota**?

**Major Themes:**
- Health is more than health care
- Health equity—it’s its own domain but also underlies all other domains, needs to be both explicit and embedded
- Cross-sector collaboration and accountability
- Working with communities and focusing on their health and well-being
- Agile/adaptable model and orientation
- Rigorous evidence-base
- Actionability
- Cost and affordability as part of access—should focus particularly on the cost of care for patients/individuals/families

If you were designing a framework for Minnesota, what **key domains** would you choose?

**Major Themes:**
- Access to health care (possibly including tech, telehealth, interoperability, affordability/financial access)
- Advisory
- Clinical outcomes
- Affordability
- Community-level factors
- Individual-level/patient-reported outcomes
- System performance and affordability
- Policy
What is a Measurement Framework for Health & Health Equity?

- A set of domains that together form a structure for identifying appropriate and meaningful measures of health and health equity for the whole population of Minnesota.

- Reflects the understanding that a broad range of systems and social, economic, and environmental factors create, influence, and perpetuate the health status of individuals and communities.

- Expresses a set of values and principles that guide decision-making for the framework and connected collaborative efforts to improve health and health equity.
What is a Measurement Framework for Health & Health Equity?

The measurement framework will:

- Clearly frame the **range of factors** that need to be addressed to “**move the needle**” on health outcomes
- Be informed by those experiencing the **most negative health outcomes**, and reflect the **lived experience of people**
- Uncover factors that **historically have been obscured or ignored**
- Enable the establishment of **health improvement goals**
- Inform **decision-making, action and accountability** to drive:
  - Allocation of resources and strategic investments
  - Intentional action (working on the right things)
  - New and expanded partnerships, collaboration, and other alignment of efforts
  - Innovation
What is a Measurement Framework for Health & Health Equity?

The measurement framework will:

- Demonstrate improvement or catch eroding trends for:
  - Social, economic, and environmental factors that impact health
  - Population health outcomes
  - Health inequities
  - Health care delivery and other systems

- Frame public communication about health improvement efforts
  - With easy to understand graphic depiction
The following synthesizes input from 12 Steering Team members who provided feedback on Meeting #2 (July 29th) via an online survey conducted by Turnlane.

All responses to questions below are on a scale from 1 – 5 with 1 being “Strongly Disagree” and 5 being “Strongly Agree”.

- The materials provided... helped me feel prepared to participate in discussion
  - Average: 4.3 out of 5

- I felt that my perspectives were heard in this meeting
  - Average: 4.0 out of 5

- I had adequate opportunities to voice my input in this meeting
  - Average: 4.2 out of 5

- I feel like I understand the goals of this project
  - Average: 3.9 out of 5

- I feel like I understand my role in this project
  - Average: 3.8 out of 5
Themes and Suggestions

Fix technology issues—they’re distracting and frustrating

Use clear, consistent language and modeling

Use a physical "parking lot" for ideas to keep discussions relevant

It is still unclear to many what we are trying to accomplish.

Keep discussion on track by using frequent grounding, consistent reminders of our goals, and stricter limits on people taking up too much time

“At the beginning, we were talking about principles and decision making. This was frustrating to me and others - here we are in our second of three meetings, and these are such basic things. How will we get to the desired outcomes?”
Minnesota Framework for Health and Health Equity Measurement and Improvement

This document reflects input from the measurement framework steering team to-date, and will be updated following the September 16 meeting.

Vision

A framework for health and health equity measurement and improvement is a set of domains that together form a structure for identifying appropriate and meaningful areas of health and health equity measurement and improvement for Minnesotans.¹

A framework for health and health equity measurement and improvement reflects the understanding that a broad range of systems and social, economic, and environmental factors create, influence, and perpetuate the health status of individuals and communities.

A framework for health and health equity measurement and improvement also expresses a set of values and principles that guides decision making for the framework and connected, cross-sector collaborative efforts and partnerships. It will evolve over time as informed by measure results, and as health priorities and conditions change.

The framework will:

- Clearly frame the range of factors that need to be addressed to “move the needle” on health outcomes
- Be informed by those experiencing the most negative health outcomes, and reflect the lived experience of people
- Uncover factors that historically have been obscured or ignored
- Enable the establishment of health improvement goals
- Inform decision-making, action and accountability to drive:
  - Allocation of resources and strategic investments
  - Intentional action (working on the right things)
  - New and expanded partnerships, collaboration, and other alignment of efforts
  - Innovation

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

- Demonstrate improvement or catch eroding trends for:
  - Social, economic, and environmental factors that impact health
  - Population health outcomes
  - Health inequities
  - Health care delivery and other systems
  - With easy to understand graphic depiction

Values and Principles

Values
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, 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, 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, not what is easiest. A measurement framework should provide “signal strength”—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.

