MINUTES
BOARD OF DIRECTORS MEETING

Washington, DC
November 22, 2014
8:00am – 4:30 PM ET

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
Nancy Giunto, Washington Health Alliance
Andy Webber, Maine Health Management Coalition
Barbra Rabson, Massachusetts Health Quality Partners
Kate Kohn-Parrot, Greater Detroit Area Health Council
Craig Brammer, The Health Collaborative
Pat Montoya, HealthInsight New Mexico
Jo Musser, Wisconsin Health Information Organization
Ana English, Center for Improving Value in Healthcare
Trilby DeYoung, Finger Lakes Health Systems Agency
Diane Stewart, California Quality Collaborative
Joe Lastinger, North Texas Accountable Care Collaborative
Chris Amy, South Central Pennsylvania AF4Q
Randy Cebul, Better Health Greater Cleveland
Sanne Magnan, Institute for Clinical Systems Improvement
Cathy Davis, Kansas City Quality Improvement Consortium

Via Phone

Cindy Munn, Louisiana Health Care Quality Forum
Karen Feinstein, Pittsburgh Regional Health Initiative

Board Members Absent

Tom Evans, Iowa Healthcare Collaborative
David Lansky, Pacific Business Group on Health
Chris Queram, Wisconsin Collaborative for Healthcare Quality
Tom Williams, Integrated Healthcare Association

Invited Attendees:

David Kendrick, MD, MyHealth Access
Cindy Schlough, Wisconsin Collaborative for Healthcare Quality

Staff

Elizabeth Mitchell, President & CEO
Louise Merriman, Director of Communications
Janhavi Kirtane, Sr. Director of Strategic Partnerships and Network Development
Dianne Hasselman, Senior Director, Strategic Programs
Ellen Gagnon, Senior Project Director (phone)
Harriet Wall, Senior Business Analyst and Project Manager (phone)
Kristin Majeska, CHT Senior Project Director (phone)
Mike Wilson, VP of Finance and Operations (phone)

I. Welcome & Introductions

Mylia welcomed everyone and acknowledged veterans both in the room and around the country expressing appreciation for their service.

Mylia reviewed the agenda for the day. Elizabeth Mitchell noted that it was only two years ago that the Executive Committee made a decision to expand the NRHI organization, its strategic goals and activities. Based on feedback from the Board, we are freeing up more of the agenda for dialogue and discussion to ensure that the staff hears the thoughts and consensus of the group. All members introduced themselves, gave a brief description of their community efforts as well as what they find most beneficial or energizing about NRHI. Elizabeth summarized; 'we are mission driven entity of change agents who love data!'

II. Meeting Goals

Mylia reviewed the meeting goals and asked if there were any changes or additions. None noted.

The meeting was turned over to Elizabeth who articulated our vision as including many components, but overall focus on the transformation- using data. We have been opportunistic pursuing certain areas of focus, for example total cost of care and transparency. These have been early priorities because the money is available and these efforts align with and support our mission and the strategic objectives of NRHI. Elizabeth highlighted some of the results from our NRHI Member Survey and noted we had 15 respondents. The full results are available to members and will be posted on the NRHI website member portal under Board of Directors.

Elizabeth identified some of the questions the Board needs to decide today; if NRHI members want to be serving as 'regional data utilities' and whether we pursue a TCoC renewal. The proposal reflects the overall role of NRHI and use of data for transformation and include 1) sustaining the work in five sites; 2) disseminate and expand lessons to new sites; 3) Integrate population health, quality and public health measures; 4) use data for physician training; 5) using TCOC results for payment reform; and 6) use cost information for broader community engagement.

Elizabeth recognized that not everyone is in the same place in terms of producing and using total cost of care reporting, however the larger question is whether we are ready to move forward in these directions in a more collective fashion and which areas are our shared priorities.

Mylia summarized that she sees data as the foundational piece with these four building blocks and asked if our members are bringing these four building blocks in their community? Does this resonate with them?

