MINUTES
BOARD OF DIRECTORS MEETING

Tuesday, November 5, 2013
9:00 a.m. – 4:30 p.m. CST
Austin, Texas

Attendance

Board Members Present

Mylia Christensen, Oregon Health Care Quality Corporation, Chair
Marc Bennett, HealthInsight, Vice-Chair
Jim Chase, Minnesota Community Measurement, Treasurer
Randy Cebul, Director, Better Health Greater Cleveland
Louise Probst, Midwest Health Initiative
Sanne Magnan, Institute for Clinical Systems Improvement
Mary McWilliams, Puget Sound Health Alliance (by phone)
Andy Webber, Maine Health Management Coalition
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
Joe Lastinger, North Texas Accountable Care Collaborative
Tom Mahoney, Finger Lakes Health Initiative (by phone)
Phil Kalin, Center for Improving Value in Healthcare (by phone)

Invited Guests

Pat Montoya, HealthInsight New Mexico
Dolores Yanagihara, Integrated Healthcare Association
David Lansky, Pacific Business Group on Health
Michael DeLorenzo, Maine Health Management Coalition
Chris Amy, South Central Pennsylvania AF4Q
Keith Kanel, Pittsburgh Regional Health Initiative (by phone)
Anne Weiss, Robert Wood Johnson Foundation (by skype)
Patrick Conway, Center for Medicaid and Medicare Innovation (by phone)
Edie Sonn, Center for Improving Value in Healthcare

Board Members Absent

Tom Evans, Iowa Healthcare Collaborative
Karen Feinstein, Pittsburgh Regional Health Initiative
Tom Williams, Integrated Healthcare Association
Shelley Hirshberg, P2 Collaborative

Diane Stewart, Pacific Business Group on Health

Staff

Elizabeth Mitchell, President & CEO
Louise Merriman, Director of Communications
Ellen Gagnon, Senior Project Director

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

I. Current Environment and Position of NRHI

Elizabeth Mitchell reviewed decisions from the September Board meeting and actions since the meeting. Mylia Christensen noted amazing progress since the NRHI Executive Committee and Board chose a new strategic direction less than 12 months ago and 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. There is a need to review strategic and work plan at each board meeting to ensure we are moving together in consensus through exciting evolution.

An environmental shift from 'if change will happen' to 'how to implement change' creates demand for transformation support and a need for alignment. There is a growing recognition of RHICs as sources of that support but also a need for a national strategy and the ability to demonstrate scalability. Many see a shift in focus to the need to bridge population health and medical care.

Successful kick off of national total cost of care project highlights NRHI's ability to leverage regional work for national impact. RWJF has also noted their priority is taking regional efforts to national scale. Different strengths of different members may be brought to bear on shared priorities- ie community engagement around transparent cost information.

1. NRHI has increasing influence on federal policy and with national funders. It is important for us to define 'what we want'.
2. Variation across regions and members will continue to make consensus challenging. There is value in seeking to find common ground for national work and to show national presence. However, not all members will be served by every initiative and standardization will not always be possible. NRHI members will need to continue to weigh trade-offs of standardization.
3. The NRHI Board will need to review the strategic and work plan at each board meeting to ensure we are moving together in consensus during period of change. Governance will be increasingly important for the evolution or the organization. Tension between being responsive and moving quickly but need to remain collectively well grounded. Projects are testing the organization and membership.
4. Relationships with State Governments will be an increasing focus. Cycle 3 Funding for price transparency, SIM and other policy priorities and programs will require thoughtful relationship building. It will be important for NRHI to carefully explore partnerships with NGA, NCSL and others.
5. The Regional Resource Network grant will challenge NRHI to include a broader group in our work beyond members. This will require careful thought about how to continue to prioritize member needs while serving and connecting a broader audience. NRHI should carefully consider partners in advisory roles only and ensure that they reflect and support NRHI's strategic vision.