Domains
There are four emerging domains of health and health equity measurement and improvement areas:

- The **community conditions and outcomes** domain contains geographic-specific and population-specific indicators that are actionable for organizations that work on behalf of specific communities.
- The **health care and social services** domain contains indicators associated with access, affordability, quality and expectations of services.
- The **statewide conditions and outcomes** domain contains high-level social and structural indicators to assist in placing other indicators into the broader context of what creates health.
- The **policy environment** domain contains health care policy, economic policy and other policy indicators related to health priorities that impact statewide conditions and outcomes.

Using these four domains for any identified health and health equity measurement and improvement priority will allow for the identification of existing measures and measure gaps. Framework health priorities will be determined through the governance process with community input.

<table>
<thead>
<tr>
<th>Health priority</th>
<th>Community conditions and outcomes</th>
<th>Health care and social services</th>
<th>Statewide conditions and outcomes</th>
<th>Policy environment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Public engagement and belonging (social isolation, sense of community, etc.)</td>
<td>Access to services (health care, mental health, dental, health insurance, housing assistance, SNAP benefits)</td>
<td>Health outcomes (mental health status, functional status, mortality, birth weight)</td>
<td>Policies that advance or constrain our ability to achieve health (minimum wage, paid parental leave)</td>
<td></td>
</tr>
<tr>
<td>Environment (walkability, access to healthy food, parks and recreation utilization, etc.)</td>
<td>Affordability of services (health care, mental health, dental, health insurance)</td>
<td>Socio-economic (housing, education, income)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Community partnerships (health care benefit agenda, local health initiatives)</td>
<td>Health care collaboration (health care use of framework)</td>
<td>Social environment conditions (safety, poverty)</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>Physical environment; natural and built environment (water, air, housing quality)</td>
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<td></td>
</tr>
</tbody>
</table>

- Statewide policy indicators
- Localized policy indicators
- Other (corporate, religious, etc.)
<table>
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<tbody>
<tr>
<td></td>
<td>Social service collaboration</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td><em>(social service use of framework)</em></td>
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<tr>
<td></td>
<td>Quality of services</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td><em>(health care, mental health, dental, health insurance, housing service, SNAP benefits)</em></td>
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<td></td>
</tr>
<tr>
<td></td>
<td>Patient/recipient/beneficiary experience of services</td>
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<tr>
<td></td>
<td><em>(patient experience survey)</em></td>
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</tbody>
</table>
Infant Mortality Measurement Example

The following health priority and measures serve as an example of how the draft framework model may look when implemented. Measures were selected from a variety of sources including Minnesota state agency indicators and existing frameworks reviewed by the Steering Team (HOPE, RWJF and IOM).