- Barbra (MHQP) questioned whether data needs to be your 'own data' or do you just need access to the data? Consensus that as long as you have relationships that work and you can access the data, there is no need to own it.
- Cindy said this does resonate with where they focus (WCHQ) and did note some concern about the word "value" as it is often misunderstood and the definition varies.
- David Kendrick noted same struggle at the federal level. Getting specific about what "value" is would be very important work for this group.
- Trilby (FLHSA) noted the absence of the word "disparity" and that the work needs to be not just about healthcare, but about health.
- Pat Montoya (HealthInsight NM) cautioned against presuming a functioning market. With more transparency there is an expectation that consumers can make choices of where they obtain healthcare, but that is not always the case.
- Jim Chase (MNCM) highlighted NRHI's role of working across markets and need to be able to show it is making a difference.
- Randy (BHGC) agrees we should try to do something in common knowing that there are differences for a reason. Data should be at the bottom, not in the middle, and goal should be the triple aim.

There was agreement that we should stay away from publically portraying ourselves as RHICs being different and really focus on where we are similar. This will help us to portray a more unified image. Elizabeth noted the key theme is readiness to move from the individual "market" strengths of each member to developing a national platform with a more collective offering as a *network*.

Andy Webber shared that reporting TCOC is transforming the conversation in their state. He likes the direction we are taking collectively and how the different uses of the information is starting to emerge. In Maine, they are sitting down with all the plans and asking if they can adopt TCOC into their ACO contracts. Clarity is still needed on the 'regional data intermediary' and specifically what role would NRHI play in that work. Elizabeth mentioned there is clear support from the feds for a regional data infrastructure and the feds need to have something that is consistent and exists across communities. "Regional"

has not yet been fully defined and Feds may define regional as "multi-state' like QIOs. Requests are coming from federal, private and individuals, including Dept. of Health and Human Services, ONC etc.

Jim urged better articulation of the need for data and why people should care (employers, providers, government, consumer, providers). CHT "user group" is working to define what it is they would need and use and then we can build the data and reporting capability to meet these needs. The Arnolds have said *if* we come up with the right plan they will support implementation. Andy proposed that with so many good proposals on the table – the board should give green light to staff and work should move forward including community triple aim dashboards.

Mylia cautioned of many bright shiny objects and the need to prioritize.

David Kendrick reviewed the "nationwide health information network" and noted the most critical element is governance and no one could make that work on a national level -need to build at the regional level. He proposed we align with these efforts and is building a 10 year roadmap for interoperability.
Jo Musser supported further development of regional data intermediaries, and capturing the window of opportunity now as it relates to what is going on at the national landscape and others out there who are looking to be in this space.

Themes

- A national network of data regional entities (direction from funders and feds)
- **RHICs differentiated by how they use that data effectively**

Concerns noted:

- Interoperability - how do you bring all of these people together to play nice nationally when we can't even do it in our communities
- Need to determine what we bring to the table that is different, of value and how it aligns with the goals of HIEs?
- NRHI being spread too thin because there is so much opportunity emphasizing the need for priority setting and investigating the opportunities. *Then we need to commit the resources to do whatever we prioritize well.*
- Need to live with the tension of trying many things because the solution requires all of it brought together.
- RHICs have been pioneers in their community and now environment is asking us to take a dose of that medicine and function together.
- Do we want to "lead" or "serve" the market? We have historically led the market and then turned it over to others to serve –from a funding point that is really difficult to sustain. It also requires different staff. We may need to do both.
- Healthcare leadership is about teams – and we ought to be promoting this.

- We need strategic partnerships – particularly employers - as opposed to going it alone. Opportunities coming from NRHI may exceed ability to participate and contribute given limited RHIC resources.
- Caution of pursuing shiny objects in a group of all type A and wants to save the world. We should be developing the skills of negotiation and focus on making sure we are clear about expectations. Under promise and over deliver.
- Cannot jeopardize losing the trust we've earned.

