



ESSENTIAL
HOSPITALS
INSTITUTE

Board of Directors Meeting

October 30, 2014
Liaison Hotel | Washington, DC



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Agenda
Institute Board of Directors Meeting
October 30, 2014
8 am – Noon

8 – 8:05 am	Call to Order and Disclosure of Conflicts of Interest (Ms. Jacobs)	
8:05 – 8:10 am	Approve June 25 Minutes (Ms. Jacobs)	ACTION
8:10 – 8:55 am	Institute Director's Report (Dr. Engler)	
8:55 - 9 am	Nominating Committee Report (Ms. Roth)	
9 – 9:30 am	Treasurer's Report (Dr. Haley) • 2014 Financial Update • Socially Responsible Investment Policy	ACTION
9:30 – 9:45 am	Office Relocation Update (Ms. Gold)	
9:45 – 10 am	Break	
10 – 10:20 am	Education Committee Report (Mr. Finley) • Fellows Screening & CEO Engagement	
10:20 – 10:40 am	Research Committee (Ms. Jacobs) • Appoint Committee Members	ACTION
10:40 – 11 am	Essential Women's Leadership Academy (Ms. Fritz)	
11 – 11:30 am	Research Projects (Dr. Perez)	
11:30 – 11:40 am	EHEN Update (Ms. Callahan)	
11:40 am – noon	Characteristics Report (Ms. Reid)	
noon	Adjourn	



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2014-2015

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2014-2015 Institute Board of Directors Meeting Dates

Thursday, October 30, 2014

8 am – noon
Liaison Hotel
Washington, DC
Held in conjunction with Innovations Summit, October 29, 2014

Tuesday, March 17, 2015

8 am – noon
Westin Georgetown
Washington, DC
Held in conjunction with Policy Assembly, March 17-18, 2015

Wednesday, June 24, 2015

8 am – noon
Westin Gaslamp Quarter
San Diego
Held in conjunction with VITAL2015, June 24-26, 2015



Essential Hospitals Institute
Board of Directors Meeting
June 25, 2014
San Antonio, TX

Board Members Present (13):	Board Members Absent (3):	Staff Present (9):
Ann Scott Blouin John Bluford III Julie Cerise (Ex Officio) Delvecchio Finley Don Goldman Leon Haley Caroline Jacobs (Secretary) Erika Murray Christine Neuhoff Anna Roth (Treasurer) Bruce Siegel (Ex Officio) Clifford Wang (Chair) Winston Wong	Susan Moffatt-Bruce Reuven Pasternak Alan Weil	Sarah Callahan David Engler Beth Feldpush Rhonda Gold Carl Graziano Tara McFann Kristine Metter Bianca Perez Katie Reid

Agenda Items	Minutes
Call to Order and Disclosure of Conflicts of Interest	<ul style="list-style-type: none">• Wang called meeting to order at 8:04 am.• Wang reminded board members to complete their conflict of interest documents and return them to Metter by the end of the meeting.
Welcome New Board Members	<ul style="list-style-type: none">• Siegel welcomed new board members. He also presented the newly published history of America's Essential Hospitals and its members.• Siegel congratulated Bluford on his impending retirement from Truman Medical Centers.
Approve April 1 Minutes (ACTION)	<i>Wang requested a motion to approve the April 1 meeting minutes. There was a motion, a second, and unanimous approval of the minutes.</i>
Institute Director Report	<ul style="list-style-type: none">• Engler reported on Institute activities, including work to increase partnership opportunities, create a research committee to oversee the research agenda, and improve the Institute's financial stability. The Institute has submitted and is developing multiple grant proposals with partnering organizations, including The George

