



AMERICA'S
ESSENTIAL
HOSPITALS

Board of Directors Meeting

March 16, 2015
The Westin Georgetown

essentialhospitals.org

AMERICA'S ESSENTIAL HOSPITALS
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Association Board of Directors Meeting
March 16, 2015
11 am - 5 pm ET
Agenda

11 – 11:05 am	Call to Order and Disclose Conflicts of Interest (Walker)	
11:05 – 11:10 am	Approve Consent Agenda (Walker)	ACTION
	• December 2014 minutes	
	• New members	
11:10 – 11:25 am	President's Report (Siegel)	
11:25 – 11:30 am	Review and Approve Institute Board Nominations (Walker)	ACTION
11:30 – 11:35 am	Nominating Committee Report (Spisso)	
11:35 – 11:50 am	Revised UHC Memorandum of Understanding (Siegel)	ACTION
11:50 am – 12:15 pm	Board Member Expectations (Walker)	ACTION
12:15 – 12:45 pm	Lunch	
12:45 – 1:45 pm	Membership Committee Report: Member Satisfaction Survey Results (McKinley Advisors)	
1:45 – 3 pm	Policy/Advocacy Update (Feldpush)	
3 – 3:15 pm	Break	
3:15 – 3:30 pm	Education Committee Report (Belzer)	
3:30-3:45 pm	Strategic Planning Committee Report (Karpf)	
3:45 – 4:15 pm	Essential Hospitals Institute Update (Engler)	
4:15 – 4:30 pm	Office Move and Financial Update (Gold)	ACTION
4:30 pm	Adjourn	
4:30 – 5 pm	Executive Session	



AMERICA'S ESSENTIAL HOSPITALS

America's Essential Hospitals Board of Directors 2014–2015

CHAIR

William B. Walker, MD
Director and Health Officer
Contra Costa Health Services

George B. Hernandez Jr., JD (2014–2016)
President and CEO
University Health System

CHAIR-ELECT

Johnese M. Spisso, MPA, RN
Chief Health System Officer, UW Medicine and VP
for Medical Affairs
UW Medicine

Wright Lassiter III (2014–2015)
President
Henry Ford Health System

PAST-CHAIR

Thomas P. Traylor, MBA
Vice President, Federal, State, and Local Programs
Boston Medical Center

Santiago Muñoz (2013–2015)
Chief Strategy Officer
UCLA Health System

SECRETARY

Michael Karpf, MD (2013–2015)
Executive Vice President for Health Affairs
UK HealthCare

Sharon O'Keefe (2014–2016)
President
University of Chicago Medicine

TREASURER

Reginald W. Coopwood, MD
President and CEO
Region One Health

Ramanathan Raju, MD, MBA (2014–2015)
President and CEO
New York City Health and Hospitals Corporation

AT-LARGE DIRECTORS

Michael B. Belzer, MD (2014–2016)
Medical Director and Chief Medical Officer
Hennepin County Medical Center

Sheldon Retchin, MD, MSPH (2014–2016)
Executive Vice President for Health Sciences, Chief
Executive Officer
The Ohio State University Wexner Medical Center

Timothy M. Goldfarb (2014–2016)
EVP, for Regional & Governmental Affairs
UF Shands HealthCare

Donna Sollenberger, MA (2014–2016)
Executive Vice President and CEO, UTMB Health
System
The University of Texas Medical Branch

John Haupert (2014–2016)
President and CEO
Grady Health System

Roxane Townsend, MD (2014–2016)
Vice Chancellor for Clinical Programs and CEO
University of Arkansas for Medical Sciences

EX OFFICIO

Irene M. Thompson
President and CEO
UHC



2015 – 2016 Association Board Meeting Dates

Tuesday, June 23, 2015

11 am – 5 pm

Westin Gaslamp Quarter

San Diego, CA

Held in conjunction with June 24–26, 2015, VITAL2015

Monday, October 26, 2015

11 am – 5 pm

Hyatt Regency Washington on Capitol Hill

Washington, DC

Held in conjunction with October 27-28, 2015, Policy Assembly

December 2015 conference call – TBD

Monday, March 7, 2016

11 am – 5 pm

Hyatt Regency Washington on Capitol Hill

Washington, DC

Held in conjunction with March 8-9, 2016, Policy Assembly

Tuesday, June 14, 2016

11 am – 5 pm

Seaport Hotel

Boston, MA

Held in conjunction with June 15–17, 2016, VITAL2016

October 2016 – TBD

December 2016 conference call - TBD



Board of Directors Meeting
Monday, December 1, 2014
Meeting by Telephone

Board Members Present (13)	Board Members Absent (5)	Staff Present (7)
Reginald W. Coopwood, MD Timothy M. Goldfarb John M. Haupert George Hernandez Jr., JD Michael Karpf, MD Wright L. Lassiter III Sharon O'Keefe Ramanathan Raju, MD, MBA Sheldon Retchin, MD, MSPH Donna K. Sollenberger, MA Roxane A. Townsend, MD Thomas P. Traylor, MBA William B. Walker, MD	Michael B. Belzer, MD Steven G. Gabbe, MD Santiago Muñoz III Johnese M. Spisso, MPA, RN Irene M. Thompson	Bruce Siegel, MD, MPH David Engler, PhD Beth Feldpush, DrPH Rhonda Gold Kristine Metter Jummy Siwajuola Caitlyn Furr

Agenda Item	Minutes
Call to order (Walker)	<ul style="list-style-type: none">Walker called the meeting to order at 11:02 am.
Approve Consent Agenda (Walker)	<p>Members reviewed the October 28 meeting minutes.</p> <p>Walker requested a motion to approve the consent agenda. There was a motion, a second, and unanimous approval of the consent agenda.</p>
Review and Approve 2015 Proposed Budget (Coopwood/Gold)	<ul style="list-style-type: none">Gold reported that the 2015 proposed budget was approved by the finance committee on November 21, and budgeted activities support the 2013-2018 strategic plan.Budgeted 2015 revenue is \$10.2 million, an increase of 15 percent (or \$1.3 million) from the 2014 projection and 18 percent more (or \$1.5 million) than the 2014 budget.The largest increase is in membership dues. The 2015 budget assumes six new members. The bad debt line reflects the

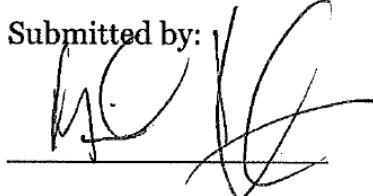
	<p>deactivation of four members (totaling \$266,000) as a result of the new dues structure. The 2015 membership dues invoices reflecting the new tiered dues structure were sent to members at the beginning of November.</p> <ul style="list-style-type: none"> Budgeted dues are \$1.23 million (or 23 percent) more than the 2014 projected level. Of that increase, \$285,000 is based on new 2014 members paying full-year dues in 2015, \$252,500 represents new 2015 member recruits, and \$128,000 stems from reclassification of memberships to different membership categories. In addition, \$568,000 comes from the change in dues structure. The new corporate affiliate member category (approved at the October 28 board meeting) created the need to reclassify \$80,000 from the sponsorship line, into the membership category. Budgeted sponsorship revenue is \$200,000. The 2015 budget reflects \$260,000 for conference registration fees, of which \$151,000 is for VITAL2015 and \$34,000 is for registration fees for an in-person waiver meeting. The conference registration line is substantially higher than 2014 (by 55 percent) because the Government Relations Academy occurs every other year. Total budgeted expenses for 2015 is \$8.8 million, of which \$4.4 million is in association salaries and fringes, an increase of 8 percent from the 2014 budget. This includes the addition of three new budgeted positions. Health insurance increases of 25 percent recently assessed by Carefirst are substantially higher than 2014 and prior years. This is because the association was classified in the under 50 employees market which is not competitively priced in the marketplace. Budgeted expenses also include a \$595,000 contribution to the Institute to support research and analytics work that is not externally funded. Because Kaiser Permanente's three-year grant to support the Transformation Center ended in 2014, core support from membership dues is once again necessary to continue the Institute's important research and analytical work in support of the membership. Without this funding, the Institute's budgeted operating deficit would be \$672,000 (versus a budgeted \$80,000 deficit, the same budgeted level as in 2014). The policy line reflects \$294,000 in budgeted expenses, an increase of \$26,000 (or 10 percent) from the 2014 projected level and 19 percent more than the 2014 budget. The increase in budgeted costs is primarily due to outsourcing of sophisticated quantitative analysis and analytical modeling to KNG Health and The Moran Company (for \$190,000). The increase in this line item recognizes an expected need for analysis of regulatory and legislative proposals. The advocacy line reflects \$653,000 in budgeted expenses, an increase of 43 percent from the 2014 budget. It includes the hosting
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	<p>of two policy assembly events (\$244,000); Holland & Knight LLP retainer fees (\$156,000) for general advocacy services; Schrayer and Associates consulting services (\$40,000); site visits and outside meetings (\$27,000); and dues, subscriptions, licenses, and webinars (\$43,000).</p> <ul style="list-style-type: none"> • The budget for conferences reflects a 40 percent from the 2014 projected amount and 4 percent increase from the 2014 budget. VITAL2015 will be held in San Diego, which is a more expensive location. • Member services is budgeted at the same level as 2014 and reflects site visits for membership recruitment and retention activities, awards and education committee expenses, membership materials and mailings, sponsorships to other organizations, and conference site visit travel. • The communications line was reduced by 25 percent from the 2014 budget because of the reclassification of \$50,000 for the Coalition to Protect America's Healthcare to the advocacy line. • Consulting is budgeted at \$117,500, which is a decrease from 2014. The amount budgeted for the retainer has also decreased from 2014, as the association is making efforts to scale back its use of Eyman Associates and utilize internal staff instead. • Rent is budgeted at \$385,000, which is a 2 percent increase from the 2014 projected amount. This amount does not include rent for the new space, as the association will move in December 2015. • Travel and professional development is budgeted at \$180,000. This is an increase of 41 percent due to increased staff professional development opportunities to include continuing education and professional certification classes, new staff training initiatives, a site visit to a member hospital, licenses for online professional development videos, and budgeted training opportunities as recommended by the leadership team. The association has created an internal staff committee on professional development to encourage staff development. • Taxes/insurance/miscellaneous is budgeted at \$87,000. The largest increase in this budget line is due to a higher line of credit bank fees as a result of the move. • Depreciation is budgeted at \$157,000, which is an increase of 108 percent from the 2014 budget. \$93,000 was reclassified into depreciation because the new website and branding are now an ongoing operational expense. • The 2015 budgeted operating surplus is \$1.4 million, before moving expenses (of \$435,000) funded from reserves, for a gain in net assets (surplus) of \$972,000. • Total budgeted net assets are \$9.45 million, of which \$450,000 is restricted for the office relocation in late 2015. This budgeted ending net asset balance of \$9.45 million represents almost one year of the association's operating expenses in reserves.
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	<p>Walker requested a motion to approve the 2015 proposed budget. There was a motion, a second, and unanimous approval of the 2015 budget.</p>
Policy Advisory Committee (Feldpush)	<ul style="list-style-type: none"> • Haupert directed the board to the draft principles on equity of care. • America's Essential Hospitals has not had an official position on equity of care. The association decided to create a set of guiding principles for members, for use when the association is asked about its stance on socioeconomic status (SES) and equity of care. • The policy advisory committee met three times by phone in the fall and drafted 11 principles. The committee began by stating that essential hospitals have a responsibility related to equity of care, and by reflecting on the definition of essential hospitals. • The board reviewed each of the principles aloud. • The third principle says that health care providers need to proactively assess the needs of their community in order to promote equity. Sollenberger commented that the language of the third principle gives the impression that hospitals would take the leadership role, but it is important for the communities to be engaged. She suggested rewording the principle to state that "health care providers will work proactively with communities to assess..." • O'Keefe asked if the committee considered the community benefits survey that hospitals are already required to perform. Feldpush replied that there are synergies that could be leveraged with existing assessments, but that the committee really wanted to highlight the importance of addressing disparities. • Principle 11 says that essential hospitals incur a disproportionate part of the cost of care and should receive reimbursement. Walker mentioned that this principle addresses SES factors that the association is approaching with National Quality Forum. Feldpush said that principle 10 also addresses SES. The committee discussed principle 10 as being a broad statement, but also felt that there should be specific language about payments. <p>Haupert requested a motion to approve the principles of care. There was a motion, a second, and unanimous approval of the principles of care.</p>
Advocacy Update (Feldpush)	<ul style="list-style-type: none"> • Feldpush gave a postelection update on the state of affairs in Washington. • Congress is back in session, which will be good for the December 8-9 Policy Assembly. • As expected, the Senate will be controlled by Republicans in January, and Republicans will continue to control the House.

	<ul style="list-style-type: none"> • Sen. Orrin Hatch, (R-UT), will chair the Senate Committee on Finance beginning in January. His staff has an aggressive agenda and would like to reopen some changes to the Medicaid program and the Affordable Care Act. There are no firm details at this point as to how the plan would work, or the budget implications. Hatch's staff has also targeted the medical device tax, which is concerning from the hospital side because we would want to assure that no hospital funding is used to offset the cost of the device tax repeal. Hatch's staff has also discussed revising Medicaid with per capita caps. • Rep. David Camp (R-MI) is retiring and Rep. Paul Ryan (R-WI) will become the new chair of the House Committee on Ways and Means. Ryan has specific health care ideas and is likely to look at per capita caps and entitlement program reforms. • In the short term, Camp put out a discussion draft of legislation that has a number of hospital-related items. The hospital package includes a payment policy for short-term inpatient stays, SES risk adjustment, and an end to the moratorium on physician-owned specialty hospitals. The association plans to encourage the delay of Medicaid disproportionate share hospital (DSH) cuts through 2017 in this legislation. • The administration has established readiness tiers for hospitals, but has done little else on Ebola preparation. • Sollenberger mentioned the expenses related to treating Ebola at the last board meeting. The University of Texas Medical Branch has been asked what it would take to have a working bio-containment facility. The hospital is creating a white paper that outlines what it takes to staff one Ebola patient. Sollenberger will share the white paper with Feldpush and the board. • Association staff have prepared messages for the Policy Assembly on protecting Medicaid payments, the importance of the 340B Drug Pricing Program, SES risk adjustment, and protecting Medicare payments
Adjourn (Walker)	<ul style="list-style-type: none"> • Walker adjourned the meeting at 12:05 pm.

Submitted by:



Michael Karpf, MD
Secretary



DATE March 10, 2015
TO Board of Directors
FROM Kristine Metter, Vice President for Member Services
RE New Member Applications

MEMORANDUM

The following six hospitals have applied for membership with America's Essential Hospitals:

- CaroMont Regional Medical Center, Gastonia, North Carolina
- Medical University of South Carolina, Charleston, South Carolina
- Presence Health, Chicago
- Regions Hospital, St. Paul, Minnesota
- UC Health, Cincinnati
- University of Virginia Medical Center, Charlottesville, Virginia

CaroMont Regional Medical Center

Doug Luckett, MBA, President and CEO

Established in 1946, CaroMont Regional Medical Center employs 3,800 staff, including a medical staff of 452. The 435-bed, not-for-profit general and acute care facility is the anchor of CaroMont Health, a health care system that includes a network of 46 primary and specialty physician offices.