6. NRHI and its member Collaboratives should be vocal in providing input on national initiatives such as measure alignment, the Patient Safety Initiative, etc. to shape them in a positive way. NRHI members should participate in national forums to the extent possible. There is a particular emphasis on the need to align with emerging QIO direction.

- **Action:** NRHI should continue to build relationships with national organizations including those working with state governments ie the National Governors Association.
- **Action:** NRHI should continue to pursue the Regional Resource Network and build on AF4Q work and lessons. NRHI will address questions of non-member involvement in the RRN through the Governance Committee.
- **Action:** NRHI should facilitate member representation in priority national forums to shape policy and national direction.

Future Roles of NRHI and Collaboratives

NRHI will need to grow to meet environmental demands/opportunities and member needs and leverage communication opportunities across regions. This should not be 'growth for growth's sake' and NRHI should not become a large centralized entity, but more capacity is needed to achieve objectives. There is a need for expanded operations and a focus on strategic partnerships -including Anne Weiss/RWJ, Patrick Conway/CMS and David Lansky in the Board meeting are good examples. All efforts and changes must preserve the value of networking, sharing experiences and best practice across members. Any NRHI strategic plan should reflect and include work that helps regions to be successful. NRHI strategic and operational plans need to better state high level shared goals that are aspirational (ie Triple Aim, improving health).

Several key funders and partners including RWJF and CMMI are shifting focus to bridging health care and population health. The role of Regional Collaboratives could be to bring different sectors together as delivery systems are being asked to be accountable for population health. Health care quality improvement still demands significant time and focus but it will be important for RHICs to respond to this shift in focus and provide 'empirical thought leadership' and data. Currently, ACOs do not seem to feel 'obliged to the community' but delivery system redesign provides multiple experiments and opportunities to shape a new movement with RHIC input.

- RHICs could use data to develop population health dashboards and population health metrics for communities.

- Priority for NRHI should be Total Cost of Care measurement and reporting to enable community level conversations about reinvesting resources into health.
- Payment reforms will accelerate move towards population health and need for new measures and care delivery. This draws on strengths of RHICs and must be reflected in NRHI strategic priorites.
- There needs to be a mechanism for measuring performance in a community in order to encourage and support change in the community, but the role of Collaboratives in measurement and reporting will likely change over time:

  - Some aspects of performance measurement will increasingly be moving to a national level like Physician Compare, so Collaboratives' roles in measurement and reporting will need to move toward (a) more customized analysis to identify opportunities for improvement and (b) development and testing of new performance measures.
  - CMS is potentially interested in partnering with NRHI members to test measures in communities before reporting in federal programs. This could include a role for improvement and providing multi-stakeholder input on measure selection.
  - It will also be important to counteract the trend toward simplistic quality improvement efforts based on narrowly-defined measures and EHR-driven alerts, rather than more comprehensive measures and fundamental redesign of processes.
  - NRHI's network of Qualified Entities is a unique and important resource that should be leveraged in reporting and improvement roles.

- RHICs are increasingly recognized as 'Treasure Troves' of data- both clinical and claims- as well as reliable provider directories. These unique resources should be aligned for greater impact and will require NRHI to have greater expertise in HIT and provide member forums focused on HIT and integrating and leveraging clinical and claims data. An exclusive focus on claims data will miss emerging opportunities.

  - NRHI members have important expertise with EHRs and registries that could inform national policy and implementation.
  - NRHI should further develop and share expertise in supporting HIEs and leveraging clinical data for care transformation.
  - HIEs and clinical data sharing will be impacted by local market dynamics and RHICs could contribute to the development of an effective regional infrastructure.

In summary, the Board agreed that the planned work in the draft Strategic planning document was appropriate and supports continued development of joint national initiatives across NRHI members. Higher level goals for impact are needed.

- **Action:** NRHI will establish a strategic planning committee to thoroughly review near and long term organizational goals and operational priorities. A revised plan will be presented at the next NRHI board meeting.

