Participants

Steering Team:

• Bill Adams
• Courtney Jordan Baechler
• Karolina Craft
• Ellen De la torre
• Marie Dotseth
• Lisa Juliar
• Scott Keefer
• Rahul Koranne
• Deb Krause
• Deatrick LaPointe
• Jennifer Lundblad
• Gretchen Musicant
• Sarah Reese (phone)
• Diane Rydrych
• David Satin
• Janet Silversmith
• Julie Sonier
• Tyler Winkelman
• Pahoua Yang (phone)
• Maiyia Yang Kasouaher

MDH Project Staff:
Sarah Evans, Stefan Gildemeister, David Hesse, Denise McCabe, Jeannette Raymond

Turnlane:
Alex Clark, Cassandra Canaday
Meeting Objectives

- Refine the initial draft of the framework model design
- Discuss the work required to provide effective governance for this project moving forward
- Begin discussing an initial governance structure that will make decisions about framework implementation activities

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 Karolina Craft from the Department of Human Services. They also shared that Tuleah Palmer is unfortunately unable to participate on the Steering Team.

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

Steering Team Agreements

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).
Jeannette Raymond provided an overview of the draft model design and the process for its development. Of particular note, this initial draft model was informed by Steering Team input from the June and July meetings.

Additionally, the Steering Team was provided with examples of how the framework model might function with two distinct health priority areas – infant mortality and mental health; Jeannette walked the Steering Team through the infant mortality example. See Appendices A and B for the draft framework model design and the examples, respectively.
Draft framework model design refinement

Through small and large group discussion, the group shared their initial reactions, thoughts, and reflections on the draft framework model. Many noted that this model is different than they had envisioned and that it takes steps in the right direction. Several noted that after reviewing this draft, they’d had an “aha!” moment that created a sense of clarity.

The following provides a synthesis of group input. See Appendix C for more detail on input gathered.

*What Resonates*
- Enables priority setting
- Promotes a vision of cross-sector collaboration
- Creates space for various stakeholders and may foster bipartisanship

*What to Change*
- More explicitly capture health equity focus
- Reinforces some of what is already done
- Create greater clarity on how this leads to collaboration
- Complexity and potential to overwhelm
- Ensure differing communities’ needs can be accounted for
- Integrate community and individual voices

*Small Group Discussion Questions*
- Does this design help stakeholders envision the work that’s needed to improve health in Minnesota moving forward?
- Does it help identify which stakeholder partners are needed to make progress?
- What might prevent this framework from working? What do we need to do to make this work?
- What, if anything, would you change about the design (What would you add? What would you remove?)?

*Barriers to Acknowledge & Address*
- Lack of evidence
- Failure to incentivize (creating an unfunded mandate)
- Partisanship
- Lack of buy-in from stakeholders
- Lack of progress tracking and accountability
- Some may see framework as too prescriptive or irrelevant

**Next Step:** A work group (Karolina, David, Marie, and any other volunteers) will form and meet to further develop the draft framework model before the November meeting.
Alex Clark provided participants with a brief overview on the topic of governance, which was intended to inform the Steering Team’s subsequent discussions and development of a governance approach for future phases of work on the framework model.

Our selected governance approach will:

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

Alex noted some of the responsibilities the governance body could hold and decisions they may be responsible for making (see Appendix D for further detail), and then provided examples of how consideration of the following core characteristics could impact the governance model:

- Authority
- Flexibility
- Representation
- Participation and Engagement

- How the solution will be used and by whom
- Charge
- Accountability
Governance Discussion

What is the work of this governance body?

Meeting participants separated into trios and pairs to discuss the two most foundational governance considerations:

- How the Solution Will be Used and by Whom
- The Charge

After a period of discussion, trios and pairs presented brief reports on their group’s conversations to the larger group. See Appendix E for a detailed summary of this discussion.