CaroMont Statistics

Beds	435
Employees	3,800
Discharges (Medicare)	50.1%
Discharges (Medicaid)	27.0%
Outpatient visits	324,852
Total Admissions	22,303
Births	2,427

*Source: AHA 2013 utilization statistics

Medical University of South Carolina (MUSC)

Patrick Cawley, MD, Executive Director and CEO

The Medical University of South Carolina has served the citizens of South Carolina since 1824. It has expanded from a small private college for physician training to a state university with a medical center and six colleges for educating a broad range of health professionals.

MUSC Statistics

Beds	709
Employees	6,727
Discharges (Medicare)	32.3%
Discharges (Medicaid)	26.5%
Outpatient visits	75,791
Total admissions	34,441
Births	2,149

*Source: AHA 2013 utilization statistics

Presence Health

Sandra Bruce, President and CEO

Presence Health, created in November 2011 through the merger of Provena Health and Resurrection Health Care, is the largest Catholic health system based in Illinois. It has 12 hospitals, 27 long-term care and senior living facilities, dozens of physician offices and health centers, home care, hospice, and behavioral health services. The locations joining are Presence Saints Mary and Elizabeth Medical Center in Chicago and Presence Mercy Medical Center in Aurora, Illinois.

Presence Health Statistics

	Saints Mary and Elizabeth	Mercy Medical Center
Beds	495	292
Employees	-	788
Discharges (Medicare)	42.9%	42.1%
Discharges (Medicaid)	19.4%	27.0%
Outpatient visits	193,734	269,976
Total admissions	19,406	9,238
Births	1,512	433

*Source: AHA 2013 utilization statistics

Regions Hospital

Megan Remark, CEO

Established in 1872, Regions Hospital is part of HealthPartners, the largest consumer-governed, nonprofit health care organization in the nation. It is a teaching hospital, level I trauma center,

and full-service private hospital with special programs in heart, cancer, behavioral health, and burn.

Regions Hospital Statistics

Beds	454
Employees	3,148
Discharges (Medicare)	36.6%
Discharges (Medicaid)	31.8%
Outpatient visits	245,910
Total admissions	24,395
Births	2,481

*Source: AHA 2013 utilization statistics

UC Health

Rick Lofgren, MD, MPH, President and CEO

UC Health brings together the region's top clinicians and researchers to provide world-class care to Cincinnati. The flagship hospital is the University of Cincinnati Medical Center. UC Health is continually recognized for excellence and backed by the academic strength of the University of Cincinnati, one of the nation's top 25 public research universities.

UC Health Medical Center Statistics

Beds	771
Employees	4,294
Discharges (Medicare)	30.5%
Discharges (Medicaid)	28.7%
Outpatient visits	360,482
Total admissions	31,987
Births	2,520

*Source: AHA 2013 utilization statistics

University of Virginia Medical Center

Richard Shannon, MD, Executive Vice President for Health Affairs

The University of Virginia Health System is an academic health care center associated with the University of Virginia. The system includes a medical center (with main hospital, children's hospital, and clinic network), school of medicine, school of nursing, and health sciences library. It provides inpatient and outpatient care and patient education and conducts medical research and education.

University of Virginia Medical Center Statistics

Beds	676
Employees	6,556
Discharges (Medicare)	40.1%
Discharges (Medicaid)	19.3%
Outpatient visits	1,702,522
Total admissions	28,802
Births	1,572

*Source: AHA 2013 utilization statistics



DATE March 10, 2015
TO Association Board of Directors
FROM Anna Roth, RN, MS, MPH, Institute Nominating
 Committee Chair
RE Institute Board Vacancies

MEMORANDUM

The Institute nominating committee met January 20 to consider nominees for vacancies in the treasurer and at-large member positions, both created by the end of Clifford Wang's term.

Requested Action:

1. *Confirm Susan Moffatt-Bruce, MD, PhD, as the recommended candidate for treasurer.*
2. *Confirm Susan Currin, RN, MS, as the recommended candidate for at-large member director.*

Candidate for Treasurer: Susan Moffatt-Bruce, MD, PhD

The nominating committee recommends Susan Moffatt-Bruce, MD, PhD, for treasurer. The term will begin July 1, 2015 and run through June 30, 2016. Moffatt-Bruce has served on the board of directors since 2012 and also serves on the finance committee.



Susan Moffatt-Bruce, MD, PhD
Chief Quality and Patient Safety Officer
The Ohio State University Wexner Medical Center

Moffatt-Bruce is a cardiothoracic surgeon and chief quality and patient safety officer at The Ohio State University Wexner Medical Center (OSUWMC). As chief quality and patient safety officer, she is responsible for data collection, analysis, and process improvement for the 7-hospital, 1400-bed, 1200-physician academic medical center.

Moffat-Bruce completed her undergraduate degree at McGill University and her medical school and general surgery residency at Dalhousie University. She completed her doctor of philosophy in

transplant immunology at the University of Cambridge and her cardiothoracic surgery fellowship at Stanford University with additional training in thoracic transplantation. Moffat-Bruce was on staff at the University of British Columbia for two years before she was recruited to OSUWMC.

Over the past eight years at OSUWMC, Moffat-Bruce has developed a passion for quality and patient safety initiatives. She was trained at Intermountain Healthcare and the Institute for Healthcare Improvement and is a Black Belt in Six Sigma. She recently completed her master of business operational excellence at the Fisher School of Business.

Moffatt-Bruce is currently associate professor of surgery, Division of Thoracic Surgery, in the Department of Surgery and associate professor in the Department of Molecular Biology, Immunology, and Medical Genetics. She was appointed associate dean of clinical affairs for quality and patient safety in 2012.

Since becoming chief quality and patient safety officer in 2010, Moffat-Bruce has been responsible for the implementation of the safe surgical checklist and crew resource management across the medical center. She has also standardized processes that have reduced central line infections, pressure ulcers, and ventilator-associated pneumonia. With the recent introduction of an integrated electronic medical record, she has worked to reduce medication safety events and has led the organization to be very successful in the Centers for Medicare & Medicaid Services' Hospital Value-Based Purchasing Program. In 2013 and 2014, Moffatt-Bruce helped lead OSUWMC to third place in the UHC Leadership and Quality rankings. She designed a curriculum for medical students around quality, patient safety, and high reliability and recently organized a multi-professional resident quality forum that allows residents to identify and solve patient safety issues.

Candidate for At-Large Member Director: Susan Currin, RN, MS

The nominating committee recommends Susan Currin for at-large member director. The initial term for this position will begin July 1, 2015 and run through June 30, 2017. She will be eligible for re-election for up to two additional two-year terms. Currin is completing her third year of service on the education committee.



Susan Currin, RN, MS
CEO
San Francisco General Hospital and Trauma Center

San Francisco General Hospital and Trauma Center (SFGH) is the sole provider of trauma and emergency psychiatric services for the City and County of San Francisco. As leader of the medical center that serves approximately 100,000 patients annually and provides 20 percent of the city's inpatient care, Currin oversees a dynamic organization that offers a wide spectrum of inpatient and outpatient services to a diverse patient population.

As San Francisco's public hospital, SFGH's mission is to provide quality health care and trauma services with compassion and respect to patients, including the city's most vulnerable. SFGH is also one of the nation's top academic medical centers and partners with the University of California, San Francisco on clinical training and research. SFGH is the lynchpin of the Healthy San Francisco Program, which provides primary and specialty care access to the uninsured.

SFGH is designated by the American College of Surgeons for trauma services and The Joint Commission on the Accreditation of Healthcare Organizations for stroke and traumatic brain injury care. It is also the only hospital in San Francisco to earn the World Health Organization's Baby Friendly certification. Currin is currently leading SFGH's pursuit of magnet nursing status. She is also presiding over the construction of a new acute care building, a project that a record number of San Francisco voters support.

Currin has more than 25 years of experience as a hospital leader. Before becoming CEO, she served as chief operating officer and chief nursing officer at SFGH. Before joining SFGH, she was quality and service leader at Kaiser Permanente.

Currin is chair of the San Francisco health plan board. She gained special recognition for hospital fiscal management from the mayor's municipal fiscal advisory committee in 2007 and was named one of the "Most Influential Women in Bay Area Business" by the *San Francisco Business Times* in 2011. She has successfully secured millions in grant funding for a nursing internship program, medication error reduction project, and patient safety initiatives. Currin also helped develop SFGH's world-class Acute Care for Elders (ACE) Unit, which focuses on improving patient outcomes and satisfaction while shortening lengths of stay and reducing nursing home admissions.



DATE March 10, 2015
TO Board of Directors
FROM Johnese Spisso, RN, MPA, Nominating Committee
 Chair
RE Board Vacancies

MEMORANDUM

The nominating committee met January 20 to consider candidates for six vacancies on the board. The committee considered candidates for two officer positions: chair-elect and treasurer, to fill vacancies created by the end of Thomas Traylor and Reginald Coopwood's terms. The committee also considered candidates to fill four at-large director vacancies, two of which were created by Steven Gabbe's resignation and the end of Santiago Muñoz's final term. The committee will present its recommendations to the membership in the spring by electronic ballot.

Bios for the recommended candidates follow below.

Candidate for Chair-Elect: John Haupert

The nominating committee recommends John Haupert for chair-elect. The term will begin July 1, 2015 and run through June 30, 2016. Haupert has served on the board of directors since 2014 and on the policy advisory committee since 2012. He currently serves as chair of the policy advisory committee.



**John M. Haupert, FACHE
President and CEO
Grady Memorial Hospital**

Haupert began his tenure at Grady in October 2011. Grady Health System is the safety net health care system serving Fulton and DeKalb Counties in Georgia. It is the primary level I trauma center and burn center for the Atlanta metropolitan area. In addition, Grady is home to many nationally recognized clinical services including the Marcus Neuroscience and Stroke Center, the Correll Cardiac Center, the Georgia Cancer Center, and Grady EMS. Grady is also the primary training site for the Morehouse and Emory Schools of Medicine.

A native of Ft. Smith, Arkansas, Haupert is a graduate of Trinity University in San Antonio where he earned a master of science degree in health care administration. He also holds a bachelor of science in business administration from Trinity.

Haupert's career in health care management began at Methodist Health System in Dallas, Texas in 1992 where he served for 14 years in various roles, including president of one of the system's hospitals and executive vice president for corporate services and business development. In October 2006, Haupert left the Methodist Health System to become chief operating officer at Parkland.

Haupert is a Fellow in the American College of Healthcare Executives (ACHE) and is a recipient of the ACHE Regent's Leadership Award. Haupert served as ACHE regent for North and East Texas. He also served as Chairman of the board of trustees of the Dallas/Fort Worth hospital council, Chairman CareFlite's board, and as a delegate to the American Hospital Association's regional policy board.

In Atlanta, Haupert is a member of the Rotary Club of Atlanta and serves as a member of the board of directors of Central Atlanta Progress, The American Heart Association, and The Atlanta Committee for Progress. He is also a member of the advisory boards for The Healthcare Institute at Georgia State University and the Department of Community Health.

Nationally, Haupert serves on the health advisory committee to the Pew Charitable Trusts, on America's Essential Hospital's board, and on UHS' member board.

Candidate for Treasurer: Roxane Townsend, MD

The nominating committee recommends Roxane Townsend, MD, for treasurer. The term will begin July 1, 2015 and run through June 30, 2016. Townsend has served on the board of directors since 2014 and also serves on the finance committee.



Roxane Townsend, MD
Vice Chancellor for Clinical Programs, CEO University Medical Center
University of Arkansas for Medical Sciences

Townsend is responsible for strategic oversight of the University of Arkansas for Medical Sciences (UAMS) hospital and clinics, which together have more than 3,000 full-time employees. More than 23,000 patients are discharged from UAMS annually, and there are more than 388,000 outpatient visits annually. UAMS is the only adult level I trauma center in Arkansas. It has a high-level neonatal intensive care unit, specialized services for high-risk pregnancies, and extensive cancer services.

Townsend joined UAMS as vice chancellor for clinical programs and chief executive officer of UAMS Medical Center in February 2013. She previously served as assistant vice president for health systems at Louisiana State University (LSU) in Baton Rouge. In that role, she worked with the system's 10 hospitals and their clinics to develop operational strategies and systemwide policies.

Townsend was also CEO of the Interim LSU Public Hospital in New Orleans, Earl K. Long Medical Center in Baton Rouge, and as CEO of the LSU Health Care Services Division. Prior to joining LSU in 2007, Louisiana Gov. Kathleen Blanco appointed her secretary for the Louisiana Department of Health and Hospitals (DHH) for the transition to a new administration. She also served DHH as the Medicaid medical director and deputy secretary of the Department.

A native of Pennsylvania, Townsend holds a bachelor's degree in nursing from Duquesne University in Pittsburgh. After nine years working as a nurse, she entered medical school at LSU in New Orleans. She graduated from medical school in 1992 and completed a residency in internal medicine.

Candidates for At-Large Director

The nominating committee presents four candidates for consideration to join the board as at-large director:

- Akram Boutros, MD, president and CEO, The MetroHealth System
- Stan Hammack, CEO, University of South Alabama Medical Center
- Carlos Migoya, president & CEO, Jackson Health System
- Sam Ross, MD, CEO, Bon Secours Baltimore Health System

The initial term for these positions will begin July 1, 2015 and run through June 30, 2017. Candidates will be eligible for re-election for up to two additional two-year terms.



Akrom Boutros, MD
President and CEO
The MetroHealth System

The MetroHealth System is one of the largest, most comprehensive health systems in Northeast Ohio. Boutros joined MetroHealth in June 2013 after 20 years of successful hospital leadership, including five years as President of BusinessFirst Healthcare Solutions, an international advisory firm to health systems.

Boutros has led successful projects focused on strategic repositioning, operational redesign, clinical and physician integration, and accountable care organization development. He has served as an executive leader of community and specialty hospitals and academic medical centers.

A graduate of Harvard Business School's Advanced Management Program, Boutros is using his business acumen and collaborative leadership style to lead a transformation as The MetroHealth System moves from sick care to health care and plans for a new physical plant to deliver the health care of the future.



Stan Hammack
CEO
University of South Alabama Medical Center

Hammack became vice president of the University of South Alabama (USA) Health System in November 2006 after more than 30 years serving the university's medical mission in positions of increasing responsibility. He has an extensive background in medicine, starting as a pharmacist at USA Medical Center before transitioning into administrative leadership positions in USA hospitals.

During Hammack's tenure, the University of South Alabama Health System has become recognized as the Gulf Coast's most respected provider of health care, with nationally acclaimed physicians and the latest scientific and medical technologies found together only in academic health care.

Hammack is a tireless advocate for health care quality and accessibility in Alabama. In 2012, Governor Robert Bentley appointed him to the Alabama Medicaid Advisory Commission. The governor also appointed him to the Medicaid Hospital Services and Reimbursement Panel to represent public and governmental hospitals. He is chair of the Alabama Hospital Association's Medicaid steering committee, serves on the Business Council of Alabama's board, and is chair of America's Essential Hospital's membership committee.

Hammack has served with a wide range of health care organizations, including as Chairman of the Alabama Hospital Association, on the regional policy board of the American Hospital Association, and on the boards of Blue Cross and Blue Shield of Alabama, the Alabama Department of Public Health, and the Southwest Alabama Medicaid Maternity Care Program. The American Hospital Association honored him as Alabama's recipient of the Grassroots Champion Award in 2013. The Alabama Hospital Association awarded him the Gold Medal of Excellence in 2009.

