mn DEPARTMENT OF HEALTH

Meeting Summary: Measurement Framework Steering Team Meeting #1

Date: 06/28/2019
Summary prepared by: MDH staff
Location: Orville L. Freeman Building, B144

Attendance

Steering Team

- Bill Adams
- Graham Briggs
- Ellen De la torre
- Marie Dotseth
- Renee Frauendienst
- Olivia Jefferson
- Courtney Jordan Baechler

- Lisa Juliar
- Scott Keefer
- Rahul Koranne
- Deb Krause
- Deatrick LaPointe
- Jennifer Lundblad
- Gretchen Musicant
- Sarah Reese (phone)

- Diane Rydrych
- Janet Silversmith
- Marcus Thygeson
- Maiyia Yang Kasouaher

MDH Project Staff: Debra Burns, Magie Darling, Sarah Evans, Stefan Gildemeister, Denise McCabe, Jeannette Raymond

Action Items

- Review measurement framework examples
- Engage with colleagues on meeting discussion questions and topics
- Read "A Measurement Framework for a Healthier Minnesota" report
- Attend MDH presentation of an overview of Phase 1 of measurement framework development (optional)

Agenda and Meeting Notes

Welcome and Introductions

The co-chairs, Jennifer Lundblad and Marie Dotseth, welcomed everyone to the meeting and acknowledged the breadth of expertise and perspectives represented on the Steering Team. Marie noted that both the Phase 2 Steering Team and Minnesota Department of Health (MDH) staff involved in the project represent broader perspectives, as compared to Phase 1 given stakeholder consensus that we should expand the scope beyond health care to health broadly. Jennifer reviewed the Steering Team Agreements, which outline core principles to guide Steering Team member interactions.

Steering Team members then introduced themselves and shared their thoughts on the potential for the project. Members articulated that the project provides an opportunity:

- For Minnesota to be bold and innovative, and create a new tomorrow that moves beyond the status quo to impact and improve population health.
- To move beyond quality reporting to health reporting, and make measurement meaningful not only for systems, but for individuals and communities.
- To come together as a state to decide what is important, align our systems, and create a broad enough framework so that everyone sees their place in it.
- To create intentional opportunities to work together—ensuring that patient and community voices are included—to produce something tangible that organizations can use.
- To be intentional about how to achieve health equity, including how to use our resources most effectively.

Introduction to the Measurement Framework Project

Marie reviewed the project's background, including its legislative origins, and Jennifer walked the group through "Measurement Framework Development: Progress and Remaining Work"—a table from the "Measurement Framework for a Healthier Minnesota" report—which summarizes what was accomplished in Phase 1, the roadmap for completing framework development in Phase 2, and the vision for implementation in Phase 3. Jennifer remarked that this will be a living document, and changes are expected based on the work of the Steering Team as it further develops the framework.

Co-chairs, returning Steering Team members and MDH staff shared the following reflections on the work of Phase 1:

- There was a very intentional process to develop measurement framework values and principles that included a lot of stakeholder engagement and discussions about trust and transparency, stewardship and governance, and the importance of community-engagement.

- It was a complex struggle to understand the clinical and quality measurement aspects, but measures seem underutilized and it was important to be open to what is missing in our current system. I'm glad we are looking at how to better utilize what we already have.
- We got a lot of feedback from the community. There was tension on the values, but high-level consensus. The full list of contributors is in report Appendix E.
- Throughout the stakeholder engagement process, we uncovered many connections that exist between the work of the Minnesota Department of Health (MDH) and others, including the Minnesota Medical Association and community groups.
- In a project conducted by the Quality Measurement Enhancement Project (QMEP) Community Engagement Team, community members reflected on their experiences as patients and what quality primary health care means to them. MDH will send the report, "Community Leaders' Perspectives of Health, Quality Primary Health Care, and Payment Based on Quality Measures" to the Steering Team. The project demonstrated how important community engagement is to health quality measurement work, and that we can, in fact, engage with community members on quality measurement. Marie commented that the meeting during which this report was presented to Commissioner Malcolm was one of the most impactful meetings on patient experience she had attended.
- There is a great deal of pride for what Minnesota has accomplished, in terms of leadership in quality and safety measurement and reporting, which leads to a natural desire to see what's next.

Jennifer then reviewed meeting goals, the Steering Team's role, and the scope of work for Phase 2. One Steering Team member asked for clarity about how the Steering Team will make decisions. Jennifer explained that in Phase 1, the Steering Team used consensus-based decision-making. Jennifer said that this group will decide what decision-making method to use during the July meeting.

Values and Principles Refinement

Jeannette Raymond introduced the values and principles that were developed during the first phase of the measurement framework project, and Steering Team members took turns reading each value and principle aloud. Afterwards, Steering Team members worked in small groups and discussed the following:

- **What language or concepts need clarification? Or need to be added?**
- **Where do you see existing or potential tensions?**
- **In light of the tensions you've cited, what are the implications for a governance or decision-making structure? What needs to be in place? Who can make these decisions?**

Steering Team members recorded their feedback on discussion sheets and reported the following highlights to the group:

- We need to clarify what we mean by "quality." Is it only health care? Or do we need to get to health?
- There's some ambiguity in the quantum leap from clinical quality to health. In the future, we envision health measurement and health improvement, so clinical quality has to reflect that.
- The first principle should be more action-oriented.
- It should be clear that we are elevating the patient perspective above that of clinicians and payers.
- We should be more direct about what is included.
- We should better highlight a culture of equity that includes structural racism and its impact on health. That would be Minnesota stepping out and calling it as it is.
- We need to leverage aspects of existing quality measurement that tracks patient experience. A health equity framework could fit within that work.
- It takes a village. If we are going from a clinical measurement framework to health, it takes a collaborative, community-wide effort. We need to make sure we are inclusive of all partners.

Public observers offered the following feedback:

- We have all the data. So what?

Minnesota Measurement Framework Vision and Mission

To begin developing a shared understanding of what a measurement framework is, Jeannette presented the following definition to the Steering Team for consideration:

Definition: A structure that contains a set or sets of measures that will:

- Be used by many to inform decision-making, action and accountabilities to:
    - Improve individual health outcomes
    - Improve population health outcomes
    - Reduce health inequities
    - Improve health care quality and patient experience
    - Reduce costs for patients, health care providers and purchasers
    - Spur innovation (e.g., advancing health equity, healthy communities, engaging patients, value-based purchasing)
    - Other…
- When measured over time, demonstrate improvement, opportunities for further action or catch an eroding trend
    - Some measures will be publicly reported
    - Some efforts may use the framework structure to determine measures, but these may not be publicly reported

Steering Team members responded with the following feedback on the definition:

- The concept of using the framework to recognize where collaboration is happening can be clearer, specifically how the framework can foster collaboration.
- Consider incorporating the idea of an adaptive approach. I feel uncomfortable defining this as a set of measures. Perhaps instead, it is a set of concepts to be measured.
- Consider including the idea that measures may evolve over time as we change our approach.
- It seems like a leap to go from framework to measures. We first need to define what the framework is and its purpose.
- It is important that we philosophically agree that that clinical quality and quality measurement is still only oriented to 10-20% of the population. We need to reorient our language to capture the broadening of our scope to health generally.
- We should be clear that improvement applies both to what we are doing and what data we are collecting and analyzing.

To further develop the framework mission and vision, Steering Team members worked in small groups and discussed the following:

- **How can you envision a measurement framework being used to drive health improvement and innovation, and by whom?**
- **How might you, your community, or your organization use a measurement framework?**
- **Are there others that would use it and how?**
- **Are there things that came up in the discussion that could inform a refinement of our definition of a framework?**

Steering Team members recorded their feedback on discussion sheets and small groups reported on the following examples of how the framework could be used:

- Beyond the clinical space
    o It could be used as a health equity model to better allocate resources. It could also be used to inform technology infrastructure to help capture, synthesize, and disseminate information.
- Alignment
    o It could be used to bring different systems together, and to help us look at collective roles to better understand the different pieces leading to an outcome.

Public observers offered the following feedback:

- As a large employer, the framework is a conversation starter. We pay an inordinate amount for health care. We can use the framework as a way to talk to insurance administrators. It will help us think more about the social determinants of health and ensure we're all on the same page to affect change.
- It will help us recognize who our partners should be.

Measurement Framework Models and Preparation for July Meeting

Jeannette introduced the homework for the next meeting, which is for Steering Team members to review four existing measurement framework summaries alongside questions to guide the review. Jeannette then asked for Steering Team member volunteers willing to work in small groups that MDH will facilitate to review and present a framework during the July meeting.

The existing measurement frameworks are:

- Robert Wood Johnson Foundation (RWJF) Vision to Action Framework;
- Health Opportunity and Equity (HOPE) Initiative;
- Institute of Medicine (IOM) Vital Signs: Core Metrics for Health and Health Care Progress; and
- Centers for Medicare & Medicaid (CMS) Meaningful Measures.

Steering Team members were encouraged to offer additional framework suggestions. One member suggested that the group consider Blue Cross Blue Shield of Minnesota's "The Cost of Health Inequities in Minnesota."

Public Reflection and Comments

There was no public comment.

Closing

Co-chairs thanked the Steering Team for its work. Co-chairs and Steering Team members offered the following closing comments:

- I want to challenge us to be specific in who we are talking about and who we are impacting. When we talk about users of the system, we should be more intentional about acknowledging those most impacted by disparities.
- There is tension in the broad scope of the project and the details.
- We're talking about changing a complex system. There is significant risk of harm due to unintended consequences. Structure drives process drives outcomes.
- There is a framework for health-in-all-policies. We may want to use that to help us navigate unintended consequences.
- We should be aware of our own biases and perspectives. A lot of times in a setting of innovation, some are passionate and some are just along for the ride. Let's be transparent.
- As we go through the next few meetings, we should all be thinking about what this means for our respective organizations. The biggest fear is creating something we don't use. I want to express the hope that we are all thinking about this in the same way.

Next Meeting

Date: July 29, 2019
Time: 1:00-4:00 PM
Location: HIWAY Federal Credit Union, 840 Westminster Street, St. Paul, MN 55130
Agenda items: Compare and discuss measurement framework models, identify desired features of a Minnesota measurement framework

Minnesota Department of Health
PO Box 64882
St. Paul, MN 55164-0882
651-201-3550
health.sqrms@state.mn.us
www.health.state.mn.us

07/22/19

To obtain this information in a different format, call: 651-201-3550. Printed on recycled paper.

Measurement Framework Steering Team
PERSPECTIVES AND PROJECT POTENTIAL

A summary of Steering Team member perspectives and thoughts about the project's potential, as shared during the June meeting.
Denotes members who served on the Phase 1 Steering Team.

Bill Adams, Community/patient member
Representing: Rural community and patient perspectives
- Perspectives: patient voice, Healthy Minnesota Partnership, local community
- Project potential: To do something different to make the system work better for patients and providers.

Graham Briggs, Director of Public Health Services, Olmsted County Public Health
Representing: Public health perspective
- Perspectives: public health, population, risks and outcomes
- Project potential: The ability to see at the population level.

Ellen De la torre, Chair, Rural Health Advisory Committee
Representing: Rural community and patient perspectives
- Perspectives: health disparities, immigrants and migrants, patient voice
- Project potential: To look at health through a prevention lens.

Marie Dotseth, *Steering Team Co-Chair,* Assistant Commissioner, Minnesota Department of Health
Representing: Minnesota Department of Health
- Perspectives: state role, patient safety, quality improvement
- Project potential: To take a leap and propose something bold that will impact population health.

Renee Frauendienst, Public Health Division Director/Community Health Services Administrator, Stearns County Public Health
Representing: Public health perspective
- Perspectives: public health, healthy living, changing communities
- Project potential: To help make a better future for the next generation.

Olivia Jefferson, Equity and Holistic Grantmaking Director, Greater Twin Cities United Way
Representing: Communities most impacted by health inequities perspective
- Perspectives: intersectionality, philanthropy, data and evaluation
- Project potential: To do something different and create something tangible that organizations can use.

Courtney Jordan Baechler, Assistant Commissioner, Minnesota Department of Health

Representing: Minnesota Department of Health
- Perspectives: physician, prevention, integrative health
- Project potential: To create a broad enough framework so that we all see our place in it.

Lisa Juliar, Engagement Specialist/Patient Partner, Minnesota Alliance for Patient Safety

Representing: Communities and patients most impacted by health inequities perspectives
- Perspectives: mother of a child with a physical disability, patient advocate, patient safety
- Project potential: To include the voice of community members.

Scott Keefer, Vice President, Public Affairs, Blue Cross and Blue Shield of Minnesota

Representing: Blue Cross Blue and Shield of Minnesota, and health plan perspectives
- Perspectives: public policy, collaboration, patient and physician engagement
- Project potential: If we can reorient resources, we can make measurement meaningful for patients and truly address population needs.

Rahul Koranne, Chief Medical Officer, Minnesota Hospital Association

Representing: Minnesota Hospital Association and health system perspectives
- Perspectives: visibility of measurement to clinicians and patients, clinical perspective, system intersectionality
- Project potential: To do something different and create a new tomorrow.

Deb Krause, Vice President, Minnesota Health Action Group

Representing: Minnesota Health Action Group and health care purchaser perspectives
- Perspectives: business, collaboration, innovation
- Project potential: To be bold, innovative and action-oriented.

Deatrick LaPointe*, Independent Consultant

Representing: Digital health solutions to advance health equity
- Perspectives: public health, health research, digital health technology
- Project potential: To measure health equity efforts and make health equity resource allocation more efficient.

Jennifer Lundblad*, *Steering Team Co-Chair*, President and Chief Executive Officer, Stratis Health

Representing: Stratis Health and health care quality improvement perspective
- Perspectives: quality, collaboration, national perspective and context about measurement
- Project potential: This is breakthrough work that moves beyond quality to Minnesota health reporting.

Gretchen Musicant, Commissioner, Minneapolis Health Department

Representing: Public health perspective
- Perspectives: population health measurement, upstream influences on health, prevention

- **Project potential:** To develop methodologies that have meaning to people in their daily lives, in addition to systems change.

Tuleah Palmer, Executive Director, Northwest Indian Community Development Center
Representing: American Indian health perspective
- Perspectives:
- Project potential:

Sarah Reese, Polk-Norman-Mahnomen Community Health Services Administrator/Polk County Public Health Director
Representing: Public health perspective
- Perspectives: local public health, rural public health, systems
- Project potential: To create a synergy of population and performance-level accountability.

Diane Rydrych*, Division Director, Minnesota Department of Health
Representing: Minnesota Department of Health
- Perspectives: role of state government, quality measurement, health improvement
- Project potential: To come together as a state and decide what is important and also to align this work across our agency to support our mission and vision.

David Satin*, Family Medicine Physician, University of Minnesota and University of Minnesota Physicians
Representing: Health care and safety net provider perspectives
- Perspectives: underserved primary care, academic medicine, health care performance measurement
- Project potential: For Minnesota to make the next quantum leap and be a leader in a quantitative approach to quality improvement.

Janet Silversmith, Chief Executive Officer, Minnesota Medical Association
Representing: Minnesota Medical Association and health care provider perspectives
- Perspectives: data to inform quality improvement, connecting measures to patient care, physician lens
- Project potential: To provide greater strategic planning for how we measure and what we want to accomplish, and stay disciplined about reigning in unlimited good ideas about what to measure so we focus on what matters most.

Julie Sonier*, President, MN Community Measurement
Representing: MN Community Measurement and health care quality measurement perspectives
- Perspectives:
- Project potential: To support strategic decisions by the state, and perhaps others, about where to invest in improvement and to evaluate progress toward goals.

Marcus Thygeson, Chief Health Officer, Bind On-Demand Health Insurance
Representing: Health plan perspective

- Perspectives: health insurance as a public health agency, high-value care, health improvement
- Project potential: To help Minnesota continue to evolve by using health measures to improve health and move beyond the status quo.

Tyler Winkelman, Clinician-Investigator, Hennepin Healthcare
Representing: Health care and safety net provider perspectives
- Perspectives: primary care physician, safety-net health system and county jail, health services researcher
- Project potential: To advance our most important public health goals by aligning across our top priorities, measurement, incentives, and payment.