III. Strategic Discussion
Defining RHICs in a regional data and Improvement Infrastructure

Elizabeth encouraged an environmental scan and evaluation of how it would influence what we might do. Staff wants feedback from the Board on how, or if, we relate to others who are in the similar space as NRHI and RHICs. NRHI 's goal is that each RHIC is visible and is on the radar screen both locally and nationally.

Janhavi – The November Health Affairs Issue is all about Community –everyplace you look now, you see "collaboratives", "communities" all around. Everyone is moving down toward Health, including RWJF and IHI.

- **IHI Guiding Coalition** –NRHI is one of the founding partners for this work and have an interest in making sure that it is not disconnected from what we are already doing but instead leverages our work. Broad approach with as many partners as possible.
- **Way to Wellville –**Viewing health as a product and view as a symbiotic relationship with NRHI/CHN – very broad around food, education etc. They are looking to have a tight geography so they can truly enhance health. Janhavi noted the 5 communities including Niagara Falls, NY, led by former NRHI board member Shelly Hirshberg.
- **ReThink Health** – Funded by Ripple and RWJF. Focus is on disease prevalence and a tool to get more sophisticated understanding of costs and tradeoffs. Craig had 90 leaders from his community and facilitated tables to help better understand how pulling individual levers does not results in improved health. NRHI is being strongly being encouraged to partner with ReThink. Barbra Rabson started working with them and currently using them as consultants to bring the community together around a particular disease (e.g. diabetes). ReThink was very helpful in this role.
- **County Health Rankings and Roadmaps –** RWJF funded program to measure public and population health. (EM is on the Scientific Advisory Group)
- **Communities Joined in Action –** Vibrant learning community, more focused on FQHCs and disparities.

No other groups in the private sector came to mind to put on our short list for relationship development with CHN. It was noted however that the new focus on "health" requires us to better bridge public health and healthcare and consider broader partnerships.

Trilby shared that in NY the Medicaid Transformation waiver attracting significant attention and offering a huge amount of money- distracting previous partners. One of the domains proposes to look at population health creating an opportunity to build data on health outcomes and bring more 'doers' into the fold. This is something to think about as we further discuss standardized measures.

What is the optimal way NRHI should engage these entities and their stakeholders? Should we engage at the NRHI national level or local community level and what is most helpful for NRHI to do or influence?

- Staff encouraged to create a matrix of other organizations working in member communities. NRHI could then meet with all of these groups and identify where the opportunities are to complement our work.
- At the national level NRHI could work with the groups to determine possible shared work at the local level (ie workforce).
- Focus on how NRHI can help implement as opposed to support local convening – the RHICs are competent in this area. If we approach the public health side, we need to be able to do something specific as an NRHI-wide project
- Avoid always 'looking left and right'- everyone will give different advice. Should understand landscape but look at what needs to be done that sits within our 'collective toolkit'. Identify what needs to be done and get funding to do it.
- CHN can be a great disseminator of our successes

➢ ***Action item****: NRHI will identify three key things to highlight for potential external partners to make sure they understand the value RHICs offer in their communities and to elevate our visibility in priority areas where we want to be seen as the market leader. We will share this with potential partners.*

After reminding the Board about the confidential nature of our meeting content, Elizabeth shared developments among national entities entering the field to play the role of national data aggregators and advising both industry and government that there is 'no need for' regional data entities. The approach is aggressive and attempting to discourage employers and health plans from submitting their data to APCDs or RHICs. As an example of the potential divergence, the health plan representative on the CHT Executive Committee resigned as she was unable to support the CHT guiding principles of making data available to all. As a follow up, Elizabeth and David Lansky have approached American Health Insurance Plans to see if they would like a seat at the table, however no response as of yet. This is reflective of ongoing and potentially escalating tension among plans unwilling to share data they consider proprietary and developing their own alternatives. Similarly on the clinical data side, EHR vendors are not entirely supportive of interoperability. If our vision is access to this data, these will be real barriers.