Hammack is a graduate of Auburn University and holds a master's degree in public administration from the University of South Alabama.



Carlos A. Migoya
President & CEO
Jackson Health System

Migoya has served as President and CEO of Jackson Health System since May 2011. He oversees one of the nation's largest and most respected public health care networks. Jackson has the distinction of bringing world-class medical care – including the medical school faculty and students from the University of Miami and Florida International University – to a taxpayer-owned system that guarantees a single high standard of care for all residents of Miami-Dade County. The system is

anchored by Jackson Memorial Hospital, one of the top-ranked hospitals in Florida. The system also includes two neighborhood community hospitals, Holtz Children Hospital, Jackson Behavioral Health Hospital, Jackson Rehabilitation Hospital, two nursing homes, and numerous clinics.

Before joining Jackson, Migoya served as city manager for Miami, and successfully tackled the city's ailing budget issues. Most of his professional life was spent in banking. Over more than 40 years, he rose through the ranks from part-time teller to regional president and CEO. He spent many years working for Wachovia, most recently as regional president in North Carolina and CEO for the Atlantic region, where he was responsible for banking in New Jersey, Connecticut, and New York.

Migoya is actively involved in several community organizations, including having served as foundation chairman of Florida International University and as member of the university's dean's council, the College of Business Administration's principal advisory board. Since 2006, Migoya has served as a director of AutoNation, the largest auto retailer in the United States. He currently serves on the boards of the Downtown Charter School in Miami and the Jazz at Lincoln Center in New York City.

Migoya holds an undergraduate degree in finance and a master of business administration in finance from Florida International University.



Sam Ross, MD, MS
CEO
Bon Secours Baltimore Health System

Ross is responsible for the direction and management of Bon Secours Baltimore's integrated urban health system, which includes a 125-bed acute care hospital, a community-based primary care site, two substance abuse treatment centers, behavioral medicine, HIV/AIDS and renal dialysis services, preventive health/education programs, and an extensive community housing redevelopment program. Along with his responsibilities as CEO of Bon Secours Baltimore, Ross has an expanded role within Bon Secours Health System where he is market leader for Bon Secours Kentucky. The CEO of the Kentucky market reports to him. Ross also coordinates CEO forums for the system. He is a member of the board of directors of the prestigious Federal Reserve Bank of Richmond, Baltimore branch. The May 2012 issue of *Modern Healthcare* named Ross as one of the "Top 25 Minority Executives in Healthcare."

Ross is known for his commitment to quality health care as demonstrated by his membership in distinguished professional organizations such as the National Association of Health Services Executives (NAHSE). He received the 2010 Community Service/Health Care Executive Award from NAHSE for his work to improve health care and narrow the gap of disparities in Baltimore City. Ross is a member of the National Medical Association and the Maryland Hospital Association. He is committed to improving our community and is active in a number of

professional organizations focused on moving health care forward. His professional affiliations include the American Diabetes Association, the Alzheimer's Association, the American Heart Association, the American Cancer Society, the Maryland Patient Safety Center, and the Greater Mondawmin Coordinating Council.

Before arriving in Baltimore, Ross was a member of the staff of Parkland Health & Hospital System in Dallas, Texas, where he served in varied positions for more than 14 years including as executive vice president and chief medical officer of the medical staff/house staff division. Formerly, he was an associate director of the family medicine residency program at St. Paul Medical Center. Ross was also clinical professor in the Department of Family Medicine at the University of Texas Southwestern Medical Center and associate dean for clinical affairs at Parkland.

Ross holds a medical degree from the University of Texas Health Science Center Medical School in San Antonio, Texas, and a master of science in medical management from the University of Texas at Dallas, in Richardson, Texas.



DATE March 10, 2015
TO Board of Directors
FROM Bruce Siegel, MD, MPH
RE Revised UHC Memorandum of Understanding

MEMORANDUM

America's Essential Hospitals has revised the memorandum of understanding (MOU) for our long-standing partnership with UHC, at the request of UHC. The proposed revised MOU clarifies the association's relationship with UHC and details the benefits to both parties. It does not change the core business terms of the partnership.

The board is asked to grant Bruce Siegel, MD, MPH, the authority to execute the enclosed proposed revised MOU.

MEMORANDUM OF UNDERSTANDING

among

National Association of Public Hospitals & Health Systems,
America's Essential Hospitals, Essential Hospitals Institute
National Public Health and Hospital
Institute and UHC
University HealthSystem Consortium

This Memorandum of Understanding (the "MOU"), initially executed in March 2003, amended January 1, 2007 and July 1, 2009 is hereby revised effective [January 1, 200 7], and entered into by and among University HealthSystem Consortium (UHC), an Illinois nonprofit corporation, and with America's Essential Hospitals ("associationAEH"), formerly the National Association of Public Hospitals the National Association of Public Hospitals & Health Systems (NAPH), a District of Columbia nonprofit corporation, and the Essential Hospitals Institute ("Institute"), formerly the National Public Health and Hospital Institute (NPHHI), a District of Columbia nonprofit corporation and charitable affiliate of the associationAEH. NAPH_ (NAPH and NPHHI together, NAPH/NPHHI, the second party). America's Essential Hospitals and the Essential Hospitals Institute are collectively referred to as "the association". The terms of this revised MOU will prevail and apply without exception, and shall supersede and replace the terms of all previous versions of the MOU entered into by the parties.

Definitions and Purposes of MOU

- A. UHC. UHC is a consortium of academic health centers operated for charitable, educational, and scientific purposes, and specifically to promote high quality, efficient and effective delivery of health care services at nonprofit teaching hospitals and health systems.
- B. America's Essential Hospitals. America's Essential Hospitals is the leading association and champion for hospitals and health systems dedicated to high-quality care for all, including the most vulnerable. Since 1981, America's Essential Hospitals has initiated, advanced, and preserved programs and policies that help these hospitals ensure access to care. It supports members with advocacy, policy development, research, and education. NAPH. The association NAPH is an association of represents safety net public and other metropolitan area hospitals and health systems with a common mission of making their programs and services available to all residents of their community, without regard to race, ethnicity, gender, physical ability, creed, income or health insurance status.
- C. Essential Hospitals InstituteNPHHI. The Essential Hospitals Institute NPHHI is a charitable and educational organization established to address, through applied research and education activities, the major issues facing public hospitals, academic health centers and other safety net institutions, under served communities and related health policy issues of national priority. the private, nonprofit research arm of America's Essential Hospitals. The Institute researches and promotes best practices in health care, especially for vulnerable populations and underserved communities. It uses data analysis and lessons learned to help members of America's Essential Hospitals AEH and the larger health care industry improve quality and efficiency, and it educates and trains senior administrators and clinical leaders.
- D. Environment. Academic health centers and metropolitan area public essential hospitals are facing an increasingly turbulent and unstable health care delivery system. Uneven expansion in health

insurance coverage, looming cuts to hospital payments, increased competition for insured patients, diminished prospects for health care reform, unstable sources of financing, rapidly changing technology, increased pressure on medical education funding, direct links between quality and safety and hospital payments, growth in the number of uninsured Americans increased expectations for hospitals to partner with others in the community and assume more risk and responsibility for patient health and health care, shifts to non-hospital settings, increased focus on quality and safety, and other trends all threaten the fragile structure well-being of both university and public hospital and essential hospitals and health systems. In particular, the dependence of university and essential hospital systems on a myriad of funding streams to support their multiple missions makes them vulnerable to a cumulative and negative impact from legislative and regulatory changes. Supplemental funding programs, including but not limited to Medicaid and Medicare disproportionate share hospital (DSH) payments, graduate medical education (GME) funding, indirect medical education (IME) funding, savings from the 340B program, Medicaid upper payment limit (UPL) funding, and others are all critical to the survival of university and essential hospitals systems, and yet all of these are constantly under threat from adverse congressional action.

E. Mutual Benefits. The Executive Committees Boards of Directors of UHC, the association AEH and the Institute and NAPH, and the NPHHI Board, have determined that a close working relationship between all parties UHC and NAPH/NPHHI has resulted and will continue to result in numerous benefits to each organization, including:

- i. Benefits to the members of UHC from of America's Essential HospitalsAEH's leadership on key legislative and regulatory advocacy issues, such as Medicaid and Medicare DSH funding, GME and IME payments, the 340B program, and other funding streams that finance the care of vulnerable patient populations and support the unique role that university and essential hospital systems fill in their communities;
- ii. Access for UHC and its members to the association's AEH and the Institute's targeted publications, communications, and website(s) providing resources for essential hospital providers; and
- iii. Access of each organization and its members to educational meetings, conferences, teleconferences, and webinars of the other organizations, and the associated benefits of expanded networking;
- iv. Benefits to the members of both organizations formUHC and AEH from the research and analyses conducted on performance improvement and benefits to UHC of the aAEHssociation's policy and legislative analyses and impact assessments;
- v. Enhanced access to potential new members; and

I.

— Access of each organization'sAEH and UHC's members to additional types of benefits and services.:

H.

II. Access of each organization and its members to educational meetings, conferences and teleconferences of the other, and the associated benefits of expanded networking;

IV. Benefits to UHC and the association's its members' of NAPH's advocacy on legislative, regulatory and policy issues at both the national and state levels, including Medicaid and Medicare Disproportionate Share Hospital (DSH) and similar funding programs, financing of care to

vulnerable populations, and preservation of the health care safety net;

v. Access for UHC and its members to the association's NAPHINPHHI's targeted publications and web site addressing concerns of safety net health care providers; and

vi. VI. Benefits to UHC and its members of the research, education and communication activities of the association NAPH/NPHHI, including among others, educational presentations, webinars and participation in UHC conferences by NAPH Counsel Powell Goldstein LLP.

Terms of Agreement

UHC and NAPHINPHHI therefore All parties hereby agree as follows:

1. UHC Membership in the AssociationAEH, in NAPH. On behalf of and in furtherance of the purposes of its members, UHC will be a fullFull, voting, multi-provider health system in Member of the association and InstituteAEH NAPH, under the following terms.

1.1. Board. Pursuant to the organization'sthe AEH NAPH Bylaws, UHC will have at least one seat on the NAPH Board of Directors, or more as may be determined by the NAPH Executive Committee.

1.2. Dues. UHC dues to NAPH will be set annually in advance in an amount reasonably reflecting the member privileges accorded to UHC and its members. Calculations may take into account the number of UHC members that were not also NAPH members (using prior year's membership for administrative convenience), and such other factors as deemed significant. The parties anticipate that the level of dues will remain consistent with past levels. NAPH will consult with UHC prior to finalizing the UHC dues levy, then issue a dues invoice to UHC. Dues shall be paid in equal quarterly installments.

1.3.1.1. Executive Committee. the President of UHC will be granted an ex officio voting seats on the association's and Institute's AEH Board of Directors NAPH Executive Committee for the duration of UHC's Full Membership in AEH, its full multi-provider membership in NAPH, the association, as may be permitted by set forth in NAPH the association's AEH Bylaws. Biannually, the President of UHC is permitted to designate a senior UHC executive to serve, ex officio, as a voting director of the Institute. Consistent with the organization's AEH-NAPH Conflict of Interest policy, the UHC President will be excused/must recuse him or herself from any votes taken by AEH on this MOU, its own the UHC dues level, or other issues presenting a conflict. Consistent with the Institute Conflict of Interest policy, the UHC representative serving on the Institute Board must recuse him or herself from any votes taken by the Institute on this MOU, or other issues presenting a conflict.

1.4.1.2. Direct Benefits to UHC Members. UHC member health systems will continue to receive certain direct NAPH AEH member benefits from the association. For example, the chief executive officers of UHC members would receive the NAPH association AEH newsletters and publications, and Safety Net publications, and upon request UHC members would have access to the NAPH association AEH website, AEH NAPH member teleconferences and webinars, additional copies of publications, reduced rates for NAPH association AEH conferences, and other benefits.

2. UHC Participation in NPHHI. UHC will participate in NPHHI under the following terms.
- 2.1. Board. UHC will be granted an *ex officio* voting seat on the NPHHI Board of Directors for the duration of its full multi provider membership in NAPH, as may be permitted by NPHHI Bylaws. Consistent with the NPHHI Conflict of Interest policy, UHC will be excused from any votes taken on this MOU, its own dues level, or other issues presenting a conflict.
- 2.2. Direct Benefits to UHC Members. UHC member health systems will continue to receive certain NPHHI member benefits. For example, UHC members would receive copies of publications, and upon request UHC members would have access to the NPHHI website, reduced rates for additional copies of publications, and other benefits.
- 3.2. America's Essential Hospitals/AEH NAPH Membership in UHC. The associationAEH_NAPH will be a nonvoting member of UHC, under the following terms.
- 3.4.2.1. Board and Executive Committee. The associationAEH_NAPH will be granted a non-voting *ex officio* seat on UHC's Member Board of Directors and Governing Board. Consistent with the UHC Conflict of Interest policy, America's Essential Hospitals/AEHNAPH will be excused from any votes taken on this MOU, its own dues level, or other issues presenting a conflict.
- Dues. NAPH dues to UHC, if any, will be set annually in advance, in an amount reasonably reflecting the member privileges accorded to reasonably reflecting the member privileges accorded to NAPH and its members and taking into account such factors as deemed significant. UHC will consult with NAPH prior to finalizing any dues levy, then issue a dues invoice to NAPH.
- 4.3. Individual Membership -Eligibility.
- 4.4.3.1. UHC Members. UHC members meeting America Essential Hospitals'AEH_NAPH/NPHHI membership criteria will be eligible for membership in the associationAEH-NAPH/NPHHI, subject to all established membership policies and procedures and the AEH bBylaws.
- 4.4.3.2. NAPH/NPHHI AssociationAEH Members. NAPH/NPHHI AssociationAEH members meeting UHC membership criteria will be eligible for membership in UHC, subject to all established membership policies and procedures and the bylaws.
- 4.4.3.3. Privileges. Except as otherwise explicitly provided in this MOU, UHC and AEH will each organization will treat members of the other party, which join it pursuant to this Section 34, no differently than any of its other members within the same membership category.
5. Other Activities.
- 5.1. Enhanced Member Activities. In the event that NAPH makes enhanced member activities available to UHC or UHC's members, then NAPH will calculate a reasonable charge for such activities and provide an invoice to UHC.
- 5.2. Grants. From time to time, NPHHI may request grants from UHC, either for particular

~~projects or as ongoing support to further NPHHI's charitable purposes. UHC will consider any such requests and respond in its sole discretion and consistent with its own goals and purposes; however, UHC anticipates that grant levels will at least remain consistent with past levels. Any such grants will be properly documented between the organizations.~~

- 5.3. ~~Sponsorships. At its discretion, UHC will sponsor NAPH/NPHHI conferences, website, or other appropriate activities, consistent with its own goals and purposes. UHC anticipates~~

~~that sponsorship levels will at least remain consistent with past levels. Any such sponsorships will be properly documented between the organizations.~~

4. Term and Termination.

4.1. Term. The initial term of this MOU as revised will be January 1, ~~2007-2015~~ through December 31, ~~2011-2019~~. The MOU will be automatically renewed at the end of each term for an additional five-year term, unless it is terminated as provided in this Section ~~64~~.