Pahoua Yang, Vice President, Community Mental Health and Wellness, Amherst H. Wilder Foundation
Representing: Mental health and communities most impacted by health inequities perspectives
- Perspectives: Hmong community, provider who serves diverse communities, behavioral health provider
- Project potential: To create not only a vision that we can all work toward as a state, but also intentional opportunities for stakeholders to sit together, like pieces of a puzzle, to make that vision real.

Maiyia Yang Kasouaher*, Independent Research Consultant, SoLaHmo Partnership for Health and Wellness at Minnesota Community Care; Community Engagement Lead, Program in Health Disparities Research, University of Minnesota
Representing: Communities most impacted by health inequities perspective
- Perspectives: diverse communities and identities, communities affected by health disparities, community-based participatory action research
- Project potential: To improve patient experience and how patients navigate the health care system.

Marie Zimmerman, Assistant Commissioner, Minnesota Department of Human Services
Representing: Minnesota Department of Human Services
- Perspectives:
- Project potential:

Health Opportunity and Equity (HOPE) Initiative
SUMMARY

Reviewers and context

- Olivia Jefferson, Marcus Thygeson, Maiyia Yang Kasouaher
- Reviewers were unfamiliar with the HOPE framework and appreciated the opportunity to learn about it.
- The National Collaborative for Health Equity and Texas Health Institute, in partnership with Virginia Commonwealth University's Center on Society and Health, and with support from the Robert Wood Johnson Foundation, created the HOPE Initiative to identify state and national metrics designed to spur action to improve health and well-being for all, regardless of race and ethnicity or socioeconomic status.

Discussion

Alignment with Minnesota health priorities, and framework vision, values, and principles

- There is **general alignment** between the HOPE framework and Minnesota's health priorities and framework vision, values, and principles.

Principles

- We should be more specific about what some of the values and principles mean in the Minnesota framework, e.g., **measuring what is most important**. HOPE gives us examples of what we should measure and what matters in terms of social and structural determinants of health that are not directly related to the health care system, but still affect health outcomes.
- It is good that HOPE puts great emphasis on important factors for health; however, there is **little about health care** and the potential impacts on health outcomes with the exception of access to care. This framework may swing too far the other way; maybe there's an intermediate place we'd like to land for Minnesota.
    - The health care system may not necessarily see itself in the HOPE framework and health care entities may not see how this framework is actionable to them considering that the framework emphasizes the upstream factors that impact health. How do we have the social and structural determinants of health conversation within health care?

Desirable features

Asset-based approach

- The HOPE framework has a **strength-based approach**. The people who will be measured by the Minnesota framework have assets; it's important to think of people this way and not in terms of deficits. It is very important for the Steering Team to center on assets as a core value of thinking about how we measure health, and to continue to leverage an asset-based approach throughout the framework development and implementation processes.
- The way we will **hold people accountable** in the Minnesota framework is to use an asset-based perspective.

Equity lens

- The HOPE framework **applies an equity lens to health**; the Minnesota framework should use an equity lens as well. For example, the HOPE framework is cognizant of the balance of power, and the structural changes that need to happen to advance health equity.
  - The term "equity" itself is a catchall phrase, and we need to be careful when we are using the term. For example, if equity means racial equity, then the equity concept looks different.
- To apply an equity lens to the Minnesota framework means **we will need to ask communities which health indicators are important to them**. This highlights the importance of how we do this work and what we choose to include is beyond those at the Steering Team table. Determining how we incorporate additional voices and perspectives that are not at the Steering Team table is as important as determining what the measures are.

Social and structural determinants of health

- **Different populations are affected by different issues.** The HOPE framework explicitly addresses structural issues in communities which is very important in terms of influencing health—this is a strength of this framework. At the same time, some of the HOPE indicators are emergent phenomena (e.g., assault rate). How do we distinguish between structural factors and emergent phenomena?
- Things like crime and food security can predict health. It is critically important to consider these and other factors when we think about **policy changes** that we need to enact. We need to do something with the Minnesota framework measures to push policymakers to create more equitable policies. We must think broader than the use of these measures by the health care system, community and philanthropic organizations will also use these measures.

Promoting a culture of health

- The HOPE conclusions section talks about promoting a "**culture of health**". This hasn't really been talked about in Steering Team discussions. When thinking about health equity, health care access, and social and structural determinants of health, the concept of a

"culture of health" comes to mind first. We could explore what a culture of health means in creating the Minnesota framework.

Use of framework, actionability, and accountability pathways

- Most of the **measures** are important indicators of health and the social and structural determinants of health, although not every indicator is optimized for what Minnesota wants to do (e.g., social environment indicators, colorectal cancer screening, murder rate).
    - There may be some things **missing,** and there are questions about what would be best for Minnesota in **different regions** of the state. We should consider policy and economic type indicators like homeownership, persons of color-owned businesses, trade industry education, physical activity ordinances, livable income, etc. We must think about what is coming, and not just past trends.
    - If we adopted this kind of approach, **population segmentation** would be a way to measure what matters and align improvement with what matters. This would force us to do a lot of hard work, but that shouldn't be a deterrent to taking this on. We should not only improve average performance, but improve equity by demographic factors.
- If we were to adopt the HOPE framework across the board, lots of **work would need to be done to make information actionable, and to help stakeholders understand what it means for them** by translating concepts into terms and measures that are relevant to different stakeholders in terms of what they should be doing to address the framework measures.
- The HOPE framework fosters **cross-sectoral approaches** to improving health.
    - Considering that this framework does not include much health care content, it will be important to **leverage partnerships** between health care and philanthropy, non-profits, legislators, business owners, and mental health.
    - If Minnesota made a commitment to a subset of the HOPE indicators, it would drive a lot of cross-sectoral work. To get that kind of commitment requires a lot of political work to get alignment. There may be a subset of indicators for which it will be easier to get **political alignment** on than others; to get political alignment on other subsets might be a bridge too far—not because they're not important, but because it may not be feasible to get alignment on everything. If we started with a subset of politically feasible indicators, there would be a lot of work to do to understand the work for different stakeholders and then to come up with cross-sectoral approaches.
- There are lots of things for communities to measure and track in this framework, and **hold local government and institutions accountable to improve**.
- It is **unknown who is using the HOPE framework**. It may be worth checking-in with HealthPartners and Patrick Remington at the University of Wisconsin considering their work around community health measures.

Adoption

- **Portions of the HOPE framework should be adopted** for the Minnesota measurement framework.
    - We should adopt the **equity lens**.

- Getting **community alignment** on some of this framework would be a huge step forward.
- To have something like HOPE in place will be a good **leverage point for us to convince and persuade policymakers** to adapt measures for social and structural determinants of health.
- **If we were to adopt the HOPE framework, it would not replace the measurement system we already have, but it would expand what we currently have.**
  - Our current measures look at health and the health care system; HOPE is important because it expands beyond this by recognizing that health is more than health care and looking at social and structural determinants of health. We don't have to throw away what came before, but we can modify and change the measurement system and include additional measures.

MA DEPARTMENT
OF HEALTH

Robert Wood Johnson Foundation (RWJF) Vision to Action Framework
SUMMARY

Reviewers and contextual considerations

- Bill Adams, Courtney Jordan Baechler, Rahul Koranne, Janet Silversmith
- One reviewer was familiar with the framework while others were not and volunteered because they were interested in learning about an alternative model.
- RWJF created this framework with the intent of generating unprecedented collaboration and charting the nation's progress toward building a culture of health. Equity and opportunity are overarching themes to highlight health disparities and move toward achieving health equity.

Discussion

Alignment with Minnesota health priorities and framework vision, values, and principles

- The RWJF framework is **highly aligned** with Minnesota's health priorities and framework vision, values, and principles.

Values

- The RWJF framework is oriented toward **action** to accomplish health, while the Minnesota framework, as defined in Phase 1, is more oriented toward health care quality measurement. The frameworks come from different places—i.e., an action framework to accomplish health versus the Statewide Quality Reporting and Measurement System (SQRMS) and thinking about how we change health care quality measurement—but they may ultimately fit together.

Principles

- Many of the Minnesota framework principles lead with **quality measurement and medical quality measurement**, while the RWJF framework leads with action and measurement follows. We'd need to think about how to change quality measurement to align with the RWJF framework. We didn't talk about social and quality of life measurement. The Minnesota framework is already looking to evolve measurement.
- The **overall vision** of the RWJF framework presents a complete picture of health and well-being and the ways that we create health.
- We need to be discrete and specific about whether the Minnesota framework is about **quality, quality measurement and medical quality**, or, **quality of life, population health,**

5

and the health of Minnesotans. The RWJF framework is more oriented to population health.

- The RWJF framework has commonalities with **Accountable Communities for Health** (ACH), though ACHs still hold delivery providers serving a set population at the epicenter.

Desirable features

Action areas, drivers, measures

- The **action buckets** make sense for a Minnesota framework and would help pull together different sectors to achieve health for our state. They are broad, so we should have pointed areas on which to focus. But the broadness provides a good challenge and could be adapted as needed to fit Minnesota priorities. MDH would not regulate all of this. How do we pull together different sectors collectively? What will it take to achieve health for the state of Minnesota? How will we work in a way to achieve these health goals?
- The RWJF framework has more value in part rather than whole. **Action areas** 3 and 4 should be the core of the Minnesota framework. Action areas 1 and 2 are more like implementation issues.
- We should **evolve** the Minnesota framework toward a model like RWJF and think about measuring differently, but some pieces of the model feel like too big of a leap from where we are. The actions and drivers make sense, but a **meaningful measure set** for Minnesota may not include the RWJF measures, which may be too far upstream for the next evolution of measurement. Other areas feel less evolutionary and more revolutionary in terms of changing where we are. We can evolve dramatically with an evolutionary approach without making leaps that don't feel grounded enough in terms of where the Steering Team is.
  - Minnesota cares about **health care costs**, but right now, we have a broken system of cost measurement. The "average health care expenditure by family" measure in this framework is fantastic. The way MDH measures health care costs is one way of measuring with one set of data.
  - Would we feel comfortable as a Steering Team to attach the names of organizations to each of these broad categories of measures?
  - It makes sense for MDH to be the main organization for some of the measures, such as health in all policies. For other measures, other social service organizations, counties, and other organizations should be given a chance to lead.

Use of framework, actionability, and accountability pathways

- The RWJF framework, if adopted, would demand that we **get out of the medical comfort zone** and start looking at public health resources, non-governmental organizations, and others. Then, delivery providers, payers, and the Minnesota Department of Health (MDH) would become partners, rather than the epicenter.
- It seems like the RWJF framework should already be used in public health departments to create health. **Collaboration and partnerships** are needed. This framework will be helpful in moving away from strict clinical measures toward what creates health.
- The RWJF framework includes a very broad swath of everything all health care organizations and stakeholder organizations talk about—e.g., public safety, population

health, accountable care organizations, health care systems, financing, government, etc. As a vision, this framework may be fine, but if we get to the pragmatics of what specifically we will all focus on and what the metrics of success are, there is a **chasm between the metrics in this model versus what we can do in the very near future**. If we want to have a 20-year vision, that is okay, and it will take work to get there.

- If Minnesota wants to **bridge the chasm** and create a framework like RWJF, we need to articulate how our envisioned world is different from our current world. We need to discuss change management, be comfortable with changing power and control, and name the chasm.
- The RWJF framework would help Minnesota move away from plans and systems bearing all the responsibility by moving toward **interconnectedness**. Hopefully the RWJF framework is helpful to health care systems and plans, which are one piece of the puzzle, and this framework can help lift a little burden. This framework shows how stakeholders are intertwined and interconnected to bigger goals.
- We need to have a discussion about the **role of government**, and we need a way to build trust and be transparent. In the June meeting, a good metaphor was used about the framework being a tree with branches and leaves; we need a discussion about what the tree trunk is. Is MDH the central player that will put regulations around the framework? This would be a big mistake and minimize or diminish the authority, power, and control of other organizations. Can we get to another place in Minnesota? What is the central body or table where decisions will come from and who is responsible? Hopefully this table will be MDH-convened and not MDH-controlled. We need to call out that a part of MDH will be part of an external collective concerned with the health of the population. If we don't call this out, it will limit our progress.
  - It makes sense for MDH to think about the contributors to health that are most relevant, and to help create focus them, help organize relevant stakeholders and draw their attention to the contributors, and to lead action.
- We need to define that **central body** of the Minnesota framework and find a way for **stakeholders** to measure together and find consensus. Right now, measurement is so politicized and sensationalized that stakeholders look unfavorable to the consumer, who we're beholden to. We're in a backwards place right now and we need to get to a spot where we can let loose a little control. It will be hard to get there with this MDH-controlled and convened table.
- There must be **consensus** with overall framework adoption among stakeholders. It is not possible for MDH alone to implement a framework. A broader group is essential.

Adoption

- **We should consider adopting the RWJF framework with modifications.** Minnesota can pick and choose relevant pieces, and some pieces may be broader goals saved for the future.
  - This is a great thing to have MDH start doing within various county health departments as an overarching framework and having this as a vision.

Institute of Medicine (IOM) Vital Signs: Core Metrics for Health and Health Care Progress
SUMMARY

Reviewers and contextual considerations

- David Satin, Marcus Thygeson, Tyler Winkelman
- Reviewers were familiar with and supportive of the IOM framework, and recognized that they were a homogenous group in terms of perspectives.
- IOM created this framework to identify core measures for health and health care that could provide consistent benchmarks for health progress across the nation and improve system performance in the highest-priority areas.

Discussion

Alignment with Minnesota health priorities and framework vision, values, and principles

- The IOM framework is **highly aligned** with Minnesota's health priorities and framework vision, values, and principles.

Values

- The IOM framework does not emphasize **health equity** to the same degree as the Minnesota framework does. It's embedded in the concepts of shared decision-making, life expectancy and well-being.
  - For Minnesota, we may want to say that we will look at variation within and across populations, and explicitly state that we want to improve the average and reduce the variation.
- The **connection and collaboration** value is not explicitly well-addressed in the IOM framework.

Principles

- The IOM framework's **scope** is much larger than disease-specific measures and more meaningful from a population perspective; the scope aligns with the Steering Team's desire for a more comprehensive approach.
- The IOM framework may still focus too much on health care measurement; the Minnesota framework recognizes that **health is more than health care**. A focus on the cross-sector nature of measurement is missing.
- A challenge with the IOM framework is that many **stakeholders** may struggle to see themselves in it.

8

Desirable features

Core measure set

- The priority measures included in the IOM framework are well-aligned, but the Minnesota framework should go beyond to include measures of **social and structural support systems** (e.g. health care, communities, food distribution, parks).
  - If we had a dashboard to track system sustainability—in other words, the **health care ecosystem** and its health—it would encourage us to think more broadly.
  - A lot of measures are already available at the state and county levels.
- The Minnesota framework should include more explicit **measurement of social determinants**. The IOM framework includes measures like addictive behavior and unintended pregnancy, and they might have similar drivers, like homelessness.
  - We like to think that clinic work makes a difference, but social determinants of health are probably the **main drivers**, and they would help us **interpret** the rest of the data.
  - A better understanding of social determinants of health would help us know which collaborations to prioritize and **encourage innovation in partnerships** between clinics and social programs in the community.
- When looking at the IOM measure list, one challenge is that lots of stakeholders may say, **"What do I do about that and how does it apply to me?"** Part of the implementation work will involve getting aligned at the state level on a set of key health indicators that we want to improve. This is a good set to start with, then different stakeholders will want to work at different levels of scale, and think about what is the measure or outcome measure relevant to ones work that flows up to a county or state level, while others will scale down (e.g., clinics measuring self-assessed health status). Each stakeholder can preserve parsimony around measurement and see how they fit-in to higher-level measures. They can measure what matters to them and roll-up to higher measures that matter to the community.
  - Some measures will ably to some organizations more than others; eventually, everyone will be pulled in and accountable. If we settle on the 15 IOM measures, that's the complete suite and not everyone will do all of the measures.

Triple aim

- The IOM framework includes **affordability, experience of care, and a strong emphasis on health**, not just clinical quality. What is missing is the sustainability of the health care system and social network—this is a gap that we would need to think about.
  - **Systems sustainability** is important for the Minnesota framework, e.g., social, health care, food, education.