- **Action:** Form NRHI affinity group for clinical data, HIEs and registry development and develop NRHI staff capacity in HIT.

- **Action:** Continue to pursue CMS/CMMI partnerships in measurement and reporting and other areas.

NRHI Members Pursuing Joint National Initiatives

NRHI continues to support and promote joint national initiatives reflecting member priorities. The Total Cost of Care project is now funded and successfully launched and 'PIC 2' application submitted. DOCTOR Project is proceeding with 3 collaboratives but will explore how to transfer work to NRHI over time. NRHI is now officially invited to submit application for the RRN. Though the projects bring many benefits, it will be important for the NRHI Board to acknowledge and address challenges created by new initiatives as national projects raise strategic questions of 'autonomy' v 'collective' efforts and the feasibility of standardization. These initiatives also have significant implications for NRHI staffing and budget as well as the role of NRHI with members. Projects also attract attention of national organizations seeking to learn from and with NRHI including Dartmouth, NQF and others. NRHI is the only existing national network capable of implementing improvement nationally.

Although common goals/initiatives do not need to be driven solely by federally-defined priorities, if Collaboratives do not respond to federal priorities they will be less able to get federal funding and other support and they may see an alternative network of organizations be created or expanded to implement federal priorities, e.g., the QIOs, that may compete with Regional Health Improvement Collaboratives. Moreover, it may be very hard to keep local healthcare providers focused on locally-defined initiatives if there is strong pressure from federal agencies to do something else. Similarly national market trends create time sensitivity in several projects. The ideal would be initiatives that lie at the intersection of local and national priorities. NRHI should assist in identifying these opportunities.

- National initiatives address both technical and political challenges and total standardization is unlikely in near term. Planning for future joint projects helps to identify opportunities for standardization- ie in the design of physician directories.
- Participation in joint initiatives is valued by members for several reasons. Development of national benchmarks creates needed context and national scope and lends credibility locally. Peer support and sharing experience accelerates

individual efforts. This includes experience with vendors that may inform future RFPs.

- Success of NRHI national initiatives demonstrates how to implement change 'from the ground up' engaging all constituencies.
- Not every NRHI member needs to participate in all initiatives, and each Collaborative will still pursue unique local priorities in addition to the multi-Collaborative initiative. NRHI needs to carefully clarify criteria for participation in each initiative as well as planning to support participation in future rounds.
- Demonstrating regional impact- even across multiple regions- does not automatically translate into change in payment from national payers. Additional strategies working with NRHI will need to accompany initiatives.
- NRHI support to members *not* participating in joint initiatives is needed and will enable members to participate in future phases and accelerate adoption across all members.
- Collaboratives should not just respond to just any national initiative, but should choose those that build on the Collaboratives' unique strengths – particularly their neutral, multi-stakeholder nature.
- Regional Health Improvement Collaboratives will have to find ways to distinguish themselves from or partner with QIOs, which are being pushed by CMS to take on a community convening role. MedPAC is going to be making recommendations as to new roles and approaches to quality improvement in communities, and this may provide new opportunities for Collaboratives.

NRHI's strategic plan and goals should include the desirability of having multiple Collaboratives jointly pursuing *national* initiatives, but not necessarily *federal* initiatives. A revised statement consistent with these points will be developed including criteria for participation and NRHI support for dissemination and engagement of all members and circulated to the Board for final approval.

- ❖ **Action:** NRHI should continue to identify appropriate opportunities for joint national initiatives. These should reflect an intersection of national/federal priorities and local RHIC strengths.

- ❖ **Action:** NRHI should develop clear and transparent criteria for participation in joint projects.

- ❖ **Action:** NRHI should ensure dissemination effectively enables members to participate in future phases and develop and provide support to non-participating members to ensure readiness.

II. Priority Projects, Proposals and Partnerships

- **Pacific Business Group on Health: Transparency Project**

David Lansky, CEO of the Pacific Business Group on Health was invited to present a partnership proposal to the NRHI Board.