<table>
<thead>
<tr>
<th>Community conditions and outcomes</th>
<th>Health care and social services</th>
<th>Statewide conditions and outcomes</th>
<th>Policy environment</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Public engagement and belonging</strong></td>
<td><strong>Access to services</strong></td>
<td><strong>Health outcomes</strong></td>
<td><strong>Statewide policy indicators</strong></td>
</tr>
<tr>
<td>Sense of community (sense of community index)</td>
<td><strong>Access to primary care</strong> (Portion of people living in counties with a population-to-primary care physician ratio of less than 2,000:1)</td>
<td><strong>Infant mortality</strong> (# of infants who die before their 1st birthday annually per 1,000 live births)</td>
<td>Support for working families (Annual percentage of families with parents eligible for Family Medical Leave Act coverage who can also afford it)</td>
</tr>
<tr>
<td>Social support (Percentage of people noting that they have adequate social support from partner, family and friends)</td>
<td><strong>Access to mental health services</strong> (Percentage of people who report having mental health or substance abuse problems, and who received treatment)</td>
<td><strong>Rate of pre-term births</strong></td>
<td>Targeted care for those at greatest risk (state coverage of enhanced prenatal care interventions for women enrolled in Medicaid or the Children’s Health Insurance Program who are at risk for a preterm birth)</td>
</tr>
<tr>
<td>Voter participation (Percentage of eligible voters who reported voting in the general election)</td>
<td><strong>Medicaid enrollment for women of childbearing age</strong></td>
<td><strong>Rate of Sudden Unexpected Infant Deaths</strong></td>
<td>Safe sleep (state promotion of interventions to improve infant safe sleep practices, including public education campaigns)</td>
</tr>
<tr>
<td><strong>Environment</strong></td>
<td><strong>Affordability of services</strong></td>
<td><strong>Rate of pregnancies that are planned</strong></td>
<td>Smoking cessation (state coverage and provision of smoking cessation for pregnant women and cigarette taxation)</td>
</tr>
<tr>
<td>Availability of healthy food</td>
<td><strong>Affordable health care</strong> (Portion of adults who did not delay or forgo any medical care they needed due to cost in the past year)</td>
<td><strong>Rate of teen pregnancies</strong></td>
<td></td>
</tr>
<tr>
<td>Walkability</td>
<td><strong>Health insurance coverage</strong> (Portion of people under age 65 with any kind of health insurance)</td>
<td><strong>Quality of services</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Community partnerships</strong></td>
<td><strong>Post-secondary education</strong> (Portion of adults with at least some college education after graduating from high school)</td>
<td><strong>Measure of comprehensive, culturally appropriate, coordinated health care</strong> women receive during preconception, pregnancy and post-partum periods</td>
<td></td>
</tr>
<tr>
<td>Community health benefit agenda</td>
<td><strong>Connected youth</strong> (Portion of young people age 16-24 enrolled in school or working, including military enlistment)</td>
<td><strong>Low poverty concentration</strong> (Portion of people in neighborhoods)</td>
<td></td>
</tr>
<tr>
<td>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, other community-based agencies)</td>
<td><strong>Employment</strong> (Portion of people in the labor force who are employed)</td>
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</tr>
<tr>
<td>Health care provider organizations and obstetricians use framework to implement disparity reduction interventions,</td>
<td></td>
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<tr>
<td><strong>Socio-economic</strong></td>
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<tr>
<td>Affordable housing (Portion of households spending no more than 30% of monthly household income on housing and related expenses)</td>
<td></td>
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<td></td>
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<tr>
<td>Post-secondary education</td>
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</tr>
<tr>
<td>like providing culturally competent care</td>
<td>Patient/recipient/beneficiary experience of services</td>
<td>with less than 20% of residents living in poverty)</td>
<td>• Low rape rate (Portion of people living in counties with fewer than 36.9 reported cases of rape per 100,000 population annually)</td>
</tr>
<tr>
<td>• Community-based organizations use framework to inform community interventions, like safe sleep education, and track progress</td>
<td>• Measure of comprehensive, culturally appropriate, coordinated health care women receive during preconception, pregnancy and post-partum periods</td>
<td>Physical environment; natural and built environment</td>
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<td></td>
<td></td>
<td>• Housing quality (Portion of households living in homes with no severe housing problems)</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>• Air Quality—Particulate Matter (Portion of people living in countries with average daily density of fine particulate matter below 12 micrograms per cubic meter)</td>
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</tr>
</tbody>
</table>
Mental Health Measurement Example

The following health priority and measures serve as an example of how the draft framework model may look when implemented. Measures were selected from a variety of sources including Minnesota state agency indicators and existing frameworks reviewed by the Steering Team (HOPE, RWJF and IOM).