**How the solution will be used and by whom**

<table>
<thead>
<tr>
<th>The Framework and How It Will Be Used</th>
</tr>
</thead>
<tbody>
<tr>
<td>+ Spark a broad change movement</td>
</tr>
<tr>
<td>+ Enable increased equity and reduction of disparities</td>
</tr>
<tr>
<td>+ Track and measure progress and performance</td>
</tr>
<tr>
<td>+ Incentivize action, investment, and engagement</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Who Will Use the Framework</th>
</tr>
</thead>
<tbody>
<tr>
<td>+ MDH and DHS</td>
</tr>
<tr>
<td>+ Health care and social service providers</td>
</tr>
<tr>
<td>+ Payers of services</td>
</tr>
<tr>
<td>+ Politicians and policymakers</td>
</tr>
<tr>
<td>+ Communities and advocates</td>
</tr>
</tbody>
</table>

**The Charge of this Governance Body**

<table>
<thead>
<tr>
<th>The Core Function of this Governance Body</th>
</tr>
</thead>
<tbody>
<tr>
<td>+ Design, development and maintenance of the framework</td>
</tr>
<tr>
<td>+ Identify threats and emerging issues</td>
</tr>
<tr>
<td>+ Advise the MDH Commissioner</td>
</tr>
<tr>
<td>+ Continuously refine and rethink the model</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>The Buckets of Work and Focus Areas</th>
</tr>
</thead>
<tbody>
<tr>
<td>+ Set guidelines and principles</td>
</tr>
<tr>
<td>+ Oversee topic area work subgroups/work groups</td>
</tr>
<tr>
<td>+ Provide knowledge and insight</td>
</tr>
</tbody>
</table>

Next Step: A work group (Gretchen, Julie, Jennifer, and any other volunteers) will form and meet to further develop the governance approach before the November meeting.
Public Comments
There were no comments from public observers.

Next Steps
- Provide input via the post-meeting survey (Steering Team members)
- Work group formation for phase 2 components:
  - Next iteration of the draft framework model (Karolina, David, Marie, and any other volunteers)
  - Continued development of the governance approach (Gretchen, Julie, Jennifer, and any other volunteers)
## Draft Framework Model Design

### Health priority

<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>Public engagement and belonging</td>
<td>Access to services</td>
<td>Health outcomes</td>
<td>Policies that advance or constrain our ability to achieve health (minimum wage, paid parental leave)</td>
</tr>
<tr>
<td>(social isolation, sense of community, etc.)</td>
<td>(health care, mental health, dental, health insurance, housing assistance, SNAP benefits)</td>
<td>(mental health status, functional status, mortality, birth weight)</td>
<td>• Statewide policy indicators</td>
</tr>
<tr>
<td>Environment</td>
<td>Affordability of services</td>
<td>Socio-economic</td>
<td>• Localized policy indicators</td>
</tr>
<tr>
<td>(walkability, access to healthy food, parks and recreation utilization, etc.)</td>
<td>(health care, mental health, dental, health insurance)</td>
<td>(housing, education, income)</td>
<td>• Other (corporate, religious, etc.)</td>
</tr>
<tr>
<td>Community partnerships</td>
<td>Health care collaboration</td>
<td>Social environment conditions</td>
<td></td>
</tr>
<tr>
<td>(health care benefit agenda, local health initiatives)</td>
<td>(health care use of framework)</td>
<td>(safety, poverty)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Social service collaboration</td>
<td>Physical environment; natural and built environment</td>
<td></td>
</tr>
<tr>
<td></td>
<td>(social service use of framework)</td>
<td>(water, air, housing quality)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Quality of services</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>(health care, mental health, dental, health insurance, housing service, SNAP benefits)</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>Patient/recipient/ beneficiary experience of services</td>
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<td></td>
<td>(patient experience survey)</td>
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Appendix B

Draft Framework Model Examples

Infant Mortality Measurement Example
(attached under separate cover)

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 (WHO, RWIF and IOM).