~~4.2. Termination.~~ Any party may terminate the MOU with or without cause, effective as of December 31 of any year, upon written notice to the other party by July 1 of that year. ~~In the event of a material breach of this MOU by any party, written notice of such breach shall be provided to the breaching party by one or both of the non-breaching parties. If the breaching party fails to cure such breach within thirty (30) days of receipt of such notice, the non-breaching parties may terminate this MOU immediately.~~

~~4.2.~~

~~4.3. Effect on Memberships.~~ Upon termination of the MOU ~~for any reason, each UHC~~ ~~any reason~~ ~~breach shall be pr~~ organization's membership in the ~~other party~~ ~~UHC~~ will automatically be terminated. Those members of each organization that joined the other party pursuant to Section ~~4.3~~ above, may continue their membership in the other party, provided they remain eligible under that party's membership policies and procedures. No such member will be retroactively assessed any dues, fees or payments as a result of termination of this MOU or of the parties' membership in the other.

~~4.4.~~

5. Financial Terms (“core financial commitment”)

~~As mutually agreed in the Addendum to the MOU on July 2009, UHC agrees to pay a total of \$3.57 million (representing the original \$3.2 million from the MOU addendum dated July 2009 increased by 2% annually through December 31, 2014) in annual membership dues, sponsorships, grants and enhanced member activities to America’s Essential Hospitals AEH and the Essential Hospitals Institute (“Core Payment”), with the allocation of the Core Payment between the two organizations to be determined in the sole discretion of AEH and the Institute. UHC will increase its Core Payment by 2% annually on July 1st of each year of the term beginning in 2010. However, should there be a material adverse effect on UHC’s revenues, UHC will limit its Core Payment to the association AEH and Institute to the lesser of \$3.57 million (adjusted annually by 2%) or 1.7% of UHC’s total operating revenue.~~

6. Indemnification.

~~Each party agrees to indemnify, save and hold harmless the other parties, and their respective officers, directors, employees, and agents from and against any and all losses, expenses (including, but not limited to, payroll and income taxes and attorneys’ fees), damages, claims, suits, demands, judgments, and causes of action of any nature arising from or as a result of (i) the performance of indemnifying party’s obligations under this MOU, or (ii) the failure of the indemnifying party to comply with any term or condition of this MOU.~~

7. Confidentiality.

During the term of this MOU, each party, and its respective employees, officers and agents may receive or have access to data and information that is confidential and proprietary to the other parties. All such data and information made available to, disclosed to, or otherwise made known to a party (the "Receiving Party") in connection with this Agreement (collectively, the "Confidential Information") shall be considered the sole property of the disclosing party (the "Disclosing Party"). The Receiving Party hereby agrees to maintain the confidentiality of all non-public data and information provided by the Disclosing Party. The Receiving Party shall not disclose the Confidential Information to any third party, nor shall the Receiving Party use or duplicate any proprietary information belonging to or supplied by the Disclosing Party, without the prior written consent of the Disclosing Party. The confidentiality provisions of this MOU shall remain in full force and effect after the termination of this MOU.

5.8. General Provisions.

5.1.8.1. Notices. All notices under this MOU must be in writing and sent or delivered to the following addresses or to such other address as the respective organization may designate by notice:

If to UHC: 2001 Spring Road, Suite
700-155 North Wacker
Drive
Chicago, Illinois,
60606 Oak Brook, IL
60523
Attn: Irene Thompson

Attn: Robert J. Baker
Email: Baker@UHC.edu
Fax: (630) 954-5926

If to NAPH/NPHH/America's Essential Hospitals AEH:

1301 Pennsylvania Avenue NW, Suite 950
Washington, DC 20004
Attn: Christine C.
BurchBruce Siegel, MD,
MPH

Email: bsiegel@essentialhospitals.org CBurch@NAPH.org
Fax: (202) 585-0101

If to the Institute:

1301 Pennsylvania Avenue NW, Suite 950
Washington, DC 20004
Attn:

Email:
Fax:

Notices are deemed to be given at the time of mailing, if sent by certified mail, first-class postage prepaid, or at the time received, if hand delivered or sent by facsimile, electronic mail, courier, or other means.

7.2. 8.2 Entire Agreement. This MOU represents the entire understanding between the parties regarding their affiliation and replaces and supersedes any prior agreements, written or oral, relating to the subject matter hereof.

8.3 Amendment. This MOU may be amended by the mutual written consent of all organizationsparties. Amendments must be in writing and signed by the President or other officer of each organizationparty to this MOU.

7.3. 8.4 No Assignment. This MOU may not be assigned by any party, by operation of law or otherwise, without the prior written consent of the other parties to the MOU.

8.5 No Agency. The relationship of the parties to each other under this MOU is that of independent contractors. This MOU does not authorize any organization, nor any of its staff or members, to act as an agent or representative of any other organization or to bind the other party in any respectcreate any association, joint venture, partnership, or agency relationship of any kind between the parties. Unless agreed to in writing by the parties, no party is authorized to incur any liability, obligation, or expense on behalf of any of the other parties, to use the other parties' monetary credit in conducting activities under this MOU, or to represent to any third party that one party is an agent of another party to this MOU.

7.4.—8.6 Counterparts; Authority. This MOU may be executed in two or more counterparts, each of which will be deemed an original, but all of which together will constitute one and the same instrument. Each individual executing this MOU on behalf of a corporation or other entity represents that he or she is authorized to do so and that this MOU constitutes a legally binding obligation of the corporation or other entity that the individual represents.

8.7 Governing Law. This MOU shall be governed by the laws of the District of Columbia, without regard to its conflict of laws rules.

IN WITNESS WHEREOF, the parties hereto have caused duplicate originals of this MOU to be executed by their respective duly authorized representatives as of the date and year set forth below.

UHC:

By: _____

Irene Thompson, President

America's Essential Hospitals:

By: _____

Bruce Siegel, President and CEO

7.5.

By: _____

7.6.

David Engler, Institute Director

7.7.



DATE March 10, 2015
TO Board of Directors
FROM Bruce Siegel, MD, MPH
RE Board Member Expectations

MEMORANDUM

During the October board meeting, we discussed the benefits of creating clear expectations for board participation. Staff was tasked with creating a document that defines what the association expects of its board members. New board members would receive this document as part of their orientation. The nominating committee also would use it to assess a member's level of engagement during reappointment.

The following board member expectations document is proposed for the board's consideration and approval.



DRAFT

America's Essential Hospitals Board Member Expectations

Legal Duties for All Board Membersⁱ

- Duty of Care
 - This duty is very broad, requiring officers and directors to exercise *ordinary and reasonable care* in the performance of their duties, exhibiting honesty and good faith. Officers and directors must act in a manner which they believe to be *in the best interests of the association*, and with such care, including reasonable inquiry, as an ordinarily prudent person in a like position would use under similar circumstances.
- Duty of Loyalty
 - This is a duty of faithfulness to the association. This means that officers and directors must give undivided allegiance to the association when making decisions affecting the association. In other words, officers and directors cannot put personal interests above the interests of the association.
- Duty of Obedience
 - This duty requires officers and directors to act in accordance with the organization's articles of incorporation, bylaws, and other governing documents, as well as all applicable laws and regulations.

Minimum Expectations for All Board Members

- Provide organizational, strategic, and financial stewardship of the association
 - Read and understand the organization's bylaws, strategic plan, and financial statements
- Consider issues brought before the board in the context of broader membership needs (not individual member needs)
 - Support the majority decision of the board
- Attend two out of three in-person board meetings annually
 - Prepare for meetings
 - Actively participate during meetings
- Serve on one to two additional committees
 - Attend conference calls and committee meetings
 - Serve as a liaison between the committee(s) and the board
- Make all reasonable efforts to attend at least one education or other in-person association meeting annually

-
- Spring Policy Assembly (usually in March)
 - VITAL, the association's annual conference (usually in June)
 - Fall Policy Assembly (in October, or in December during election years)
 - Encourage hospital staff to participate in association activities
 - Distance learning programs
 - Interest group sessions
 - In-person meetings
 - Fellows Program
 - Data collection efforts, (including the Annual Hospital Characteristics Survey)
 - Support the association's corporate relations activities
 - Participate on at least one business advisory council call per year. These biannual calls bring together premier corporate affiliate members and leaders within the membership to discuss insights on industry trends.
 - Attend the business advisory council networking event during VITAL
 - Visit with and thank sponsors at association events
 - Assist with membership recruitment and retention activities, as requested
 - Advocate in Washington, DC, on issues important to our community of members, as requested
 - To Congress, the administration, federal agencies, other
 - Support association media work on behalf of essential hospitals as requested, including being available for media interviews

Additional Expectations of Officers

- All officers
 - Serve on executive committee
 - Serve on compensation committee
- Chair
 - Chair the board and executive committee
 - Serve on nominating committee
 - Deliver chair's address at major association conferences (VITAL and Policy Assembly, for example)
 - Pass chair's gavel to incoming chair during VITAL
 - Participate in town hall meeting during VITAL
 - Approve committee appointments
- Past-chair
 - Serve on nominating committee
 - Participate in town hall meeting during VITAL
- Chair-elect
 - Chair the nominating committee
 - Chair the compensation committee
 - Receive chair's gavel at VITAL and give short address
 - Participate in town hall meeting during VITAL
- Secretary
 - Serve on finance committee

-
- Serve on investment, audit, and compliance committee
 - Review and sign minutes of each board meeting
 - Treasurer
 - Chair finance committee
 - Serve on investment, audit, and compliance committee
 - Support preparation of the annual financial report
 - Support preparation of the annual audit

¹ Tennenbaum S. Legal Duties of Association Board Members. American Society of Association Executives Center Collection. <http://www.asaecenter.org/Resources/whitepaperdetail.cfm?ItemNumber=12217>. Accessed February 2015.



DATE March 10, 2015
TO Board of Directors
FROM Stan Hammack, Membership Committee Chair
RE Member Satisfaction Survey

MEMORANDUM

Background

The membership committee recently reviewed the results of an America's Essential Hospitals member survey. Given the recent changes at the association (e.g., rebranding and expanded programming), staff believed a survey would be a timely undertaking. America's Essential Hospitals retained the experienced association consulting firm McKinley Advisors (McKinley) to conduct the assessment to better understand members' needs and challenges, as well as their perception of whether the association brings value to membership. McKinley conducted telephone interviews with member hospital and health system CEOs, as well as an online survey.

Survey Overview

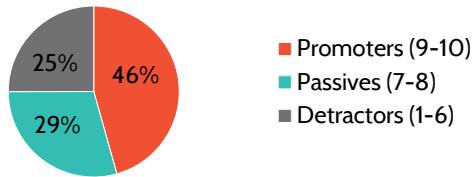
The online survey was distributed to all individuals identified in the association's database as being with a member hospital or health system. The survey spanned 33 days, from December 9, 2014, to January 12, 2015. In total, we received 390 completed and partially completed survey questionnaires, an 8.5 percent response rate.

Key Findings and Recommendations

Overall membership health is strong.

Respondents gave high marks to key membership health indicators, including overall satisfaction, likelihood to recommend, and the value of membership relative to the cost of dues. The association fares as well as, if not better than, other trade associations and associations in various health care fields. The next chart displays the association's net promoter score, which measures the willingness of customers to recommend a company's products or services to others. It serves as a proxy for gauging overall customer satisfaction with and brand loyalty to an organization. The score represents the difference between the promoter and detractor percentages, and scores greater than zero are seen as a positive indicator.

Net Promoter Score = 21
[Promoters - Detractors] (N= 311)



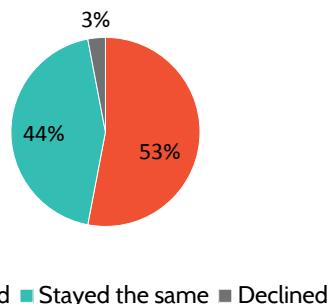
Responses to, and outcomes of, the rebranding effort are positive.

The majority of respondents (right) state that their perception of the association has improved since they first became a member, and one-third of these respondents directly attribute this improvement to the rebranding efforts and fresh leadership at the association. Furthermore, the majority of respondents say their institution is likely to renew its membership, and half of respondents are extremely confident America's Essential Hospitals will be relevant to their institution five years from now.

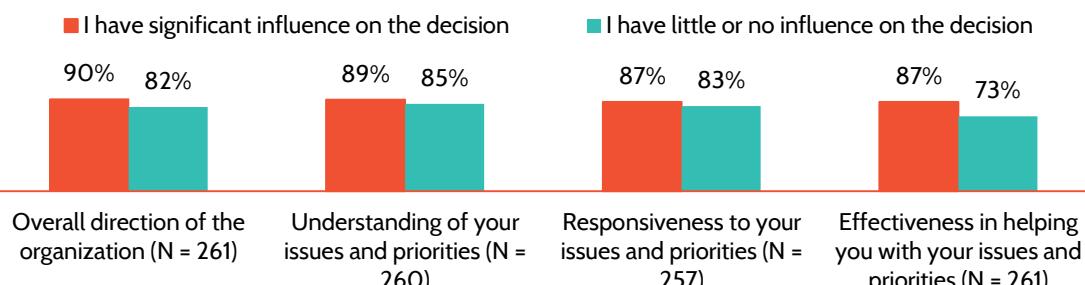
Perceptions are significantly stronger at the decision-maker level.

For nearly every data point in the survey, the decision-maker in an organization has a stronger, more positive perception of America's Essential Hospitals than does an individual who does not influence the decision to be an association member.