Use of framework, actionability, and accountability pathways

- The IOM framework calls out the kind of **collaboration** needed to foster partnerships that are long overdue.
  - The Minnesota framework will need to **bring quality metrics outside of the health care system**, and this will be conceptually challenging, require a new way of thinking, and a lot of work to make those measures a reality; though, it is a great opportunity to

do what public health knows is a reality. With multiple sectors being accountable, how do we engage such a broad coalition in thinking about who is responsible for what?

- If we're serious about **improving the health of communities**, the Minnesota framework should encourage people to get engaged and ask questions, measure, and develop and test information.
- To encourage cross-sectoral approaches, **funding** will be important and must go beyond health care organizations. There must be a real financial benefit to community partners.
  - We should **shift funding** from health care to social services and/or earmark funds for public health collaboration. There will be a lot of political challenges, logistically and politically, but it doesn't mean we shouldn't take it on and push for it.
  - The United States spends the most on health care as compared to other OECD countries, who spend more on social support and education. However, in the United States, many social services are funded through health care.
- In general, a broader framework would result in **greater accountability for and engagement from the whole community**. It would empower caregivers to be more successful if they have other allies who are also accountable.
  - When the **accountability** only lands on the health care system, it's very difficult to get other sectors (e.g. legal and justice systems) involved because they aren't motivated and don't have a mandate. With a funded mandate (sticks or carrots), then all stakeholders would be motivated to row in the same direction. In our current climate, health care organizations are highly motivated to improve, they just don't have interested partners.
- Implementing a broader community health-oriented framework statewide—one that is not just focused on the health care system—should get the **whole community engaged and accountable for their part in addressing issues** that get in the way of health. It should empower doctors and other health care professionals to be more successful because they have allies in other sectors who are also accountable for these things.
- Measurement at the system level would help to hold **government** accountable to take action on, for example, housing insecurity. Many measures are going to require government intervention and partnership.
- It's possible that **Wisconsin** is using the IOM framework, given that David Kindig and Patrick Remington at the University of Wisconsin Population Health Institute provided input on the framework's development. It may be worth looking further into whether Wisconsin has taken steps to implement the framework, and reaching out to the IOM committee staff to ask if there has been any implementation of the framework.
- The **MMA Physician-Consensus Measures of Performance to Advance Quality and Safety Work Group** is focusing on the IOM framework in its work and would be supportive of a framework based on its measures.
- It is also valuable to know **who is not using the IOM framework** and understand why not to inform our own work. For example, MN Community Measurement convened a meeting of its board and measurement committee to review the report, but there was no implementation of the framework and it is unclear why.

Adoption

- **We should consider adopting the IOM framework with modifications.** It is a thoughtful, well-vetted set of measures. The spirit of it should be adopted, but we need to tailor it to what the broader community in Minnesota wants to see. It makes a lot of sense to use the framework as a starting point from which to build.
- Starting from scratch would be painful and lengthy; it is preferable to build and modify from an existing framework, and the IOM one seems like a thoughtful, well-vetted set of measures and has so much alignment with our values and principles that it makes a lot of sense to use this as a starting point that we would build off of.
- If anyone can implement the IOM framework, it's Minnesota and doing so would be taking a quantum leap.

Centers for Medicare & Medicaid Services (CMS) Meaningful Measures Initiative
SUMMARY

Reviewers and contextual considerations

- Scott Keefer, Julie Sonier
- Reviewers were familiar with the CMS framework.
- CMS created the Meaningful Measures framework for itself as a payer of health care services to identify the highest priorities for quality measurement and improvement.

Discussion

Alignment with Minnesota health priorities, and framework vision, values, and principles

- There is **general alignment** between the CMS framework and Minnesota's health priorities and framework vision, values, and principles.

Values

- The CMS framework doesn't emphasize **disparities and equity** to the same degree the Minnesota framework does. Advancing health equity is a high priority of the Minnesota framework. The equity and disparities concepts in our framework must be inclusive of geography, including capturing rural priorities and needs.
- The Minnesota framework value of **fairness and equity** also applies to providers and risk adjusting quality measures for social determinants; this is missing from the CMS framework, perhaps because CMS measures are largely process measures which are not risk adjusted.
- **Connection and collaboration** is an important value of the Minnesota framework that is missing from the CMS framework. At the end of the day, this is about what we do with the Minnesota framework—if we as stakeholders can't sell the importance of the connection and collaboration piece, the Minnesota framework won't work.

Principles

- The CMS framework is focused on **health care** and CMS's role as a payer of health care; the Minnesota framework is bigger than health care, although we need to be clear about what is important and what the priorities are within the health care sphere of the framework.
- The CMS framework has more emphasis on **patient experience** than the Minnesota framework, although we know that patient experience is very important to communities in

12

Minnesota. MDH has some constraints measuring patient experience under the Minnesota Statewide Quality Reporting and Measurement System (SQRMS).

- The CMS framework includes **family engagement** which is a very important component.
- We haven't had a conversation about **cost and affordability** with SQRMS. Personal and population spending, and system sustainability versus impact on households and families are important considerations. Cost and affordability may be out of scope for the framework.
- There is a strong focus on **payment** in the CMS framework; the Minnesota framework acknowledges that payment is one of many potential uses of the framework.
- The CMS framework prioritizes **reducing measurement burden**; the Minnesota framework includes a principle of having parsimonious measurement that balances value with burden—we recognize that it may be difficult to measure some things, but if we determine it's important, we will measure it even if it's hard.

Desirable features

Strategic goals, cross-cutting criteria, overarching measurement categories

- The CMS framework goes from strategic **goals**, to cross-cutting **criteria**, to quality measure **domains**, and then to specific **measures**.
- **Our strategic goals seem to be embedded within the principles**. We could break out some of the items in the principles and transform them into strategic goals.
- We are missing the **cross-cutting criteria** in the Minnesota framework.
- The **six health care quality measurement categories** cogently capture all the important factors; nothing was left out.

Visual model

- The **visual depiction** of the CMS framework is very helpful.
  - It's important that we have a visual of the Minnesota framework that summarizes the Minnesota framework at a glance and is descriptive of the connections among the goals, values, principles, and measurement specifics.
  - The Minnesota framework will be much more powerful if we have a visual component so it is intuitively understandable to people.
- An **introductory narrative** to the framework that captures the goals and the challenges of our current approach to health measurement would also be helpful.

Use of framework, actionability, and accountability pathways

- The Minnesota framework should be used to **inform strategic investments**. What does the data say are the biggest opportunities to make meaningful improvements in people's lives and what will it take to get there? In order for the Minnesota framework to make a difference, it must lead to strategic investments.

- The framework and measures should be used to figure out where to put resources to achieve impact, and to ascertain whether investments are having the kind of impact that was imagined.
- The Steering Team could use the CMS framework to **inform its decision-making and determine** whether we have balanced representation of measures across the six domains, where we may be missing things, where should we do additional development, and where we might have constraints about what we can measure.
- The CMS framework does not include framework implementation steps that show how to get to the vision. An **action plan** and **call to action** are needed for the Minnesota framework.
  - If we just say what we want to measure and don't invest in what we want to change, then we won't have much chance of making an impact. The Steering Team or MDH needs to spend time on and be explicit about rolling out an action plan with identified resources for the framework.
  - What is the **there** we are trying to get to, **how** do we get from here to there, and **what will it take** to get there?
- The CMS framework is not a useful model for **cross-sector collaboration**—Minnesota is interested in connections between health care and social services, and promoting collaboration across public and private payer settings.
  - It may be politically tricky to foster some envisioned cross-sectoral collaborations through the Minnesota framework. While there is support for the concept of paying for value and not volume in health care, the reality is we have made limited progress in the last decade. The fact is that most payment remains on a per unit fee-for-service basis.
- **CMS uses this framework**; others' uses are unknown.
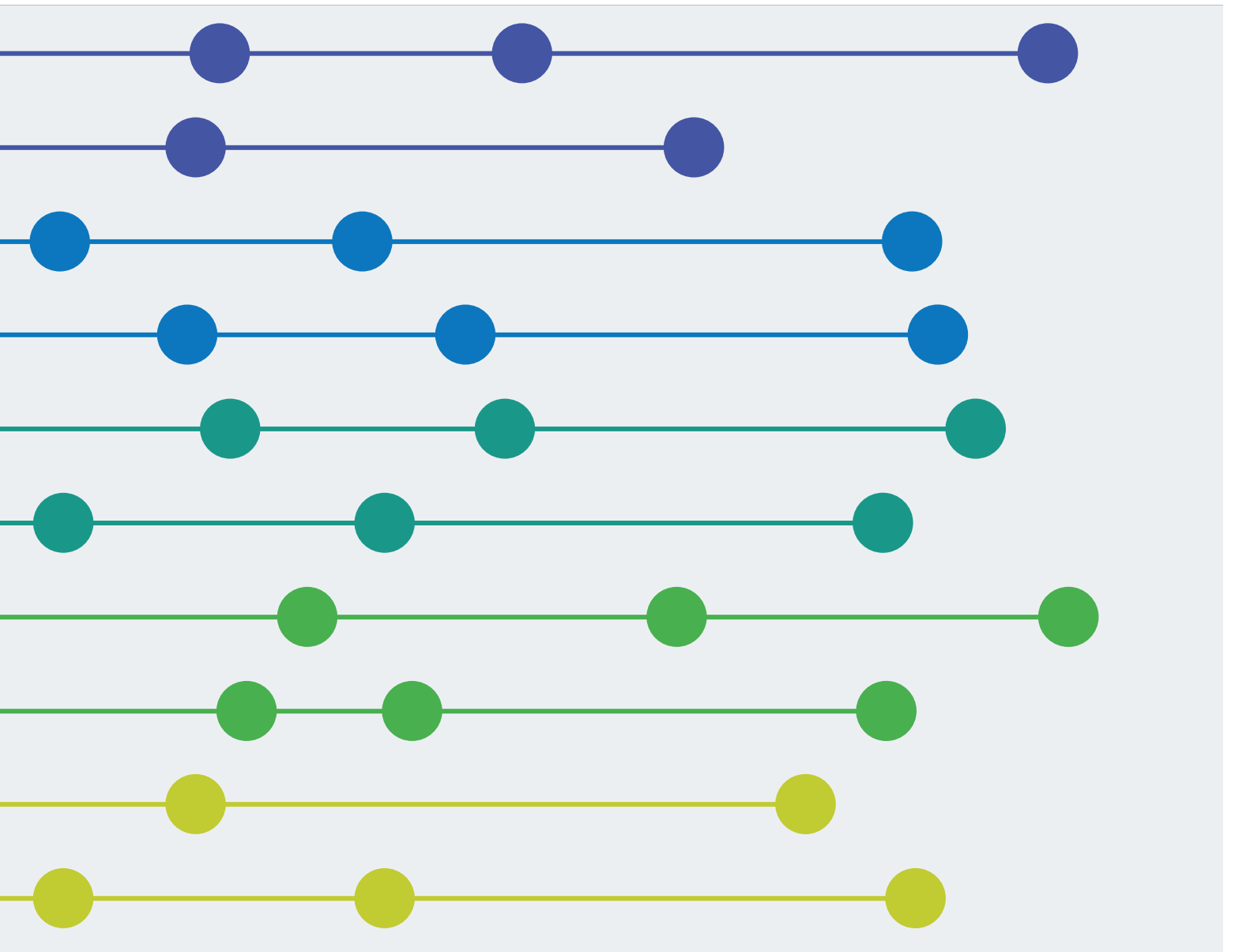
Adoption

- **The Minnesota framework should be informed by the best of all of the other measurement frameworks the Steering Team is reviewing.** We like to build things ourselves in Minnesota and part of the Minnesota framework development process is to make sure stakeholders feel ownership; if we implemented a framework that someone else developed, buy-in may be lacking and success would be a challenge.

Advancing Health Opportunity and Equity Across the United States: A State-By-State Comparison

July 2018

Credits & Acknowledgments

Recommended Citation

Wong Croal, N., Smedley, B., Andrulis, D., Woolf, S., Siddiqui, N., Wilson, K., Turner, M., & Stelter, A. (2018). The HOPE Initiative: Brief Report.

Lead Authors

Naima Wong Croal, Brian Smedley, Dennis Andrulis, Steven Woolf, Nadia Siddiqui, Kim Wilson, Matt Turner, and Anna Stelter

The HOPE Initiative Staff

NATIONAL COLLABORATIVE FOR HEALTH EQUITY

Brian D. Smedley, PhD, Principal Investigator

Naima Wong Croal, PhD, MPH, Project Director

Jalisa Whitley, MPP

TEXAS HEALTH INSTITUTE

Dennis P. Andrulis, PhD, MPH, Co-Principal Investigator

Nadia Siddiqui, MPH

Kim Wilson, DrPH, MPIA

Anna Stelter, LMSW, MPH

Matt Turner, PhD, MPH

Meghan Cocking, MSSW

VIRGINIA COMMONWEALTH UNIVERSITY CENTER ON SOCIETY AND HEALTH

Steven H. Woolf, MD, MPH, Co-Principal Investigator

Derek A. Chapman, PhD

Latoya Hill, MPH

Sarah Blackburn, MS

Lauren K. Snellings, MPH, CHES

This work was made possible with the valuable contributions of the following individuals:

National Advisory Committee (NAC)

David R. Williams, PhD, MPH, Harvard University, Chair of The HOPE Initiative NAC

Dolores Acevedo Garcia, PhD, MPA-URP, Brandeis University

Jeanne Ayers, MPH, Minnesota Department of Health

Rajiv Bhatia, MD, MPH, US Department of Veterans Affairs

Paula Braveman, MD, MPH, University of California - San Francisco

Renee Canady, PhD, MPA, Michigan Public Health Institute

Janet Corrigan, PhD, MBA, Moore Foundation

Rachel Davis, MSW, Prevention Institute

Tom Eckstein, MBA, Arundel Metrics

Ed Ehlinger, MD, MSPH, Minnesota Department of Health (formerly)

Glenn Flores, MD, Connecticut Children's Medical Center

Marjory Givens, PhD, University of Wisconsin, Population Health Institute

Doug Jutte, MD, PhD, University of California - Berkley

Ernest Moy, MD, MPH, Centers for Disease Control and Prevention (CDC), National Center for Health Statistics

Ana Penman-Aguilar, PhD, MPH, CDC, Office of Minority Health and Health Equity

Malia Villegas, EdD, National Congress of American Indians (formerly)

Robert Wood Johnson Foundation

Dwayne Proctor, PhD, Senior Adviser to the President

C. Tracy Orleans, PhD, Senior Program Officer and Senior Scientist

Nicole Collins Bronzan, Communications Officer

J. Michael White, MPH, Program Associate

Elaine Arkin, Consultant, Special Adviser on The HOPE Initiative

Burness

Special Thanks for Additional Review and Guidance

Introduction

Many circumstances in our homes, neighborhoods, schools, workplaces, and society at large affect whether we have a fair shot at living a healthy life. The opportunities for good health and well-being vary depending on our race or ethnicity, our level of education and income, and where we live, among other factors. But, it does not have to be this way. What drives health is more about the resources we have access to and the conditions in our neighborhoods, and less about medical care. Health behaviors like exercise and diet matter a lot, but our behaviors and even our ability to get quality health care depend on the opportunities and resources we can access. The good news is that we can create better opportunities for all Americans—especially for the most vulnerable among us—by expanding health equity. As Braveman (2017) states, "Health equity means that everyone has a fair and just opportunity to be as healthy as possible... measuring the gaps in health and in opportunities for optimal health is important not only to document progress but also to motivate action and indicate the kinds of actions to achieve greater equity."

To expand opportunity, we must first understand where opportunity thrives, and for whom, and where we have gaps. The Health Opportunity and Equity (HOPE) Initiative offers a new way to measure our national and state-level progress toward expanding opportunity across all racial, ethnic, and socioeconomic groups. We do so by tracking 28 indicators that span the life course, including health outcomes and indicators related to opportunity such as socioeconomic factors, the physical and social environment, and access to health care. For each measure, we set benchmarks that are aspirational but achievable—based on populations and states that have already obtained the best outcomes. We intentionally set the HOPE Initiative's measures at the national and state levels not only to track progress, but also because we understand the power held by states to create and further opportunities through policies that improve the lives of their residents.