<table>
<thead>
<tr>
<th>Community conditions and outcomes</th>
<th>Health care and social services</th>
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</tr>
</thead>
<tbody>
<tr>
<td><strong>Public engagement and belonging</strong></td>
<td><strong>Access to services</strong></td>
<td><strong>Health outcomes</strong></td>
<td><strong>Statewide policy indicators</strong></td>
</tr>
<tr>
<td>• Belonging in school (Percentage of 9th graders bullied or harassed once a week or more)</td>
<td>• Access to Psychiatric Care (Portion of people living in counties with a population-to-psychiatrist ratio of less than 30,000:1)</td>
<td>• Mental Health Status (Portion of adults who say their mental health was not good for 14 or more days in the past 30 days)</td>
<td>• Support for working families (Annual percentage of families with parents eligible for Family Medical Leave Act coverage who can also afford it)</td>
</tr>
<tr>
<td>• High School Dropout Rate</td>
<td>• Access to Mental Health services (Percentage of people who report having mental health or substance abuse problems, who received treatment)</td>
<td>• Suicide deaths</td>
<td></td>
</tr>
<tr>
<td>• Ratio of school counselors to student population</td>
<td>• Access to Paid Family and Sick Leave (Percentage of Minnesota employees with paid leave or family leave or sick leave benefits)</td>
<td><strong>Socio-economic</strong></td>
<td><strong>Localized policy indicators</strong></td>
</tr>
<tr>
<td>• Sense of community (Aggregate score on two subscales of the Sense of Community Index: emotional connection to community and sense of belonging to community)</td>
<td>• Access to Mental and Emotional Health services (The percentage of 11th grade students who received mental or emotional health treatment in the past year)</td>
<td>• Livable income (Portion of people living in households with income greater than 250% of the federal poverty level)</td>
<td>• Jurisdictional policy on welcoming/belonging (e.g. immigrant friendly communities)</td>
</tr>
<tr>
<td><strong>Environment</strong></td>
<td><strong>Affordability of services</strong></td>
<td>• Post-secondary education (Portion of adults with at least some college after graduating from high school)</td>
<td>• Dementia or aging friendly communities</td>
</tr>
<tr>
<td>• Availability of healthy food</td>
<td>• Affordable mental health care (Portion of adults who did not delay or forgo any mental health care they needed due to cost in the past year)</td>
<td>• Connected Youth (Portion of young people age 16-24 enrolled in school or working, including military enlistment)</td>
<td>• Comprehensive policy plans (e.g. that include transportation, housing, or other indicators)</td>
</tr>
<tr>
<td>• Walkability</td>
<td><strong>Quality of services</strong></td>
<td>• Employment (Portion of people in the labor force who are employed)</td>
<td></td>
</tr>
<tr>
<td>• Regional park availability usage</td>
<td>• Depression Remission at Six Months (Percentage of patients 18 years of age or older with Major Depression or Dysthymia)</td>
<td><strong>Social environment conditions</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Community partnerships</strong></td>
<td><strong>Statewide policy indicators</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• 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, other community-based agencies)</td>
<td><strong>Affordability of services</strong></td>
<td>• Low poverty concentration (Portion of people in neighborhoods with less than 20% of residents living in poverty)</td>
<td></td>
</tr>
<tr>
<td>• Student Mental Health Referrals (% of students with behavioral</td>
<td><strong>Quality of services</strong></td>
<td>• Low murder rate (Portion of people living in counties with fewer</td>
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</tbody>
</table>
## MENTAL HEALTH MEASUREMENT EXAMPLE

<table>
<thead>
<tr>
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<th>Health care and social services</th>
<th>Statewide conditions and outcomes</th>
<th>Policy environment</th>
</tr>
</thead>
<tbody>
<tr>
<td>infractions referred to mental health services versus law enforcement)</td>
<td>seen in a physician clinic who reached remission within six months)</td>
<td>than 5.1 murders per 100,000 population annually)</td>
<td></td>
</tr>
<tr>
<td><strong>Localized health outcome indicators</strong></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>• Ex: Stearns county is using population health data from CentraCare to drive health improvement efforts</td>
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</tr>
<tr>
<td><strong>Localized health outcome indicators</strong></td>
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<td></td>
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<tr>
<td><strong>Patient/recipient/beneficiary experience of services</strong></td>
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<tr>
<td>• Adverse child experiences (Percentage of population, ages 0 to 17 years, with two or more reported adverse childhood experiences, as reported by parents)</td>
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<td></td>
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<tr>
<td>• Self-reported well-being</td>
<td></td>
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<tr>
<td>• Disability associated with mental and behavioral disorders (Number of disability-adjusted life years for mental and behavioral disorders)</td>
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<td></td>
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<tr>
<td><strong>Physical environment; natural and built environment</strong></td>
<td></td>
<td></td>
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<tr>
<td>• Housing quality (Portion of households living in homes with no severe housing problems)</td>
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<td>• Air Quality—Particulate Matter (Portion of people living in counties with average daily density of fine particulate matter below 12 micrograms per cubic meter)</td>
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<tr>
<td>• Low Liquor Store Density (Portion of people living in counties with fewer than 1.736 liquor stores per 10,000 population)</td>
<td></td>
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<tr>
<td>• 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)</td>
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</tbody>
</table>
To help you envision how the draft framework model may look when implemented from your or your organization’s perspective, select your own example of a health priority and brainstorm possible measures below.

