MINUTES
BOARD OF DIRECTORS MEETING

Friday, June 20, 2014
9:00 a.m. – 4:30 p.m. PT
Portland, Oregon

Attendance

Board Members Present

Mylia Christensen, Oregon Health Care Quality Corporation, Chair
Marc Bennett, HealthInsight, Vice-Chair
Jim Chase, Minnesota Community Measurement, Treasurer
Louise Probst, Midwest Health Initiative
Sanne Magnan, Institute for Clinical Systems Improvement
Mary McWilliams, Puget Sound Health Alliance
Andy Webber, Maine Health Management Coalition (by phone)
Cindy Munn, Louisiana Health Care Quality Forum
Chris Queram, Wisconsin Collaborative for Healthcare Quality
Barbra Rabson, Massachusetts Health Quality Partners (by phone)
Kate Kohn-Parrot, Greater Detroit Area Health Council
Craig Brammer, The Health Collaborative
Tom Evans, Iowa Healthcare Collaborative
Karen Feinstein, Pittsburgh Regional Health Initiative (by phone)
Tom Williams, Integrated Healthcare Association
Pat Montoya, HealthInsight New Mexico
Jo Musser, Wisconsin Health Information Organization

Invited Guests

Keith Kanel, Pittsburgh Regional Health Initiative
Rita Horwitz, Better Health Greater Cleveland
Corey Capozza, HealthInsight Utah
Juli Jones, Oregon Health Quality Corporation

Board Members Absent

Edie Sonn, Center for Improving Value in Healthcare
Diane Stewart, Pacific Business Group on Health
Joe Lastinger, North Texas Accountable Care Collaborative
Chris Amy, South Central Pennsylvania AF4Q
David Lansky, Pacific Business Group on Health

Trilby DeYoung, Finger Lakes Health Initiative
Randy Cebul, Better Health Greater Cleveland

Staff

Elizabeth Mitchell, President & CEO
Kristin Majeska, CHT Senior Project Director
Louise Merriman, Director of Communications (by phone)
Janhavi Kirtane, Senior Director of Strategic Partnerships and Network Development (by phone)
Ellen Gagon, Senior Project Director (by phone)

Mylia Christensen, Chairman of the Board, called the meeting to order at 9:00 a.m. and determined that a quorum was present.

I. Review Goals of Meeting

The meeting primary aim is to focus on the new 3 year strategic plan and consider its implications. Mylia urged the group to really internalize the plan to give staff feedback, build 'bumpers' for decision-making as the organization grows. It is also the way for members to understand expectations of each other. Governance committee is also addressing real-time issues of organizational growth and management. Discussing shared services will also be a critical discussion for growth. We have achieved enormous growth in the past 12 months but ongoing engagement and leadership will be needed. The shared services discussion will have significant implications for the future direction of NRHI.

II. Current Context and Organizational Updates

Elizabeth Mitchell reviewed decisions from the March Board meeting and actions since the meeting. She noted excellent input of the Strategic Planning committee, particularly Sanne Magnan's explication of the value of our network as trusted peers. Our network of innovators is a great asset that has yet to be fully developed. Innovation happening in each member RHIC is riches content in country and NRHI's challenge is to adequately disseminate and share. Biggest challenge is prioritization and focus.

Mylia noted progress of the organization at the one year mark since the transition. Elizabeth shared the ongoing grants and projects and updated staffing plan and highlights from new grant funding opportunities. Though growth has been fast, we have been privileged to attract high quality staff and remain committed to consciously build an organizational infrastructure and work with partners. It remains important to move forward with individual member priorities but with a national perspective. Goal remains to ensure every member is achieving benefit from NRHI.

The role of RHICs in relation to federal and state governments is a key issue with growing pressure for alignment with phase 2 SIM projects expected and the growth of state APCDs and interest in transparency. Pat Montoya noted variable relationships with states and that Western NY introduced legislation to recognize RHICs, which could be a model to follow. Mary McWilliams highlighted the need for RHICs to enable effective purchasing particularly state and other public purchasers. Tom Evans noted a key purpose of RHICs is "sense making", one of our opportunities is to continue to play a local role of bringing together what needs to be done- regardless of who does it. Relationships with states have also become more complex as several RHICs have major contracts with state governments. Tom Williams and Mylia said that since they are now doing TA/custom work for the state, they have become a vendor excluding them from some key discussions. Jim Chase said NRHI members would all benefit from tools to help talk with our local governments, with support from NRHI.