From the time you joined America's Essential Hospitals (formerly NAPH) until now, have your impressions of the organization: (N = 215)



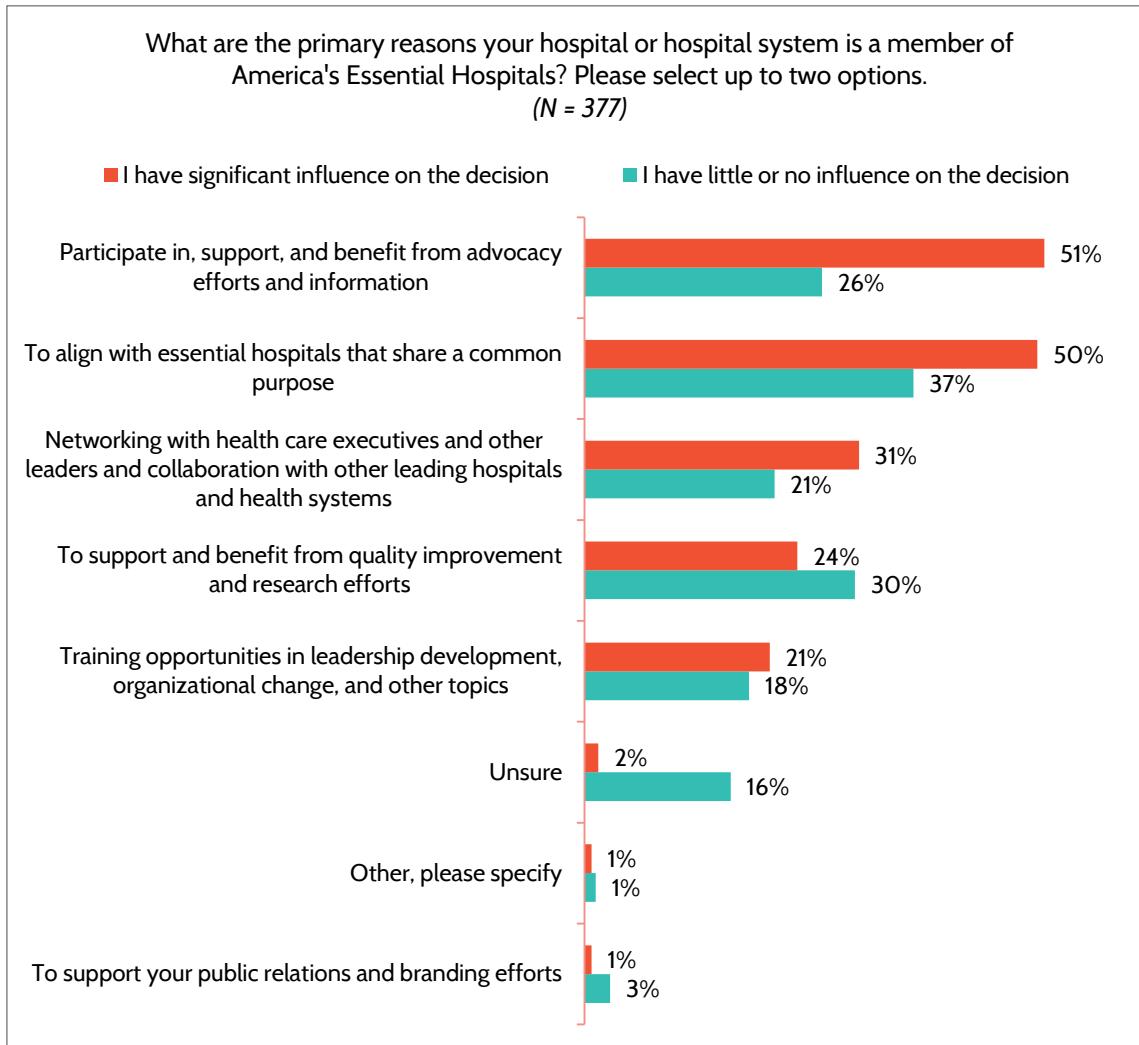
Based on your experience, how would you describe America's Essential Hospitals?



Percentages represent the sum of "excellent" and "good" responses

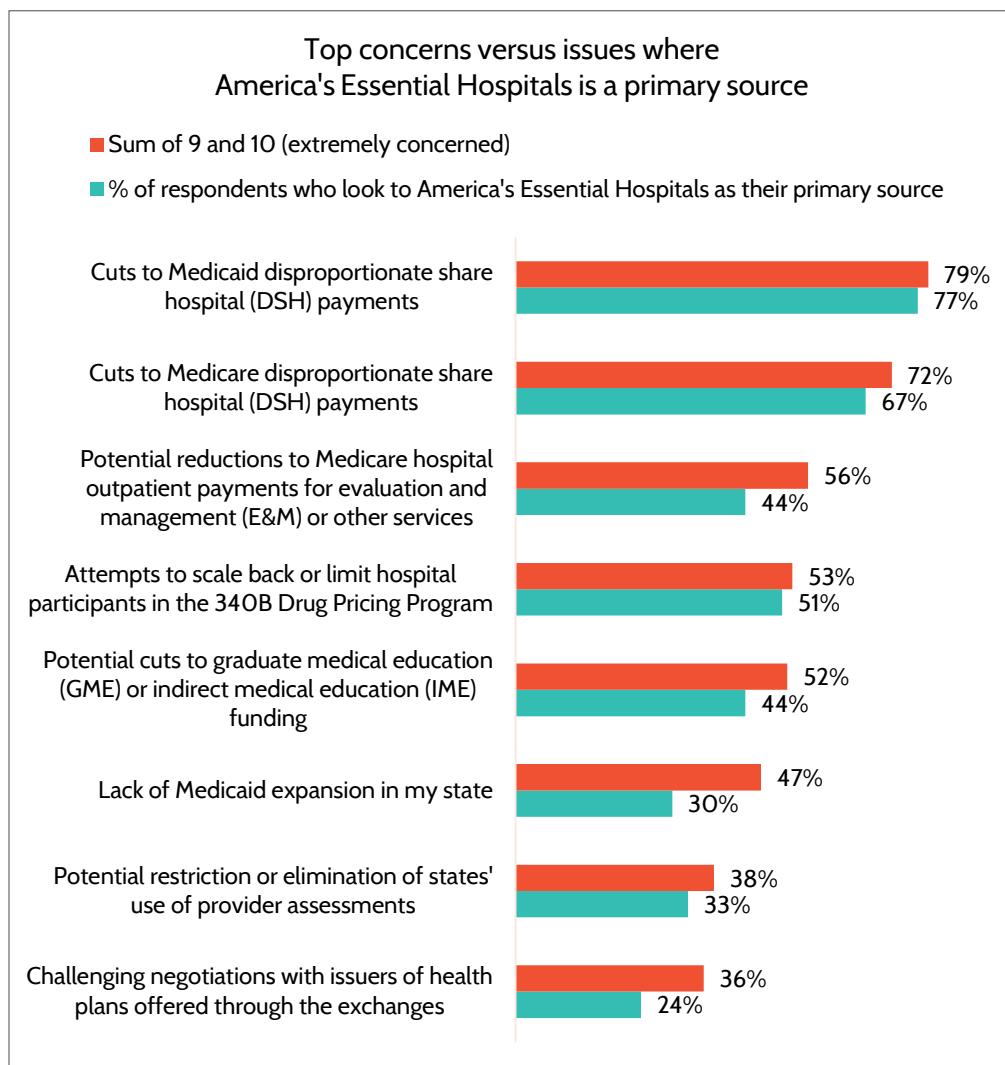
Advocacy and research/benchmarking/information sharing are the most important benefits of membership, but relative importance depends on an individual's role.

Advocacy support and research/benchmarking/information sharing were viewed universally as the most important benefits America's Essential Hospitals offers. However, individuals in higher positions in their institutions are more likely to gravitate towards the association's advocacy work, while other managers place more importance on benchmarking and best practices resources.



Respondents consider America's Essential Hospitals their primary source of support on many of their most pressing challenges.

There is a strong correlation between the challenges and issues respondents identify as most pressing and the likelihood they will turn to America's Essential Hospitals first on an issue. In other words, the association and the resources it provides are well-aligned with its members' challenges.





DATE March 10, 2015
TO Board of Directors
FROM Beth Feldpush, DrPH, Senior Vice President of Policy
and Advocacy
RE Policy/Advocacy Update

MEMORANDUM

This memo outlines advocacy and policy activities of America's Essential Hospitals since the October 2014, in-person board meeting, and details our advocacy agenda and expectations for the coming year.

2014 Election Results and Short-Term Impact on America's Essential Hospitals' Legislative Agenda

The 2014 midterm elections resulted in substantial victories for Republicans nationwide. After eight years in the Senate minority, Republicans took control of the chamber in 2015, with 54 seats. Republicans also picked up 11 seats in the House of Representatives, expanding their majority and making it the largest for Republicans since the 1940s. Republicans also fared surprisingly well in gubernatorial races across the country, winning in usually reliable Democratic strongholds, including Illinois, Maryland, and Massachusetts.

Exit polls and ballot initiative results indicate that the Republicans' historic victory was less about the party's popularity (which remains low) or a fundamental turn toward conservatism, and more about antipathy toward federal lawmakers in general—and President Obama in particular. Even in states where Republicans won significant victories, liberal ballot initiatives, including minimum wage increases, marijuana legalization, and stricter gun control laws, fared well.

The change in leadership in the Senate has meant new committee chairs: Sen. Orrin Hatch (R-UT), who now chairs the Senate Finance Committee, and Lamar Alexander (R-TN), the new chair of the Health, Education, Labor, and Pensions (HELP) Committee. In the House, Rep. Paul Ryan (R-WI) has become chair of the Committee on Ways and Means, bringing a potentially new agenda to that committee, as well. Association staff have started to engage the new leadership offices.

In the short term, the biggest issue Congress will address this spring is the need to continue to patch the Medicare physician fee schedule formula, known as the sustainable growth rate (SGR). The current patch will expire March 31. As always, we remain wary of the potential for hospital cuts to pay for a patch. We will continue to argue strongly that Congress jeopardizes essential

hospitals and the patients and communities they serve if lawmakers continue to siphon off hospital funding to pay for the broken SGR.

We are encouraged by several positive conversations regarding our key advocacy issues of Medicaid disproportionate share hospital (DSH) funding and sociodemographic risk-adjustment. Specifically, preliminary conversations with committee and party leadership staff indicate we may be able to further delay the start of Medicaid DSH cuts until fiscal year (FY) 2018. We also are hopeful lawmakers will include in the SGR legislation language to mandate that hospital readmissions measures be risk-adjusted to reflect patient sociodemographic variables (see additional details below). The eventual inclusion or exclusion of these provisions will be determined by committee chairs and House and Senate leadership over the coming weeks.

The Long-Term Outlook for 2015

In the longer term, we continue to watch Congress to find answers to two key questions:

- Will Republicans use their majority to attempt to dismantle the Affordable Care Act (ACA), or will they focus on other areas of interest, such as tax reform, immigration, and energy?
- To what extent will Obama compromise on health care issues? While the president is sure to veto any legislation that would fundamentally undermine the ACA, will he find opportunities to compromise in other areas, including Medicaid and Medicare spending, a top issue for Republicans?

While we expect that our current top issues—the 340B Drug Pricing Program, risk adjustment for sociodemographic status, Medicare and Medicaid DSH payments, site neutral payment policy for outpatient services, and others—will remain priorities, we are ready to respond to new threats, particularly to Medicaid, if Republicans increase their attacks on the ACA. Hatch, along with Sen. Richard Burr (R-NC), has developed a framework for a plan to repeal and replace the ACA. While the president surely would veto a full repeal, other significant changes may become reality. Hatch included in his plan per capita caps for Medicaid, a proposal that has some Democratic support and that could fundamentally undermine essential hospitals' funding. We will continue to talk with staff of Hatch and Burr as they develop these ideas.

Republicans have not been alone in raising concerns for essential hospitals. In early February, the Obama administration released its FY 2016 budget plan—a mixed bag for hospitals. On the positive side, the administration decided against previously proposed cuts to provider taxes and federal matching rates, and sought to extend the Children's Health Insurance Program (CHIP) through 2019 and boost funding for emergency preparedness, infectious disease response, and other public health initiatives. But the administration also proposed an additional year of Medicaid DSH reductions and these damaging cuts:

- \$30 billion over 10 years to off-campus, hospital outpatient services through a site-neutral payment policy
- \$16.3 billion over 10 years to Medicare indirect medical education (IME) payments—the largest IME cut ever proposed (the administration did include \$5.3 billion in grant

-
- funding over 10 years for a new “competitive graduate medical education program” that would focus on supporting primary and preventive care)
 - \$31 billion over 10 years to Medicare bad debt payments

Regarding site-neutral payments, we remain vigilant against this idea, which continues to generate support on and off Capitol Hill after first being raised several years ago by the Medicare Payment Advisory Commission. Although proposals vary, the policy generally would lower hospital Medicare payments for certain services to the same rates the program pays physicians for those services. If Congress legislates this approach, it would disproportionately harm essential hospitals. We have successfully blocked this idea and will continue to oppose it.

Last, we are watching for the outcome of the King v. Burwell case, which was argued in front of the U.S. Supreme Court March 4. The case will decide whether tax-credit subsidies may be extended to individuals who purchase coverage through health insurance marketplaces (exchanges) established by the federal government, in addition to individuals who purchase coverage through state-based marketplaces. We expect the court to issue its ruling in late June.

If the court sides with the plaintiffs and declares impermissible tax-credit subsidies to individuals who purchase coverage through federal marketplaces, it is unclear whether and how the Obama administration or Congress might intervene. The Robert Wood Johnson Foundation and the Urban Institute recently estimated that a ruling for the plaintiffs would add 8.2 million more individuals to the ranks of the uninsured and increase uncompensated care costs by \$12 billion. America’s Essential Hospitals filed an amicus brief with other national hospital associations in support of the government’s position that the tax-credit subsidies are permissible. We will be prepared to share relevant information and analysis with members on the ruling when it comes out in late June.

Issues in Depth

The 340B Drug Pricing Program

The Health Resources and Services Administration (HRSA) continues to craft guidance on the 340B program. As we wait for that guidance, we continue to meet with influential policymakers to stress the importance of the program to essential hospitals and the necessity for hospitals to retain all of their 340B savings so that they can continue to provide services to underserved and vulnerable individuals. We also will continue to engage the media on this issue and create opportunities to communicate the importance of the 340B program. Recent activity includes placement of a commentary by Bruce Siegel, MD, MPH, in the March 2 issue of *Modern Healthcare*, a widely read publication in health policy circles.

We expect HRSA to release its guidance informally through a subregulatory process and touch on a number of issues regarding hospital participation in the program. HRSA had been preparing a “mega-reg,” but set that aside after a court ruling on orphan drugs called into question the agency’s authority to regulate the 340B program. HRSA has indicated that even though it won’t structure its forthcoming guidance as a formal proposed rule, it will post it in the *Federal Register* and seek notice and comment on it, essentially treating it as a normal regulatory process. We

have heard little about which program elements HRSA might address in its guidance. But given debate over its program authority, we expect the agency will avoid controversial issues, such as patient definition and hospital eligibility.

As we wait for more information on the guidance, America's Essential Hospitals has advocated for immediate regulatory relief from HRSA's burdensome policy that precludes hospitals from enrolling new outpatient clinics into the 340B program until the clinics' costs appear on a filed cost report. HRSA's policy can delay a clinic's eligibility for the 340B program for up to 21 months from when the clinic opens. We believe this delay is illogical at best and, at worst, detrimental to hospitals' ability to serve patients. We know that many of our members have included ambulatory and primary care expansion as project goals under their Medicaid incentive program waivers, and we know HRSA's misguided policy threatens their ability to meet these waiver project goals. We have long advocated to HRSA that this policy should and could be changed without the need for formal rulemaking. We will continue to reach out to HRSA on this issue and involve CMS in these discussions, given the impact on waiver project progress.

Supporting Equity in Quality Measurement

America's Essential Hospitals continues to support legislative proposals that would require the Centers for Medicare & Medicaid Services (CMS) to risk adjust Medicare's Hospital Readmissions Reduction Program (HRRP) measures for sociodemographic variables. In the last Congress, two bills were introduced that, through different approaches, would ensure that the readmissions measures do not unfairly penalize hospitals that care for vulnerable patients. In the House, legislation sponsored by Rep. Jim Renacci (R-OH) would have directed the secretary of the U.S. Department of Health and Human Services to adjust the readmissions measures used for the HRRP by the proportion of dually eligible patients (a proxy for counting low-income patients) hospitals serve. On the Senate side, America's Essential Hospitals worked closely with Sen. Joe Manchin (D-WV) on legislation that would have gone further than the Renacci bill by requiring CMS to risk adjust the actual methodology of the readmissions measure for sociodemographic factors.