<table>
<thead>
<tr>
<th>Community conditions and outcomes</th>
<th>Health care and social services</th>
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</thead>
<tbody>
<tr>
<td>Public engagement and belonging</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Sense of community (sense of community value)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Social support (percentage of people reporting that they have adequate social support from partner, family and friends)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Voter participation (percentage of eligible voters who reported voting in the general election)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Environment</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Availability of healthy food</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Walkability</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Community partnerships</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Community health benefit agenda</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Hospital partnerships (percentage of hospitals that have a collaboration or alliance with one or more community organizations)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Access to services

• Infant mortality (number of infants who died before their 1st birthday annually per 1,000 live births)

Rate of preterm births

Rate of sudden unexpected infant deaths

Rate of preganancies that are planned

Rate of teen pregnancies

Socio-economic

• Affordable housing (percentage of households spending no more than 30% of monthly household income on housing and related expenses)

Post-secondary education (percentage of adults with at least some college education after graduating from high school)

Connected youth (percentage of young people age 16-24 enrolled in school or working, including military)

Statewide policy indicators

• Support for working families
• Mental Health Status

Mental Health Measurement Example
(attached under separate cover)

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 (WHO, RWIF and IOM).

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</thead>
<tbody>
<tr>
<td>Public engagement and belonging</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| • Belonging in school (percentage of students in grades 9-12 that report feeling safe at school)
• High school dropout rate

Ratio of school counselors to student population

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

Environment

• Availability of healthy food
• Walkability

Regional park availability usage

Community partnerships

Hospital partnerships (percentage of hospitals that have a collaboration or alliance with one or more community organizations in each of these)

Health care and social services

• Access to psychiatric care (percentage of people living in counties with a population to psychiatrist ratio of less than 1:10,000)

Access to mental health services (percentage of people who report having mental health or substance abuse problems, who received treatment)

Access to paid family and sick leave (percentage of Minnesota employees with paid leave or family leave or sick leave benefits)

Access to mental and emotional health services (percentage of adults with at least some college after graduating from high school or working, including military enlistment)

Affordable services

• Affordable mental health care (percentage of adults who did not delay or delay any mental health care they needed)

Statewide policy indicators

• Support for working families
• Mental Health Status

Local policy indicators

• Jurisdictional policy on welcoming/belonging (e.g., immigrant friendly communities)
• Dementia or aging friendly communities
• Comprehensive policy plans (e.g., that include transportation, housing, or other indicators)

Social environment conditions
Does this design help stakeholders envision the work that’s needed to improve health in Minnesota moving forward?

Comments and Themes:
- Generally, yes, but it needs revision

Does this framework design help identify which stakeholder partners are needed to make progress?

Comments and Themes:
- It lacks integration of citizens’ voices—the input of those impacted by it
- The governance model can help with identification of stakeholder partners
- Perhaps it should offer explicit examples
- Yes, it could encourage discussion
- Perhaps, but it’s important to note that stakeholders of governance and implementation may differ

What might prevent this framework from working? What do we need to do to make this work?

Comments and Themes:
- Lack of evidence base and transparency around evidence
- Measuring things that don’t matter
- Failure to incentivize action (unfunded mandate)
- Partisanship and politics
- Policy may not act like other domains—measurement/tracking is different + more political, so evidence base more critical
- People not seeing themselves and their role within it
- Strained inter-stakeholder relationships and lack of trust
- It needs to provide room for growth, change, experimentation, and adaptation
- Underlying issues are hard to measure (e.g., racism)
- Lack of buy-in from key stakeholders
- Lack of organizational alignment/coordination of initiatives
- No accountability requirement, tracking, or enforcement
- These complex problems may not be able to be solved by a framework alone
- It may be too prescriptive and/or otherwise irrelevant for some stakeholders, communities, and cultures
- Factors and appropriate priorities may vary between communities and at state level
- It may be too complex or unclear
- Not keeping relevant: need to determine how priority selection will work & be responsive to arising issues
What, if anything, would you change about the design (What would you add? What would you remove?)?

