
Quality Framework Steering Team Meeting Summary

MAD Draft 6/22/2018

Meeting Date: June 4, 2018

Present

Steering Team: Kelly Fluharty, Jennifer Lundblad, Ross Owen, Diane Rydrych, David Satin, Julie Sonier, Mark Sonneborn, Maiyia Yang (alternate for Monica Hurtado)

MDH Staff: Marie Dotseth, Sarah Evans, Stefan Gildemeister, David Hesse, Denise McCabe

MAD Consultants: Lisa Anderson, Ashley Johnson, Stacy Sjogren

Welcome

Stacy Sjogren from Management Analysis and Development (MAD) welcomed everyone to the meeting. Steering Team Co-Chairs Jennifer Lundblad and Diane Rydrych reminded the group of the goals of the meeting and the goals of the project. Co-Chairs reviewed Steering Team roles and the Framework Development Arc.

Diane reviewed the Steering Team Meeting 3 Summary. Members posed clarifying questions and comments:

- It will be important for the Steering Team to hear what has come out of conversations within MDH and with stakeholders.
- Members expressed concern that the gap between the values and their interpretation is too broad. For instance, regarding the value “Measurement that matters”, for whom should it matter? This has come up several times, and MDH is exploring ways to better incorporate a variety of metrics, particularly to highlight the patient and community lens.
- Meeting summaries are valuable—good length and specificity.
- A successful framework will require a both/and approach that preserves existing value and serves multiple stakeholders.

Lisa Anderson provided an update on stakeholder engagement. MAD and MDH have begun stakeholder conversations, which will occur through June. Results from those conversations will be presented at the July Steering Team meeting. The Steering Team had the following feedback:

- Be sure to talk to providers—the ones being measured.
 - MAD will interview members of the Safety Net Coalition, Minnesota Academy of Family Physicians, and the Minnesota Medical Association’s Physician-Consensus Measures of

Performance to Advance Quality and Safety Work Group which includes a number of frontline, practicing physicians. MAD has also interviewed critical access hospital representatives.

- One member observed from their experience in the critical access hospital conversation that people are interested in an ongoing conversation.
- There should be at least two sessions where MDH engages the community. Consider asking them demographic questions to understand a variety of perspectives (e.g. religious, sexual orientation, gender, race, etc.).
 - MDH will meet with three community groups: a sub-group of MDH's Health Equity Advisory and Leadership Council, health equity champions convened by Voices for Racial Justice, and community leaders convened by SoLaHmo. Deatrick LaPointe will facilitate these community conversations.
- Take advantage of opportunities where people are already gathering.

MDH will also administer a survey in June to which anyone can respond. It will largely reflect the interview questions MAD is using. MDH anticipates presenting along with MAD at the July Steering Team meeting.

Stacy reviewed the ground rules and acknowledged the challenge of adhering to the agenda versus allowing productive conversations to continue.

Gain Shared Understanding – Elements of the Framework

Stefan presented a draft diagram that included elements of the framework and their relation to one another. Conceptually, the framework should represent an evolution from the status quo of measurement that aligns with the values and principles drafted by the group Thoughts, questions and points of clarification included:

- Unit of measure could be something other than health care provider, such as patient or county.
- Goals are not listed in order of priority.
- Where does community engagement fit in?
- Why would we not have a broader category of “health quality”?
- Consideration and criteria for selection are not mutually exclusive, but they are connected. Criteria is a check against principles.
- One could imagine this framework in three dimensions with lots of interconnecting arrows.

“Strength-Test” Framework Diagram

Stacy led a group discussion to react to the Framework diagram. She asked the group what was missing, what is included that was unexpected, and what was a surprise.

Steering Team members identified the following things that were missing:

- The link from values, principles, and goals to measurement, evaluation, and evolution; a focused process for making the framework actionable.
- The unique perspective that MDH brings to this framework such as prioritizing the kinds of measures or types of goals that MDH is best equipped to pursue, that other stakeholders cannot. What is the process for making this framework actionable?
- Clear value proposition for work.

One member redrew the framework to more explicitly illustrate the flow between elements and vision for a single, unified flow diagram that loops back on itself and reassesses values and principles in the process.

- **The process**
 - Patient/ community engagement: Where does it fit? It should not only be in evaluation but at each step in the process. It could also be a unit of measure. Communities are not making policies, but they’re the ones most affected by them.
 - Omit green bar for next iteration. It is extraneous, since stakeholders are already present in values and principles.
 - Need to think about the timing of the process loop. Annual, every three years?
 - Lots of process questions remain—measuring beyond the physician clinic, engaging the community, governance process, quality improvement system. How do we address these and move beyond the status quo?
 - We need to continue the discussion about process. It is complex, but exactly the right conversation.
- **The value**
 - The framework misses the “why.” Is the goal still to assess providers? How bound by the current system do we have to (or should we) be? Or is it to measure other things, like environmental factors, to create health system action?
 - Missing clarity on how we’re measuring providers (what data do they use to improve outcomes?)
 - Providers are measured and getting paid on how well they do. People do what they get paid to do.