	<p>Washington University, Kaiser Permanente, Westat, the Institute for Healthcare Improvement, and Boston Medical Center.</p> <ul style="list-style-type: none"> The Essential Hospitals Engagement Network (EHEN) is currently seven months into Option Year 1. Future opportunities, including Option Year 2, seem promising based on the EHEN's score of 87, or exceptional, on the Centers for Medicare & Medicaid Services' scoring scale. The Institute has completed the first round of work for the Massachusetts Collaborative. Cambridge Health Alliance applied for a second round of support to continue the partnership with the Institute. A members-only summit on Medicaid Section 1115 Delivery System Reform Incentive Payment (DSRIP) waivers will be held September 29 in Chicago. The Institute has partnered with the American Hospital Association to share data, reduce the burden on members, and ensure more timely data submission to the annual hospital characteristics survey. The newly redesigned survey report will be released by August and will prominently feature infographics. The 2014-2015 Fellows Program is underway with 34 participants from 16 member organizations. Multiple staff are participating from each organization, and the expectation is that this will make member projects more robust and effective. Seven participants have withdrawn from the class, much higher than the two-to-three participant drop rate in previous years. Fellows staff are looking into developing requirements for withdrawing enrollment or reducing the amount of refund given if a Fellow withdraws after an established deadline. Bluford suggested staff work with the Fellows' organizations to ensure their participation also benefits the organization. Jacobs suggested staff hold webinars or in-person meetings with CEOs and sponsors to give more background information and encourage them to be more accountable to the Fellows. <i>Engler agreed to provide options for dealing with Fellow participant withdrawal at next board meeting.</i> The Institute is encouraging the National Quality Forum to include sociodemographic factors in quality risk adjustment methodology. This issue resonates very strongly with members and the Institute wants to ensure they are being fairly measured for their quality performance. All board members agreed that this is a very important issue to stay ahead of. They suggested that the Institute may need to test the potential impact of adding sociodemographic factors to risk adjustment. <i>The Institute will add a risk adjustment line item to the August AEH/UHC meeting to pull together resources on this issue.</i>
Treasurer's Report	<ul style="list-style-type: none"> The investment, audit, and compliance committee and finance committee reviewed and accepted the 2013 audit reports . The Institute ended 2013 with \$8.45 million in total assets, including \$7.98 million in cash and \$689,000 in liabilities. The Institute

	<p>ended the year with \$10.7 million in unrestricted revenue, offset by \$5.95 million in expenses, leaving a \$4.81 million surplus. Taking into account last year's beginning net assets, total net assets are \$7.77 million. \$2 million of the total net assets is temporarily restricted, leaving a \$5.77 million operational reserve.</p> <p><i>Roth requested a motion to accept the 2013 audited financial statements as recommended by the investment, audit, and compliance and finance committees. There was a motion, a second, and unanimous approval of the audits.</i></p> <ul style="list-style-type: none"> The Institute currently projects \$7.83 million in unrestricted revenues offset by \$7.91 million in projected expenses for a projected operating deficit of \$80,000. There are no significant budget variances to report at this time. <p><i>Roth requested a motion to accept the 2014 budget update. There was a motion, a second, and unanimous approval of the budget update.</i></p>
Investment and Reserve Policy	<ul style="list-style-type: none"> Gold gave an overview of the operating reserve policy, which designates a portion of operating funds and provides guidelines for maintaining adequate reserves to ensure the Institute's long-term financial stability. The board-designated operating reserve will have a target minimum reserve of three months' worth of operating expenses. This reserve is established at \$900,000 of available Institute cash and adjusts each budget cycle. The board can designate nonoperating, board-designated funds to develop new programs, explore new opportunities, purchase fixed assets, and other items. There are three types of nonoperating board designated funds: the special purpose fund, the building and capital asset reserve fund, and the opportunity reserve. The special purpose fund will be funded by an initial contribution of \$3.3 million, or 80 percent, of the unspent money from the EHEN contract. The other two nonoperating funds will not be funded at this time to allow for the establishment of an adequate operating reserve first. All funds will be approved by the board and reviewed every three years. The investment, audit, and compliance committee will serve both the association and the Institute. <p><i>Roth requested a motion for approval of the proposed operating reserve policy. There was a motion, a second, and unanimous approval of the operating reserve policy.</i></p> <ul style="list-style-type: none"> Mark Murphy of Raffa Wealth Management presented results of their assessment of the association's and Institute's willingness to take on risk. The three-step process included a review of current financials, interviews with key staff and board members, and a risk tolerance survey. Based on the findings, Raffa proposes the Institute allocate funds for the intermediate term reserve to be a mix of 30 percent stocks and 70 percent bonds (with a mix of international and US investments). The expected return on investments is three-five percent or