NRHI's most effective response is likely to be promoting our unique ability to *use* data for improvement. Making the case for data access by demonstrating our value and abilities

through producing community dashboards may be an effective strategy to move beyond data access debates. RHICs are in a good position to develop a common community dashboard and actually produce it, as opposed to continued talks about measure alignment that are disconnected from implementation.

HCCI, who is entirely funded by health plans, is boasting of 'unlimited budgets' with the directive to become 'the sole source of transparency for the country'. They have obtained QE status nationally but are limited in their ability to report at the provider level. They claim they will also get all clinical data. They are actively going to legislators and health plans and proposing themselves as the solution to data access and transparency, however many people they are approaching do not fully appreciate the limitations of the data. In Wisconsin, HCCI is going to employers and plans telling them they do not need regional or individual transparency initiatives and should go to one central place with all the data. They have also gone to the Arnold foundation and asked them to shift their funding to HCCI from CHT. Andy questioned their capacity to provide customized analytics. Elizabeth notes they do have alignment with 7 or 8 major research institutions and will be sending data extracts to them and will distribute reports. They are suggesting they can support transparency – however their contracts prohibit them from sharing most cost data. Louise Probst had a difference experience with them and did not see them as a threat locally and does not expect their data stream to be impacted since the role MHI will play is very different and includes practice level reporting. Jo Musser was concerned about the tactics and that two members are hearing opposite messages from the same entity. Others expressed greater concern about CVS and Walmart and their evolving roles in healthcare.

HCCI has also approached us about developing claims data standards but it remains unclear if we have shared objectives. The likely best case scenario is that HCCI become a data supplier to RHICs ***if*** data includes the fields we need.

- ***Action item****:* NRHI staff will continue to explore a partnership on data supply and standards with HCCI.

Even though not all members are in the same place, there is an opportunity to show our value to our data providers. How are we reaching out to the members and potential members of what our value is (eg blues plans)? Ana English said that the NAHDO panel of the payers sees HCCI as a national friend – but the payers' issue is that every single state needs to figure out solutions to make it easier for the payers to submit the data to us. Part of the APCD council's role and others are now using the data effectively. This will minimize the amount of work the payers need to do and they will see that as value. NRHI needs to develop a list of differentiators that we can all use (clean up data, provider master files).

- ***Action item****:* NRHI will develop key talking points that articulate how RHICs capture and use of claims data differs from other national/regional efforts so that we can

communicate more effectively to the need for access to this data to key stakeholders, specifically including health plans, employers and legislators.

Dianne Hasselman updated the Board on opportunities to address state RHIC relationships and plans for a multistate meeting focused on data use hosted by Milbank Memorial Fund. Chris Koller is focused on ensuring there is a plan of action leaving the meeting. Issues are broader than can be addressed in a meeting but work with Milbank is an important start.

David Kendrick has served as an advisor for ONC's Roadmap for Interoperability – there is a recognition that billions of dollars have not got us where we had hoped to go. Increasing recognition that governance is critical. There are likely important lessons from RHICs that can inform direction. Request for programs and lessons for those who are not far along this path.

Elizabeth wrapped up themes by summarizing key points:

- Window of opportunity at federal level to support RHICs
- APCDs are getting money and federal support and should be engaged
- Opportunity for input on the governance model (multi-stakeholder) for ONC

Important to determine how we influence the conversations happening now and position RHICs in this conversation.

IV. Business meeting

I. Approval of September Board Meeting Minutes

Marc moved to approve the September Board of Directors meeting meetings. Louise Probst seconded the motion. Passed unanimously.

II. Treasurer's Report

Jim Chase noted year to date and 2014 year end projections. We now have an accounting and budgeting system that will support organizational needs. We are in the black and projections will exceed the budget. Staff has managed expenses well.

A proposed budget approved by the Finance Committee was presented. Elizabeth and staff have been conservative with the revenue projections and only put in funding we are fairly certain to obtain. For expenses, we not projecting growth of staff and the budget will support their work going forward. Had hoped we could build in a position for business development staff time however that was not

possible this year. Will need to find a way to fund position in the future in order to generate the required unrestricted funds in the strategic plan. The budget includes some assumptions of offering optional shared services, specifically for government relations and data quality functions. These are voluntary and costs would be contracted directly with RHICs desiring the services.