Policies Can Create Opportunities for Better Health & Well-Being

Health and well-being are determined at multiple levels. On one level, people make individual choices about their health on a routine basis. This morning, you chose whether or not to eat breakfast; and, if you ate breakfast, you decided what and how much you ate. These types of daily decisions have a profound impact on individual health. Your personal health decisions, however, are not fully under your own control. Eating a banana for breakfast is a healthy choice but doing so presumes you have access to a store that sells produce and the money to purchase the banana. A human and historical chain affects the opportunity to make that decision— from the grocer, to the distributor, to the farmer, to the politicians setting trade policy, to the history and practices for cultivating the banana, among many others. For all too many, weak links or breaks in that chain greatly impede the opportunity to access affordable healthy food. This is just one, small example of the many systems that intersect beyond our individual choices that shape opportunities for health. And while the systems may be complex, they are malleable and we can construct them to reflect our values.

The opportunities to increase health and well-being are abundant. They exist in every place we live our lives—our homes, where our children go to school, where we work, where we shop, and where we socialize—as many of the social and economic factors that determine opportunities for health, and affect our quality of life, are interconnected. The factors that shape the stability of families, also determine educational attainment, employment, and retirement savings—and together shape the economic vitality and social well-being of neighborhoods across the nation. These circumstances and dynamics lead to one conclusion: good socioeconomic policy is good health policy. Improving educational opportunities is good health policy. Taking care of our environment is good health policy. And so on.

The Health Opportunity and Equity (HOPE) Initiative

Led by the National Collaborative for Health Equity (NCHE) and Texas Health Institute (THI), in partnership with Virginia Commonwealth University's Center on Society and Health (VCU-CSH), and with support from the Robert Wood Johnson Foundation (RWJF), The Health Opportunity and Equity (HOPE) Initiative begins with a set of state and national metrics designed to spur action to improve health and well-being for all, regardless of race and ethnicity or socioeconomic status (SES). Key to HOPE is that we use measures that illuminate opportunities for everyone to flourish. Specifically, the indicators allow states to see where they are doing well and where they can do better on a broad range of factors that influence health and well-being. The indicators tracked by HOPE show us where babies are more likely to live past their first birthday, where residents can more easily access a doctor, where air quality is healthier, where young children are more likely to enroll in pre-k, or where housing is more affordable. We identify states with the best outcomes and ask, "What are they doing right, how did they get there, and how can it work in my state?" Further, the data are broken down race, ethnicity, and socioeconomic status to help us better understand what it would take for members of all population groups to reach the benchmarks. Groups that have been systematically disadvantaged by racial discrimination or poverty—two key root causes of inequity (Braveman, 2017)—often have a greater distance to go, but these gaps differ by state suggesting policy and context matter.

What Is Unique About the HOPE Initiative?

HOPE is not the first or only national effort to furnish indicators on the determinants of health and equity. Other notable initiatives include *America's Health Rankings*,[1] *County Health Rankings and Roadmaps*,[2] *Health of the States*,[3] *National Equity Atlas*,[4] and the *Opportunity Index*,[5] among many others. What makes HOPE unique is that

HOPE Features

OPPORTUNITY FRAMING provides an asset-based orientation to replace measures that typically call attention to deficits rather than highlighting achievements or opportunities for improvement. We measure income, not poverty; employment, not unemployment; housing quality, not housing problems.

ASPIRATIONAL, YET ATTAINABLE GOALS for achieving equity across health and broader well-being indicators. We use "HOPE Goals" to set benchmarks that we know are reachable because they are based on actual rates we can observe among certain populations.

NATIONAL AND STATE DATA BY RACE, ETHNICITY, AND SOCIOECONOMIC STATUS, allowing for a deeper understanding of health equity and opportunity for specific population groups.

MEASURES OF PROGRESS, also referred to as "Distance to Goal," for specific population groups. This tells states, and the nation, how far they must go to achieve the goal of greater equity in health outcomes and the determinants of health for their populations.

1 americashealthrankings.org; 2 countyhealthrankings.org; 3 societyhealth.vcu.edu; 4 nationalequityatlas.org; 5 opportunityindex.org

we have reoriented our focus from health inequities to a positive frame of opportunity, focusing whenever possible on assets rather than deficits. To make progress on health equity, we need to understand who is doing well and why. We have developed a new way for the nation and states to measure opportunities for better health and well-being, to learn from where population groups are doing well, and to take action based on metrics that are rooted in an opportunity framework. The HOPE Initiative intentionally presents data not only at the national level, to track the country's progress, but also for each state and the District of Columbia. This is because the opportunity landscape differs dramatically across the 50 states. And we stratify the data by race, ethnicity, and socio-economic status, allowing for a deeper understanding of how opportunity varies among subpopulations across the states. This kind of stratification of data in a nation-wide resource breaks new ground. Previous efforts have emphasized national averages to describe inequities among population groups. HOPE shows that the story varies considerably from one state to another.

It allows states to examine where they are in the progression toward equity, where they can celebrate wins, and where to look to other states for model solutions and policies to improve opportunities for health and well-being for all.

The Domains & Indicators of the HOPE Initiative

HOPE tracks 28 indicators of child and adult health outcomes and the key resources that produce opportunities for health and well-being. These outcomes and resources, which we call *domains*, include: health outcomes, socioeconomic factors, the social environment, the physical environment, and access to health care. For each indicator within a domain, we have calculated a national benchmark which we refer to as the HOPE Goal and ranked states on their performance related to the benchmark.[6] National and state data are provided by race, ethnicity, and SES.

Measuring gaps in health and well-being is an important first step toward documenting progress and motivating action to achieve greater equity.

HEALTH OUTCOME INDICATORS

HOPE's six health and well-being indicators are intended to capture the overall physical and mental health of a population across the life cycle. These indicators measure the presence or absence of health and wellness, as well as mortality.

Adult Health Status	Portion of adults who say their health is very good or excellent
Mental Health Status	Portion of adults who say their mental health was not good for 14 or more days in the past 30 days
Child Health Status	Portion of children whose parents rate their health as very good or excellent
Premature Mortality	Number of annual deaths due to any cause per 100,000 population age 25-64
Infant Mortality	Number of infants who die before their first birthday annually per 1,000 live births
Low Birth Weight	Portion of infants weighing less than 2,500 grams at birth

SOCIOECONOMIC INDICATORS

The six socioeconomic factors tracked by HOPE reflect systemic circumstances that promote or constrain opportunities to enjoy good health. These indicators broadly measure financial, educational, and occupational conditions influencing the standard of health people and households can achieve.

Livable Income	Portion of people living in households with income greater than 250% FPL
Affordable Housing	Portion of households spending no more than 30% of monthly household income on housing and related expenses
Post-secondary Education	Portion of adults with at least some college education after graduating from high school
Connected Youth	Portion of young people age 16-24 enrolled in school or working, including military enlistment
Preschool Enrollment	Portion of children age 3-4 enrolled in preschool
Employment	Portion of people in the labor force who are employed

SOCIAL ENVIRONMENT INDICATORS

HOPE's five social environment indicators measure elements of one's social surroundings with implications for health, such as living in an environment without concentrated poverty or violence. Differences in social conditions between groups often reflect historical practices or policies that privileged certain people over others and contribute today to limited health opportunity among socially disadvantaged groups. Here, the surrogate measure for safety is low crime rates.

Low Poverty Concentration	Portion of people in neighborhoods with less than 20% of residents living in poverty
Low Murder Rate	Portion of people living in counties with fewer than 5.1 murders per 100,000 population annually
Low Assault Rate	Portion of people living in counties with fewer than 283 reported cases of aggravated assault per 100,000 population annually
Low Rape Rate	Portion of people living in counties with fewer than 36.9 reported cases of rape per 100,000 population annually
Low Robbery Rate	Portion of people living in counties with fewer than 52.1 reported cases of robbery per 100,000 population annually

PHYSICAL ENVIRONMENT INDICATORS

HOPE identified five physical environment indicators to measure dimensions of health opportunity embedded in people's physical surroundings. Together, these indicators are meant to capture the physical conditions that either promote or discourage health and wellbeing in the places where people live, work, play, and perform activities of daily living.

Home Ownership	Portion of households living in a home they own
Housing Quality	Portion of households living in homes with no severe housing problems (i.e., homes that have complete kitchens, functioning plumbing, and are not overcrowded or severely cost-burdened)
Air Quality—Particulate Matter	Portion of people living in counties with average daily density of fine particulate matter ($PM_{2.5}$) below 12 micrograms per cubic meter
Low Liquor Store Density	Portion of people living in counties with fewer than 1.736 liquor stores per 10,000 population
Food Security	Portion of people living in census tracts that are not food deserts (i.e., census tracts not designated low income and low food access)

ACCESS TO HEALTH CARE INDICATORS

HOPE's six measures of access to health care are intended to capture conditions to ensure that people can engage with clinical services when needed. Accessible and affordable health care are essential to protect people's opportunities to maintain the highest possible standard of health across the lifespan.

Access to Primary Care	Portion of people living in counties with a population-to-primary care physician ratio of less than 2,000:1
Access to Psychiatric Care	Portion of people living in counties with a population-to-psychiatrist ratio of less than 30,000:1
Health Insurance Coverage	Portion of people under age 65 with any kind of health insurance
Affordable Health Care	Portion of adults who did not delay or forego any medical care they needed due to cost in the past year
Usual Source of Care	Portion of adults who have someone they consider their personal health care provider
Colorectal Cancer Screening	Portion of adults age 50–75 receiving recommended colorectal cancer screenings

Key HOPE Findings:
What Did We Learn?

Detailed charts and data on all of HOPE's measures can be found in *The HOPE Initiative: Data Chartbook* and an in-depth description of our methods can be found in *The HOPE Initiative: Technical Summary*.[7] Several key takeaways emerged from our analysis revealing how the 50 states and District of Columbia vary in terms of health and the domains that shape health. First, we learned that the racial and ethnic disparities we see nationally hide important differences that exist across the states. As shown in Figure 1, the health status described by whites, Blacks, and other populations of color are not uniform across the country. For example, some minorities in the healthiest states—particularly those with less diversity, such as New England or the Northern Great Plains states—report better health status than do whites in other states such as West Virginia.

Second, we observed—as many others have—that the relationship between socioeconomic status and health operates as a gradient; that is, health improves progressively with greater levels of education or income. Many reports have documented this gradient in national data, but we also observed it in each state as well as variation in the size of the gradient by state. Figure 2, for example, shows that despite some variation between states on their performance in comparison to the HOPE benchmark, higher levels of educational attainment are associated with higher percentages of home ownership.

National data show that these gradients also exist within racial and ethnic groups; for example, Blacks, whites, and other racial groups with advanced degrees on average have better health than members of their racial group with less education. However, we find that education or income do not confer equal benefits to all racial and ethnic minorities, as the health profiles of the most educated people of color often resemble those of whites with less education. In Figure 4, using the health care affordability indicator, we see that Hispanics with some college education face

a greater distance to reach the HOPE goal than do whites with less than a high school degree.

Third, the HOPE Goals help us to better understand the degree of equity within and across states. Using the example of adult health status in Figure 3, the HOPE rankings show that among four southern states, Virginia is closest to the HOPE Goal at 18th, North Carolina is a bit further back at 33rd, and Alabama and Mississippi are among the farthest at 46th and 47th respectively. Despite Mississippi being relatively far from the Goal at 47th, race and ethnicity groups within the state rate themselves on health similarly, whereas, in North Carolina the degree of inequity between groups or the opportunity gap is much wider.

Finally, we have much to learn from bright spots—that is, states that are positive outliers and exhibit surprising data. While infant mortality among U.S. Blacks nationally, for example, is much higher than among whites, infant mortality in Washington State is lower among Blacks (7.1 per 1,000 live births) than among whites in Alabama (7.3), Hispanics in South Dakota (8.6), and Asian and Pacific Islanders in Utah (7.6). We have much to learn from these unexpected findings. These kinds of positive outliers raise questions about which contextual factors at the state level are driving outcomes that are different from national trends. Where we find these bright spots, we should scrutinize the social, economic and environmental conditions in that particular state because they can offer important clues for policy change.

Taken all together, these findings show that higher levels of socioeconomic status are associated with better health and opportunity, but the protective effects of SES do not fully apply to all populations or facilitate health to the same degree in all states. That is, the health of Americans is shaped not only by their personal characteristics and lifestyles but also by the places in which they live.

7 Available at www.nationalcollaborative.org/our-programs/hope-initiative-project/

FIGURE 1

ADULT HEALTH STATUS
By Race and Ethnicity

● White ● Black ● Hispanic
● Asian/PI ● AI/AN ● Multiracial

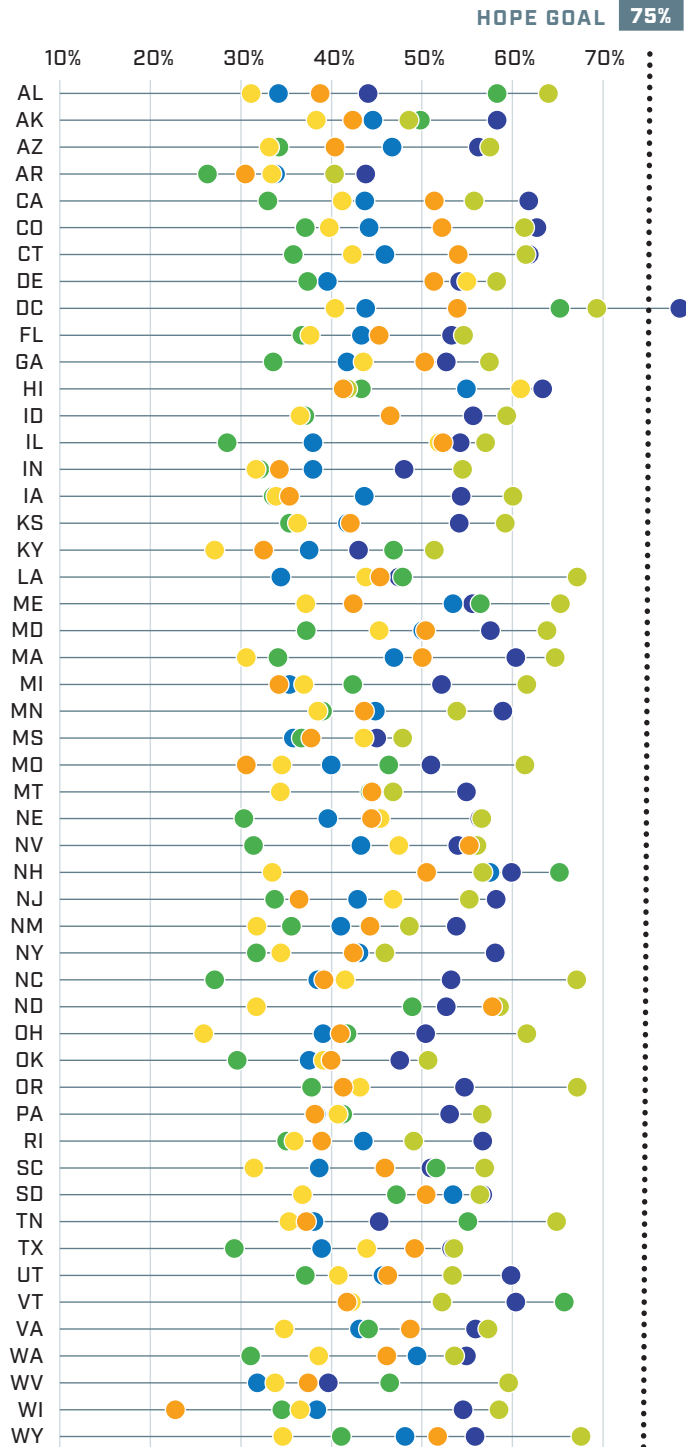Percent of Adults with Very Good or Excellent Health