Will want to think about how to leverage NRHI projects/grants for broader impact including community engagement around TCoC. We will continue to pursue new and expanded grants around all areas of RHIC work. Multistakeholder community level work is

an increasingly crowded field. Several programs are ending including AF4Q, CVE, Beacon, etc creating a need for a 'home' for similar entities. NRHI's profile is also being raised particularly around TCoC and data use in communities. Staff are seeking partnerships where possible and appropriate.

NEXT STEPS:

- **Action:** NRHI should continue to build relationships with national organizations including those working with state governments ie the National Governors Association.
- **Action:** EM to pursue Millbank opportunity for a convening of RHICs/states.
- **Action:** Capture a more aspirational vision for NRHI and RHICs

II. Strategic Goals and Objectives for NRHI: What makes NRHI a Unique Network?

Strategic Plan Discussion

At the November Board meeting a draft strategic plan was considered and the NRHI Board recommended changes to reflect more aspirational goals and the unique value of NRHI. A Strategic Planning Committee was formed to direct this work and they have proposed changes for the Board's consideration and approval.

Mary McWilliams, Chair of NRHI's Strategic Planning Committee, presented the Draft strategic plan and explained the committee work to date. Jo Musser acknowledged that the plan is very ambitious but right direction and reflective of member priorities- 'great to know this organization has its act together'. Sanne Magnan, shared strong support but added that the committee had also considered general threats to our strategic plan. For example, TCOC and cost transparency generally will generate lots of pushback among stakeholders. We as an organization and a board 'need to be very smart about this'. Staff should continue to bring issues back to Board. There was wide support for the plan though challenges were recognized. Karen Feinstein noted the need for an overarching strategic vision for NRHI components, including different types of RHICs, as well as for NRHI overall.

Differences and commonalities across RHICs continue to be a challenge. There needs to be benefit for every member despite different priorities and areas of focus and expertise. Identifying common objectives- like payment reform and transparency – as well as principles for how we approach these goals would be helpful. This should include purchaser engagement and input into delivery system reform. Sanne noted that there are different ways to support payment reform, send signals of support. It may not fit the membership to promote specific payment reform proposals but we can all promote the general need and consistent communication of support. Andy Webber suggested these common objectives be incorporated into how NRHI and its members are advancing innovation for the Triple Aim. Karen Feinstein supported development of common objectives. To support the network, NRHI must develop the opportunity for more structured communication among members. For NRHI to support RHICs, staff will need to

understand where the RHICs are going and how. Some members are not pursuing all areas- ie MHI not pursuing payment reform- but would benefit from work of others. Pat Montoya supported this direction but urged delay until AF4Q has concluded.

The outcome measures include financial goals that may be overly ambitious. Jim Chase, NRHI Treasurer assured the Board that cash reserves will be obtainable, but 6 months of unrestricted funds that will be harder. Tom Williams cautioned that we can't build up unrestricted reserves without non-grant funded resources. EM expressed concern that NRHI is highly grant dependent and operating funds are very limited. Staff time is necessarily devoted to grants, limiting available time and resources for member support.

NEXT STEPS:

- **Action:** Strategic Planning Committee to review individual member visions to develop NRHI vision and common vision and goals for members
- **Action:** Governance Committee to develop common objectives and principles for RHICs and new NRHI members
- **Action:** Staff to develop more structured mechanisms for rapid sharing of member work and dissemination of lessons learned- likely part of CHN. In some topic areas specific staff support will be required.

The Committee acknowledged and thanked Mary McWilliams for her leadership on the Strategic Planning committee.