The Laura and John Arnold Foundation has invited a proposal from PBGH to 'audaciously' transform healthcare in the US. They support high risk, large investments to achieve major cultural and structural change. They have asked PBGH to submit a proposal make all healthcare meaningfully transparent across the US within 5 years. A draft proposal was submitted from PBGH and NRHI and feedback is expected within one week. The foundation is interested in making an investment before 2014.

PBGH recommended a partnership with NRHI as sophisticated and established experts in measurement, reporting and data with a commitment to transparency. PBGH and the Arnolds have determined that 'big data' and large data vendors are not equipped to do this. They want to see change in the field based on current best practice. They have invited an 18 month planning grant to be followed by a significant investment in implementation. The primary output from PBGH's view is transparent information for the market. NRHI's primary focus may be more on using transparent information for improvement. PBGH is committed to finding a balance to these aims with NRHI.

PBGH/NRHI propose to identify a group of up to 10 Regional Collaboratives in the first round to develop standard public reporting of quality, safety and cost. Additional sites will be included in future phases. This will leverage best practice across collaboratives sharing expertise and helping each other to 'get on the escalator.' It was proposed that NRHI build a Resource Center of these best practices and tools- including legal agreements and share information across collaboratives. It is also proposed to develop a single, collective ask from national plans to send data in a standard format. Funding will be for PBGH and will be available for NRHI members and NRHI as an organization.

The proposal includes development of purchasing best practices to leverage transparent data and incent high value care. Model benefit designs and payment models will be tested and shared.

Funding is also included for innovative pilot projects to go beyond current practice- ie integrating clinical and claims data. The proposal includes a pool of funding for up to 3 'R&D' projects. There is also interest in developing an improvement strategy to identify and disseminate best practices in clinical care. The Board is eager to prioritize more innovative use of HIEs and registries and patient reported outcomes as R & D projects. Standardized data access and group purchasing are important opportunities for members. There could also be an important opportunity to challenge providers on existing cost drivers with transparent information which could align with the Total Cost of Care initiative's early results in 2015. The Regional Resource Network

may also be leveraged to disseminate information and share common tools and practices in the public domain.

NRHI members will need to consider how a big national initiative will fit with strong local constituencies and governance. The proposal reflects a federated model, leveraging regional strengths, but will challenge decision making. The Foundation is also convinced of the key role of large employers and government to demand data access which may enable local priorities as well as a national project.

The Board endorsed moving forward with the proposal noting both the risks and the immense opportunity. Elizabeth will work with David to respond to any questions from the funders and develop a final proposal. It will be important to balance the purchaser-led and multi-stakeholder perspectives to preserve the NRHI approach. It will also be important to have a transparent and objective selection criteria to select participants should the project go forward.

- **CMMI: Roles for Regional Collaboratives**

Patrick Conway, Director of Center for Medicare and Medicaid Innovation joined the NRHI Board meeting to discuss:

- Areas in which Regional Collaboratives can support implementation of reform and partner with CMMI;
- How can NRHI leverage our data infrastructure and capabilities to transform care including use of Qualified Entity data;
- Inform CMMI about work on the ground particularly around the implementation of SIM awards.

Patrick shared an overview of the National Quality Strategy and how it aligns with the CMS Quality Strategy to guide measurement and improvement work. There is significant alignment with the approach of Regional Collaboratives combining measurement and improvement. Alignment across CMS and other federal programs is a priority with a goal of 'reporting once'. The Qualified Clinical Data Registry is considered a meaningful opportunity for Regional Collaboratives to continue to drive local improvement while aligning with federal requirements.

Members raised concerns that recent signals from CMMI have not convinced providers that deeming will occur. CMS will clarify that data flow does not need to come from an EHR or use NQF endorsed measures. CMMI's intent is to develop an iterative, scalable program of deeming to include RHICs.