HOPE GOAL 75%

FIGURE 2

HOME OWNERSHIP
By Education Attainment

● Less than HS ● HS Grad ● Some College ● College Grad

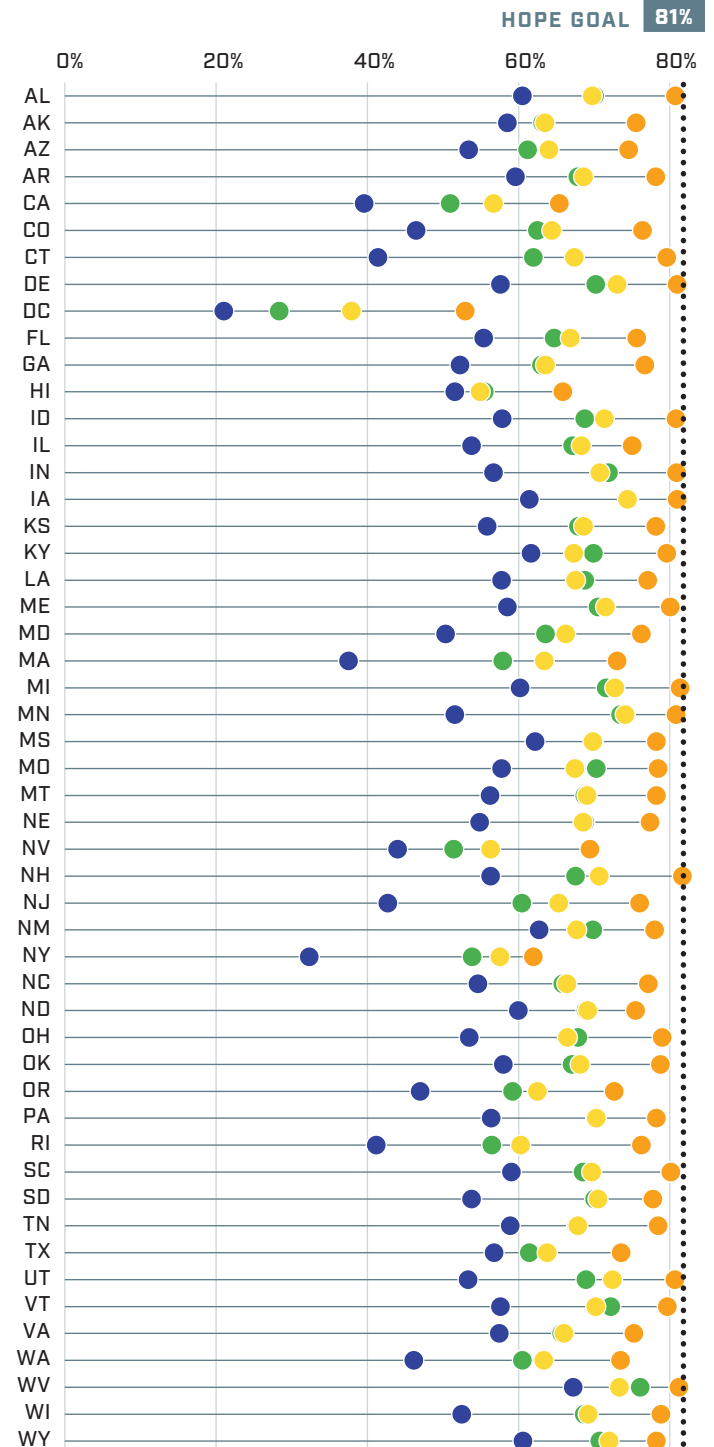Percent of Households Owning Homes

HOPE GOAL 81%

FIGURE 3

DEMONSTRATING THE DEGREE OF EQUITY WITHIN AND BETWEEN STATES USING HEALTH STATUS

By Race and Ethnicity for AL, MS, NC & VA

● White ● Black ● Hispanic
● Asian/PI ● AI/AN ● Multiracial
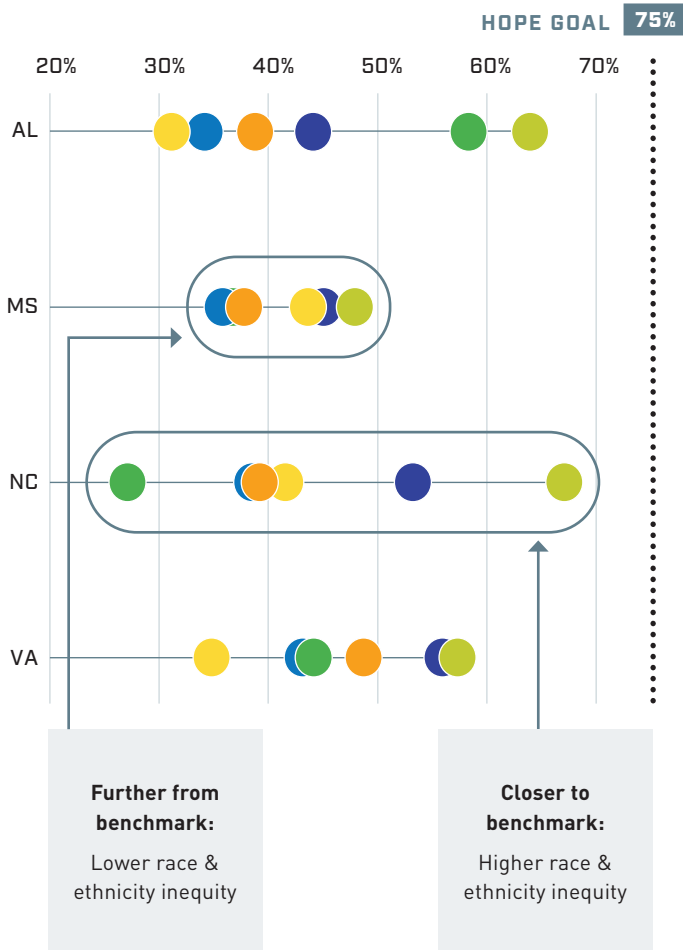
Percent of Adults with Very Good or Excellent Health

HOPE GOAL **75%**

Further from benchmark:

Lower race & ethnicity inequity

Closer to benchmark:
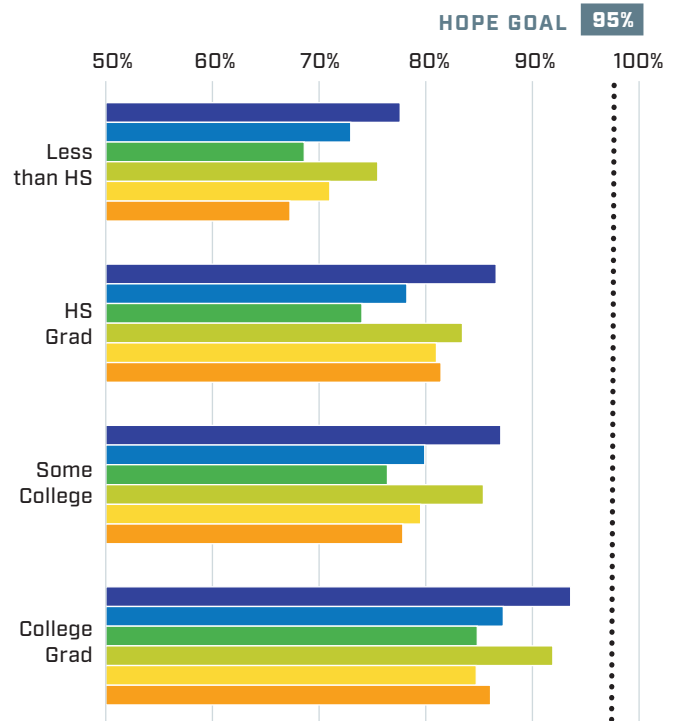
Higher race & ethnicity inequity

FIGURE 4

AFFORDABLE HEALTH CARE: NATIONAL PROGRESS TOWARD HOPE GOAL

By Race, Ethnicity, and Education

■ White ■ Black ■ Hispanic
■ Asian/PI ■ AI/AN ■ Multiracial

Percent with Affordable Health Care

HOPE GOAL **95%**

36

Socioeconomic Factors

States can expand economic opportunities, particularly for low-income families and communities, through a combination of macroeconomic, labor market, housing, and education policies, among other strategies to boost family incomes and economic security. State tax policy, for example, can help low-income families retain more of their income and encourage savings. Several states have implemented earned income tax credit (EITC), Child Tax Credit (CTC), and/or Child and Dependent Care Credit (CDCTC) policies, which provide a tax refund to eligible low-income families.[8] These policies have been shown to increase employment and income, especially for single mothers, and improve health and access to health care among poor working families (Centers for Disease Control and Prevention, 2014). Such policies are also associated with improvements in child health, including reductions in infant mortality (Arno et al., 2009; Marr et al., 2013) and low birth weight (Strully et al., 2010).

Similarly, there is robust evidence that high-quality early childhood education improves children's educational attainment, as well as health and well-being, across a range of measures. Children who attend high-quality preschool programs are less likely to show behavioral problems, score higher on standardized tests, and achieve higher levels of education relative to children who do not attend pre-kindergarten programs (Barnett et al., 2017). In addition, they are more likely to be employed as adults, and have greater adult earnings (Ruhm & Walfogel, 2011).

> Several states that perform well on HOPE measures of child health, such as Minnesota, Oregon, and Washington, rank high in ratings of quality and accessibility of state-funded pre-k programs.

State policies can also influence family earnings. Slightly less than half (49%) of salaried workers in the United States earn the federal minimum wage, and three-fourths (76%) of these are 20 years or older (Bureau of Labor Statistics, 2013). But in many communities the federal minimum wage is insufficient to meet needs, especially among families with children. Researchers have developed a "living wage" calculation that takes into consideration regional and community variation in costs related to housing, health care, transportation, food, and child care (Glasmeier, 2004), and some states have enacted minimum wage laws that require employers to pay wages higher than the federal minimum wage (U.S. Department of Labor, 2018).

> Many of that states that have the greatest distance to HOPE Goals on socioeconomic factors (e.g., Southeastern) use the federal minimum wage standard while states that are closest to the respective goals (e.g., Northeastern and Pacific Northwest) have set state minimum wages higher than the federal requirement.

Social Environment

A large body of research finds that aspects of the social environment—in particular, neighborhood poverty concentration—powerfully shape opportunities for health and well-being. Children living in high-poverty neighborhoods face greater risk for exposure to adverse childhood experiences such as violence, have less access to healthy food, face greater environmental health risks, and are too often educated in poorly-resourced schools (Kramer & Hogue, 2009; Williams, Priest & Anderson, 2016; Acevedo-Garcia et al., 2014). Policies that encourage mixed-income housing developments—where affordable housing is included with market-rate housing—have resulted in multiple benefits for families with low incomes (Joseph, Chaskin & Webber, 2007). And, the recently-concluded Moving to Opportunity study, a longitudinal, randomized control trial involving over 4,600 low-income families, found that families in an experimental condition who used housing vouchers to move from high- to low-poverty neighborhoods earned higher incomes and experienced lower levels of psychological distress, severe obesity, and diabetes relative to a control group that received no assistance to move to low-poverty neighborhoods (Chetty, Hendren & Katz, 2016).

8 www.taxcreditsforworkersandfamilies.org/state-tax-credits

While housing policy is primarily established by local jurisdictions, states can incentivize inclusionary zoning and the use of portable housing vouchers to combat high levels of neighborhood poverty concentration.

> States such as California, Colorado, and Washington have used policy incentives like inclusionary zoning and housing vouchers and by comparison perform much closer to the HOPE Goal of ensuring that no resident lives in a community with high levels of poverty concentration.

Physical Environment

Recognizing that home ownership is key to building wealth and economic opportunity, as well as promoting stable families and communities, many states have implemented policies to assist low- and moderate-income families to purchase homes. These strategies include providing down payment assistance through grants, second mortgages, or premium bonds; direct lending to first-time home buyers; and homeownership counseling.

> West Virginia, a relatively poor state, offers all three sources of homeownership support, and is ranked second among all states on HOPE's measure of home ownership. Minnesota and Michigan—ranked 3rd and 4th respectively—offer both down payment assistance and counseling. California and New York are ranked the lowest—49th and 50th—are among the most expensive states to own a home and only offer down payment assistance.

States are also increasingly implementing policy strategies to improve access to healthy food retail, particularly in low-income communities. One of the first such initiatives was launched in the Commonwealth of Pennsylvania in 2004. The Pennsylvania Fresh Food Financing Initiative (FFFI) was designed to attract supermarkets and grocery stores to underserved urban and rural communities, with the goals of stimulating investment of private capital and removing financial obstacles for supermarkets to establish in "food deserts." The program also sought to reduce the

incidence of diet-related diseases, while creating good-paying jobs for community residents. Preliminary evidence suggests that the initiative is meeting its goals: by 2010, FFFI approved 88 grocery retail projects for funding, which created more than 5,000 jobs and increased health food access to nearly 500,000 Pennsylvania residents. And while many factors influence diet-related health outcomes, researchers found an unprecedented 5% decline in rates of childhood obesity in Philadelphia where the first FFFI funds were implemented (Harries et al., 2014). The success of this effort stimulated creation of the federal Healthy Food Financing Initiative in 2011.

> The states that are closest to the HOPE goal of ensuring that 97% of residents live in communities with healthy food retail—including California, New York, New Jersey, Massachusetts, and Pennsylvania— all had adopted fresh food financing programs by 2015 (Opportunity Finance Network, 2015).

Access to health care

States have important opportunities to improve health insurance coverage through Medicaid and the Child Health Insurance Program, as well as other efforts to incentivize private insurance markets. To the extent that states equitably approach the HOPE insurance coverage goal, they will also reduce geographic barriers to care and induce health care providers and institutions to locate in medically underserved communities. But many states—particularly those in the Deep South and Mountain West that elected not to expand the Medicaid program through the Affordable Care Act—remain far from the goal. The federal government remains the primary force determining health care provider supply and distribution, through designating and funding federally-qualified health centers and supporting health care provider training and service programs such as the National Health Service Corps, but states can also create programs and incentives to align health care resources with community need. For example, 34 states have established Certificate of Need (CON) laws to regulate the citing and construction of new health care facilities, but these tools are rarely applied with equity as a guiding principle (National Conference of State Legislatures, 2016).

Conclusion

The HOPE Initiative envisions a nation where state and national policymaking prioritizes health, equity, and opportunity for all, with a particular focus on low-income families, people of color, and others who face currently face the widest gaps in opportunity and health. Ultimately, the goal of our work is to promote a Culture of Health that embraces fair and just opportunities to access needed resources, provides metrics that society can use to track progress, enables forecasting of likely outcomes of state-level policy solutions, and promotes wise, strategic investments in remedying the root causes of inequities. It's in our national interest to nurture the resources that enhance all facets of a good life—for all.

References

Acevedo-Garcia, D., McArdle, N., Hardy, E.F., Crisan, U.I., Romano, B., Norris, D., Baek M., Reece J. (2014). The Child Opportunity Index: Improving collaboration between community development and public health. Health Affairs; 33 (11):1948-1957.

Arno, P.S., Sohler, N., Viola, D., Schechter, C. (2009). Bringing health and social policy together: The case of the earned income tax credit. Journal of Public Health Policy; 30: 198–207.

Barnett, S.W., Friedman-Krauss, A.H., Wisenfeld, G.G., Horowitz, M., Kasmin, R., Squires, J.H. (2017). The state of preschool 2016. National Institute for Early Education Research. Retrieved December 7, 2017 from: http://nieer.org/wp-content/uploads/2017/08/Executive-Summary_8.21.17.pdf

Braveman, P., Arkin, E., Orleans, T., Proctor, D., Plough, A. (2017). What is health equity? And what difference does a definition make? Princeton, NJ: Robert Wood Johnson Foundation.

Bureau of Labor Statistics. (2013). Characteristics of minimum Wage Workers: 2012. Retrieved December 26, 2013 from: http://www.bls.gov/cps/minwage2012.htm

Centers for Disease Control and Prevention. (2014). Essentials for childhood: Safe, stable, nurturing relationships and environments for all children and families. Indicators of Impact. Accessed December 7, 2017 at: https://www.cdc.gov/violenceprevention/pdf/essentials_for_childhood_framework.pdf

Chetty, R, Hendren, N., & Katz, L. (2016). The effects of exposure to better neighborhoods on children: New evidence from the Moving to Opportunity project. American Economic Review; 106 (4): 855-902.

Glasmeier, A.K. (2004). Living Wage Calculator. Accessed on December 7, 2017 at: http://livingwage.mit.edu/

Harries, C., Koprak, J., Young, C., Weiss, S., Parker, K. M., Karpyn, A. (2014). Moving from policy to implementation: A methodology and lessons learned to determine eligibility for healthy food financing projects. Journal of Public Health Management and Practice; 20(5): 498–505.

Joseph, M.L., Chaskin, R.J., Webber, H.S. (2007). The theoretical basis for addressing poverty through mixed-income development. Urban Affairs Review; 42: 369-409.