	<p>\$200,000 to \$300,000 per year. He also gave an overview of the roles and responsibilities, goals, investment guidelines and procedures, asset allocation and target ranges, quarterly review and rebalancing process, standard conduct for portfolio management, and delegation. All funds will be held with Charles Schwabb.</p> <ul style="list-style-type: none"> The board requested an amendment to the policy to stipulate that investments be socially responsible. Engler suggested that the Institute begin investing with Raffa Wealth Management and conduct a basic screening for investments related to guns and tobacco. Engler will bring an amended policy including a social responsibility statement to the next board meeting. The funds will be readjusted as needed after the policy is approved. Institute board members will be surveyed to determine what constitutes a socially irresponsible investment. <p><i>Roth requested a motion to approve the investment policy statement, with the caveat that the finance and investment committee will return to the fall board meeting with a social responsibility investment statement to add to the policy and we will begin investment of the funds. There was a motion, a second, and unanimous approval.</i></p>
Forming a Research Committee	<ul style="list-style-type: none"> Wang reviewed recommendations put forth after the April 1 board meeting to guide the creation of a research committee to foster engagement and oversight of Institute work. Engler provided an overview of the draft research committee charter. The committee would consist of four Institute board members, two of the board's outside directors, and three nonboard members nominated by the board chair. Each member would serve a term not to exceed two years. The research committee would be responsible for establishing a set of principles to guide the research scope, identifying issues where the Institute can help members, developing strategies for engaging members in research activities, and identifying innovative and effective ways of disseminating findings to members and the public. <p><i>The board suggested several amendments to the draft charter. They recommended including three Institute board members, one association board member, two Institute outside directors, and three nonboard members. They also suggested that the committee establish a set of principles and criteria for the Institute's research activities that are in service to the mission of the Institute, and would consider parameters around nonfunded research. They also suggested that membership terms be staggered and that nonboard committee members be required to have research experience.</i></p>

	<i>Wang asked for a motion to approve the formation of a standing research committee. There was a motion, a second, and the motion was unanimously approved.</i>
Education Committee Report	<ul style="list-style-type: none"> • Jacobs gave an overview of the session format changes at VITAL2014, including rapid-fire sessions, mini-sessions, and member case studies. Education committee members are also moderating at the conference. • The education committee will hold a call for proposals for members to submit abstracts to present at VITAL2015 in San Diego. • Other upcoming education events include an in-person DSRI meeting, in Chicago, in September and the Innovations Summit 2014, in Washington, DC, in October. • Webinar topics for the second half of the year will include: 340B, patient- and family-centered care, the Hospital Consumer Assessment of Healthcare Providers and Systems, Medicaid expansion, and chronic disease management. Staff are analyzing webinar participation as it applies to the organization's four pillars. Results will be presented at the fall board meeting.
Defining Population Health	<ul style="list-style-type: none"> • Perez gave an overview of her staff's research to define population health. She discussed several definitions of population which would: target patients within a geographic area that may or may not seek healthcare services, intervene holistically and coordinate care with community partners, focus on prevention, and measure health care outcomes at the community and hospital level. • Perez gave an overview of population health submissions for the Gage Awards 2014. Most programs had a targeted patient population, addressed upstream factors and social determinants, and had a preventive or chronic disease care focus. No submissions involved community-level outcome measures, and most used hospital-level or process measures. • Siegel mentioned that as health care spending slows in America there is greater potential for making different investment decisions in favor of population health on the federal and state levels. Goldman mentioned the large funding pool available through the Robert Wood Johnson Foundation. Siegel proposed connecting with them on population health for union capital streams. Several board members expressed that this is an area in which we should be national leaders and suggested seeking research funding to conduct real studies and fine tune a definition that works for our members. The Institute should also emphasize data for population health studies. • Reid demonstrated a new mapping tool that will be available on the Institute website. The tool will highlight member hospitals' population health programs.
EHEN Case Studies	<ul style="list-style-type: none"> • Callahan presented three member case studies from the EHEN contract.