III. Governance – Business and Revenue Generating Opportunities

Jim Chase, NRHI Treasurer, reminded the board that one of the strategic plan goals is growing unrestricted funds. New members- particularly commercial members paying more significant amounts, could be a good source of additional funding. We need to be clear that we have what we need to pitch the reasons commercial members would join. Current appeal includes access to learning, what's happening on the ground on payment reform, etc. There is anecdotal evidence from folks wanting to join but won't know until we have an offering. Robust member offerings will also bring costs. Strategic planning goal of 6 month reserve of operating budget/unrestricted may be doable over time but only if members look to and invest in NRHI so NRHI is not fully grant dependent. Membership revenues today are only $200K and the board increased dues already in 2014. Cindy Munn highlighted the importance of being sustainable vs. grant dependent. Current status is making people very nervous and 'our foes are saying we are grant dependent, and using it against us.' Board members should all leverage our commercial relationships and bring them to NRHI.

Several board members raised concern about the proposed terminology of calling all categories 'members'. There was a proposal to have Members and Associates stay members, but call others "partners". Tom Evans suggested that 'doers are members, external supporters are partners'. HENs use a charter, what we are, what you get and what we expect from you. Sanne Magnan commended Governance committee, saying their work

is taking the organization to the next level. However, proposed expansion of membership categories requires more thought and information including a conflict of interest policy. We should anticipate that the first to the table will be pharma, Medtronic, etc. and there is and expectation of reciprocity. Board should be very deliberate about how not lose our neutrality, and be clear about what we mean by 'commercial members'. There should also be a separate category for Employer members- distinct from Commercial. Board should contemplate if there are some we would not allow? For example, ICSI does not allow anyone with medical industry ties (including grants, etc.) to be involved in our guideline groups, let alone be a member. This needs more discussion with consideration given to 'optics' of 'membership creep' beyond RHICs- we cannot jeopardize NRHI's reputation and partnerships including CMS. Our biggest commodity is trust. EM reminded group that each applicant will still require Board approval. The Governance committee will revisit member categories and criteria but should proceed with expanding membership to all but Commercial members balancing inclusiveness and need for revenue and adherence to mission. Revisions will come back to the Board in September.

> ***Motion with amendment:*** *Expand membership categories as 'partners' to include employers with clear criteria and benefits for members. Do not proceed with Commercial member category until further policies and criteria are developed that protect NRHI's interests and reputation.*
>
> ***Passed unanimously.***

Governance - Elected Board

Governance committee remains committed to a transition to an elected Board as the organization grows and matures. Marc Bennett noted that today we are a 'bit of a hybrid-board is borderline too big and is trying to combine guiding the organization and networking, content'. Tom Evans strongly supportive of direction and would prefer a slate from the nominating committee that considers what NRHI really needs. The Board should focus on running the organization and work should be on member engagement. This reflects that we have moved to the next chapter. EM is concerned about lack of resources and staff capacity to maintain member forums other than Board meetings. Sanne Magnan said preserving CEO only forum for all members a critical value of membership. Andy Webber shared complete support to move to an elected board but emphasized need to figure out how membership at large still feels a part of the process. Should consider if the decision making abilities be split between board and members. Mary McWilliams encouraged Board to move slowly on implementation and ensure at least two opportunities for members to get together that are not board only.

- **Action:** Governance Committee will develop proposal that will be brought back to Board in September regarding timing of transition and alternative member offerings.

Governance - ByLaws

EM presented revised by-laws post legal review and including new membership categories. Louise Probst asked if Board should adopt to Maine requirements given new office location? Jim Chase this could be reflected in one of two ways – explicitly include

state provisions or leave it as assumed - but then members don't always know that. EM noted revisions bring alignment with current practice but further revisions will be required for Board transition. Board supportive of adopting proposed changes as current version but anticipate additional revisions over next 12 months.

NEXT STEPS:

- **Action:** Need to fully develop offerings for additional members and seek to recruit them with Board/member assistance.
- **Action:** Add an employer member category
- **Action:** Governance Committee to develop common objectives and principles and conflict of interest policy for RHICs and new NRHI members
- **Action:** Staff to develop operational plan for member forums prior to Board transition

Motion: *Approve New Strategic plan*

Unaminously approved

Project Updates: TCOC

Ellen Gagnon and EM provided overview of project progress to date noting value of working together across sites and benefits of central organization/leadership. Louise Probst agreed that members do need to move to compromise though sometimes its not possible because of rules or infrastructure already in place. She noted that Ellen has been wonderful as has been the Maine team. HealthPartners have also appreciated very high leverage of the project with very small amount of technical assistance.