Kramer, M.R. & Hogue, C. (2009). Is segregation bad for your health? Epidemiologic Reviews; 31: 178-194.

Marr, C., Charite, J., Huang, C.C. (2013). Earned income tax credit promotes work, encourages children's success at school, research finds. Center on Budget and Policy Priorities. Retrieved December 6, 2017 from: http://www.cbpp.org/files/6-26-12tax.pdf

National Conference of State Legislatures. (2016). State certificate of need laws. Accessed December 7, 2017 at http://www.ncsl.org/research/health/con-certificate-of-need-state-laws.aspx#4

Opportunity Finance Network. (2015). Health food financing. Lessons learned. Presentation accessed December 7, 2017 and available at: http://conference.ofn.org/2015/docs/PPT_HealthyFoodLessonsLearned.pdf

Ruhm, C., Walfogel, J. (2011). Long term effects of early childhood care and education. Institute for the Study of Labor Discussion Paper No. 6149.

Strully, K.W., Rehkopf, D.H., Xuan, Z. (2010). Effects of prenatal poverty on infant health: State earned income tax credits and birth weight. American Sociological Review; 75: 534-562.

Williams, D.R., Priest, N., Anderson, N.B. (2016). Understanding associations between race, socioeconomic status, and health: Patterns and prospects. Health Psychology; 35(4): 407-11.

U.S. Department of Labor. (2018). Minimum wage laws in the states. Accessed June 10, 2018 at: https://www.dol.gov/whd/minwage/america.htm
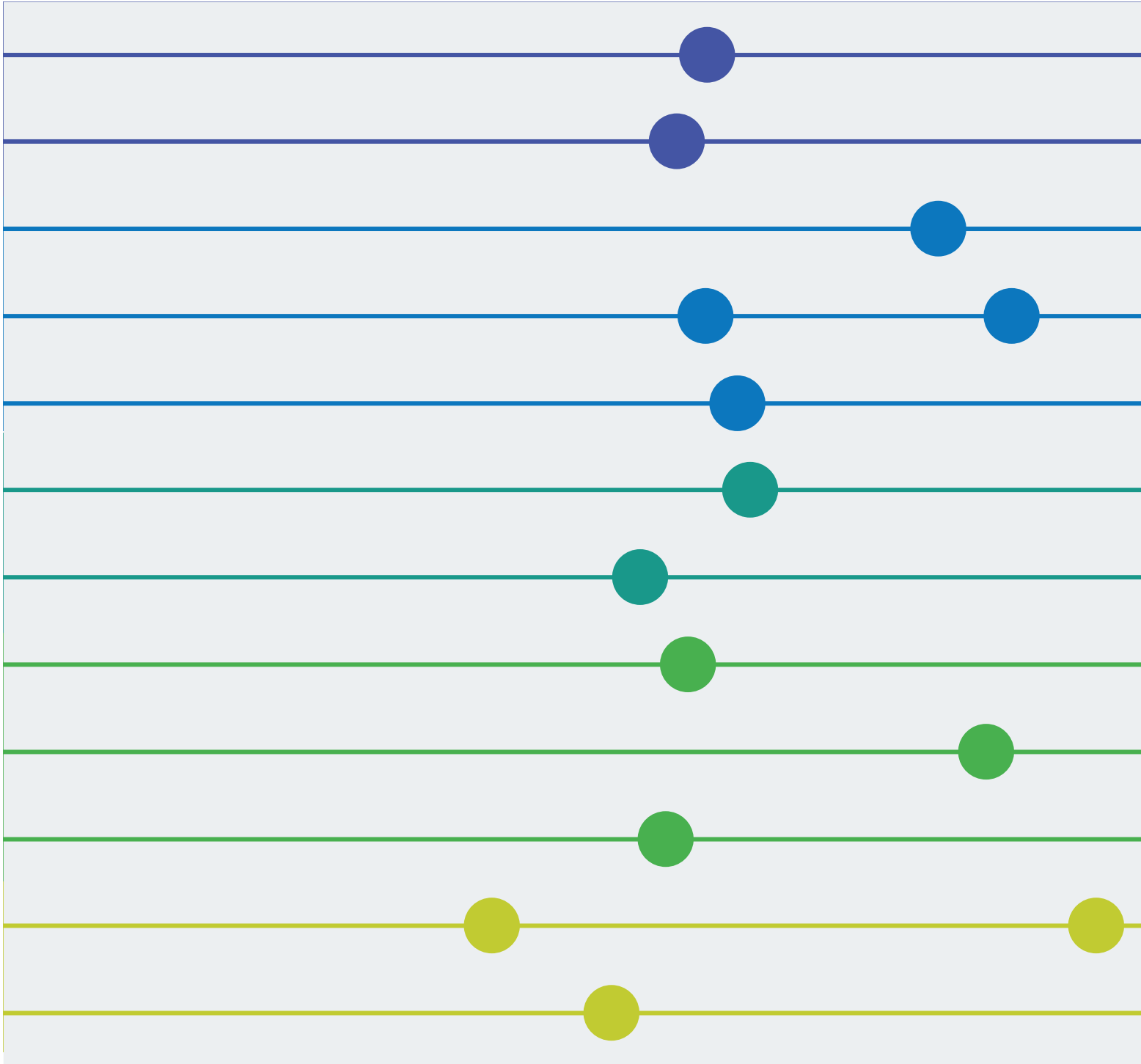
Robert Wood Johnson Foundation (RWJF) VISION TO ACTION framework

IMPROVING AMERICA'S HEALTH BY WORKING TOGETHER AND MEASURING PROGRESS

Building a national Culture of Health means creating a society that gives all individuals an equal opportunity to live the healthiest lives possible, whatever their ethnic, geographic, racial, socioeconomic, or physical circumstances happen to be.

The Action Framework reflects a vision of health and well-being as the sum of many parts, addressing the interdependence of social, economic, physical, environmental, and spiritual factors. It is intended to generate unprecedented collaboration and chart our nation's progress toward building a Culture of Health. Equity and opportunity are overarching themes of the entire Action Framework—not merely to highlight our nation's health disparities, but to move toward achieving health equity.

The Action Framework groups the many actors, and the many facets, of a Culture of Health into four Action Areas— each connected to and influenced by the others. These Action Areas are intended to focus efforts and mobilize an integrated course of action by many individuals, communities, and organizations.

Each Action Area contains a set of Drivers that indicate where our nation needs to accelerate change. The Drivers are the engine of the Action Framework, providing a set of long-term priorities both nationally and at the community level. The Action Areas and the Drivers are the essential, enduring structure of the Action Framework and will remain constant over time. Each Action Area is also accompanied by a set of national, evidence-based Measures, rigorously selected as points of assessment and engagement. By design, the Measures are not limited to traditional health indicators; instead, they encourage us to think of health in broader ways, incorporating all aspects of well-being. They are intended to serve as entry points for dialogue and action about health among a diverse group of stakeholders and across sectors.

The Measures will illustrate progress and will evolve over time to keep pace with changing conditions. The Measures highlight upstream factors that may not typically be associated with health care, and reflect actions that involve many more sectors and institutions than traditional health and health care services. Ambitious in scope, many of the Measures draw from existing sources, while others are based on new data gathered for this report.
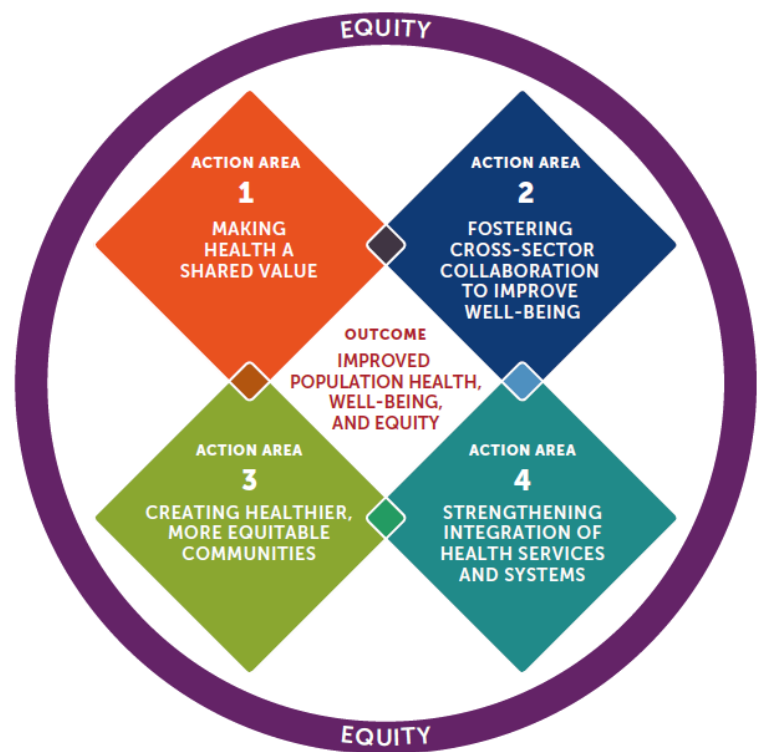
◇ ACTION AREA 1: MAKING HEALTH A SHARED VALUE

DRIVERS	MEASURES
1.1 MINDSET AND EXPECTATIONS The views and expectations we have about health ultimately inform the decisions we make as individuals, families, businesses, communities, and as a nation. Do we understand that our health affects the health of others and vice versa? Do we expect health to be prioritized in our policies and consumer choices?	**Value on health interdependence** Percentage of people who are in strong agreement that their health is influenced by peers, neighborhood, and the broader community (7) **Value on well-being** Percentage of people who are interested in how their community invests in well-being, signaling a broader expectation for well-being (8) **Public discussion on health promotion and well-being** Proportion of tweets discussing health promotion and well-being to tweets discussing acute medical care (9)
1.2 SENSE OF COMMUNITY Research suggests that individuals who live in socially connected communities—with a sense of security, belonging, and trust—have better psychological, physical, and behavioral health, and are more likely to thrive. If people do not see their health as interdependent with others in their community, they are less inclined to engage in health-promoting behaviors or work together for positive health change.	**Sense of community** Aggregate score on two subscales of the Sense of Community Index: emotional connection to community and sense of belonging to community (membership) (10) **Social support** Percentage of people noting they have adequate social support from partner, family, and friends (11)
1.3 CIVIC ENGAGEMENT Civic engagement creates healthier communities by developing the knowledge and skills to improve the quality of life for all. Voting is a key component of a healthy society, yet many Americans do not vote regularly. Activities such as volunteering, community organizing, and participating in community groups demonstrate that residents care about the outcomes of their community and want to cultivate positive change. Moreover, communities with strong civic engagement are better able to respond and recover during an emergency. These Measures reflect whether Americans feel motivated and able to participate and make a difference.	**Voter participation** Percentage of eligible voters who reported voting in general election (12) **Volunteer engagement** Percentage of adults and young people who reported volunteering (13)

⬥② ACTION AREA 2: FOSTERING CROSS-SECTOR COLLABORATION TO IMPROVE WELL-BEING

DRIVERS	MEASURES
2.1 NUMBER AND QUALITY OF PARTNERSHIPS Research indicates that building relationships among partners is the most challenging aspect of creating change, and that leadership is particularly important for cross-sector synergy. (17) Other key factors include establishing a history of collaboration between organizations, ensuring participants have the resources they need, and building a sense of shared accountability. A Culture of Health calls for assessing the effectiveness of our partnerships and the integration of healthy practices in schools and workplaces—settings where well-being can flourish or falter.	**Local health department collaboration** Percentage of local health departments that collaborated with community organizations in at least four public health program areas in the past year (18) **Opportunities to improve health for youth at schools** Annual number of school-based health centers that provide primary care (19) **Business support for workplace health promotion and Culture of Health** Index of employer health promotion and practices (by size of business) (20)
2.2 INVESTMENT IN CROSS-SECTOR COLLABORATION *(need local measures)* In addition to measuring the quality and quantity of cross-sector collaborations, it is important to track investments that support these partnerships. Corporate and federal contributions have the power to impact our nation's health and well-being, both directly and indirectly.	**U.S. corporate giving** Annual dollar amount of U.S. corporate contributions to education (K–12 and higher education) and to community/economic development sectors (21) **Federal allocations for health investments related to nutrition and indoor and outdoor physical activity** Annual dollar amount of federal appropriation to select health initiatives
2.3 POLICIES THAT SUPPORT COLLABORATION Policies can play a key role in encouraging and maintaining collaboration across sectors, as well as creating incentives for different sectors to contribute what they can to the cause of improving our nation's health. These Measures highlight policies that have the potential to catalyze widespread improvement in health and overall well-being.	**Community relations and policing** Percentage of full-time sworn personnel who have served as community policing or community relations officers, or were designated to engage regularly in community policing activities (22) **Youth exposure to advertising for healthy and unhealthy food and beverage products** Annual measure of children's exposure to TV ads for unhealthy foods/beverages (23) **Climate adaptation and mitigation** Annual percentage of states with climate adaptation and mitigation action plans (24) **Health in all policies (support for working families)** Annual percentage of families with parents eligible for Family Medical Leave Act (FMLA) coverage who can also afford it (25)

◆ ACTION AREA 3: CREATING HEALTHIER, MORE EQUITABLE COMMUNITIES

DRIVERS

MEASURES

3.1 BUILT ENVIRONMENT/PHYSICAL CONDITIONS

The built environment—or the physical space in which we live, learn, work, and play—is key to a community's well-being. For example, sidewalks in good condition and active transport routes, such as bicycle lanes, are features of the physical environment that may provide greater access to exercise and healthy food options. However, to take advantage of these opportunities, it's essential that we feel safe in our neighborhoods, parks, and schools.

Housing affordability
Percentage of families spending 50 percent or more of monthly income on housing costs for either rent or mortgage (30)

Access to healthy foods
Percentage of U.S. population with limited access to healthy foods (31)

Youth safety
Percentage of middle and high school students who reported feeling safe in their communities and schools (32)

3.2 SOCIAL AND ECONOMIC ENVIRONMENT

Our social environment, such as enduring racial and socioeconomic segregation, can also influence health and impact a community's sense of trust and cohesion. In addition, research points to strong connections between our environment, economic vitality, and health. We know that children who attend preschool are more likely to stay in school, go on to hold jobs and earn more money—all of which are linked to better health. (33) Public libraries continue to serve as important hubs of enrichment and well-being—providing community connections and computer access, and links to civic engagement, health literacy, and resilience.

Residential segregation
Evenness with which racial/ethnic groups are distributed across communities (index of dissimilarity, exposure to diversity) (34)

Early childhood education
Number of states where 60 percent or more 3- and 4-year-olds are enrolled in preschool (35)

Public libraries
Number of library outlets per 100,000 people (36)

3.3 POLICY AND GOVERNANCE

This area spotlights policy aimed at creating healthy environments, with an emphasis on collaboration between residents and large institutions, both governmental and corporate. Too often, we see health-promoting initiatives fall short without the policy structures in place to sustain them.