	<ul style="list-style-type: none"> • Eskenazi Health, in Indianapolis, reduced falls by 40 percent by implementing hourly care rounds, involving pharmacists in medication discussions, and using bed alarms and transport teams. The hospital is also working to expand patient visitation to encourage family members to present and report patient needs. • At Truman Medical Centers, standardizing turn clocks, creating prophylaxis protocols, and establishing wound care champions on each unit resulted in 50 to 90 percent compliance, a reduction in the number of pressure ulcers caused by medical devices, and nearly zero pressure ulcers in 2013. Bluford mentioned that Truman also partnered with Cerner to reduce the numbers because Cerner does not get paid for the health care-acquired pressure ulcers module unless they meet their reduction goals. • Maricopa Integrated Health System, in Arizona, formed an interdisciplinary team to review and implement evidence-based practices, standardize criteria, empower nurses, and educate patients. The hospital sustained zero early elective deliveries for 39 months. • EHEN is launching an e-learning module for race, ethnicity, and language data collection on essentialhospitals.org in September. The module will be available to all members. <i>Blouin asked that association communications staff contact The Joint Commission staff so that they can also disseminate information about the module.</i>
Website Overview	<ul style="list-style-type: none"> • Graziano gave a brief overview of the redesigned website that launched in February. The new website features a customizable home page based on user-selected interests; images of member hospital staff, advocates, and patients; user groups; and discussion boards.
Adjourn	<ul style="list-style-type: none"> • The next board meeting will be October 30. The meeting was adjourned by Wang at 12:14 pm.



Caroline M. Jacobs, MPH, MS.Ed.



DATE October 21, 2014
TO Board of Directors
FROM David Engler, PhD, Senior Vice President of Leadership and Innovation
RE Research and Education Activities: July–September 2014

MEMORANDUM

Since the June board meeting, Essential Hospitals Institute

- received a grant from the Patient-Centered Outcomes Research Institute (PCORI) in collaboration with a large consortium to study the effectiveness of transitional care;
- launched a web-based series of articles on the social determinants of health, with the latest featuring food insecurity;
- published a research brief on the impact of Section 115 Medicaid waivers on quality of care and completed our year-long waiver work plan;
- published the newly designed characteristics report, Essential Hospitals Vital Data: Results of America's Essential Hospitals Annual Characteristics Report, FY 2012;
- successfully submitted for publication in the Journal of Healthcare for the Poor and Underserved the findings of our 2013 PCORI landscape review (February 2015 issue).
- partnered with UHC and George Mason University to conduct large-scale evaluation of population health around the country;
- completed session I of the 2014 Fellows Program, featuring adaptive leadership;
- designed a new program aimed at improving executive competencies of female leaders in Essential Hospitals; the Essential Hospitals Women's Leadership Academy will launch in the last quarter of 2015;
- spearheaded efforts to reduce disparities in care through the work of Essential Hospitals Engagement Network (EHEN), which lead a national virtual event on disparities, continued work on the Ask Every Patient: REAL elearning module, and prepared to launch the module on the association website in October;
- saw the EHEN continue to score among the top five engagement networks in the country, according to federal evaluators;
- focused the EHEN on “safety across the board,” an approach of thinking about all harm done to patients;
- conducted seven EHEN webinars from July to October 2014 on the Partnership for Patients conditions, leadership, and health equity; and
- partnered with the Institute for Healthcare Improvement and Boston Medical Center and submitted an Agency for Healthcare Research and Quality grant application to evaluate a Medicaid readmissions tool.

Research Projects

Population Health

The Institute has partnered with UHC and George Mason University to conduct a large-scale evaluation of population health initiatives around the country. This landscape review comprises information from submissions to America's Essential Hospitals Gage Awards and UHC's poster presentations between 2012 and 2014. The findings will be summarized in a peer-reviewed article focusing primarily on essential hospitals and the heightened barriers they face when implementing population health. The Institute will also host two webinars on this topic to disseminate and collect information simultaneously. The first webinar will serve as a focus group for members of America's Essential Hospitals and UHC to provide feedback on the conceptual framework, research findings, and a select group of exemplar population health programs. The second webinar will feature a reactor panel of policy experts, representatives from community-based organizations, and other stakeholders, who will offer a multifaceted perspective on the findings of and questions about this work. These distance learning events will inform a second peer-reviewed article focused on the various viewpoints of population health and barriers to achieving "true" population health.

Effectiveness of Transitional Care

The PCORI-funded Project ACHIEVE (Achieving Patient-Centered Care and Optimized Health In Care Transitions by Evaluating the Value of Evidence) has these goals:

- to learn which transitional care outcomes matter most to patients
- rigorously evaluate current efforts at improving care transitions
- develop recommendations on best practices for patient-centered care transition interventions with guidance for scalability and large-scale dissemination

Year One of this three-year project, beginning January 1, 2015, will employ focus groups to identify the most important transitional care components and outcomes identified by patients and caregivers. Survey development also will take place during Year One, and will be implemented in Year Two to the cohort of patients and caregivers exposed to set care transition clusters. This will also include retrospective and longitudinal comparative analyses of patients experiencing transitional care components. In Year Three, the ACHIEVE team will complete all analyses, prepare materials for dissemination, and develop a large-scale implementation plan.