The budget for 2015 includes a 10% increase in NRHI membership dues. There is recognition that the increase is higher than inflations, but the Finance Committee feels it is reasonable. This is not a 'budget buster' but will support and provide things we care about.

Jim noted that included in the materials is an employee benefit summary and the budget includes addition of a dental plan and retirement match.

Elizabeth noted that the budget includes some NRHI in-person gatherings that will help support transition to an elected board.

Barbra asked about assumption we will receive the PCORI grant from AHRQ and is concerned since their grant processes are very competitive with lots of applicants. What happens if we don't get the grant? Jim acknowledged although we are not certain we will obtain that specific funding, it is very conservative and we expect other funding that was not booked will be obtained. Barbra suggested using the term "incoming grant".

Sanne asked clarification of the shared service positions? Government Relation and Data Quality were included as proposed shared services. We are not proposing we would bring on staff but contract out to a firm with NRHI retaining 17%. For now, funding for these positions would be optional and contracted directly with NRHI members if desired. They are not included in member dues.

Trilby asked how the increase in dues relates to the funding for NRHI meetings. Marc explained that the Board feels before we can move to an elected board, we need to have member meetings in place to ensure that members who are not on the board still get the benefit of in-person meetings. The annual meeting would become a place for all members to come together. We also need matching funds from other sources, including fee for external attendees and possibly sponsorships.

Jim moved to approve the 2015 budget as proposed. ?Motion seconded. Budget approved unanimously.

III. Governance

On behalf of the Governance Committee, Marc requested approval of a small revision to requirements for participation. The packet included sample membership applications for each of the different member categories. Additionally the committee will be working on a draft proposed for moving to an elected board for discussion at the March board meeting.

- ***Action Item:*** The Governance Committee will focus on developing a proposal to move to an elected board and bring to the NRHI March 2015 Board meeting.

a. Expectations of Members: New Policies

Jim asked for clarification of intent of the Conflict of Interest Policy and note that we do indeed compete with each other and with NRHI on grant proposals. Marc confirmed that is the intent and that item #1 should be clarified. Jim proposed the following language to replace #1 : "While members may compete with each other or NRHI for grants or contracts, NRHI members will not seek to gain a competitive advantage over NRHI or it's members." Marc moved to approve the Conflict of Interest Policy noting the amended language above. Motion seconded. Motion approved unanimously.

IV. Strategic Planning: Operational Plan

Elizabeth noted that based on the approved Strategic Plan at our last board meeting NRHI reviewed and approved an operational plan put into action at NRHI. Ellen Gagnon is leading implementation. The Strategic Planning Committee will monitor progress toward achieving strategic goals. Sanne has assumed the chair position of the Strategic Planning Committee.

V. Other

a. CEO/President Performance Evaluation- Mylia advised the board that a performance evaluation for Elizabeth is underway. The Executive Committee will finalize the process over the next few months. Mylia acknowledged the amazing amount of work of Elizabeth and staff and through her own interactions believes it is an amazing team. The Board applauded the efforts. Elizabeth acknowledged Mylia' s and the board's support.

b. Louise Merriman brought forth an application for membership from the New Jersey Health Care Quality Institute. Craig asked what the relationship of PBGH is to this organization and Louise believes that David and the CEO may have served together on a board. The Board was asked if anyone has any working knowledge of this organization. Elizabeth noted that they meet the requirements of membership we have established including a letter of recommendation from an exigent member. Cathy mentioned this might be the same entity she is somewhat familiar with and is unsure about a potential affiliation through the Hospital Association and may be worth checking.

- ***Action Item:*** The Governance Committee will verify the application response specifically related to its multi-stakeholder governance and then circulate via e-mail for approval.

