Quality Framework: e-Health Input

MDH Draft 8/30/18

Process

On August 21, MDH conducted a phone interview with four Minnesota e-Health Advisory Committee members. In conducting this interview, MDH staff used a modified version of the interview guide, and values and principles developed in collaboration with the Steering Team. Interview questions were condensed and adjusted to further explore and build on the themes that have emerged over the course of this phase of framework development, and take into account this group's experience with Minnesota's e-Health Initiative.

Key findings

Values and principles

Existing values and principles

- Participants generally agreed with the values and principles, and offered some suggestions for refinement.
- Principle #5
    - Disagree with the notion that we measure "not what is easiest". We should measure what can be measured, is most impactful and important for our population, and provides the most value. Additionally, we need to keep in mind the effort that providers, nurses, and IT systems need to undertake to collect measure data.
    - The concept of "signal strength" is unclear and provides too much wiggle room. There should be more definition of what the system should change.

New principle

- Quality measurement should recognize and reflect the diversity of care delivery and populations served. This diversity of practice and populations makes it very difficult to compare clinic performance.

Framework scope

The quality measurement framework and measurement system should:

- Identify how well health care providers are providing care and areas where care is not optimal. These results would be tied to information to help providers improve care (e.g., by partnering with the Institute for Clinical Systems Improvement (ICSI)).
- Measure that which the system needs to and can change, because what we measure is what we will change.
- Use standardized methods to show progress and/or lack thereof. Collectively pool data and resources for better analysis.
- Allow for efficient and collective action in areas that can actually produce change. There is worry about the dilution of resources due to state and federal measurement requirements. How can we use "multipliers" to produce information that is of interest to the state and actionable for others?

Data

- Data segmentation needs more consideration. For instance, metro and rural practices have different needs, as do larger and smaller practices. We should evolve our traditional ways of looking at quality measure data to better understand practice needs.

Implementation, maintenance, evolution

Opportunity

- The peripheral effect of the systems and processes that will emerge from a standardized set-up and framework that then provides value to everyone else to make things easier and more efficient and useful.
- Minnesota has a depth of experience in e-health and mandatory measures so we have an opportunity to engage in this work, which is not happening in other states.
- Consolidate measurement efforts with engaged providers and make the system less complex.

Guidance body

- It will be important to have a group or advisory board that oversees the process, as measurement will evolve over time, and is accountable and transparent in decision-making. It should be a multi-disciplinary group that includes payers, providers, and other stakeholders who are informed, interested, committed to the goals of the system, and not politically encumbered.

Communications

- Tell the story about how the measures and the framework will help achieve a vision for the people of Minnesota and improve health. Make a linkage to human health and outcomes. A story will help align stakeholders. Consider having providers help tell the story to encourage provider buy-in. Reach out to medical groups (e.g., Minnesota Medical Association, American College of Physicians, other medical groups) for their support and to be part of communications. If we can't articulate why we would measure above and beyond a CMS measure set—e.g., to move the needle on better patient care, better social care, better quality of life in our state—then this becomes bureaucratic and unclear for stakeholders why they should support it.
- Be clear about the value proposition and why people should care about this framework. Articulating the value proposition seems to be one of the biggest barriers to efforts like these. Spread awareness of the project early on and use targeted communications instead of a one-size-fits-all approach. Even within provider groups, messaging can differ. For example, the value proposition may need to be adjusted in communications to mid-level staff (e.g., nurses on the floor tracking data) to help them understand the value of their role and how it feeds into the bigger picture.

Implementation

- Design-thinking, which is an iterative, agile approach (ideate, define, frame, implement, fail/succeed), could facilitate framework implementation through smaller pilot studies. The process would require less front work and more adjustment based on data feedback.
- Try not to take on too much. It may be better to focus efforts on a particular domain of measurement. Prioritize to increase impact. Keep things simple and transparent.
- If there are changes to measures, measurement, and/or processes, we need to be mindful of time and resource implications for electronic health record (EHR) systems, vendors, providers, and training.

Technical assistance

- There should be training about measurement, not just how to report quality measures, but also the value of it, and what needs to be done and why (i.e., to improve care).
- Benchmarking measure results will help get people to understand data relative to leading practice. A partnership with ICSI and/or state Medicaid groups could help providers improve, especially for smaller, under-resourced clinics.

Framework Development: Progress and Remaining Work

Goal: A system of measurement that fosters improvement in health outcomes, health care quality, health equity, patient experience, and population health, and reduces costs for patients, providers, and purchasers

Phase 1 Progress ***March – September 2018*** ***WE HAVE…***	**Phase 2 Expected Accomplishments** ***6-12 months*** ***WE WILL HAVE…***	**Sample Implementation Activities** ***2020 and beyond*** ***WE WILL…***
Articulated **values**	• Identified **for whom** measurement should matter • Criteria for making measurement **actionable** • Recommendations on how to resolve tensions between **efficiency, simplicity and transparency**	• Establish **system vision and goals**, including improvement goals across clinical, population health, public health, and equity dimensions • Set **parameters for measurement**, including, but not limited to, selecting measures that "matter", specifying intended uses for measure data, conducting burden and benefit analyses, etc. • Continue and potentially adjust a process for **ongoing stakeholder input** to inform measurement system activities • Implement an approach to **community and patient engagement** at all levels of decision-making • Stand-up a framework **stewardship structure** • Develop processes for **evaluating the measurement system** as guided by the framework and evolving the system over time • Respond to **legislatively-mandated criteria**, including alignment with other measurement initiatives
Developed **guiding principles**	• Proposed approaches for identifying what measurement is **most important** • Identified **potentials for unintended consequences**	
Used an **intentional process** to create values and principles, and include broad stakeholder input and community voice	• Collected and incorporated **additional recommendations** from stakeholders • Recommendations on how to continue a **transparent, inclusive process** that includes broad stakeholder input and patient/community voice • Drafted a **communications plan** to disseminate information out to and receive feedback from stakeholders	
Determined that the **stewardship process** should be trusted, transparent, and able to include all perspectives	• Proposed a structure for **framework stewardship** that includes resource needs • Defined **accountability paths and ownership** for framework implementation • Recommendations for **relationship building** that promote shared accountability (providers, systems, communities) and articulate roles • Drafted a roadmap for framework implementation under **political, operational, system power, authority, and resource realities** • Determined which **roles** should be outside stewardship, i.e. be independent of it (evaluation?)	
Decided that: • measurement is **more than clinical care** and • **SQRMS exists as a subset** of the envisioned system and will evolve within it	• **Named framework clients** and identified their needs • Recommendations to guide the **measurement of health and health care**, including how to measure on different levels and across scopes (e.g., measuring the "middle" and the "edges", across systems of care, at the population/neighborhood level, etc.)	
Decided that measurement must be subject to **ongoing evaluation**	• Drafted an **evaluation plan**	