This project's patient population will include Medicare fee-for-service beneficiaries within high-risk populations. The project, which will primarily focus on hospital-to-home transitions, is headed by Mark Williams, from the University of Kentucky, and includes a consortium of research affiliates:

- America's Essential Hospitals
- Westat
- University of Pennsylvania
- Boston Medical Center
- Telligen/Colorado Foundation for Medical Care
- Kaiser Permanente Southern California
- Health Research & Educational Trust of the American Hospital Association

- Joint Commission Resources
- National Association of Area Agencies on Aging
- Caregiver Action Network
- United Hospital Fund
- Louisiana State University Sciences Center
- University of Illinois Chicago

Transforming Care Delivery in America's Safety Net: Aligning Efforts to Improve Access and Care Coordination (Partners: The George Washington University (GW) and National Association of Community Health Centers, Inc. (NACHC))

The Institute, NACHC, and GW are partnering to improve vulnerable patients' access to and quality of care. Now into Year Two of this project, funded by Kaiser Permanente Community Benefit, the partnership has created solid working relationships with community health centers and essential hospitals in Atlanta, Cleveland, Denver, and Richmond, focusing on key Affordable Care Act-related policy issues impacting their local populations. The key priorities for each of these communities include obtaining coverage expansion (Atlanta), the sustainability of Medicaid expansion (Cleveland), access to specialty care (Denver), and offering premium/copay assistance (Richmond).

The partnership is now well into the strategic work plans for each of the four communities. Since June, the partnership has worked with each community to facilitate and inform discussion and build and strengthen local strategies. For example, the partnership is working with Denver and its newly formed Mile High Health Alliance around access to specialty services and developing an agenda to present this information in November at a Denver-based stakeholder meeting. Additionally, the partnership recently held a webinar with Atlanta to present options for their waiver proposal design.

The partnership is planning to convene the four communities so they may share experiences and lessons learned. This will ideally take place by means of a teleconference later this year, and an in-person meeting in March 2015. Furthermore, the partnership is continuing its work to identify opportunities to disseminate findings and progress within and beyond the memberships of America's Essential Hospitals and NACHC. Specifically, the partnership is in the planning stages of website development for the project.

Section 1115 Medicaid Waivers

Essential hospitals in California, Massachusetts, and Texas are participating in Section 1115 Medicaid waiver demonstration projects. Other states are expected to join this movement, as well. In March 2013, the Essential Hospitals Institute released its first brief on this topic, describing the 1115 waiver work occurring in the aforementioned states. As a follow-up to this brief, the Institute conducted in-depth case studies of waiver experiences in three health systems. From February to July, the Institute engaged Santa Clara Valley Medical Center (California), Boston Medical Center (Massachusetts), and UT Health Northeast (Texas) to share their stories through a webinar series.

The Institute asked each hospital to address several key questions that highlight successes and challenges related to waiver implementation, sustainability of waiver work, and lessons learned

for other hospitals and states. We published a research brief in September and featured it at the Leadership Summit on State Medicaid Waivers.

Social Determinants of Health

In July, the Institute launched a new web-series focusing on the social determinants of health. As providers for the vulnerable and underserved, members of America's Essential Hospitals often care for patients with complex social circumstances. Examples include food insecurity, homelessness or unstable housing, and unsafe neighborhoods. The goal of the series is to highlight the importance of these issues in medical care, as well as the innovative practices essential hospitals are implementing to address patients' social factors.

The series will include seven web postings which will be released on a monthly basis through January 2015. To date, four pieces have been published on our website, including an overview of the social determinants of health, and topic pieces on social capital, food insecurity, and housing and employment.

EHEN Update

The first three years of the contract with the Partnership for Patients (PfP) and the Centers for Medicare & Medicaid Services (CMS) is coming to a close. The contract concludes on December 8. Though we do not yet have clarity about the scope and timing of a new contact, we are optimistic, given EHEN's leading role around health equity and the high evaluation marks EHEN received in August.

Staff spent much of July preparing a submission of EHEN accomplishments for the interim progress evaluation of hospital engagement networks (HENs). All the HENs are evaluated on an array of factors, including their results, other quality elements (e.g., technical assistance to hospitals, training, and project execution), and their overall business relationship with CMS/PfP. Based on the final report in August that will be used to assess HENs, the evaluator scored EHEN a 98 on their ACT (alignment, completeness, trend) report (an element of the evaluation that is based on HEN results and accounts for 66 percent of a HEN's overall score).