We are pleased that both Renacci and Manchin, along with Sen. Portman (R-OH), remain highly interested in advancing this legislation. America's Essential Hospitals has worked closely with all three lawmakers as they drafted a unified version of the legislation that would direct CMS to risk adjust the measures based on each hospital's proportion of dually-eligible individuals and available U.S. Census Bureau data during a two-year transition, and then directly incorporate applicable sociodemographic variables into the methodology of the measures. We expect introduction of unified legislation by the middle of March and are optimistic the bill will be included in this spring's SGR package, as it has already generated strong bipartisan support in both chambers of Congress.

Protecting Hospitals' Medicare DSH Payments

America's Essential Hospitals is concerned about the growing size of the ACA-mandated cuts to Medicare DSH funding. Although we support the policy goal to redirect and target Medicare DSH funding to those hospitals that serve a larger proportion of low-income patients, we know

that, over time, the size of the cuts will have a negative financial impact on most, if not all, of our members.

During the rulemaking process through which CMS developed its approach for making the Medicare DSH cuts, the association spearheaded an effort to ensure that data used to determine future Medicare DSH payments are as accurate and reliable as possible. Specifically, we have provided, and will continue to provide, comprehensive comments to CMS on the accuracy of the data elements captured on worksheet S-10 of the Medicare cost report.

CHIP Funding Extension

The ACA reauthorized CHIP through 2019, but only included funding for the program through September 30, 2015. Therefore, the extension of CHIP funding is considered “must-pass” legislation this year. While most lawmakers agree the program should continue, they are split on whether the next round of funding should continue through 2019 or just through 2017. Also, some Republican Senate staff have indicated they would like to use the CHIP funding extension as an opportunity to reopen the ACA and force a conversation with Democrats about significant changes to the law or to existing entitlement programs.

The association supports continuing CHIP funding and has engaged congressional staff in conversations on entitlement reform, although we believe they have made little progress developing such proposals. It is estimated that 2 million children would become uninsured in the unlikely event Congress fails to extend CHIP funding. The rest would gain coverage in health insurance marketplace (exchange) plans.

Meaningful Use of Health Information Technology

CMS announced in February that it will issue a rule this spring easing certain requirements of the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs. The changes will begin with the 2015 reporting year. CMS has acknowledged provider group feedback on the difficulties providers face meeting meaningful use requirements.

In a recent blog post, CMS stated that it plans to reduce the reporting period for eligible hospitals and professionals to 90 days for 2015, instead of the entire fiscal year for which hospitals are required to report. The agency also intends to shift hospitals to a calendar year reporting to align the EHR incentive programs with other quality reporting programs and to provide hospitals with more time to adopt the latest version of certified EHR technology. We will watch for the formal guidance carrying out these changes. We also expect CMS to issue the proposed rule on stage 3 meaningful use requirements this month.

Member Education and Advocacy on Medicaid Incentive Program Waivers

In 2014, the association developed a thoughtful approach to providing leadership and member resources on Medicaid incentive program waivers. We conducted a series of webinars, published several briefs on this topic, held learning sessions during our VITAL2014 annual conference, and conducted a one-day fly-in meeting in Chicago.

For 2015, we plan to continue these efforts and look to build out additional resources for our members. For example, we will design a designated waiver topics landing page on our website that will be a central repository for member resources on Medicaid waivers. The website will include our policy and research briefs, links to past webinars, information about upcoming meetings, and other information from CMS and states with waiver programs. Through our publications, we will also begin to build the case for the positive impact waiver programs can have on communities and individuals by broadly sharing the improvements our members have achieved in quality improvement, cost efficiency, and increased access to services.



DATE March 10, 2015
TO Board of Directors
FROM Michael Belzer, MD, Education Committee Chair
RE Education Committee Report

MEMORANDUM

On behalf of the education committee, I am pleased to share the following update on educational programming.

Annual Conference: VITAL2015

We shared with the board in October 2014 our plans to conduct a call for proposals to assist in identifying sessions for the annual conference program. This process is now complete. Key highlights are below:

- 79 total submissions
- 39 hospitals represented in the submissions
- 44 proposals selected for oral or poster presentation

A draft agenda is included in appendix B of this report.

Additionally, staff are working to identify alternate vehicles for using the proposals not selected for the annual conference. These include webinars, interest group meetings, blog posts, and more. Our goal is to highlight nearly every submission in some way throughout the year.

Fellows Program

We have accepted 39 applicants from 21 different organizations to the new 2015 Fellows Program class; a list of participants is attached in Appendix C of this report. This year, we targeted recruitment at new members, new CEOs, and fellows alumni. We held informational conference calls and sent personalized letters to stakeholders. We received applications from two new members, Care New England and Jersey City Medical Center. We also received six applications from organizations with new CEOs, including Hennepin County Medical Center, Cook County Health & Hospitals, Harborview Medical Center, Tampa General Hospital, West Virginia University Hospitals, and Howard University.

In the next few months, staff will hold calls with the fellows' CEOs to discuss their role as a sponsor and to go over our commitment to them and their organizations.

Appendix A: Committee Roster July 1, 2014 – June 30, 2015

Michael B. Belzer, MD
Chair (2014-2016)
Medical Director and Chief Medical Officer
Hennepin County Medical Center
Minneapolis

Sherrie D. Williams, MD, MHS
Vice Chair (2014-2016)
Medical Director of Pulmonary
Rehabilitation and Smoking Cessation
The MetroHealth System
Cleveland

D. Craig Cathcart, RN (2013-2015)
Director of Legislative Affairs and Advocacy
Swedish Covenant Hospital
Chicago

Theodore Chan, MD (2013-2015)
Chair of Emergency Medicine
UC San Diego Health System
San Diego

Susan R. Cooper, MSN, RN (2014-2016)
Chief Integration Officer, Senior Vice
President of Ambulatory Care
Regional One Health
Memphis

Susan A. Currin, RN, MS (2014-2016)
CEO
San Francisco General Hospital and Trauma
Center
San Francisco

Delvecchio S. Finley, MPP (2014-2016)
CEO
Harbor-UCLA Medical Center
Torrance, California

James R. Gonzalez, MPH (2014-2016)
President and CEO
University Hospital
Newark, New Jersey

Thomas J. Quattroche, PhD (2013-2015)
Senior Vice President of Marketing,
Planning and Business Development
Erie County Medical Center
Buffalo, New York

Arnold Tabuenca, MD (2013-2015)
Chief Medical Officer
Riverside County Regional Medical Center
Hospital Administration
Moreno Valley, California

Joseph Woelkers, MA (2013-2015)
Executive Vice President and Chief of Staff
UT Health Northeast
Tyler, Texas



*June 24-26
The Westin Gaslamp Quarter
San Diego*

Tracks: CL = Clinical Leadership; EL = Executive Leadership; I&A = Innovation and Adaption; FIN = Finance; Q&PS = Quality and Patient Safety

MONDAY, JUNE 22		
8 am – 5 pm	Fellows Program	Harbor, 3 rd Floor
TUESDAY, JUNE 23		
8 am – 5 pm	Fellows Program	Harbor, 3 rd Floor
11 am – 5 pm	Association Board of Directors Meeting (closed)	Coronado, 3 rd Floor
noon – 5 pm	Government Relations Academy	Sierra, 2 nd Floor
5:30 – 7 pm	Reception (invitation-only)	California Foyer, 2 nd Floor
WEDNESDAY, JUNE 24		
7 am – 7 pm	Conference Registration Open	California Foyer, 2 nd Floor
7 – 8 am	Continental Breakfast	California Foyer, 2 nd Floor
7:30 am – 1:30 pm Tracks: CL, EL, I&A, Q&PS	Site Visit to UC San Diego (space is limited and preregistration is required) Tour Option #1: Sulpizio Cardiovascular Center Tour Option #2: Moores Cancer Center Tour Option #3: Jacobs Medical Center Building Site (hard hat tour)	Offsite, Buses will depart the hotel lobby at 7:30 am
8 am – noon	Institute Board of Directors Meeting (closed)	Coronado, 3 rd Floor
8 am – 2 pm	Fellows Program	Harbor, 3 rd Floor
8 am – 2 pm	Government Relations Academy	Sierra, 2 nd Floor
INTEREST GROUP MEETINGS		
Tracks: EL, FIN	340B Interest Group Meeting	Santa Fe, 2 nd Floor
Tracks: CL, EL	Medical Leaders Interest Group Meeting	Plaza, 2 nd Floor
3:30 – 5 pm	Opening General Session Welcome & Conference Overview	California Ballroom, 2 nd Floor

	<p>Chairman's Remarks William B. Walker, MD – <i>Director and Health Officer, Contra Costa Health Services; Board Chair, America's Essential Hospitals</i></p> <p>Opening Keynote Speaker Eric Topol, MD – <i>Director, Scripps Translational Science Institute and Author, The Patient Will See You Now and The Creative Destruction of Medicine</i></p>	
5:30 – 7 pm	Opening Reception	Garden Terrace, 4 th Floor
THURSDAY, JUNE 25		
7 am – 4:30 pm	Conference Registration Open	California Foyer, 2 nd Floor
7 – 8 am	Continental Breakfast and Targeted Networking	California Foyer, 2 nd Floor
8 – 9 am	CRITICAL CONVERSATIONS (choose one of five)	
Track: CL	<p>Understanding and Using REAL Data to Target Culturally Competent Care</p> <p>Moderator: Matilde Roman, JD – <i>Senior Director, Office of Culturally and Linguistically Appropriate Services, New York City Health and Hospitals Corporation</i></p> <p>Julia Joseph-Di Caprio, MD, MPH – <i>Chief of Pediatrics and Assistant Chief of Provider Services, Hennepin County Medical Center</i></p> <p>Victor Sosa – <i>Co-Founder and Director, Natividad Medical Foundation's Indigenous Interpreting+</i></p>	Plaza, 2 nd Floor
Track: EL	<p>Integrating Rural Providers in a Revitalized Strategic Plan</p> <p>Mark Birdwhistell, MPA – <i>Vice President, Administration and External Affairs, UK HealthCare</i></p> <p>Rob Edwards, MBA – <i>Director of Strategic Initiatives and Regulatory Affairs, UK HealthCare</i></p>	Santa Fe, 2 nd Floor
Track: I&A	<p>Street Medicine, Respite Care: Meeting the Needs of Homeless Populations</p> <p>Dan Castillo, MHA – <i>CEO, LAC+USC Medical Center</i></p> <p>Mercy Egbujor, DNP, APRN – <i>Family Nurse Practitioner, Santa Clara Valley Medical Center, Valley Homeless Healthcare Program</i></p> <p>Leslie Enzian, MD – <i>Director, Medical Respite Program, Harborview Medical Center</i></p>	Del Mar, Lobby Level
Track: FIN	Foundations of Essential Hospitals Financing	Sierra, 2 nd Floor
	<p>Sarah Mutinsky, JD, MPH – <i>Deputy General Counsel, America's Essential Hospitals; Associate, Eyman Associates, PC</i></p>	
Track: Q&PS	<p>How Safe is Your Hospital? Really?</p> <p>James L. Reinertsen, MD – <i>President, The Reinertsen Group; former Chief Executive Officer (CEO), Park Nicollet Health Services and Caregroup</i></p>	La Jolla, Lobby Level

9 – 10:15 am	General Session President's Remarks and Town Hall Meeting	California Ballroom, 2 nd Floor
10:15 – 10:45 am	Networking Break	California Foyer, 2 nd Floor
10:45 am – noon	EDUCATION BREAKOUT SESSIONS (choose one of five)	
Track: EL	Sustaining Philanthropic Support While Under the Media Microscope Frederick Cerise, MD, MPH – <i>Chief Executive Officer, Parkland Health & Hospital System</i> George Engdahl, MA – <i>Vice President of Development and Capital Campaign Director, Parkland Foundation</i> David Krause, D.Min. – <i>President & CEO, Parkland Foundation</i> Cynthia A. Scott, MSW, MBA – <i>Senior Development Officer, Parkland Foundation</i>	Santa Fe, 2 nd Floor
Track: FIN	New Models of State Medicaid Financing Speakers TBD	Sierra, 2 nd Floor
Track: I&A	Integrating Behavioral Health and Primary Care via Texas' 1115 Waiver Brittney Nichols – <i>Program Manager, Regional Learning Collaborative, UT Health Northeast</i> Alan Podawiltz, DO, MS – <i>Chair of Psychiatry, JPS Health Network</i> Wayne Young, MBA – <i>Senior Vice President, Behavioral Health, JPS Health Network</i>	Plaza, 2 nd Floor
Track: I&A	The Intersection of Hunger and Health Kathy Chan – <i>Director of Policy, Cook County Health & Hospitals System</i> Diana B. Cutts, MD – <i>Director, Office of Pediatric Research and Advocacy, Hennepin County Medical Center</i> Steven McCullough, MBA – <i>Vice President of Community Partnerships, Greater Chicago Food Depository</i>	Del Mar, Lobby Level
Track: Q&PS	LEAN and other Tools for Operational, Clinical, and Service Excellence Cathy Duquette, PhD, RN – <i>Executive Vice President, Nursing Affairs, Lifespan/Rhode Island Hospital</i> Susan Ehrlich, MD, MPP – <i>Chief Executive Officer, San Mateo Medical Center</i> Iman Nazeeri-Simmons, MPH – <i>Chief Operating Officer, San Francisco General Hospital</i> Nidia Williams, MA – <i>Administrative Director, Operational Excellence (OpX), Lifespan/Rhode Island Hospital</i>	La Jolla, Lobby Level

noon - 2 pm	Gage Awards Luncheon	California Ballroom, 2nd Floor
2:15 – 2:45 pm	MINI-SESSIONS (choose one of five)	
Track: CL	Care Transitions Taskforce: Bridging Silos from Hospital to Home Karishma Oza, MPH – <i>Care Transitions Analyst, San Francisco General Hospital</i> Michelle Schneidermann, MD – <i>Associate Clinical Professor of Medicine, San Francisco General Hospital</i>	Plaza, 2nd Floor
Track: EL	Leading a Hospital Turnaround in a Non-Expansion State Robert Brooks, MBA – <i>Executive Vice President & COO, Erlanger Health System</i>	Santa Fe, 2nd Floor
Track: FIN	Current Finance Issues Speaker TBD	Sierra, 2nd Floor
Track: I&A	Innovations in Health Care Julie Cerese, RN, MSN – <i>Senior Vice President, Performance Improvement, UHC</i>	Del Mar, Lobby Level
Track: Q&PS	The Daily Safety Brief: A Real-Time Review Anne Aulizio, MSN, RN – <i>Patient Safety Officer, The MetroHealth System</i>	La Jolla, Lobby Level
3 – 3:30 pm	MINI-SESSIONS (choose one of five)	
Track: CL	Clinical Workforce Practices to Maximize Clinical Effectiveness Speaker TBD	Plaza, 2nd Floor
Track: EL	Care Coordination among DSRIP Partners Maureen E. Fahey, RN, MBA – <i>President, PMA, Inc.</i> John “Skip” F. Williams Jr., MD, EdD, MPH – <i>President, Downstate Medical Center, State University of New York</i>	Santa Fe, 2nd Floor
Track: FIN	Better Care and Lower Costs with Proactive Palliative Care Heather Harris, MD – <i>Associate Medical Director, Supportive & Palliative Care Service, San Francisco General Hospital</i> Anne Kinderman, MD – <i>Director, Supportive & Palliative Care, San Francisco General Hospital</i>	Sierra, 2nd Floor
Track: I&A	Culture of Health – 100 Million Lives Campaign Speaker TBD	Del Mar, Lobby Level
3 – 3:30 pm	MINI-SESSIONS (continued, choose one of five)	
Track: Q&PS	Self-Administered Home Antimicrobial Infusion for the Uninsured	La Jolla, Lobby Level

