NRHI Board Meeting
September 9, 2013
Pittsburgh, PA
DRAFT MINUTES

Participants:

Board Members: Chris Queram, WCHQ; Karen Feinstein, PRHI; Mylia Christensen, Q-Corp; Jim Chase, MNCM, Mary McWilliams, PSHA, Marc Bennett, HealthInsight; Phil Kalin, CIVHC; Craig Brammer, Healthbridge and The Collaborative; Cindy Munn, LHCQF; Kate Kohn-Parrott, GDAHC; Shelley Hirshberg, P2; Diane Steward, PBGH; Barbra Rabson, MHQP; *Absent:* Tom Evans, IHC; Tom Williams, IHA; Sanne Magnan, ICSI; *Others:* Elizabeth Mitchell, NRHI; Harold Miller, NRHI: Keith Kanel, PRHI; Claire Neely, ICSI, Christie North, HealthInsight Utah; Michael DeLorenzo, MHMC; Dolores Y., IHA (phone)

Agenda Item Comments	**Decisions**	**Action Items/Next Steps**
1) Approval of Minutes	Approved	EM to distribute
2) Welcome and Introductions Mylia Christensen opened the meeting and welcomed the Board members noting it had been a year since the Board had convened in person. Thanks to PRHI for hosting and administrative support. MC noted how quickly things are evolving in NRHI and review of recent Board and EC meetings and momentum from current environment- feeling that 'this is NRHI's time'. Significant growth potential is clear focus for Board. BR wants to recognize the contribution of Gordon Mosser from ICSI who originally defined RHICs. SH wants to develop history of NRHI and recognition of those who were part of founding. KH also noted contribution of Gail Amundson. Members agreed to review files to compile history.		

3) NRHI Overview and Update- Review of Board Direction EM updated Board on activities of past 6 months in each priority area. Clear direction is to grow and grow quickly. Reviewed work in each category; Advocacy- comments, direct work with Congress and federal staff, EM on IOM Consensus Committee, chairing Implementation Task Force, MAP and Chair of HIX Task Force, NQF Board, etc.- well placed in national forums. Member Support- affinity groups, webinars, visits. If we were RRN what would members want? Joint R&D- TCoC pending, PIC Phase 2 under KF's leadership with Nancy Jaeckels representing NRHI. Members being asked to confirm the direction and set priorities. EM noted need for better communications. EM shared updated org chart from July Board meeting and who has been hired. Two positions filled- BJ Dacko is Executive Assistance and Louise Marcotte as Grants Manager. Others being delayed until funding secured. RWJ has been asking for staffing plan and concerned about small staff. Will be need for many more positions if RRN and others successful. RWJ concerned about financial controls- recommending internal finance director. Need to consider as Board. New staffing plan will come to Board in November.		
4) Review Goals of Meeting MC noted significant accomplishments of past 12 months consistent with Board decisions. Need to be deliberate and strategic as organization and provide support to CEO in time of fast growth. Need timely input from Board for multiple urgent questions. Goals are to reaffirm direction, share member input/expertise, and develop operational plans. Need to think through how aspirations fit with organizational capacity. KF noting RWJF comment about concern for lack of capacity. Important to call on members- not looking for centralized organization. If all members have ownership and role, makes us stronger- need to communicate to RWJ that we are different. BR noted need for all members to promote NRHI and be 'on message'.	Members need to support and promote NRHI.	
5) Business Meeting **Minutes:** SH seeking more information on 'Tipping'. **Potential New Member:** North Texas Accountable Healthcare Partnership. MM had talked with consultant for organization and proposed membership in exchange for her advice and guidance. **Consent Calendar Approval:** EM noted that Exec Comm managing day to day but wanting to provide brief update. NRHI moved in to new office. EM	Minutes Approved New Member Approved	EM to notify