It will be critical to think about how to present the information to stakeholders. This is still a work in progress. Maine will be doing focus groups and thinking about different ways to communicate so consumers don't immediately equate more $ signs with better quality. There will potentially be different public reporting strategies but all are benefitting from the power of saying we are "not just one community". Needs to be ok with physicians AND consumers too. Tom Williams said it would be helpful to clarify the messaging. We're 'really deep in this', several members are working with states by all payer points, and need to preserve these relationships. Stakeholders get nervous and progress could 'blow up' when reported at individual physician level. Need to deliberately build and preserve support. Tom and Sanne both urged group to develop better messaging. In Minnesota when there was an attempt to use TCoC it got people really scared –they feared they would become targets. Project envisions publicly reporting to key stakeholders but not consumers. This reporting is better at the practice level because care is a team sport. TCoC at practice level also provides important information for connecting the dots with ACOs. All ACO contracts have TCOC components- we could enable their success. Total cost of care trend is also really important. Jim Chase said that their experience shows that practice groups will want much more information underneath TCoC results. This creates a great opportunity but it is not clear how to pay for it and whether it is do-able without an APCD.

Jim Chase noted that cost measurement is now as chaotic as quality measurement. Doing the project through NRHI- shows that we are not one off local projects, we can expand across US from the ground up. Sanne Magnan said can use it for goal setting- this needs to be the message that we are about. Mylia Christensen said we need to communicate this project and bring others in. We should plan a fall gathering around value - how to marry quality measurement, how to develop messaging and learn from each other and not drag everyone down. NRHI is a rich source for collecting learnings/best practice- they should be widely shared.

TCoC project is not intended for a consumer audience. Group practice level is not actually that useful for consumer choice. Out of pocket price and individual Dr. is what consumers want. Opportunity with 'bitter pill' media coverage to grow support for broader transparency. Jo Musser shared that they did lots of professional consumer focus groups and it is clear that our website will not be what they want, rather a compromise so, will initially keep a low profile. Pat Montoya said consumers aren't using information that is available. Now plans and players who have been at the table are developing their own competing portals. This is occurring across markets as transparency and reporting is an increasingly crowded and competitive space.

To maintain support and momentum and enhance relevance for intended stakeholders, it will be important to balance with quality measures. Andy Webber shared that they are doing private reporting to data members for their purchasing: networks, etc. and marrying quality with cost, first to motivate providers and also to advance more narrow networks. It has been important to lead with quality. Craig Brammer noted that academic medical centers and other systems indicating willingness to compete on Total Cost of Care instead of unit cost. If Medicare uses the measure it will greatly enhance uptake and support.

Physician engagement in use of results is a key opportunity for NRHI and a future phase of the work. Physician Leadership Seminar in August will test model. Many members want to benefit from lessons learned in this area so seminar will be videotaped and NRHI will work to disseminate information through CHN. Louise Probst agreed that physician leadership has strong implications for NRHI beyond TCOC. EM pursuing additional funding from the Peterson Foundation to support practice transformation and QI support using TCoC results. Will be important to share all of these developments with the members.

NEXT STEPS:

- Develop better messaging for cost reporting to manage community understanding and maintain support
- Develop a summit to highlight value measurement capabilities/expertise of NRHI members.
- Disseminate all lessons and materials from Physician Seminar to members.
- Pursue additional funding to expand practice transformation and QI support, leverage TCoC results.

Population Health

Pat Montoya presented on population health approaches and the shift by the Robert Wood Johnson Foundation to focus on population health. She noted there is a need for NRHI support to help clearly articulate the vision and develop a road map and to look at public health measures. Sanne added that the biggest opportunities in measurement are of population health and global health (total health of a patient). We're good at measurement and changing the culture of healthcare to think about the whole person. Jim Chase moving to PROMISE-validated, self-reported health measures of symptoms, function and perceptions and in the public domain so no cost barrier. The challenge remains needing providers to use the tool vs. getting it from claims.