**What the group liked and would keep**
- Ability to set priorities
- Helps envision cross-sector collaborations
- Getting domains and subdomains is key to the process
- This can be bipartisan

**What the group didn’t like and would change**
- Seems to reinforce what we already do
- It’s very complex and possibly overwhelming—should simplify
- Need to have a balanced (not excessive) number of measures
- Ways to collaborate need to be more clear
- Community vs. state-level: what’s the distinction? (consider metric approach)
- Doesn’t allow for adaptation to varying community needs
- Add to design: high-level dashboard
- Clarify how data sharing standards would be created/upheld
- Consider how to promote community collaboration vs. competition
- Model requires us to get clear on who this engages/Involves
- Needs to incorporate health equity more actively and explicitly
- Design doesn’t clearly reflect goal
- Are these indicators deep enough?
- How can it balance patient voice with evidence base?
- Prioritize areas in need of collaborative effort
- Measure outcomes, not processes—don’t be too prescriptive
- Conditions and outcomes are different, and should maybe be tracked/measured separately
- Need to include community/citizen voices more intentionally and explicitly
Our governance body will have a number of responsibilities. Some of the responsibilities they could have and decisions they could be asked to make might include:

- Deciding on priority areas for measurement
- Selecting and/or revising domains and sub-domains
- Choosing appropriate measures and/or updating them as needed
- Identifying the need for new work groups
- Helping to form and oversee work groups
### What is the solution we are creating and how will it be used?

**Comments and Themes:**
- Tracking and measuring progress and performance
- Incentivizing action, investment, and engagement
- A tool for reducing disparities and increasing equity
- A broader change movement
- Facilitating improvement vs just reporting
- Fostering collaboration
- Innovation/experimentation
- Setting priorities and goals for the state
- Driving investment of time, money, and other resources
- Requiring accountability and ownership
- Holistic view of what drives health
- Values should tie to the solution
- Different stakeholders, users, and impacted persons would likely use it in different ways

### Who will use it, and therefore, who needs to be involved in our governance model?

**Comments and Themes:**
- Not only the people who use it should be involved in governance—those who would be affected despite not being core users should be included too
- Should clarify/specify benefits to users
- Define who **must** use framework & **consider** who **should** use it
- MDH
- DHS
- Possibly employers, if it’s clear enough how they would use it
- Health care system/providers
- Social service organizations
- Payers/plans
- Politicians and policymakers
- Researchers and experts
- Communities and advocates
- Investors
What is the core function of this governance body?

Comments and Themes:
- Establishment of the framework (e.g., identifying priorities, articulating domains, selecting measures)
- Maintenance and updating the framework
- Identifying emerging needs, threats, and other issues
- Advisory to MDH commissioner
- Revise and rethink the model, ensure sustainability through continued relevance
- Set parameters (e.g. evidence, actionability)
- Promote equity and ensuring that all community perspectives and experiences are informing process
- Maintain transparency
- Consider/implement incentives required to assume organizations will utilize this
- Create reporting cadence to track progress and promote accountability
- Make actionable recommendations for change

What are buckets of work and focus areas necessary to perform this function?

Comments and Themes:
- Oversee topic area subgroups/workgroups
- Oversee administrative needs
- Set guidelines/principles
- Provide knowledge/wisdom/advice
- The governance body and processes will need to be structured in a way that minimizes the potential for governance body membership to bias governance body decisions (e.g., possibly priority areas)
- MDH should uphold leadership and authority

Additional notes and discussion:
- The governance body needs to be structured in a manner that allows it to evolve as needed to address new issues and include new relevant perspectives
- The main governance body doesn’t have to do or know everything, work groups can be relied on for expertise
- The goal is for the governance body to lead and take some ownership of this work
- The governance body needs to be structured in a way that minimizes the potential for governance body membership to bias governance body decisions (e.g., possibly priority areas)
- MDH should uphold leadership and authority

Comments and Themes:
- What are buckets of work and focus areas necessary to perform this function?
- Oversee administrative needs
- Set guidelines/principles
- Provide knowledge/wisdom/advice
- The governance body and processes will need to be structured in a way that minimizes the potential for governance body membership to bias governance body decisions (e.g., possibly priority areas)
- MDH should uphold leadership and authority

Appendix E