reviewed all infrastructure development, financial implementation, bank accounts, transfer from Harold. MM asked about ability to recruit in Maine. EM noted that many applicants coming from across US. Planning to enable remote work/distributed staff. MM asked if NRHI would pay relocation- EM said no resources available. MC reminded group of interest in transparency and availability of information on operational and financial work. **Treasurer's Report:** JC shared that financial structure still a work in progress- not final financial statements as HM's information not yet integrated. Cash position included- started year with $217k in cash, about $9k over budget for year due to start up costs. In good position for now. Finance Committee overseeing reporting and working with accountants. 990 filed by new accountants- want Board review. RWJ had wanted to see. JC shared feedback from RWJ and shift from very supportive policy team to financial/legal team- more scrutiny. Tipping issue required time and legal expense for NRHI to develop plan to avoid tipping in year 5. IRS wants to see diversity of funding sources or we would become a private foundation. Will develop 5 year plan to avoid. KF noted that NRHI does not want to be a private foundation. If we were to 'fail' the test we could lose 501©3 status. Attorneys doing analysis and working with JC and EM. JC reviewed progress in financial management structure and preparation to become larger organization- will plan for audit. RWJ asking about staffing and wanting to see capacity. Plan endorsed by Board important. EM asked to develop 2 year projection and diversity of funds. Largely 'aspirational'- not secured but if realized no threat of tipping. Important to identify other forms of revenue. EM planning for future revenue opportunities from successful completion of grant projects – ie TCoC. JC urged more conservative view but agreed goals are reasonable. BR said DOCTOR project could lead to significant growth at NRHI and result in commercial revenues to include in later years. KF urged board to consider other private foundations- making ACA successful would be very attractive to other funders and should approach them. SH, MM and PK urged EM to revise with more conservative figures and additional sources but taking projection beyond 2016. KF urged EM to identify at least 2 new funders to approach- CHCF and Rippel, Hartford Foundation. KF said breadth appealing and end of year important time to approach as they need to hit 5%. MC thanked members for work of Finance Committee - responsive to prior Board interest in better financial controls and	EM to revise with more conservative projections.	Members to contact EM with connections/ideas for funders. EM to reproject- more conservative,

transparency.	Treasurer's Report approved	further out.
6) Expectations of Members: Board Development MC observed need for stronger governance activity- move from early preliminary by-laws to more robust committee structure. To discuss Board membership and increased external focus will require a Governance Committee to provide focused consideration. Need to support EM and staff. Board exceeding size for optimal function. Board membership and responsibilities will grow with organization. Will need to clarify who each member is representing- own org or NRHI. Policy engagement and need for quick response will challenge current Board structure. JC does not want NRHI to become too burdened with managing Board and committees- may not need standing committee but committees devoted to targeted areas. Policy requests will increase and unlikely to be best addressed by full Board. BR's org developing decision matrix to be explicit and clear. KF also supports ad hoc, time limited governance committee to avoid bureacratizaton. EM just seeking formal Board affirmation as best practice. Reviewed questions from July meeting about membership criteria and governance. RRN will challenge our current definitions. EM reviewed current by-laws and Board structure and brought proposal as requested. EM not ready to change Board structure because need for forums for member sharing not yet met otherwise. Should plan for future member forums to allow shift to governing Board. May also want to invite funders to serve as ex-offidios as allowed in bylaws. Some opposed to inviting funders to join Board- advisory council of key funders/partners preferable. MM said need to start with ad hoc committee to consider these issues. BR challenged notion that RRN will require us to change structure- will need to define who we serve, not who members are. RWJF should not be the driver of NRHI's direction. KF wants to revisit Associate Membership- should be time limited or limited to very small organizaitions. Should only be 'on-ramp' and Associates should be required to contribute at same level of others. SH agreed but may be difficult to get local Board support for higher dues- originally supported by RWJ. MM said we will need more from Associate membership starting in 2014. KF said members should pay according to their assets- more fair. DS recommended that Committee should address both membership and governance. Not necessary for committee established	Create advisory council of funders/partners but not invite to join Board. Ad Hoc Governance	