EM noted further opportunity of marrying TCoC results with population health measures for picture of health and costs. Craig Brammer suggested a strategic relationship with CDC. Rita Horowitz noted CDC grant on racial and ethnic approaches to health with a focus on consumer which could work in a consumer reporting tool. Several reporting and consumer engagement opportunities including a 'senior tracking tool' in Detroit that could be integrated into medical system to improve coordination. There should also be inexpensive technology enabled patient experience tools to give physicians feedback in real time.

Marc said NRHI could be most helpful to members by connecting to work like the county health rankings and how they could be used in communities. Several members involved in other population health initiatives including IOM round table. Will be important to help collect and disseminate findings and best practices.

NEXT STEPS:

- Create public reporting template/tools that integrate population health measures.
- Identify opportunities/funding to test and use PROMIS tools
- Pursue partnership with CDC and other population health measurement efforts including County Health Rankings.

PHYSICIAN ENGAGEMENT FOR QUALITY IMPROVEMENT

Tom Evans shared HEN experience leading provider focused transformation work. An early learning was that the Medical society needed to understand what they can't do first. Choosing Wisely engaged physicians and lead consensus to more appropriate utilization. Ultimately only two things move doctors '1) their paycheck 2) no one thinks they are in the bottom 50% '. Measurement and reporting can be a catalyst for engagement. We need to change the focus from 'protecting providers from change' to enabling them to lead change. Marc shared their approach to target and focus on what doctors care about. Physicians are overwhelmed by all that's hitting them. A value add is to try to rationalize and work with the partners to align. There is a particular need to help Drs with multipayer payment reform – help them be successful in the new world. It remains challenging to

make it multi-payer and sufficient % of market so that matters to their practice. It is also very effective to appeal to their values as physicians, and leaders in the community. There are also several opportunities to pursue joint interests. Independent physicians were the voice that got HIEs to advance because they needed those connections.

Keith Kanel shared that PRHI has achieved significant quality improvement in 5 target areas pre-SIM and have identified lots of progressions – controlled, scalable projects. For physician engagement, you really can't beat the intimacy of being in their office or community hospital and doing something that really helps their practice. There has been significant funding support for the work. PRHI currently has 3 CMS innovation grants and it has been helpful to do SIM grant with the state of PA. They have also received private funding, public to private contract for PCMH related work and eventually got contracts from PA Business Group on Health. In many projects, the team typically entered and was not sure what to be doing but figured it out. PRHI sees its greatest investment in personnel, a high performing team and clear deliverables like teaching materials, data collection tools…such as with PIC and readmission reduction. Would love to begin sharing info. and benefiting from others. Bottom line – high performing transformation teams in targeted areas do work, are widely 'deployable' and expand us to new partners.

EM asked what NRHI could do to support members in physician engagement and practice transformation. Mylia noted that in Oregon, the state created their own certification. It is not clear what's the business model for RHICs when so many consultants in this space and states are even using SIM money for transformation center that competes with the Q-Corp institute. McKinsey will be doing it in several regions as well. Tom noted that NRHI – through its members- has plenty of content but developing that into teaching materials is hard. Pittsburgh has capacity in this area which could be an important shared services opportunity. New Business line for NRHI could include Independent practice improvement leveraging expertise, experience of members. This could be increasingly appealing when practices are facing performance mandates.

NRHI should be helpful on consumer engagement too. MHQP will be holding a national meeting for increasing availability of patient experience data addressing barriers and building a roadmap. This will be co-sponsored by CHT/NRHI. We could help link this to multipayer funding models and performance bonuses linked to patient experience.

Craig Brammer shared experience on consumer reporting efforts. Based on P&G research, consumers really don't like Consumer Reports format for healthcare. Preference is for approach that is very focused on Doctor/patient team approach – the conversation that happens between them. Trending information is also very important to consumers – they want to see 'my practice improving'. These lessons could be transferrable to other RHIC communications/public reporting projects. Very designed for scale - potential white space. Better presentation and use has enabled new business opportunities. United Healthcare now rewards doctors with Healthbridge data. All major health systems also using Healthbridge metrics and data for internal practice reviews

NEXT STEPS:

- Design ways to capture current practice transformation support for deployment to more communities
- Produce guides/tools/reports from regional projects as a shared service offering and improvement package
- Explore scalability of public reporting tools/platforms ie Healthbridge
- Facilitate engagement with employers/business coalitions to enable physicians to play leadership role in payment reform.