	Kavita P. Bhavan, MD, MHS – <i>Medical Director, Infectious Diseases/OPAT Clinic and Medical Director, Antimicrobial Stewardship, Parkland Health and Hospital System</i>	
3:30 – 4:15 pm Tracks: CL, EL, FIN, I&A, Q&PS	Poster Session (see attached for listing of poster presentations)	California Ballroom, 2 nd Floor
4:15 – 4:45 pm Tracks: CL, EL, I&A, Q&PS	<p>Rapid-Fire Presentations</p> <p>Quick, Effective, Preventive: Routine, Opt-Out HIV Testing Nancy Miertschin, MPH – <i>Manager, HIV Projects, Harris Health System</i></p> <p>Better Maternal Experience, Better Patient Retention Sue Kehl, RN, MSN – <i>Director, Women's & Children's Health, Santa Clara Valley Medical Center</i></p> <p>Empowering At-Risk Communities HERE and Now Aaron Byzak, MBA – <i>Director of Government and Community Affairs, UC San Diego</i></p> <p>Safer Care from Tragedy of Patient Stairwell Death Jeff Critchfield, MD – <i>Medical Director, Risk Management, San Francisco General Hospital and Trauma Center</i></p>	California Ballroom, 2 nd Floor
6:30 – 10 pm	VITAL2015 Celebration Sponsored by Supplemental Health Care	Offsite, USS Midway
FRIDAY, JUNE 26		
7 am – noon	Conference Registration Open	California Foyer, 2 nd Floor
7 – 8 am	Breakfast	California Foyer, 2 nd Floor
8 – 9 am	CRITICAL CONVERSATIONS (choose one of five)	
Track: CL	<p>Breaking Barriers to Improve Gender Disparities</p> <p>Kathy Donofrio, DNP, MBA, RN – <i>Associate Vice President, Nursing and Women's Health Director, Swedish Covenant Hospital</i></p> <p>Jennifer Tscherney, MPS – <i>Executive Director, Swedish Covenant Hospital Foundation</i></p>	Plaza, 2 nd Floor
Track: EL	<p>The Neuroscience of Leadership</p> <p>Lynn Elliott – <i>Managing Director, Fahy Consulting</i></p> <p>Patty Fahy, MD – <i>Principal, Fahy Consulting</i></p>	Santa Fe, 2 nd Floor
Track: FIN	<p>Medicaid and Medicare DSH: Current Rules & Future Challenges</p> <p>Sarah Mutinsky, JD, MPH – <i>Deputy General Counsel, America's Essential Hospitals; Associate, Eyman Associates, PC</i></p>	Sierra, 2 nd Floor
8–9 am	CRITICAL CONVERSATIONS (continued, choose one of five)	
Track: I&A	How to Create a Positive LGBTIQ Atmosphere in Your Hospital	Del Mar, Lobby Level

	Julie Weckstein, MSW – <i>Licensed Clinical Social Worker, UC Davis Health System</i>	
Track: Q&PS	Reducing Violence and Building Skills for Psych Patients: The Role of a Behavior Support Team Renuka Ananthamoorthy, MD – <i>Chief of Service, Kings County Hospital Center</i> Jennifer Morrison-Diallo – <i>Coordinating Manager, Kings County Hospital Center</i> Liliane Rocha – <i>Assistant Director of Hospitals, Kings County Hospital Center</i>	La Jolla, Lobby Level
9am – noon	Closing General Session Federal Legislative and Regulatory Update Beth Feldpush, DrPH – <i>Senior Vice President for Policy and Advocacy, America's Essential Hospitals</i> Shawn Gremminger, MPP – <i>Director of Legislative Affairs, America's Essential Hospitals</i> National Health Policy: Views from Policymakers National and state policy leaders will speak on issues affecting hospital funding and member hospitals. Closing Keynote Speaker Zubin Damania, MD – <i>Director of Healthcare Development, Downtown Project Las Vegas</i>	California Ballroom, 2 nd Floor
1 – 4 pm	POSTCONFERENCE WORKSHOP (registration is required and additional fee applies)	
Track: EL	Providers of Choice: Essential Hospitals in a New Era of Competition Rich Neimand – <i>President and Creative Director, Neimand Collaborative</i> David Clayton – <i>Consultant, Neimand Collaborative</i>	Santa Fe, 2 nd Floor

PRELIMINARY LISTING OF POSTER PRESENTATIONS

Evaluation of a Falls Pilot on a Medical-Surgical Unit
Eskenazi Health

Patient Flow Intervention
Harbor-UCLA Medical Center

Documentation of Hierarchical Condition Categories Using Scribes
Hennepin County Medical Center

Disease and Access to Nutritious Food among Highland Hospital Patients
Highland Hospital, Alameda Health System

Arizona Partners with California to Improve Perinatal Outcomes
Maricopa Integrated Health System

School Health: Linking Medical Homes to Student Success in Cleveland
The MetroHealth System

Transitions Before Noon
Norwegian American Hospital

ProACTive Care Transition Communication Reduces Repeat ED Visits
Olive View-UCLA Medical Center, Olive View-UCLA Education and Research Institute

Optimizing Specialty Care within the Safety Net Hospital System
San Francisco General Hospital and Trauma Center

Sounding the Alarm on Inpatient Falls: Icons and Education
San Francisco General Hospital and Trauma Center

Reentry Medicine: A Medical Home for the Recently Incarcerated
Santa Clara Valley Medical Center

Outpatient Care Coordination for Complex Patients
Santa Clara Valley Medical Center

Ambulatory and Inpatient Teamwork Improves Patient Safety
UAB Hospital, University of Alabama Health Services Foundation, PC

Supply Optimization – An Ongoing Cycle of Improvement
UC Davis Health System

Creating and Sustaining One-piece Flow in the Primary Care Setting
The University of Texas Medical Branch

Preparing for Population Health: Information Competency
The University of Texas Medical Branch

Reducing Acute Care Utilization of Frequently Admitted Patients
The University of Texas Medical Branch

Appendix C: Fellows Roster

Fellow's Name	System Name
Mary Marran	Care New England
Matthew Quin	Care New England
Jordana Bailey	Coney Island Hospital/NYCHHC
Matthew Luu	Contra Costa Regional Medical Center
Gabriela Sullivan	Contra Costa Regional Medical Center
Timothy Thompson Cook	Contra Costa Regional Medical Center
Irene Marks	Cook County Health & Hospitals System
Krishna Das	Cook County Health & Hospitals System
David Payne	Grady Health System
Ben McKeeby	Grady Health System
Hany Atallah	Grady Health System
Kristina Lundberg	Grady Health System
Johanna Wood	Harborview Medical Center
Drew Lo	Harborview Medical Center
Belma Andric	Health Care District Palm Beach County
Christopher George	Hennepin County Medical Center
Jeffrey Morken	Hennepin County Medical Center
Jeanette Gibbs	Howard University
Kenneth Garay	Jersey City Medical Center
Rita Smith	Jersey City Medical Center
Renuka Ananthamoorthy	Kings County Hospital/NYCHHC
Christine Clare	LA County Harbor- UCLA Medical Center
John Jurenko	New York City Health and Hospitals Corporation
Kristen Baumann	New York City Health and Hospitals Corporation
Ivelesse Mendez-Justiniano	New York City Health and Hospitals Corporation
Dov Marocco	Santa Clara Valley Health and Hospitals System
Laura Haubner	Tampa General Hospital
Jordan Demoss	UAB Hospital
Terri Poe	UAB Hospital
Leah Meraz	University Health System
Virginia Mika	University Health System
Camerino Salazar	University Health System
Carmen Sanchez	University Health System
Doris Tinagero	University of New Mexico Hospital
Toni Davis	University of New Mexico Hospital
Thomas Long	University of New Mexico Hospital

Cody Boyd	University of Texas Health Science
Michele Bosworth	University of Texas Health Science
Manuel Vallejo	West Virginia University Hospital



DATE March 10, 2015
TO Board of Directors
FROM Rhonda Gold, Chief Financial Officer
RE Office move update

MEMORANDUM

In our last board update, we informed you that we had executed a nonbinding letter of intent with Boston Properties to lease for new office space the south side of the ninth floor at 401 9th St. NW, Washington, DC. This is a class A LEED Gold building, two blocks from the Archives/Navy Memorial Metrorail subway station and three blocks from the Gallery Place/Chinatown Metrorail stop. Since then, we and our attorney, Thomas R. Petty of Miles & Stockbridge PC, have worked diligently to negotiate final lease terms.

We are pleased to report that after several rounds of negotiations, we have a fully executed lease consistent with the significant terms the board approved at its October meeting. The board authorized Bruce Siegel to sign the lease as long as the terms do not differ substantially from the letter of intent.

To foster collaboration and staff input on the office move, we formed a design team and a move committee. The design team comprises association leadership, several additional staff members, architects, real estate brokers, and our project manager. The move committee, led by Human Resources Director Alan Burk, will be responsible for providing staff input on related decisions and projects as they arise (e.g., designing the staff café).

Recently, we approved a floor plan that includes larger conference facilities to accommodate the full staff, host board meetings, and conduct educational activities. The floor plan also includes a member lounge, staff café, webinar room, several team rooms, and collaborative work areas for informal staff interactions. We recently met with our architects to begin work on the schematic design, which should start to give us a better idea of the “look and feel” of the office.

We will be particularly active in the design phase over the next several weeks. Work will begin on the audio-visual plan, furniture selection, office theme, and phone/data systems. In addition, our project manager will begin seeking requests for proposal from general contractors.

We will update you on the office move process as our planning progresses. Our expected move-in date will be in late December 2015. If you have questions, please contact me at 202-585-0109 or rgold@essentialhospitals.org



DATE March 10, 2015
TO Board of Directors
FROM Rhonda Gold, Chief Financial Officer
RE 2014 Financial Update and Proposed 2015 Revised
Budget

MEMORANDUM

This memorandum updates you on the 2014 preaudited financial results compared with the last projection, presented in October, and presents proposed revisions to the 2015 approved budget. Our audit fieldwork began March 2; we will forward to you audited financial statements once they are final and reviewed by the audit and compliance committee. For your information, we have included a copy of the auditor's engagement letter with this material.

Staff asks the board to vote on revising the 2015 approved budget to reflect \$176,000 in additional operating expenses and the rollover of 2014 unspent office move expenses (of \$152,000), as described in this memo.

2014

The 2014 preaudited financial results of America's Essential Hospitals compared with budget and the October projection is shown in column 3 of Attachment I. The association ended the year with 2014 income of \$8.96 million, which is offset by \$7.32 million in expenses (before items funded from reserves), leaving a change in net assets (operating surplus) of \$1.64 million before rebranding and office move costs funded from reserves (of \$111,200) and investment income (of almost \$185,000). The change in net assets (surplus), after non-operating income items, is \$1.71 million (17 percent profit margin), an increase of \$890,000 from budget and \$4,200 less than last projected. Income and expenses are 3 percent and 4 percent better than budget, respectively.

After accounting for investment income, total net assets are \$8.47 million, of which \$450,000 is restricted net assets for the association's office relocation in December. We are pleased to report that this ending net asset balance continues to represent more than one year of association operating expenses in reserve.

2015

Attachment II presents the approved and revised budgets, which reflects three proposed budget changes in the personnel, office expense, and office move lines.

-
- Personnel: an increase of \$160,000 (from \$4.48 million to \$4.64 million) for personnel costs related to the addition of a new administrative position to support the demands of an enlarged advocacy team and the president and CEO and senior vice president for policy and advocacy; and compensation committee decisions on senior executive compensation.
 - Office expenses: an increase of \$16,000 (from \$212,500 to \$228,500) for webinar expenses that are above our current monthly contract.
 - Office move: a rollover of \$152,000 from 2014 for legal and architectural services related to the office move that were not incurred until early 2015.

The revised budget reflects budgeted income of \$10.2 million, offset by \$9.01 million in expenses, leaving a change in net assets (operating surplus) of \$1.23 million before office move expenses (of \$587,000) funded from reserves, for a net surplus of \$644,000. The revised budgeted surplus represents a 12 percent and 6 percent operating margin before and after office move expenses, respectively (compared with 14 percent and 9 percent in the approved budget). The reduced budgeted operating margin is primarily due to the rollover of unspent budgeted office move expenses from 2014.

We will review these materials with you at the March board meeting. However, if you have questions before then, please contact me at 202-585-0109 or rgold@essentialhospitals.org.

Attachments:

2014 financial projection compared with budget (Attachment I)
2015 revised budget (Attachment II)
Audit engagement letter