Other business

None noted. Business meeting completed.

V. The Collaborative Health Network

I. Launch of the Collaborative Health Network

Janhavi explained the on-line platform is close to being available. Three key needs:

- dissemination channels

- How can this be of utility for you in your market?

- Digital footprint

What is CHN? RWJF, inspired by the different regional improvement work happening, sparked the discovery path of what communities would need to continue to support work on the ground post-AF4Q so no one has to 'start from scratch'. Identified need for better sharing of resources online with ability to go deeper in specific topics. IHI did the planning grant and NRHI received the implementation grant. Over the last 3-6 months, we have been refining based on feedback from the field. It is critically important that it meets the needs of the field. We have been soliciting from our members a beta group. Starting out as public forum with private communications among members. Asked if it is similar to "State Reforum"- similar but CHN is broader in terms of topics. Everyone shares their links, videos, documents and more of a crowd sourcing approach to resources. There are people looking for a platform like this who might be willing to pay for it. Ana questioned how they could participate in CHN and still maintain their own branding and keep it accessible to others- this could be a use case. Barbra asked whether she could use this platform with her board to share materials privately. This would also be a test use case in the beta phase.

Total cost of care is a topic that people within NRHI and outside of NRHI are interested in and used. The other topic is around Collaborative leadership. Jay Want, Michael DeLorenzo and Ellen Gagnon will begin the TCOC roll out on CHN.

Recommendations from social media experts to best operate the CHN:

1. Everyone has recommended how the staff uses executive time.

2. Figure out the top 10 questions that Jim as the CEO of Minnesota Community Measurement gets and share broadly (as example) to expand access to his expertise.

3. Do not recreate what works well in person but offer content to others who don't have access.

- ***Action Item:*** CHN will identify eight other NRHI members who want to be part of the beta launch. Members should contact Janhavi if interested and have an idea to be tested.

VI. 2015 & Emerging Opportunities

Elizabeth will review some specific proposals in the context of the direction.

1. TCOC Renewal – Expanding and Using Cost Information

Craig and others support project and renewal as board members, but concerned about the local challenges associated with building a national report citing resource constraints, variability in current status. Elizabeth heard support for moving forward with the six areas, that it is directionally correct whether the funding comes from RWJF or not.

- ***Action Item:*** NRHI will continue to pursue the TCOC renewal funding from RWJF, and other potential funders, as proposed.

II. Community Dashboards

There are many groups trying to define core measures. Elizabeth noted that some of the large private employers and fed entities need consistent information across regions. Barbra asked if this is about 'packaging' -could a region display some information if they don't have all the elements. Producing common measures is conceptually a great idea, but will be a heavy lift to get to common ground. Most likely to work if regions don't undo what they are doing, but new measures are additive. As with every dashboard everyone would be starting at a different place. Need to understand what the value of the measure is based on analysis that is complemented by value proposition, communication etc. Need some sort of socioeconomic measure and utilization statistics. Jim mentioned the HCI3 analysis - designed so that every community gets point for having a measure, additional for performance. This sets a threshold for what is possible. General support for a dashboard but respect for different communities and where they are.

- **Action Item:** NRHI will form a committee to explore development of a common community dashboard and bring back to March meeting.

III. Product & Shared service offerings

Physician Leadership Seminars: Randy Cebul noted that physician education is a crowded space – would be concerned that NRHI embarrass ourselves if we are not experts. NRHI strength may be focus on total cost of care. Jim and Sanne – recognized it is not their niche but they would appreciate a turnkey product to offer in their market. Would still need to wrestle with having sponsors to defer the cost but is something we are willing to do. Maybe governance committee will address sponsorship. Suggestion that we do something in partnership with local medical associations, possibly partner with the AMA. Budget assumes $5K coming to NRHI from this effort.

- ***Action Item:*** NRHI will proceed with proposal for offering a Physician Leadership Network with adequate caution by piloting in Minnesota.