CMMI clearly prioritizing transparency and patient reported outcomes and population health measurement. Measurement planned to occur at individual physician, practice and system levels which aligns with NRHI member plans. Patrick emphasized recognition that work must happen in the field engaging all stakeholders. Regional Health Improvement Collaboratives are 'key to improvement work' envisioned by CMMI. Want input and feedback from NRHI members about how best to accelerate work and align with CMS.

CMS is in transition to a more population health focus. Current measurement programs are heavily focused on clinical and patient experience measures but CMS/CMMI are seeking more health oriented measures. CMS will be giving physicians feedback on community health and performance that could lead to tying payment to population health outcomes. SIM has an explicit focus on population health-denominators are entire state populations. NRHI urged additional link between cost and population health and reinvestment in health promotion activity from savings in healthcare. Patrick noted this reinvestment approach may gain more traction than proving prevention can reduce spending.

A key SIM challenge is payer alignment and particularly engaging CMS as a payer in regional initiatives. CMMI has recognized the differences between states with established Regional Collaboratives and their ability to bring payers together and those without that existing multistakeholder infrastructure. CMS is developing criteria for multistakeholder participation and what is necessary for successful multi-payer approach and Medicare funding. In Round 2 SIM program there is interest in providing technical support to all states. Lessons learned from Implementation states will be brought to others.

The concept of measure test beds in communities is of great interest to CMS/CMMI and could look to RHICs to do this work. NQF has been asked to develop this concept. There are concerns that the NQF and MAP processes remain focused on science and technical merits of measures rather than consequences of measure use. This is particularly true for cost measures. There are questions about whether NQF is maintaining a consensus process or whether process is dominated by organizational interests. Maintaining a credible consensus process is critically important.

CMS is seeking to prioritize and accelerate alignment with the private sector and recognizing the need for widespread payment change. The Pioneer ACO experience is demonstrating savings for Medicare but other payers are not participating. Success in care transformation is costing providers and is not sustainable without widespread payment change. If early ACO leaders do not experience needed payment change they will fail and 'actively' revert back to FFS. This must be avoided.

CMMI will be seeking to scale innovative pilots into national programs including CPCI. The portfolio of projects CMMI will be seeking to include:

- outpatient specialty care;

- practice transformation ie readmission reductions with payment reforms;
- working with physicians and clinicians through regional entities to report quality and cost and transition to alternative payment models;
- moving to capitated payment models with 'next generation' ACOs- including community based ACOs bound by geography rather than provider attribution/ownership;
- home health and skilled nursing facilities;
- health plan innovation in alignment with CMMI and possibly employers; and
- Medicare beneficiary engagement.

Patrick asked how best to structure practice transformation assistance. The Regional Extension Centers could include practice transformation support through same infrastructure. The QIO network or Primary Care Extension Centers may also enable this work. CMMI may define outcomes desired and allow any regional entities to compete for support work. This will vary by market and CMS should consider the extent they want to incent integrated systems. Preserving independent small practices will need to be a deliberate priority or they will be forced into ownership. 'Business transition models' will need to be developed with clear signals from CMS about what outcomes are expected. Primary Care Extension Centers could also connect small primary care practices with community support and technical assistance.

CMMI will organize internal teams to address individual NRHI proposals and schedule with Elizabeth.

- **Anne Weiss, Future Directions of RWJF**

Anne Weiss, Senior Program Officer of RWJF was invited to share perspectives of Foundation moving forward. Internal strategic discussions moving forward and reflect a new environment and the end of AF4Q. The 'culture of health' will be a critical theme and will be reflected in an integrated approach across programs. This concept includes health as a core value and should be as central to being an American as other core values. Multistakeholder approaches will continue to be a core theme and collaboration is considered critical to structuring new models though partners may expand. The recent Population Health meeting has confirmed this direction for the Foundation though they recognize there will be challenges bridging health care and public health organizations and stakeholders. Community and local market focus will continue but will shift to a focus on health.