Complete Streets policies
Number of jurisdictions with Complete Streets policies in place (37)
Adopting a Complete Streets policy means that every transportation project will make the street network better and safer for drivers, transit users, pedestrians, and bicyclists. These policies allow communities to direct their transportation planners and engineers to routinely design the entire right of way to enable safe access for all users, regardless of age, ability, or mode of transportation. (38)

Air quality
Percentage of population covered by comprehensive smoke-free indoor air laws (39)

◆ ACTION AREA 4: STRENGTHENING INTEGRATION OF HEALTH SERVICES AND SYSTEMS

DRIVERS	MEASURES
4.1 ACCESS Several factors influence access to health services, including the expansion of health insurance coverage. But access must be more than having insurance. It must be more broadly defined as being able to get comprehensive, continuous health services when needed and having the opportunity and tools to make healthier choices.	**Access to comprehensive primary care*** Percentage of population (regardless of insurance) who utilize a comprehensive patient-centered primary care home health system (43) **Access to stable health insurance** Percentage of population, with stable health insurance, or no change in the source of health insurance (44) **Access to mental health services** Percentage of people who report having mental health or substance abuse problems, and who received treatment (45) **Routine dental care** Percentage of people who report a dental visit in the calendar year (46)
4.2 CONSUMER EXPERIENCE & QUALITY When people don't feel connected to, or in control of, the full complement of medical and social services, they are more likely to delay or avoid care. In a Culture of Health, health care providers help patients thrive by planning for the care that's needed inside and outside the clinic. This means that all individuals are treated with dignity, and that cultural differences are honored and respected. Also, provider networks can improve the consumer experience by creating a coordinated health care system, with a network of doctors and hospitals sharing financial and medical responsibility for patients' health.	**Consumer experience** Consumer Assessment of Healthcare Providers and Systems (CAHPS) summary measure of consumer experience across ambulatory, hospital, and home health care settings (47) **Population covered by an Accountable Care Organization (ACO) [or CCO]** Percentage of population whose health care provider is part of an ACO (48)
4.3 BALANCE AND INTEGRATION A Culture of Health calls for better balance between prevention and acute/chronic care services, as well as the intentional integration of public health, social service, and health care systems. When these systems work in sync, we will see an improvement in the efficiency and quality of care delivered, leading to reduced hospital re-admissions, decreased health costs, and a more seamless health care experience. (49) In short, more people will get the preventive and social services they need early and avoid unnecessary medical care.	**Electronic medical record linkages** Percentage of physicians who share data with other providers and hospitals, with the goal of encouraging integration, collaboration, and communication (50) **Hospital partnerships** Percentage of hospitals that have a collaboration or alliance with one or more organizations in each of these categories: local government, state agencies, and other community-based agencies (51) **Practice laws for nurse practitioners** Number of states that have laws and regulations that support full scope of practice for nurse practitioners (52) **Social spending relative to health expenditure** A ratio of annual social spending to annual health expenditures in the United States (53)

◈ OUTCOME: IMPROVED POPULATION HEALTH, WELL-BEING, AND EQUITY

DRIVERS	MEASURES
O.1 ENHANCED INDIVIDUAL AND COMMUNITY WELL-BEING The Culture of Health Action Framework emphasizes well-being, which can be evaluated by both subjective and objective data. Individual well-being can be defined as the extent to which people experience happiness and satisfaction, and are realizing their full potential. Key aspects of community well-being include community health, economic resilience, educational capacity, and environmental adaptation. By measuring well-being among individuals, communities, and care-givers, we gain a window into whether health has been woven into the fabric of our culture.	**Well-being rating** Well-being rating in three areas: Health, Life Satisfaction, Work/Life Balance (58) • *Health: Average life expectancy and percentage of population who report "good" or better health* • *Life Satisfaction: Weighted sum of different response categories based on people's rating of their current life relative to the best and worst possible lives for them on a scale from 0 to 10, using the Cantrell Ladder* • *Work/Life Balance: Percentage of dependent employees whose usual hours of work per week are 50 hours or more, and average number of hours per day that full-time employed people spend on leisure and personal activities* **Caregiving burden** Average amount of out-of-pocket financial and emotional investment in caregiving, as reported by adults 18 years and older (59)
O.2 MANAGED CHRONIC DISEASE AND REDUCED TOXIC STRESS A Culture of Health is intended to support a trajectory of well-being throughout the lifespan, addressing any health issues as early as possible. Today, more than half of all Americans suffer from one or more chronic diseases; by 2020, the number of those with chronic conditions is expected to grow to 157 million. There are significant disparities, with the burden of chronic conditions experienced disproportionately by low-income people and ethnic minorities.60 In addition, a growing area of research has focused on the relationship between childhood trauma (such as domestic violence, substance abuse, and neglect) and the risk for physical and mental illness in adulthood. By measuring the prevalence of chronic disease and adverse child experiences (ACEs), we can gauge whether the health of the population is improving.	**Adverse child experiences (ACEs)** Percentage of population, ages 0 to 17 years, with two or more reported ACEs, as reported by parents (61) **Disability associated with chronic conditions** Number of disability-adjusted life years (DALYs) for the top 10 U.S. chronic diseases (62)

O.3 REDUCED HEALTH CARE COSTS

It is well understood that health care costs are placing a significant burden on all sectors of American society, and that the United States spends more per capita on health care than other countries. Our nation has also seen the steepest increase in health care spending, even though our health outcomes have not markedly improved. As we measure overall health costs in relation to outcomes, we must also keep a close eye on how and when we spend. Progress will entail not only improving efficiency and avoiding unnecessary procedures, but managing issues early and preserving dignity across the lifespan.

Family health care cost

Average health care expenditure by family (63)

Potentially preventable hospitalization rates

Overall U.S. admission rates for chronic and acute conditions per 100,000 population, including:

- *Chronic: Diabetes with short-term complications; diabetes with long-term complications; uncontrolled diabetes without complications; diabetes with lower-extremity amputation; chronic obstructive pulmonary disease; asthma; hypertension; heart failure; angina without a cardiac procedure*
- *Acute: Dehydration; bacterial pneumonia; or urinary tract infection (64)*

Annual end-of-life care expenditures

Annual average Medicare payment per decedent in the last year of life (65)

Vital Signs
Core Metrics for Health and Health Care Progress
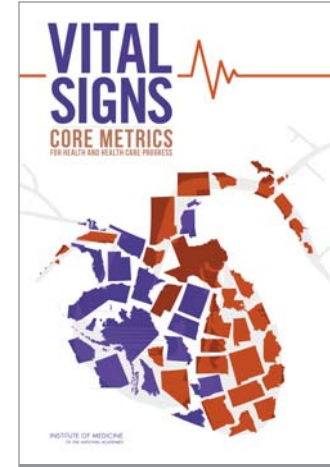
Thousands of measures are in use today to assess health and health care in the United States. Although many of these measures provide useful information, their sheer number, as well as their lack of focus, consistency, and organization, limits their overall effectiveness in improving performance of the health system. To achieve better health at lower cost, all stakeholders—including health professionals, payers, policy makers, and members of the public—must be alert to which measures matter most. What are the core measures that will yield the clearest understanding and focus on better health and well-being for Americans?

With support from the Blue Shield of California Foundation, the California Healthcare Foundation, and the Robert Wood Johnson Foundation, the Institute of Medicine (IOM) convened a committee to identify core measures for health and health care. In *Vital Signs: Core Metrics for Health and Health Care Progress*, the committee uses a four-domain framework—healthy people, care quality, lower cost, and engaged people—to propose a streamlined set of 15 standardized measures, with recommendations for their application at every level and across sectors. Ultimately, the committee concludes that this streamlined set of measures could provide consistent benchmarks for health progress across the nation and improve system performance in the highest-priority areas.

A streamlined set of measures could provide consistent benchmarks for health progress across the nation and improve system performance in the highest-priority areas.

The Measurement Landscape

Health measurements are requested or required by many organizations for many purposes, including efforts to track population, community, and individual health; assessments of health care quality and patient experience; transparency monitoring; public reporting and benchmarking; system or professional performance requirements; and funder reporting. Many of these measures are very similar, with only slight variations in terminology and methodology. However, their differences are often significant enough to prevent direct comparisons across states, institutions, and individuals. In addition, many measures focus on narrow or technical aspects of health care processes, rather than on overall health system perfor-

4. Addictive behavior: Addiction, including to nicotine, alcohol, and other drugs, is prevalent in the United States, representing a complex challenge for the health system, communities, and families. Every year, substance abuse and addiction cost the country more than $500 billion.

5. Unintended pregnancy: Unintended pregnancy, a significant challenge for both individual and community health, is a measure that aggregates a variety of social, behavioral, cultural, and health factors—particularly women's knowledge about and access to tools for family planning.

6. Healthy communities: Individual health is a function of a wide range of socioeconomic and community factors, from infrastructure to social connections. Community health includes critical elements of health that fall outside the care system, such as housing, employment, and environmental factors.

7. Preventive services: Preventive services (for example, screening for hearing loss or counseling for tobacco cessation) present a valuable opportunity for both improving health and reducing costs.

8. Care access: A person's ability to access care when needed is a critical precondition for a high-quality health system. Factors that could hamper access to care include lack of health insurance, clinician shortages, lack of transportation, cultural and linguistic barriers, and physical limitations.

9. Patient safety: Avoiding harm is among the principal responsibilities of the health care system, yet adverse outcomes are common. Ensuring patient safety will require a culture that prioritizes and assesses safety through a reliable index of organizational results.

10. Evidence-based care: Ensuring that patients receive care supported by scientific evidence for appropriateness and effectiveness is a central challenge for the health care system. Currently, an estimated one-third of U.S. health care expenditures do not contribute to improving health. Aggregating carefully selected and standardized clinical measures can provide a reliable composite index of system performance.

11. Care match with patient goals: Systematically assessing each patient's individual goals and perspectives ensures that the health care system is focusing on the aspects of care that matter most to patients.

12. Personal spending burden: Care that is too expensive can limit access to care, lead people to avoid care, or prevent them from spending money in other areas of value to them—with far-reaching economic impacts.

13. Population spending burden: Health care spending consumes a large portion of the U.S. gross domestic product, dwarfing the health care spending of other nations. This burden can be measured at national, state, local, and institutional levels.

14. Individual engagement: Given the effects of personal choices on health, as well as the increasing use of personal health devices, it is critical for individuals to be aware of their options and responsibilities in caring for their own health and that of their families and communities.

15. Community engagement: Across the United States, communities have and utilize different levels of resources to support efforts to maintain and improve individual and family health—for example, addiction treatment programs, emergency medical facilities, and opportunities for social engagement.

The committee recognizes that these 15 measures will not be sufficient to meet every interest for each organization, nor are there established methods for measurement in each area. To begin to accommodate these challenges, the committee identifies 39 additional priority measures that can act as surrogates while refinement is under way (see Box).

Committee on Core Metrics for Better Health at Lower Cost

David Blumenthal (Chair)
The Commonwealth Fund

Julie Bynum
The Dartmouth Institute

Lori Coyner
Oregon Health Authority

Diana Dooley
California Health and Human
Services

Timothy Ferris
Partners HealthCare

Sherry Glied
Robert F. Wagner Graduate
School of Public Service, New
York University

Larry Green
University of Colorado at
Denver

George Isham
HealthPartners

Craig Jones
Vermont Blueprint for Health

Robert Kocher
Venrock

Kevin Larsen
Office of the National
Coordinator for Health
Information Technology

Elizabeth McGlynn
Center for Effectiveness
and Safety Research, Kaiser
Permanente

Elizabeth Mitchell
Network for Regional Health
Improvement

Sally Okun
PatientsLikeMe

Lyn Paget
Health Policy Partners

Kyu Rhee
IBM Corporation

Dana Gelb Safran
Blue Cross Blue Shield of
Massachusetts

Lewis Sandy
UnitedHealth Group

David Stevens
National Association of
Community Health Centers

Paul Tang
Palo Alto Medical Foundation

Steven Teutsch
Los Angeles County
Department of Public Health

Study Staff

Elizabeth Malphrus
Study Director

Elizabeth Johnston
Senior Program Assistant

Robert Saunders
Senior Program Officer
(through March 2014)

J. Michael McGinnis
Senior Scholar and Executive
Director, Roundtable on Value
& Science-Driven Health Care

Refinement of the measures and methodology will require leadership from stakeholders across sectors.

Implementation of the Core Measures

Successful implementation of the core measures will depend on their relevance, reliability, and utility to stakeholders. Implementation challenges include multiple competing priorities for stakeholders, the sizable degree of change proposed, and the slow pace of change overall in the health system. Progress can be accelerated by ensuring that the core measurement set is applied by, and adds value to, existing measurement activities. The committee stresses that leadership will be required at nearly every level of the health system. CEOs of health care organizations, payers and employers, standards organizations, and public health agencies will have important roles in the uptake, use, and maintenance of the core measures as practical tools. The committee recommends that the Secretary of the Department of Health and Human Services, with support from the Executive Office of the President, lead the effort to refine, standardize, and implement core measures throughout the nation.

Conclusion

The set of core measures proposed by the committee is a tool for enhancing the efficiency and effectiveness of measurement. Ultimately, widespread application of a limited set of standardized measures could not only reduce the burden of unnecessary measurement but also align the incentives and actions of multiple organizations at multiple levels. *Vital Signs* lays the groundwork for the adoption of core measures that, if systematically applied, could yield better health at lower cost for all Americans.

INSTITUTE OF MEDICINE
OF THE NATIONAL ACADEMIES

Advising the nation • Improving health

500 Fifth Street, NW
Washington, DC 20001
TEL 202.334.2352
FAX 202.334.1412

www.iom.edu

Overview of the CMS Meaningful Measures Initiative

Launched in 2017, CMS's new comprehensive "Meaningful Measures" initiative identifies high priority areas for quality measurement and improvement to improve outcomes for patients, their families, and providers while also reducing burden on clinicians and providers.

The Meaningful Measures initiative draws on prior measure work performed by the Health Care Payment Learning and Action Network, National Quality Forum, and National Academies of Medicine. It includes perspectives from patient representatives and additional experts such as the Core Quality Measures Collaborative, and many other external stakeholders.

Principles for Identifying Meaningful Measures

Meaningful Measures will move payment toward value by focusing everyone's efforts on the same quality areas and advancing specificity by identifying measures that:

- Are patient-centered and meaningful to patients, clinicians, and providers
- Address high-impact measure areas that safeguard public health
- Are outcome-based where possible
- Minimize level of burden for providers
- Create significant opportunity for improvement
- Address measure needs for population based payment through alternative payment models
- Align across programs

Rethinking Our Approach to Meaningful Outcomes

The Meaningful Measures Framework builds upon multiple concepts that defined **high impact areas** for quality measurement and quality improvement. We refer to these high impact areas as "Meaningful Measure Areas" (see Meaningful Measures graphic below). These Meaningful Measure areas:

- Offer more granular details in terms of what measurement areas to focus on
- Use a new approach to development and implementation of meaningful quality measures while reducing the burden of quality reporting on all clinicians and providers

Mapping It Out—The Framework

The following Meaningful Measures Framework shows how at CMS the **patient is always at the center of everything we do. Our strategic goals surround the patient:**

1. Improve the CMS customer experience
2. Usher in an era of state flexibility and local leadership
3. Support innovative approaches to improve quality, accessibility, and affordability
4. Empower patients and doctors to make decisions about their health care

Meaningful Measures Framework
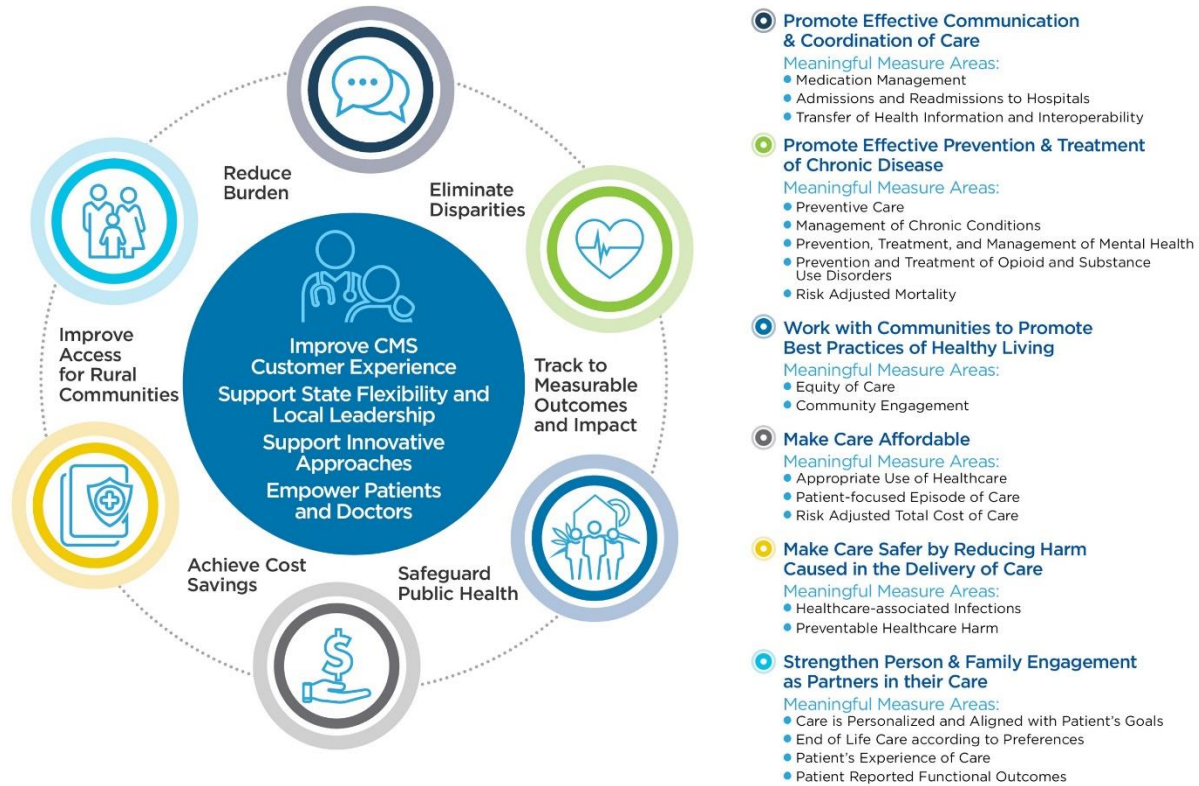
The **four CMS strategic goals** are encircled by **six cross-cutting criteria** that are applied to any Meaningful Measure area:
1. Eliminating disparities
2. Tracking to measurable outcomes and impact
3. Safeguarding public health
4. Achieving cost savings
5. Improving access for rural communities
6. Reducing burden