Data Quality: Data Quality proposal offers the possibility of sharing the cost of data quality audits. This would be a voluntary offering and not part of dues. Leverages some of the expertise in RHICs that can be shared with others. Louise Probst supports- it would have been great to have someone to help during vendor contracting. Mylia anticipated conflict- this is a noble task and spreads quality data but concern that we will continually be asked to help those in our own space who compete (either as a contractor or committee member). Could also find themselves in a position to offer this as well. Strong interest from subset of members.

- ***Action Item:*** NRHI will assess level of interest to design offering.

Government Relations (federal only): Members asked to decide to pursue RFP proposal for contracted support. Economies of scale to cover issues we care about – for example SGR, several bills about data standards, QE program changes – would need a committee to review the list of potential topics. This would help raise awareness and track issues. Pat supports the concept – maybe accept an electronic feed – maybe a joint subscription to a service. Concern that it may not be a good time to invest given lack of funding opportunities. Other members feel strongly that this should be a core offering of NRHI membership. Given differences among members would need to be voluntary option at this time.

- **Action Item:** – NRHI will explore options for offering government relations support and will set up a call to review and discuss with members.

IV. Communications

Tabled

V. Transitioning to Population Health

Tabled

VI. Affinity Groups

Elizabeth noted diversity of member needs and interests and challenges of meeting them with small staff and limited unrestricted resources. Staff feels a need to group work around priority affinity groups – can only staff four. Joe indicated interest in an HIE Affinity group for members working with clinical data. This is not offered in other NRHI forums but several members work in this space. Support for formation of Affinity groups depending on topic and level of member interest.

- **Action Item:** – NRHI will assess what priority topics warrant dedicated time and identify staff to support.

VII. Emerging Threats and Opportunities:

What are the biggest **threats** that we have not talked about today?

- Our stakeholders as competitors– health plans and others building their own data sets

- Threat to NRHI to diversify revenue because Board did not approve any of the proposed new business ideas

- Idea that consensus building is too slow and others may do it quicker. Need to take action and produce value instead of just talking.

- A lot of states want a role but they are not relevant in healthcare

- Members in different places. How does staff keep a balanced agenda and offerings to keep diverse members engaged?

- If we do too much and don't have an area of expertise – we may dilute our value

What are the biggest **opportunities** that we have not talked about today?

- Idea of creating a CHN for our members that NRHI could staff and our NRHI members will pay for

- Shared vision of how we are moving forward – communication and unified messaging

- Raise our visibility – perfect time for us to show our wares and sharing our results

- Our strength is our diversity. If we can figure out how to segment work so we meet varied needs across our members, we will have broad impact and support.

- Roadmap development of ideal model of an organization that could apply to APCD/HIE/QIO

1. How does NRHI balance and meet differing member needs and interests?

Elizabeth invited more guidance about how NRHI should proceed with the feds:

- Define what would we need from the feds to be successful. Is data sharing a requirement? Is it policy changes? Can we do this with private funding?

- We are bringing forward a group of entities that will bring a common solution.

- Someone will fill the space – do we want it to be us and if so what are we willing to trade off?

- **Are we prepared to move forward collectively on these projects or even define ourselves collectively? More unified actions and messaging will strengthen our presence and impact and expand our collective opportunities.**

Mylia wondered it be possible for NRHI to describe a future state (not just data) – what are the necessary elements and then how this incremental work moves us toward the vision - it is about stating the idea of what we think the future is. Look out 5 years - something aspirational. Barbra – give us a glide path to standardization – give them examples of how it is happening anyway – we need to know if we want to play? Board members will need to bring it to their boards. Mylia noted time spent on the strategic plan – already decided we are moving (TCOC, CHT, CHN) in many areas. Need to connect to overall vision.

Elizabeth feels priority steps include: 1) Exploring the community dashboard; 2) Pilot the physician leadership seminar; and 3) Need to come up with something to diversify the revenue

- ***Action Item:*** NRHI staff to look to the strategic plan and determine how activities fit and connect to overall aims. Will review at March board meeting.

Adjournment