PAYMENT REFORM

Tom Williams shared results of bundles payment initative to be released in Health Affairs- showing 'failure' but major lessons learned. Have learned how important both extrinsic vs. intrinsic motivators are. Business barriers remain substantial- payers want to pay just on their members. Despite statewide PfP programs and payment changes, costs have not come down. All stakeholders need direct line of sight to cost- this is why TCoC is so important for the global budget perspective. Have now integrated quality and cost by using a 'Quality gate', then use trend in cost increase: High payers CPI plus one, average is CPI plus 3% or no shared savings.

Mylia Christensen shared that 3.5 years ago Q-Corp didn't see payment reform as theirs but now they do because of the global budget from Medicaid – providers have to succeed or give back. New state directive: "You must implement payment reform" has generated lots of activity and consultant interest but not signs of improvement.

NRHI Challenges – so much variation and little success. In many cases the convening role is still critical- Communities didn't even know the names of the top commercial carriers and need help with basic facilitation. NRHI should map activity and provide communication of all that's happening. Members need to know who to learn from, whose efforts to share? Craig suggested RHICS should be the go to for consultants when knowledge is demonstrated effectively.

NEXT STEPS:

- Share best practices and lessons learned across members.
- Expand focus and application of TCoC.

Shared Services

Kristin Majeska walked the board through the range of shared services opportunities and models with varying levels of NRHI involvement. She also shared the results of a Data Services meeting of NRHI members with the proposal to offer a broad package of services. Short term things are easy but as we move down to larger, more

centralized offerings, it would be more challenging to support by staff. This is an important new frontier to consider but need to understand organizational implications.

Members voiced concern that shared services could be a distraction and that they want to preserve focus on network. NRHI as a network enables sharing and should not be about sales. It may be best to first explore shared discounts- ie on episode groupers or legal services. Craig pointed out that a consortium could define the needs but not collectively manage products. Mary McWilliams urged to wait and see how CHT develops before committing to other offerings.

Jim Chase suggested we move forward with some of the analytics from centralized support. This would also allow us to get to know more than one of our databases. To start we would need a real functional project that would be funded rather than just 'play with the data'. Ideally we would identify staff, someone who has worked with our data before from a member. Mylia Christensen also noted that if some are selling services we will need rules of engagement so all are still trusted. Andy Webber agreed on need for further development but that the proposals are 'directionally correct'.

NEXT STEPS:

- Explore individual projects that move in direction of shared services
- Consider 'rules of engagement' to preserve member trust.

Public Policy

There are significant opportunities for advocacy emerging and NRHI needs to be the 'expert' to testify about multi-state efforts. NRHI also needs to help facilitate state efforts and relationships with states. Tom Evans agreed that we have the right priorities, so much progress- we are a trusted national network with local application- but need to add policy focus and a cohesive policy strategy. NRHI needs to equip our members to be effective advocates and demonstrate that we are leaders of innovation and implementation. NRHI needs members to help make the case for our work and NRHI needs active presence in federal and state policy development. EM cannot do all lobbying- policy group could look into structural options. Board should develop a communication structure- who does what, what requires board approval, what happens when we don't agree, what are top state and federal advocacy opportunities, etc. This will enable us to bridge organizations, build relationships, and share other organizational materials. EM can take public positions without too much approval process – it is often the case that NRHI can take a stand easier than members given local constraints.

It will be important to build the NAHDO bridge. APCD council built a workaround with CMS for Medicare data and current version of QE public reporting useless Right now we need to spread the word of pros/cons of APCDs v RHICs. APCDs have a different mission and objective than RHICs. First step needed is for NRHI to write a paper describing functions and differences.

NEXT STEPS:

- Publish a paper on the differences between RHICs and APCDs.
- Establish Public Policy Committee to accelerate federal and state policy presence and impact on behalf of members with dedicated resources.
- Share best practices and lessons learned across members.

Wrap Up and Next Steps:

Members shared positives and negatives of the meeting and expressed appreciation for opportunity to work with a great network of leaders. Requests for made for broader board and staff involvement of member RHICs to expand benefit.

Meeting adjourned at 4:00pm.