in by-laws- ad hoc only. CM and KKP volunteered to participate. CB offered staff resource. SH to represent Associate members. CN asked about multiple organizations. MB said value of membership comes when multiple staff can participate. Will pay as appropriate. JC wants Board to consider how members are included in regional projects and how to include non-members. MD noted challenge of keeping Baord informed as multiple committees and projects created. PK urged group to think about power of network to influence national agenda. Could impact NRHI direction- creates a strategy question. MC recognized need for formal strategic plan for NRHI. Should not develop Policy Committee at this time. Need to be sure NRHI has all needed insurances. MB does not want to over legislate EM- needs flexibility to respond effectively- should seek alignment when possible. Responsibility of members to inform EM when positions are taken. MJC said MHI maintains broad policy statements, not specific positions. EM could develop.	Committee to be created to address both Governance and Membership questions. CM, KKP and SH to join. CB to offer staff to contribute. [MB to Chair as officer.] No need for ad hoc Policy Committee- EM to solicit questions from select members by issue when possible. Otherwise EM authorized to respond.	
7) Environmental Scan: Relationships with Key Stakeholders MC introduced section to hear from members and inform strategic plan development. CM shared LHCQF work and new partnerships with health systems and strong partnership with Medicaid. Most challenging relationship with Beacon- predatory/competitive. Recently launched analytics creating challenges with Hospital Association- looking to partner and offer product at lower cost. BR interested in analytic products. Hospital Assoication providing market share analyses- very different from LHCQF- but seen as possible threat to sole data source and revenue. LHCQF providing analytics to local providers/practices ie ED utilization. CB has same challenges and complicated by membership of Hospital Association. Do additional analytics for private customers and run HIEs for multiple orgs and regions. CB strongly urged members to think about how to leverage skills/resources of other members- not recreate. Now focusing on business community. CB said feds paying more attention to RHICs- noting good work and challenge of working with states. RHICs need to better define themselves. Patrick Conway strong champion of RHICs- change from Rick Gilfillan who focused on health systems. Working across sectors- education, business, etc for 'collective impact'. MD noted extreme similarity of Maine environment- all trying to define value proposition across orgs. SIM will force some resolution. Focus now on governance and sustainability- what		

will be business model post SIM? Putting complete claims data set together that will be state resource. Confusion over state APCD role.		
8) Joint R & D JC explained status of DOCTOR project- considering 2nd phase after successful pilot. Multiple activities in one project. Customers (Consumer Reports) key partners driving some content and helping with message. Not challenge of new data- challenge of communicating to public and stakeholders. Opportunity of using clinical data and patient experience enabling Triple Aim data. Challenge of standardizing when different regions have different data leading to development national patient experience effort. Provider directory is primary asset/criteria to make data projects happen- should be leveraged. Physician specific data must be goal as it is what public wants. EM asked if NRHI could become the national source of clinical and claims data for quality reporting- not through another vendor/platform. KF shared PIC experience and introduced Keith Kanel, CMO for PRHI and PI for PIC grant. PIC considered very successful project by funders. Themes of partnership – need honest assessment of capabilities- shared strong need to select ready partners- MUST be successful- everyone watching. Need dedicated staffing and financial capacity. Need time with other partners dedicated. What are criteria for choosing to proceed with a project? Who is eligible- all accountable? Short and long term benefit to members, support and TA must be adequate. Will need to live with some customization- we are all different- will need to make some accommodations. Should be developing collective vision and inventory skills needed. What does the nation need and how does NRHI meet that. Need individual AND collective analysis- what can NRHI provide? What can be centralized and what should RHICs do? RHICs should pursue new capabilities and develop what is needed. Communications must be developed- need ongoing, regular, individual and collective communications. Funders will fund NRHI if we tell their stories to reach their constituencies. NRHI role perfectly postioned to spread/disseminate learnings. Need to connect people within and across organizations. Should leverage IOM report "Shorter Lives Poorer Health' and focus on healthcare and public health intersection. SIM not clearly right approach but 'can't ignore it'. NRHI will need to hold members accountable if in lead role. What is role of board and executive committee if NRHI project? Will need	Goal must be physician level reporting to meet consumer need. Provider directories and quality of data unique and key asset. Joint projects require: Strong capabilities, dedicated staff, financial management, dedicated and planned time for partner meetings. Should assess centralized v RHIC functions. NRHI ideal for dissemination. Better communications will attract funding. Connect staff and leadership of RHICs.	EM to develop communications plan with new staff.