<table>
<thead>
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<td>Access to services</td>
<td>Health outcomes</td>
<td>Statewide policy indicators</td>
</tr>
<tr>
<td></td>
<td>(health care, mental health, dental, health insurance, housing assistance, SNAP benefits)</td>
<td>(mental health status, functional status, mortality, birth weight)</td>
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</tr>
<tr>
<td>Environmental</td>
<td>Affordability of services</td>
<td>Socio-economic</td>
<td>Localized policy indicators</td>
</tr>
<tr>
<td></td>
<td>(health care, mental health, dental, health insurance)</td>
<td>(housing, education, income)</td>
<td>•</td>
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<tr>
<td></td>
<td>Health care collaboration</td>
<td>Social environment conditions</td>
<td>Other policy indicators</td>
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<td></td>
<td>(health care use of framework)</td>
<td>(safety, poverty)</td>
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</table>

(insert health priority)
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<td>Physical environment; natural</td>
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<tr>
<td>(social service use of framework)</td>
<td>(social service use of framework)</td>
<td>and built environment</td>
<td></td>
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<td></td>
<td>•</td>
<td>(water, air, housing quality)</td>
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<tr>
<td>Quality of services</td>
<td>Quality of services</td>
<td>•</td>
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</tr>
<tr>
<td>(health care, mental health, dental, health insurance, housing assistance, SNAP benefits)</td>
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<tr>
<td>Patient/recipient/beneficiary</td>
<td>Patient/recipient/recipient/</td>
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<tr>
<td>experience of services</td>
<td>beneficiary experience of</td>
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<tr>
<td>(patient experience survey)</td>
<td>services (patient experience</td>
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<td>survey)</td>
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The Basics of Governance: An Overview

A governance model aims to address three key factors: 1) accountability, 2) authority, and 3) decision-making.

Our selected governance model will:
- Identify what groups, sub-groups, roles, and responsibilities are necessary to support the development and implementation of Minnesota’s measurement framework,
- Delineate who is accountable for performing certain tasks, and
- Outline which roles hold decision-making ability and authority.

This includes clarifying roles, responsibilities, and accountabilities among communities and patients, health care organizations and clinicians, public health practitioners, the State (MDH and DHS), policy makers, and potentially others.

Key Considerations

The following examples are intended to highlight various characteristics and priorities which can affect governance structure design. These are not intended to present either/or dichotomies nor provide specific prescriptive advice. Rather, there are possibilities that serve to spark thinking on governance structure design. In some cases, it may be possible for both examples to be relevant and/or accurate.

How the solution will be used and by whom

The work product that this governance body will oversee and manage (the measurement framework) is a primary consideration in how to design the most appropriate governance approach.

Examples: The governance structure most suitable for the group might look different if …

- The framework will solely be used for the purposes of state reporting on the health of Minnesota
- The framework will be used to foster a shared approach and collaborative efforts that drive health improvement across various organizations and sectors

The Charge

The work that will be asked of this governance body and others involved should be a primary consideration in designing the most effective governance model.

Examples: The governance structure most suitable for the group might look different if …

- The group is charged with providing input on framework measures and framework updates as needed
- The group is charged with promoting stakeholder adoption of the framework and increasing its use

Accountability

The governance approach should clearly indicate who on the governance body (and work groups) will be held accountable for what and by whom, and how the governance structure upholds these accountabilities.

Examples: The governance structure most suitable for the group might look different if …

- Just one stakeholder or organization is to be held accountable
- Many or all stakeholders are to be held accountable
### Authority

The level of influence and authority each member has in decisions should be stated clearly in governance roles and responsibilities. Increasing individual-level authority could improve engagement and equity but will also increase the time required to make decisions.

Examples: The governance structure most suitable for the group might look different if...

| Decisions are intended to be centrally determined by a few people | Decisions are intended to be decentralized with all members weighing in on most decisions |

### Flexibility

The speed with which decisions will need to be made should be considered in the governance model design.

Examples: The governance structure most suitable for the group might look different if...

| Work needs to be delivered on in a fast, rapid-response fashion | Work can be done and decisions can be made at a more moderate, tempered pace |

### Representation

The desired breadth of representation (from organizations, sectors, and communities) is a primary consideration in how to design the most appropriate governance approach.

Examples: The governance structure most suitable for the group might look different if...

| It’s acceptable to gather input primarily from those willing and able to provide it in a timely fashion | Input from all sectors that influence health (e.g. transportation, housing, etc.) is desired |

### Participation and Engagement

The required level of participation, engagement, and time commitment of each governance body member will result in differing levels of buy-in and ownership, which should be reflected in the governance model design.

Examples: The governance structure most suitable for the group might look different if...

| The intent is that members will take a more advisory role in informing MDH’s focus areas (a less significant level of participation and engagement) | The intent is that members will take ownership and buy in to the process to the extent that they bring the framework to their organization (a more significant level of participation and engagement) |