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# **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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*Protecting, Maintaining and Improving the Health of All Minnesotans*

February 27, 2019

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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](mailto:jan.malcolm@state.mn.us), or Stefan Gildemeister, the State Health Economist, at 651-201-3554 or [stefan.gildemeister@state.mn.us](mailto: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.<sup>1</sup> 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.<sup>2</sup> 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.<sup>3</sup>

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.

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<sup>1</sup>MN Community Measurement (MNCM), [mncm.org](http://mncm.org).

<sup>2</sup>Minnesota Statutes, Section 62U.02.

<sup>3</sup>To 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.<sup>4</sup> 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.

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<sup>4</sup>According 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.

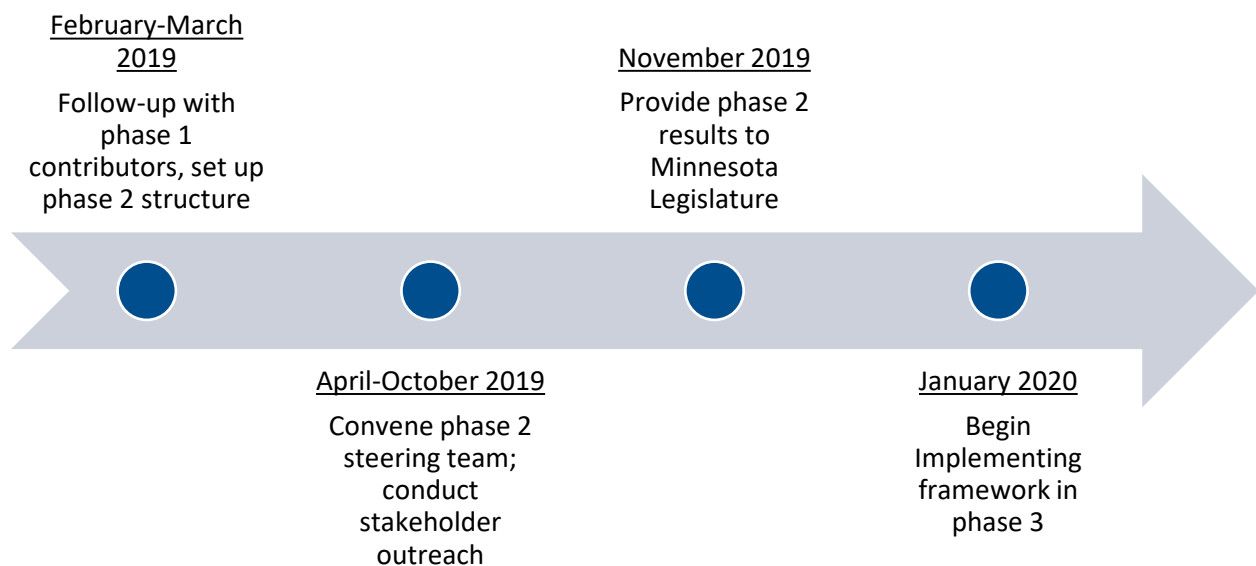
# A Roadmap for Completing the Development of the Measurement Framework

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

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

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.<sup>5</sup> 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.<sup>6</sup>

### 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

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<sup>5</sup>The 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.

<sup>6</sup>SHADAC 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 Council<sup>7</sup>;
- Health equity champions convened by Voices for Racial Justice<sup>8</sup>; and
- Community representatives convened by West Side Community Health Services’ Somali, Latino and Hmong Partnership for Health and Wellness (SoLaHmo)<sup>9</sup>.

## 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 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.

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<sup>7</sup>MDH 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.

<sup>8</sup>Voices 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.

<sup>9</sup>SoLaHmo 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
<b>Consumer, community and advocacy organizations representing diverse communities and patients</b>			
1	June 15	MDH Health Equity Advisory and Leadership Council Subgroup	<ul style="list-style-type: none"> <li>▪ Abiola Abu-Bakr, Minnesota Black Nurses Association</li> <li>▪ Joann Usher, JustUs Health</li> </ul>
2	June 20	Patient advocacy representatives	<ul style="list-style-type: none"> <li>▪ Matt Flory, American Cancer Society</li> <li>▪ Jill Heins-Nesvold, American Lung Association</li> <li>▪ Amanda Jansen, ClearWay Minnesota</li> <li>▪ Mary Olsen Baker, Minnesota Department of Human Services and Minnesota Board on Aging</li> <li>▪ Joan Willshire, Minnesota Council on Disability</li> </ul>
3	June 27	Health equity champions convened by Voices for Racial Justice	<ul style="list-style-type: none"> <li>▪ Huda Ahmed, Grassroots Solutions</li> <li>▪ Julia Freeman, Voices for Racial Justice</li> <li>▪ Monica Hurtado, Voices for Racial Justice</li> <li>▪ Roxana Linares, Centro Tyrone Guzman</li> <li>▪ Rosa Tock, Minnesota Council on Latino Affairs</li> <li>▪ Vang Xor Xiong, Asian American Organizing Project</li> </ul>
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"> <li>▪ Pilar de la Parra, West Side Community Health Services</li> <li>▪ Hsajune Dyan, St. Paul Public Schools</li> <li>▪ Cindy Kaigama, Healing Virtue, LLC*</li> <li>▪ Abelardo Mena, Student</li> <li>▪ Ana Rodriguez, Student</li> <li>▪ Isolina Soto, West Side Community Health Services</li> <li>▪ Marcela Soto, West Side Community Health Services</li> <li>▪ Demetria Turnage, Minnesota CarePartner*</li> <li>▪ Bai Vue, Student</li> <li>▪ Song Xiong, West Side Community Health Services</li> </ul>

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

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

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

19	July 25	MN Community Measurement	<ul style="list-style-type: none"> <li>▪ Liz Cinqueonce</li> <li>▪ Julie Sonier</li> </ul>
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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"> <li>▪ Sara Chute</li> <li>▪ Dan Fernandez-Baca</li> </ul>
	Community & Family Health	<ul style="list-style-type: none"> <li>▪ Janet Olstad</li> <li>▪ Dawn Reckinger</li> <li>▪ Virginia Zawistowski</li> </ul>
	Health Care Homes	<ul style="list-style-type: none"> <li>▪ Chris Dobbe</li> <li>▪ Bonnie LaPlante</li> </ul>
	Health Promotion & Chronic Disease	<ul style="list-style-type: none"> <li>▪ James Peacock</li> </ul>
	Health Regulation Division	<ul style="list-style-type: none"> <li>▪ Martha Burton Santibanez</li> </ul>
	Office of Health Information Technology	<ul style="list-style-type: none"> <li>▪ Karen Soderberg</li> </ul>
	Office of Statewide Health Improvement Initiatives	<ul style="list-style-type: none"> <li>▪ Ann Zukoski</li> </ul>

Agency	Program	Representative(s)
Minnesota Department of Human Services	Integrated Health Partnerships	<ul style="list-style-type: none"> <li>▪ Karolina Craft</li> <li>▪ Heather Petermann</li> </ul>
Minnesota Management and Budget	State Employee Group Insurance Plan	<ul style="list-style-type: none"> <li>▪ Joshua Fangmeier</li> </ul>

## Community Engagement Facilitator

- Deatrick LaPointe

## Project Team

### Minnesota Department of Health

- Sarah Evans
- Stefan Gildemeister
- David Hesse
- Denise McCabe
- Diane Rydrych

### Minnesota Management Analysis and Development

- Lisa Anderson
- Ashley Johnson
- Stacy Sjogren

## 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?