- There may be a connection between goals and domains. Improving health outcomes is not only measuring clinics but also behaviors and social determinants. Perhaps the measurement should be data-driven determinants of health, i.e., what science tells us will get the “best bang for the buck”? The Institute of Medicine’s Vital Signs report helps set the stage.
- The measurement system in Minnesota today measures hospitals and clinics. Medicare measures individual clinicians. We also have the rest of the continuum of health care, e.g., mental/behavioral, home health, lots of providers (and communities) that we haven’t talked about. We have a narrow measurement system today—we’re missing the rest of the continuum of care and the whole community piece. Where does data and social determinants of health tell us we should be measuring?

Coming to agreement on scope

Co-chairs facilitated an open discussion about what the scope of the framework should be:

- Clinic and hospital measurement is necessary but not sufficient to address quality. Clinic and hospital measurement is possibly one element of measurement, and the law does not preclude us from measuring the system as a whole (e.g. public health, transitions of care, etc.). The legislation implies that the discussion starts with clinic and hospital measurement, but there is no constraint from thinking beyond clinic and hospital measurement.
 - A more evolved measurement system may extend beyond MDH and serve other entities in the state. We want to respond to the community, who wants greater participation in the process. Feedback on pros, cons, benefits, etc. will result in design changes to the framework and staging of outcomes. This may be the natural evolution of an advanced system, and a naturally uncomfortable discussion. This is what breaking new ground feels like.
- Clinic and hospital measurement is one element of a broader framework. We should be grounded in what problems we are trying to solve with this framework and the role of different stakeholders in problem-solving. The framework cannot be everything to everyone. Who is accountable and how? What are the incentives? What change are we trying to drive and what are the mechanisms by which this happens? We risk merely admiring the problems.
- Accountability and implementation mechanics are important. We also shouldn’t be constrained by them.
- We need to recognize that with an iterative process, we will probably get it wrong the first time, and we need to recognize that.
- We need to think about what changes we’re trying to drive. What problems are we trying to solve? How are stakeholders contributing?

- How do we get from abstract to practical (i.e. measuring clinics and hospitals to measuring across the care continuum)? What does stewardship look like? Can envision the integrated delivery systems that dominate the state’s health care landscape like a health ecosystem.
 - The level of integration is highly variable, so different parts of the system have different needs. Sense-making and gap identification is an important part of what we need to do.
- Community-based participatory action research will be an essential approach and may shift some accountability onto the patients. Community voice will make measurement more powerful.

The group collectively agreed that the framework is broader than clinic and hospital quality measurement. In sum, Steering Team members offered the following closing comments:

- We still need to address what units of measurement will be used.
- We are open to system-wide measurement.
- We need to better understand the value of the existing framework and then discuss how to supplement the program and potentially measure in a new way.
 - Another way to think about it is that SQRMS ought to be the framework and exist as an input to the future system. We need to build-in space to say what are the existing tools, programs, and systems that can contribute to the framework (e.g., adverse health events).
 - The legislative report will recognize the productive outcome of the process so far and set the foundation for next steps.
- We may need to revisit the problems we are trying to solve.
- These big ideas are good, but we should also be rooted in political, operational, resource, and other realities that limit what can really be done. How can we increase the chances that this will succeed? We want locus of measurement to expand in concentric circles beyond clinics and hospitals, we want to think about this in terms of community involvement, our specific charge, and this moment. We can improve clinic and hospital measurement, and more.
- How can we maintain the momentum of big thinking as we go through incremental change? Perhaps the group provides guidance on how to make measurement beyond clinical more relevant. Don’t need to restrain the group for fear of hard work ahead.
- We should continue to reflect on this conversation, talk to others, and provide input in the interim as well. We might need to focus on how, who, resources, processes, concentric circle model, stages, and how to ensure broad buy-in for the concepts we discussed today.

There was a question based on today’s conversation about whether anything should be asked of stakeholders differently in the remaining interviews, and staff responded that the survey might be a place for new questions as the interviews are already underway.

Next Steps

The next Steering Team meeting will be **Monday, July 2nd from 9:00 a.m. to 12:00 p.m.** at HIWAY Federal Credit Union.

Homework

There was no homework.

Public Comment

There was no public comment.