The 'winds against change' are very strong. AF4Q demonstrated how wealthy and powerful the agents of the status quo are in healthcare. There will not be big wins from AF4Q but the investment in the community infrastructure will pay off in the long run. Each community has strong and sustainable commitment to drive to better care even if

it is not reflected in their 'numbers'. A 'movement' is often not reflected in small results but should not diminish importance of change.

Anne noted the interesting developments at NRHI over time since the Foundation's first investment. This year there were multiple opportunities identified for NRHI that raised questions for the legal and financial teams within the Foundation. Though eager to work with NRHI, the lack of infrastructure limited the number of opportunities to pursue. A network based strategy will continue to be the focus for community level organizations.

Other priorities that may warrant greater involvement are payment reform and measure alignment. NRHI and member RHICs seem well positioned to influence the direction of measure development and selection. NRHI is also emerging as an important voice in federal policy and RWJF wants to support this without using all of our time in DC. This 'durable' role in influencing policy is unusual and impressive. The Foundation is 'thrilled' by our direction and eager to know more about NRHI work as it helps them promote us as a 'high value partner'.

The 'readiness' of NRHI members individually and collectively through NRHI to lead change is exciting and promising. Networks will be the future of rapid and successful dissemination. NRHI was ahead of this curve and functions like a 'Learning Collaborative' by putting strengths together to do something bigger. The RRN will hopefully evolve to a full network to promote the culture of health.

The Board voted to continue to pursue the RRN but hopes to see measurable outcomes in the proposal -ie number of communities engaged and with functional collaboratives. It will also be important to highlight how NRHI members and Alliances can improve health and reduce costs and benefit from expanded network. Proposal should also highlight value of 'human interaction' and spread over technology.

III. Business Meeting

I. Jim Chase, NRHI Treasurer, presented 2013 financial statements and the proposed 2014 NRHI budget. 2013 spending is tracking very closely with projections despite the transition. It is also notable that finances are completely transparent and shared monthly with Finance Committee. The 2014 budget includes only secure revenue and conservative projections. New staff are primarily grant funded and additional revenue will need to be realized to expand further and sustain current team. Proposed budget includes $100k shortfall over year. Additional expected revenue of $100k now unlikely to materialize creating an even greater gap. Finance and Executive committee confident in direction of organization and ability to overcome shortfall with continued growth. Finance Committee has recommended approval of budget with commitment to revisit financial situation at end of Q1. This underscores the strategic priority for Elizabeth to raise revenue.

Vote: 2014 Budget Approved

II. Governance Committee reported recommendations (attached). All proposals were approved.

Dues proposal of 3 tiers of dues will be based on organization size. Final decisions of the Board are as follows:

Associate member dues will immediately move to $2500 and Associate member status will be limited to one year.

To recognize differing abilities and sizes of members, full member dues for 2014 will change as follows:

Tier 1: Dues for organizations with revenue up to $1.75 million will be $4k

Tier 2: Dues for organizations with revenue from $1.75 to $5m will be $8k

Tier 3: Dues for organizations with revenue over $5m will be $11k

Differentiating member benefits will be very important as dues levels change. Invoices to be sent as soon as possible.

III. Membership Application: WHIO

Chris Queram moved approval of WHIO as an NRHI member. Discussion reflecting complexities of local markets and relationships among organizations but recognition of value of alignment and inclusion.

Concern raised that WHIO does not meet approved criteria for membership without consumer representation on Board. Consumers are involved in work through committees. WHIO does meet other membership criteria.

NRHI board will need to consistently impose criteria.

Board requested that WHIO be encouraged to add a consumer representative to their Board.

Governance Committee asked to consider representation on NRHI Board for multiple organizations from same region. This will be important as NRHI transitions to a representative Board. Governance Committee will also review interpretation of criteria and adherence to requirements.

Elizabeth will notify WHIO.