Attachment I

2014 Pre Audit vs. Fall Projection and Budget

	col 1 2014 Revised Budget	col 2 2014 Fall Projection	col 3 2014 Pre Audit Projection	col 4 Pre Audit vs Budget	col 5 Pre Audit vs Fall Proj	Pre Audit vs Budget %
REVENUE:						
Membership Dues	\$ 5,153,100	\$ 5,379,800	\$ 5,379,800	\$ 226,700	\$ -	4%
UHC Membership Dues and Sponsorships	\$ 3,150,000	\$ 3,150,000	\$ 3,150,000	\$ -	\$ -	0%
Other sponsorships	\$ 245,000	\$ 240,000	\$ 246,995	\$ 1,995	\$ 6,995	1%
Conferences	\$ 162,200	\$ 167,700	\$ 172,228	\$ 10,028	\$ 4,529	6%
Publication Sales/Misc.		\$ 3,500	\$ 17,077	\$ 17,077	\$ 13,577	100%
TOTAL REVENUE	\$ 8,710,300	\$ 8,941,000	\$ 8,966,100	\$ 255,800	\$ 25,101	3%
EXPENSE:						
Personnel Labor & Fringes	\$ 4,140,000	\$ 3,950,000	\$ 4,255,000	\$ (115,000)	\$ (305,000)	-3%
Policy	\$ 246,700	\$ 268,000	\$ 260,424	\$ (13,724)	\$ 7,575	-6%
Advocacy	\$ 456,000	\$ 461,800	\$ 426,781	\$ 29,219	\$ 35,019	6%
Member Services	\$ 232,500	\$ 249,200	\$ 253,160	\$ (20,660)	\$ (3,960)	-9%
Consulting/Prof Fees	\$ 135,000	\$ 122,000	\$ 111,051	\$ 23,950	\$ 10,950	18%
Retainer	\$ 400,000	\$ 400,000	\$ 400,000	\$ -	\$ -	0%
Information Technology	\$ 114,000	\$ 121,000	\$ 98,118	\$ 15,882	\$ 22,882	14%
Rent	\$ 384,200	\$ 376,000	\$ 358,500	\$ 25,700	\$ 17,500	7%
Office expenses/equipment rental	\$ 223,100	\$ 183,100	\$ 157,318	\$ 65,782	\$ 25,781	29%
Communications	\$ 307,600	\$ 283,700	\$ 230,784	\$ 76,816	\$ 52,916	25%
Conferences	\$ 612,200	\$ 454,000	\$ 437,190	\$ 175,010	\$ 16,810	29%
Travel and Prof Development	\$ 125,500	\$ 127,500	\$ 111,579	\$ 13,921	\$ 15,921	11%
Taxes, Insurance and Misc.	\$ 69,000	\$ 69,000	\$ 71,157	\$ (2,157)	\$ (2,157)	-3%
Depreciation/Amortization	\$ 75,500	\$ 30,600	\$ 33,950	\$ 41,550	\$ (3,350)	55%
Project Development	\$ 100,000	\$ 100,000	\$ -	\$ 100,000	\$ 100,000	100%
TOTAL EXPENSE	\$ 7,621,300	\$ 7,195,900	\$ 7,205,012	\$ 416,288	\$ (9,112)	5%
Changes in Net Assets before funding from reserves	\$ 1,089,000	\$ 1,745,100	\$ 1,761,088	\$ 672,088	\$ 15,989	
Other Items funded from Reserves:						
Office move	\$ (212,000)	\$ (60,000)	\$ (18,177)	\$ 193,823	\$ 41,823	
Rebranding (including depreciation on website)	\$ (100,000)	\$ (93,000)	\$ (93,000)	\$ 7,000	\$ -	
Changes in Net Assets, after funding from reserves (operating surplus) & before non-operating income	\$ 777,000	\$ 1,592,100	\$ 1,649,911	\$ 872,911	\$ 57,812	
Non-Operating Income:						
Interest/Dividend Income	\$ 50,000	\$ 20,000	\$ 75,295	\$ 25,295	\$ 55,295	
Realized Capital Gains/(Losses)	\$ -	\$ 559,000	\$ 558,944	\$ 558,944	\$ (56)	
Unrealized Gains/(Losses)	\$ -	\$ (450,000)	\$ (449,270)	\$ (449,270)	\$ 730	
Total Non-Operating Income/(Loss)	\$ 50,000	\$ 129,000	\$ 184,969	\$ 134,969	\$ 55,969	
Changes in Net Assets, after Non-Operating Income	\$ 827,000	\$ 1,721,100	\$ 1,834,880	\$ 1,007,880	\$ 113,781	

Attachment I (continued)

2014 Pre Audit vs. Fall Projection and Budget

	col 1 2014 Revised Budget	col 2 2014 Fall Projection	col 3 2014 Pre Audit Projection	col 4 Pre Audit vs Budget	col 5 Pre Audit vs Fall Proj
NET ASSETS:					
Prior Year Net Assets	\$ 6,759,350	\$ 6,759,350	\$ 6,759,350	\$ -	\$ -
Change in Net Assets	\$ 827,000	\$ 1,721,100	\$ 1,834,880	\$ 894,100	\$ 113,780
Total Net Assets after funding of special projects	\$ 7,586,350	\$ 8,480,450	\$ 8,594,230	\$ 894,100	\$ 113,780
Contribution to Restricted Net Assets:					
Office Relocation (restricted net assets)	\$ (100,000)	\$ (200,000)	\$ (200,000)	\$ (100,000)	\$ -
Total Contribution to Restricted Net Assets	\$ (100,000)	\$ (200,000)	\$ (200,000)	\$ (100,000)	\$ -
Summary of Total Net Assets:					
Unrestricted Net Assets	\$ 7,236,350	\$ 8,030,450	\$ 8,144,230	\$ 794,100	\$ 113,780
Restricted Net Assets for office relocation	\$ 350,000	\$ 450,000	\$ 450,000	\$ 100,000	\$ -
Total Net Assets	\$ 7,586,350	\$ 8,480,450	\$ 8,594,230	\$ 894,100	\$ 113,780

Attachment II
2015 Revised Budget

	col 1 2014 Pre Audit Projection	col 2 2015 Approved Budget	col 3 2015 Revised Budget	col 4 Budget change
REVENUE:				
Membership Dues	\$ 5,379,800	\$ 6,612,000	\$ 6,612,000	\$ -
UHC Membership Dues and Sponsorships	\$ 3,150,000	\$ 3,170,000	\$ 3,170,000	\$ -
Other sponsorships	\$ 246,995	\$ 200,000	\$ 200,000	\$ -
Conferences	\$ 172,228	\$ 260,000	\$ 260,000	\$ -
Publication Sales/Misc.	\$ 17,077	\$ -	\$ -	\$ -
TOTAL REVENUE	\$ 8,966,100	\$ 10,242,000	\$ 10,242,000	\$ -
EXPENSE:				
Personnel Labor & Fringes	\$ 4,255,000	\$ 4,480,000	\$ 4,640,000	\$ (160,000)
Policy	\$ 260,424	\$ 294,000	\$ 294,000	\$ -
Advocacy	\$ 426,781	\$ 653,000	\$ 653,000	\$ -
Member Services	\$ 253,160	\$ 244,700	\$ 244,700	\$ -
Consulting/Prof Fees	\$ 111,051	\$ 117,500	\$ 117,500	\$ -
Retainer	\$ 400,000	\$ 350,000	\$ 350,000	\$ -
Information Technology	\$ 98,118	\$ 111,300	\$ 111,300	\$ -
Rent	\$ 358,500	\$ 385,000	\$ 385,000	\$ -
Office expenses/equipment rental	\$ 157,318	\$ 212,500	\$ 228,500	\$ (16,000)
Communications	\$ 230,784	\$ 231,000	\$ 231,000	\$ -
Conferences	\$ 437,190	\$ 637,000	\$ 637,000	\$ -
Travel and Prof Development	\$ 111,579	\$ 180,000	\$ 180,000	\$ -
Taxes, Insurance and Misc.	\$ 71,157	\$ 87,000	\$ 87,000	\$ -
Depreciation/Amortization	\$ 33,950	\$ 157,000	\$ 157,000	\$ -
Project Development	\$ -	\$ 100,000	\$ 100,000	\$ -
Contribution /Support to Institute	\$ -	\$ 595,000	\$ 595,000	\$ -
TOTAL EXPENSE	\$ 7,205,012	\$ 8,835,000	\$ 9,011,000	\$ (176,000)
Changes in Net Assets before funding from reserves	\$ 1,761,087	\$ 1,407,000	\$ 1,231,000	\$ (176,000)
Other Items funded from Reserves:				
Office move/Rebranding	\$ (111,177)	\$ (435,000)	\$ (587,000)	\$ (152,000)
Changes in Net Assets, after funding from reserves (operating surplus) & before non-operating income	\$ 1,649,910	\$ 972,000	\$ 644,000	\$ (328,000)
Non-operating (Investment) Income	\$ 184,969	\$ -	\$ -	\$ -
Changes in Net Assets, after Non-Operating Income	\$ 1,834,879	\$ 972,000	\$ 644,000	\$ (328,000)

Attachment II (con'td)

2015 Revised Budget

	col 1 2014 Pre Audit Projection	col 2 2015 Approved Budget	col 3 2015 Revised Budget	col 4 Budget change
<u>NET ASSETS:</u>				
Prior Year Net Assets	\$ 6,759,350	\$ 8,594,230	\$ 8,594,230	\$ -
Change in Net Assets	\$ 1,834,880	\$ 972,000	\$ 644,000	\$ (328,000)
Total Net Assets after funding of special projects	\$ 8,594,230	\$ 9,566,230	\$ 9,238,230	\$ (328,000)
Contribution to Restricted Net Assets:				
Office Relocation (restricted net assets)	\$ (200,000)	\$ -	\$ -	\$ -
Total Contribution to Restricted Net Assets	\$ (200,000)	\$ -	\$ -	\$ -
<u>Summary of Total Net Assets:</u>				
Unrestricted Net Assets	\$ 8,144,230	\$ 9,116,230	\$ 8,788,230	\$ (328,000)
Restricted Net Assets for office relocation	\$ 450,000	\$ 450,000	\$ 450,000	\$ -
Total Net Assets	\$ 8,594,230	\$ 9,566,230	\$ 9,238,230	\$ (328,000)

November 21, 2014

Ms. Rhonda Gold
Assistant Vice President for Financial Operations
America's Essential Hospitals
1301 Pennsylvania Avenue, N.W.
Suite 950
Washington, D.C. 20004

Dear Ms. Gold:

We are pleased to confirm our understanding of the services we are to provide for America's Essential Hospitals for the year ended December 31, 2014.

We will audit the statement of financial position of America's Essential Hospitals as of December 31, 2014, and the related statements of activities and change in net assets, functional expenses and cash flows for the year then ended.

We will also prepare America's Essential Hospitals' Federal Form 990, Return of Organization Exempt from Income Tax, for the year ended December 31, 2014 and the D.C. personal property return.

Audit Objective

The objective of our audit is the expression of an opinion about whether your financial statements are fairly presented, in all material respects, in conformity with U.S. generally accepted accounting principles. Our audit will be conducted in accordance with U.S. generally accepted auditing standards and will include tests of your accounting records and other procedures we consider necessary to enable us to express such an opinion. If our opinion is other than unmodified, we will discuss the reasons with you in advance. If, for any reason, we are unable to complete the audit or are unable to form or have not formed an opinion, we may decline to express an opinion or to issue a report as a result of this engagement.

Audit Procedures

Our procedures will include tests of documentary evidence supporting the transactions recorded in the accounts, tests of the physical existence of inventories and direct confirmation of receivables and certain assets and liabilities by correspondence with selected individuals, funding

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MEMBER OF THE AMERICAN INSTITUTE OF CERTIFIED PUBLIC ACCOUNTANTS' PRIVATE COMPANIES PRACTICE SECTION

sources, creditors, and financial institutions as deemed necessary. We will also request written representations from your attorneys as part of the engagement, and they may bill you for responding to this inquiry. At the conclusion of our audit, we will require certain written representations from you about the financial statements and related matters.

An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements; therefore, our audit will involve judgment about the number of transactions to be examined and the areas to be tested. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the financial statements. We will plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement, whether from (a) errors, (b) fraudulent financial reporting, (c) misappropriation of assets, or (d) violations of laws or governmental regulations that are attributable to the organization or to acts by management or employees acting on behalf of the organization.

Because of the inherent limitations of an audit, combined with the inherent limitations of internal control, and because we will not perform a detailed examination of all transactions, there is a risk that material misstatements may exist and not be detected by us, even though the audit is properly planned and performed in accordance with U.S. generally accepted auditing standards. In addition, an audit is not designed to detect immaterial misstatements or violations of laws or governmental regulations that do not have a direct and material effect on the financial statements. However, we will inform the appropriate level of management of any material errors and any fraudulent financial reporting or misappropriation of assets that come to our attention. We will also inform the appropriate level of management of any violations of laws or governmental regulations that come to our attention, unless clearly inconsequential. Our responsibility as auditors is limited to the period covered by our audit and does not extend to any later periods for which we are not engaged as auditors.

Our audit will include obtaining an understanding of the organization and its environment, including internal control, sufficient to assess the risks of material misstatement of the financial statements and to design the nature, timing, and extent of further audit procedures. An audit is not designed to provide assurance on internal control or to identify deficiencies in internal control. However, during the audit, we will communicate to you and those charged with governance internal control related matters that are required to be communicated under professional standards.

We may from time to time, and depending on the circumstances, use third-party service providers in serving your account. We may share confidential information about you with these service providers, but remain committed to maintaining the confidentiality and security of your information. Accordingly, we maintain internal policies, procedures, and safeguards to protect the confidentiality of your personal information. In addition, we will secure confidentiality agreements with all service providers to maintain the confidentiality of your information and we will take reasonable precautions to determine that they have appropriate procedures in place to prevent the unauthorized release of your confidential information to others. In the event that we are unable to secure an appropriate confidentiality agreement, you will be asked to provide your consent prior to the sharing of your confidential information with the third-party service provider. Furthermore, we will remain responsible for the work provided by any such third-party service providers.

Management Responsibilities

You are responsible for making all management decisions and performing all management functions; for designating an individual with suitable skill, knowledge, or experience to oversee the tax services and any other nonattest services we provide; and for evaluating the adequacy and results of those services and accepting responsibility for them.

You are responsible for establishing and maintaining internal controls, including monitoring ongoing activities; for the selection and application of accounting principles; and for the fair presentation in the statements of financial position, changes in net assets and cash flows in conformity with U.S. generally accepted accounting principles. You are also responsible for making all financial records and related information available to us and for the accuracy and completeness of that information. You are also responsible for providing us with (a) access to all information of which you are aware that is relevant to the preparation and fair presentation of the financial statements, (b) additional information that we may request for the purpose of the audit, and (c) unrestricted access to persons within the organization from whom we determine it necessary to obtain audit evidence. Your responsibilities include adjusting the financial statements to correct material misstatements and confirming to us in the management representation letter that the effects of any uncorrected misstatements aggregated by us during the current engagement and pertaining to the latest period presented are immaterial, both individually and in the aggregate, to the financial statements taken as a whole.

You are responsible for the design and implementation of programs and controls to prevent and detect fraud, and for informing us about all known or suspected fraud affecting the organization involving (a) management, (b) employees who have significant roles in internal control, and (c) others where the fraud could have a material effect on the financial statements. Your responsibilities include informing us of your knowledge of any allegations of fraud or suspected fraud affecting the organization received in communications from employees, former employees, grantors, regulators, or others. In addition, you are responsible for identifying and ensuring the organization complies with applicable laws and regulations.

With regard to the electronic dissemination of audited financial statements, including financial statements published electronically on your website, you understand that electronic sites are a means to distribute information and, therefore, we are not required to read the information contained in these sites or to consider the consistency of other information in the electronic site with the original document.

You are required to disclose in the financial statements the date through which subsequent events have been evaluated and that date is the date the financial statements were issued versus the available date to be issued. You agree that you will not date the subsequent event note earlier than the date of the management representation letter.

Engagement Administration, Fees and Other

We understand that your employees will prepare all confirmations we request and will locate any documents selected by us for testing.

Amy Boland is the engagement partner and is responsible for supervising the engagement and signing the report or authorizing another individual to sign it. We expect to begin our audit at a mutually agreed upon date. We will issue our audit report and the information return(s) at the conclusion of the audit and tax process.

We estimate that our fee for these services will be \$24,900. We will bill you only for the time expended, plus out-of-pocket costs such as travel, report production, typing, postage, etc. Additional expenses are estimated to be \$500. The fee estimate is based on anticipated cooperation from your personnel and the assumption that unexpected circumstances will not be encountered during the audit. Our invoices will be rendered each month as work progresses and are payable on presentation. If we elect to terminate our services for nonpayment, our engagement will be deemed to have been completed upon written notification of termination, even if we have not completed our report. You will be obligated to compensate us for all time expended and to reimburse us for all out-of-pocket expenditures through the date of termination.

We appreciate the opportunity to be of service to you and believe this letter accurately summarizes the significant terms of our engagement. If you have any questions, please let us know. If you agree with the terms of our engagement as described in this letter, please sign and return it to us.

Sincerely,

GELMAN, ROSENBERG & FREEDMAN



Amy Boland
Certified Public Accountant

RESPONSE:

This letter correctly sets forth the understanding of America's Essential Hospitals.

Officer Signature

Title

Date