to focus on benefit to external customers. DOCTOR project raising questions about NRHI infrastructure and capacity. Local boards want to see local value- not detracting from local mission and benefit. Also need to be published in academic literature and consider other publications- not necessarily peer reviewed journals (Volume to Value). SH said NRHI needs to identify legal contracts in advance. CB said focus on second phase of implementation should be planned for each project. Plan and start inviting non-participating member staff to learn at multiple points in the project.	NRHI multi-region projects should include interim dissemination meetings with all members.	
9) Member Support Panel to identify key member needs and support opportunities. GDAHC engaged NRHI to do stand alone project to enable local boards to understand NRHI member projects. Using RWJ TA money to conduct work and will share with all members and AF4Q Alliances. Setting precedent of hiring NRHI and sharing results. Could sell to broader audiences. HM brings incredible expertise for local TA- important resource to maintain and support. Also brands and promotes NRHI while creating latitude for local RHICs. NRHI also enables connections, best practice sharing quickly and practically. NJ support has allowed P2 to be ready for new funding opportunities- key to their sustainability. Joint projects more likely to get funded in the future. NRHI-branded communications materials very useful in communities while also promoting NRHI. Should be made broadly available. Strong and broad communications plan for NRHI urgently needed. May find resources at NPO to help tell NRHI story. Conferences and summits should remain a high profile opportunity to share work and engage stakeholders. Need annual and regional summits. Should explore new partnerships with NCSL, NASHP, others.	Members should use NRHI to develop products to share across members. NRHI TA from HM, EM, NJ- very valuable and should be continued. NRHI communications plan a priority. Need to tell success stories. NRHI national and regional summits should continue.	
10) Advocacy: Federal Opportunities EM shared 3 proposals for Board to consider submitting to HHS at their invitation. Key opportunities include relationships/division of labor with QIOs, supporting physician payment reform through data analysis, pilot measure testing on the local level. MC noted that several weave together- QE language is formative and great at describing orgs that qualify that do what RHICs do. Single most important thing that could effect all issues would be to lay out criteria of what type of org could do all of these functions- data analysis, QI, payment reform, etc- which other requests would fall under- ie any entity that wants to do x must be part of the	Need to articulate overarching strategy and criteria about role and function of RHICs. All proposals would fit within this framework.	

collaborative/NRHI and what is evidence. Overarching strategy is to articulate vision about what should be done in the community and how- all pieces have logical framework. JC asked about work on price disclosure and whether this is additional opportunity. Valuable in community – could we get endorsement from NRHI? Several members pursuing- need broader opportunity than just cycle 3 funding. KF noted challenge of expanding beyond current QIO orgs and functions. MB said new focus is on Triple Aim – much broader. Need to work with Patrick Conway as strong champion of RHICs. What is our ask? KF wants us to define 'data for what'. We are not NAHDO- not just data to have/sell but to improve care. This differentiates RHICs. HM talked about the power of bringing people together to understand the different roles we play and how they can complement each other. KF feels strongly NRHI should convene those roles. PK also said NRHI needs to be 'very smart' on 11th scope and do outreach to existing QIOs to explain what RHICs bring to the table and how they can help them meet their new obligations. We need to know where and how to partner. CN recommended outreach to QIO network (trade association). MB said benefit may be higher working directly with QIOs. BR highlighted different program demands for data (PCMH, QE, CPCI) and NRHI needs to advocate for coherent and deliberate approach to data as shared, multipurpose resource across programs and supporting common measures. Exacerbated by range of consultants hired to support different projects. CB noted added challenge of multiple data vendors- no alignment. Need to be planning for future relationships at CMS (post-PC). Should exploit HITECH 90-10 match. NRHI could assist states using funds. Also need to 'show love to feds' – should highlight positive impact of MU specs, help make them successful. Every EHR will need to do this- should align. Priority NRHI advocacy proposals/tasks in order: 1) Define the payment and delivery reform structure/role of RHICs; 2) Ensure QE rules enable RHIC role in payment/delivery reform; 3) Define division of labor with states, APCDs, QEs, RHICs; 4) Support physicians in payment reform through data, learning and diffusion; 5) Influence QIO 11th scope to include RHICs and define division of labor with QIOs/RHICs.	NRHI should convene other related orgs for face to face meetings to understand roles. NRHI should do outreach to QIOs to seek partnership opportunities for RHICs in 11th scope of work. NRHI should help CMS define 'all-program' measurement capability.	EM to share proposals with CMS/CMMI.
11) Population Health EM: What can RHICs do to accelerate population health improvement?		