The Meaningful Measures Framework aligns CMS measure work with the **six overarching quality categories**, which also serve to organize the **19 Meaningful Measure areas** into specific quality domains. These six quality categories are:

1. Promote Effective Communication and Coordination of Care
2. Strengthen Person and Family Engagement as Partners in their Care
3. Promote Effective Prevention & Treatment of Chronic Disease
4. Work with Communities to Promote Best Practices of Healthy Living
5. Make Care Affordable
6. Make Care Safer by Reducing Harm Caused in the Delivery of Care

Meaningful Measures Framework Example

The following is an illustrative example of how the overarching domains, goals, criteria, and measures are interrelated in the Meaningful Measures Framework. The quality category of "Promote Effective Prevention and Treatment of Chronic Disease" includes five Meaningful Measure areas as listed in the above Framework including the Prevention and Treatment of Opioid and Substance Use Disorders. The opioid crisis has been declared a public health emergency and therefore it has been recognized as a high priority focus area for measurement.
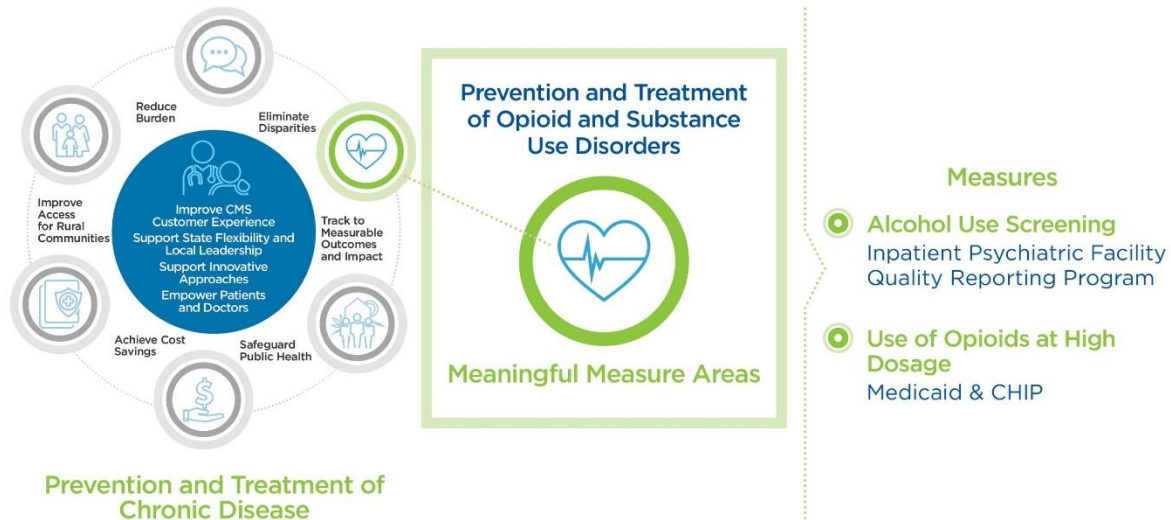
Next Steps

There are three dimensions to the implementation of Meaningful Measure areas:

1. Conduct thorough review of existing measures and remove ones that don't meet criteria;

2. Analyze measure sets to identify gaps based on the Meaningful Measures Framework; focus any new measures on filling these gaps and moving from lower value process measures towards higher value measures such as outcome measures; and

3. Work with clinicians, providers, registries, EHR vendors and other federal stakeholders to advance measurement systems to lower burden particularly around the area of reporting.

Additionally, there will be ongoing efforts to receive stakeholder input to further improve the Meaningful Measures Framework, work across CMS components to implement the Framework, and evaluate current measure sets to inform measure development.

For More Information

Visit the CMS Website: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityInitiativesGenInfo/CMS-Quality-Strategy.html

DEPARTMENT OF HEALTH

Measurement framework values, principles, vision, and mission
MEETING 1 DISCUSSION NOTES

MDH transcribed content from the notes that Steering Team members and public observers recorded during their small group discussions at the first Steering Team meeting on June 28. MDH also included content from pre-meetings with Steering Team members who were unable to attend the June meeting.

Discussion #1. Values and principles refinement

What language or concepts need clarification, or need to be added?

Clarifications:

- What we mean when we're talking about health equity and health
- Innovation and efficiency (values can mean different things)
- Fairness as determined by who?
- Principle # 1 – more (declarative?) A measure framework should reflect that health is broader than framework
- Values and principles are solid
  - What should be explicitly stated/emphasized more, and what is already there/implied?
  - Access, cultural responsiveness, and accountability are important values/concepts
  - Collaboration & connection are essential
  - Clarify that health is both physical & mental health
- 1.c. – talks about exploring factors at the pop/neighborhood factors—but no specification is included
- Connecting and collaboration—1st
- Monitor—self regulating #6 inclusive
- 4 – "not duplicating other efforts" – what specifically are those "other efforts." Name them. How do we maximize/evolve what we have that is good to then build from there?
- Need to be specific about the patients that we are talking about—those exp. health-healthcare inequities.
- Does clarification need to happen in values?

Additions:

- People with disabilities seem to be left out of the values – this is important!
- How do we better highlight structural racism that impact health- let's call it what it is.
- Maybe considering inclusion (open to all)

- Would like to incorporate more of the "suggested additional values + principles for consideration" incorporated into the current values or principles that were determined by the first Steering Committee.

Where do you see existing or potential tensions?

- Between value and judgement
- Competing priorities
- Concepts of health and health care. It is important to be clear up front that this is a question of "both/and" – not "either/or"
- Health – Does that include cost/affordability?
- Measuring in the middle and measuring at the tails
- Innovation in measurement and alignment with existing measures. Innovation and minimizing burden in measurement do not need to be mutually exclusive.
- Standardization and recognizing reasonable variation
- Connection and collaboration
- Racial equity in a conversation about measurements that are grounded in inequity seems to miss the mark
- There is a lot of oversimplification of the debate about how much health care contributes to health versus other factors and little to no basis for the commonly cited figure of 10%.
- Want a transparent and simple measurement framework, but measurement science is inherently complex. The framework will serve different stakeholders—make the "front of the house" simple and have the sophisticated econometrics in the "back of the house".
- Structure and flexibility
- Big government versus small government approach

In light of the tensions you've cited, what are the implications for a governance or decision-making structure? What needs to be in place? Who can make these decisions?

Structure

- Good board—help steward the values of framework with accountability/transparency.
- Governance board can help define this equity framework
- What are the "major buildings/community centers (measurement centers)" in our village? How (what?) do each of them need to do to evolve? What major structures are missing that we need to build together? Can they all roll up to a statewide scorecard or progress report on quality and health?
- A governance structure gets at idea of evidence-based policy making. Ultimately, set a health goal, measure it, and if we're not hitting the target, we need to recalibrate. In order for all of this to happen, there needs to be very clear goals reliable measurement, and the will to make potentially radical changes if priorities are not met. There needs to be a real commitment to changing goals and measures which may seem daunting in a political process.

- I've been a part of top-down groups, and consensus-seeking groups—both approaches provide ample opportunity for paralysis. It may be that a group is needed that picks an initial direction, decides on some things, and moved forward with the opportunity to revisit these initial decisions and make changes as needed. There should be a structure to provide feedback on a continuous loop that doesn't undo work or derail the work needs to be done.
- The governance structure depends on how MDH plans to use the framework, and to what degree it includes specific measures and/or goals.
- We're not reinventing a new model, we're simply improving a metric we already track.
- Community Measurement already tracks patient experience, this metric can be better utilized by integrating a Health Equity Framework: Physical, behavioral, social economic, genetic, and clinical—drivers to track experience, offer improvements to improve health outcomes.

Resources

- A substantial investment in infrastructure and personnel are needed to make the measurement framework work. A paid central infrastructure team is crucial to ensure an ongoing feedback mechanism and the ability to respond quickly to new data. Communities most impacted by health disparities must be at the table, and must be financially compensated for their involvement and contributions; this cannot be a coalition of those with the most resources and most to lose in defending their turf. There would be a risk of this happening without a central body.
- Even if MDH is in charge of the framework, there must be legislative buy-in and supporting resources to make the framework become a reality.

Discussion #2. Vision and mission development

How can you envision a measurement framework being used to drive health improvement and innovation and by whom?

Framework as a guide

- Measurement framework creates the focal point for impact
- Guide for all to know what to do and align efforts for greatest impact
- Overall imp(rove) goals – how does measurement support that
- Explicit tie to outcomes/imp(rove) health
- So what
- Set priorities and impose discipline
- Set achievable health goals that are outcome-oriented. We are so heavy on process measures in health care, when the ultimate care objectives relate to quality of life. Innovation will come by setting firm targets, and allowing organizations to try ways in which they think they will achieve that established goal.
- Conversation starter; goal-setting with conversation about how to get these with potential actions/incentives of the stakeholders for identified measures.

- I liked the analogy of the tree with the branches being something less likely to change (more like the overarching goals) & the leaves being things (measures) more likely to change

Systems change

- SSDOH
- Change system
- Use framework to uncover those barriers that we are blind to
- Help see structural impediments – racism
- We actually are hurting community/patients by not changing this.
- Consensus re: SDH/Pop health, but need to figure out path there through measurement
- Factors that influence health are a thread that runs through all measures.
- Produce health = focus; don't let "measurement" as an activity overwhelm focus on ↑ health and equity
- Alignment→ (correcting?) misaligned measurement/values

Inclusivity and collaboration

- Creating a framework that includes everyone
- Understanding the key organizations, who is doing what. Informing. Partnerships—building bridges
- What are the key parts of the strategy that include all the players (and relevant for each individuals role) all moving toward the same outcome
- Innovation and improvement can more easily occur when we collectively have a better direction for where we are trying to go.
- Engage new voice in interpreting the data (community)
- Inform community based intervention strategy (CHNA, CHIP)
- Improving what's important to (patients and docs?) to improve system. } Pt experience
- Improve health by what is important to the patients and providers
- Measure what (is) important/relevant to patients and doctors
- Measure patient experience – feel healthy, feel cared for
- (QTAW?) could be a partner in convening the non-profit + business sectors to come together to better understand their roles in this issue, how measurement of inequalities impact their staff & communities to ultimately champion the use of the measures @ the Legislature.
- This framework could have potential influence in other states, and initiatives in other states could inform our work. Every state having 50 ways of measuring health is interesting, but not efficient.

Resources and action

- In order to be worthwhile, the framework must be used to drive strategic investments in health. Change won't happen without clear direction and resources to get there. An interesting question will be whether those investments will be public, private, or both.
- Health care quality measures and quality improvement resources go hand-in-hand. The measurement framework will signal what we should all be working on.

- A large investment in this framework is needed to achieve a large return.
- Reward the achievement of meeting measure benchmarks <u>and</u> showing improvement.

How might you, your community, or your organization use a measurement framework?

Roles and accountability

- Establish accountability
- Incentivize population health
- All major purchasers should see an incentive to invest in the measurement framework.
- Help systems/organizations/entities/communities see role and impact
- MDH will use the framework as the minder of the understanding all that unique parts + attributes that get us to the goal in mind. Then question yourself, what needs to be done differently to meet the needs of those facing disparities.
- The framework/overall direction/vision/goals can be used to align other MDH work (e.g. work around HIE and governance)

Inclusivity and collaboration

- Health systems and payers are involved in this work
- Recognize appropriate partners to engage with
- Alignment
- We need health equity framework
- Redefine/refine what is considered to be "quality"
- Integrated Care measure? Cross-sector collaborations on measurement
- Recognizing how to help maximize the roles of the other key stakeholders
- Engaging new voices
- Bring together different systems to look at collective roles in outcomes
- Comm./diff. voices to interpret data
- Comm(unity) engagement in framework
- Get us rowing in the same direction
- Shared decision making – state our values about pt voice
- More informed and focused conversations
- Conversation starter; goal-setting with conversation about how to get these with potential actions/incentives of the stakeholders for identified measures
- Inspire conversations and collaborations at multiple levels to improve outcomes
- The framework will be helpful for us as a state to think about where we should head, where we fit-in, and what our part is to get all of us to achieve the bigger picture. When presented with various health frameworks, it's hard to see what our part could be in helping to achieve the bigger picture of health in the given framework even though we ourselves know what our part is. We know we can help create change from the bottom-up or the top-down. The framework can lay out, "here is where we're headed, and here's your part."
- There is a role for community partners outside of the health care system. It is unlikely that a health system could achieve health improvements without partners. Incentivize

cooperation and show collaborating in some way with organizations that is relevant to achieving the desired outcome.

- Examples of health care system partners include jails, homeless shelters, mental health facilities, and counties. We could use the framework to think about the different services that patients are utilizing, and align these disparate lines of service into a more cohesive service line. This would force us to think more about what we're doing outside the walls of the hospital.
- Patients are important and underused in terms of resources and users of measurement. There should be partnership with patient groups like the Minnesota Alliance for Patient Safety (MAPS).

Resources and action

- Dedicate $ to pop health versus clinical care.
- Help allocate resources more effectively
- Wringing waste/inefficiency out of system. Ex LVS.
- Inform evolutions
- Develop, identify, evaluate

Are there others that would use it and how?

- All stakeholders here – to take actions
- Identify stakeholders (example RARE) and convene – define goals, suggest incentives, ROI
- Upgrade health information technology infrastructure to improve the way MN collects, synthesizes, and disseminates data to stakeholders
- Having clear goals/outcomes we are working towards makes it much easier to implement health information technology/HIE towards a common goal/vision for health, etc.
- Depends on each measure
- Centers for Medicare/Medicaid needs tech infrastructure upgrade
- Influence other state/federal governments

Are there things that came up in the discussion that could inform a refinement of our definition of a framework?

- Community engagement at multiple steps in framework development and use
- Who would use this and how will it be used?
- Improve access to information for all – from patient to community level
- Social determinants are important
- Affordability
- Quality of Life measures – how do they fit into the framework
- Sustainability – burn out; the model has to be sustainable; including workforce issues, geographic issues, etc.
- I liked the comment about "true north," this could be a way to brand some of this work

What is a measurement framework for health and health equity?

A measurement framework for health and health equity[1] is a set of domains that together form a structure for identifying appropriate and meaningful measures of health and health equity for the whole population of Minnesota.

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

A measurement framework for health and health equity also expresses a set of values and principles that guide decision making for the framework and connected collaborative efforts to improve health and health equity.

The measurement framework will:

- Clearly frame the range of factors that need to be addressed to "move the needle" on health outcomes
- Be informed by those experiencing the most negative health outcomes, and reflect the lived experience of people
- Uncover factors that historically have been obscured or ignored
- Enable the establishment of health improvement goals
- Inform decision-making, action and accountability to drive:
    - Allocation of resources and strategic investments
    - Intentional action (working on the right things)
    - New and expanded partnerships, collaboration, and other alignment of efforts
    - Innovation
- Demonstrate improvement or catch eroding trends for:
    - Social, economic, and environmental factors that impact health
    - Population health outcomes
    - Health inequities
    - Health care delivery and other systems
- Frame public communication about health improvement efforts
    - With easy to understand graphic depiction

---

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

The measurement framework will not:

- *To be informed by Steering Team*