Priority direction, need to bridge healthcare and population health. Claire Neely presented on work of ICSI- changing conversation with healthcare providers and seeking to engage broader community members. Starting with determinants of health- healthy behavior and social determinants far more important than healthcare. Decreasing costs should be seen as part of population health improvement- redirection of revenues away from healthcare and in to healthy communities and infrastructure. Context helps to engage physicians. New grant from RWJ to define framework and communications to healthcare community- will be available to NRHI members. Diamond, PIC, SBIRT all underway but not getting adequate traction on population health-expanding to law enforcement, education, etc. Assumption that communities 'are not ready' was incorrect. Community survey identified problems and awareness and interest in change. New community forums around community wide issues- now re-framed. How to measure impact? Is there a global health measure to determine health of community? Currently surveying available measures- including PROs. Partnership with local television and grass roots groups addressing policy issues. Mary Jo shared grant developing web based tool 'Yelp for Health' to connect community members to existing resources. Not looking for new programs- connecting existing ones. BR leading Healthy Roxbury- asking neighborhood for their perceived needs. Focus on pediatric asthma and adult diabetes. Going to school parent nights and other school events. Working with Re-Think Health to identify benefits of change/re-allocation of funding. MB established goal of engagement in pop health seeking bigger impact- new approach. Submitted CMMI application aimed at increasing physical activity among adults, recruited 3 communities- engaged mayors, schools, religious communities instead of providers. Sophisticated cost/benefit analysis required. KKP leading FindMICare working with 3 hospital systems to change discharge practices for people coming to ER for primary care- will find and refer to local clinics. Smartphone APP developed. Medicaid will be engaged. CB asked to lead community benefit analysis and lead overall needs assessment. SH has very different strategic plan based on Wisconsin framework- new portfolio of work. How to develop ROI/quantify? Will require new metrics. Facilitating 8 counties community health planning with plans due in November. Current resources not aligned- planning should increase impact. State developing incentives and penalties	NRHI members to be involved in developing/using communications re: population health developed by ICSI. Community readiness underestimated. Need ways to engage. New health programs not needed- aim to maximize and connect existing ones. Critical to reach beyond healthcare stakeholders. New metrics required for population health- not traditional healthcare measures Payers- including govt should	ICSI to reach out to NRHI members for input and share framework when developed.

for lack of progress. MC approached by public health to partner on assessments- asked because of reform. CB has unique relationship with hospitals that may enable role for assessments. JC noted counter- pressure and challenge of providers to see value of this work- particularly health plans. Good to leverage community benefit requirement. MJC noted hospital requirement to 'spend money on health' but lack of familiarity with appropriate initiatives. DY working on health indicators project to start collecting HEDIS by zip code to make available and develop community dashboards. Need for measures of health to go along with measures of healthcare. How to align and set priorities? What do you do about identified priorities? Reinvestment strategy required but not planned. What is business case for providers? Who gets savings? This should inform NRHI overall vision for future- how do we go beyond healthcare? Need to develop community dashboards on Triple Aim. Could include interactive data with GIS. Getting dialogue started and communication will move us past alignment problems. NRHI could be 'ahead' of group. PK noted that as we hear from different communities about their challenges we can connect them to others addressing them. KF recommended using measures for IOM Shorter Lives report- affluent countries being measured against. Do GPS analysis of variation against measure set across member communities. Can we take this on given other priorities? SH said necessary for transformation. CB said discretionary depending on 'footprint' of org. MM said desirable but is public health also addressing? Need to be collaborative. May be driven by State Govt. Can't distract from other core functions. Regardless of collaborative role, need for measures/measurement for community progress. Health metrics are only ones that really matter.	create incentives. Community benefit requirement opportunity for some RHICs depending on relationship with hospitals. Incentives, business case and alignment not determined. NRHI needs to develop plan. NRHI should develop 'NRHI Triple Aim Measure Set' to build community dashboards and discussion mechanism. Bridge health and healthcare. Health metrics most important.	NRHI to convene group to consider/develop population health measures and community dashboards with community convening plan.