On July 15, EHEN participated in an interview process with the PfP performance evaluation contractor (PEC) to provide feedback and observations to include on the PEC annual report.

During this third year, in addition to its focus on health equity, EHEN has increasingly worked with participating hospitals to focus on "safety across the board," an approach of thinking about all harm done to patients (including all 10 conditions originally outlined by the PfP), patient and family engagement, leadership, transparency, and sustainability.

In July, a new hospital joined EHEN: United Medical Center, which brings the network to 23 hospitals. We continue our recruitment efforts to those members who are still not aligned with a HEN.

The work on the Ask Every Patient: REAL project continues. This work kicked off in March as one of the special focuses in 2014. The project aims to improve quality of care for all patients by promoting standardized collection of race, ethnicity, and language (REAL) information so

hospitals can build a robust and accurate picture of the people they serve. That information will also help hospitals identify disparities in care and outcomes.

Collecting this information is the first step hospitals can take to align their improvement efforts and address disparities in a more thoughtful and effective manner. Since forming our equity action team, which includes representatives from more than half of the EHEN, as nominated by CEOs, the team completed an assessment that will drive the development of this elearning module. As the module is being designed, Ask Every Patient: REAL will conduct training events with critical stakeholder groups from the hospitals (e.g., staff from quality, registration, and information technology). The online module will go live on the association's website in October.

In May, the PfP asked the EHEN to lead work to address disparities with the 25 other HENs. As part of that effort, we worked with CMS and its National Content Developer to organize and lead an “all hospitals” virtual event August 5. The Institute’s director of performance improvement continues to serve on the PfP disparities group.

To continuously capture and disseminate evidenced-based practices, EHEN conducted a best practices survey midway through this year. Roughly half of the network hospitals provided responses regarding condition team characteristics, top interventions and transparency of data with staff and the public, a critical platform for EHEN this year. Preliminary results indicate commendable progress in the involvement and awareness of senior leadership on frontline safety issues, including regular participation on condition teams. Frequency of meetings (at least six times in the past year) and data review reinforced the importance of constant vigilance in reaching zero harm. Notably, catheter-associated urinary tract infections lack consistency in the attention provided by leadership in terms of participation and rounding. Throughout the fall, EHEN improvement coaches are providing valuable tailored feedback to individual hospitals and their condition teams, based on their response to the best practice survey in relation to their peers.

We offered seven webinars covering the PfP conditions, leadership, and health equity between July and October. We attracted 179 participants, representing 17 EHEN hospitals (more than 70 percent of the network), 32 non-EHEN members, and 4 other organizations (e.g., other hospital engagement networks, national partners).

Data Collection and UHC Subcontract

The EHEN subcontracts with UHC to collect and analyze data required by the hospital engagement contract. Data collection has been challenging for the project; however, the entire network now reports data through one or more of our data streams. More than 90 percent report through UHC and 100 percent of our hospitals share information through the National Healthcare Safety Network. This fall, UHC collected amendments from our members reporting through the CDB Lite (those HEN members that are not UHC members and do not already report into their clinical database). The amendment addressed elements related to the Omnibus Rule not previously included in the Business Associated Agreements.

Leadership Programs

Fellows Program

During session I of the 2014 Fellows Program, the class strengthened the skills needed to lead adaptive change in complex environments. Participants had the opportunity to learn the adaptive leadership framework developed by Harvard University's Ron Heifetz and Marty Linsky. The framework helps individuals and organizations through consequential change by confronting the status quo and identifying technical and adaptive challenges.

After the first session, fellows began planning their projects and have been engaged in monthly, hour-long group coaching webinars. These webinars support fellows' project work and helps them understand their Myers-Briggs Type Indicator.

During session II, fellows took a deeper dive in understanding their own Myers-Briggs Type Indicator, as well as the other's preferences. They learned the foundations of leading cultural change by enhancing their communications, coaching performance management, and selection skills.

Essential Hospitals Women's Leadership Academy

The Essential Hospitals Women's Leadership Academy is a new program designed to increase the aspirations, promotions, and executive competencies of female leaders at essential hospitals. The Academy addresses the unique challenges Essential Hospitals face and brings together a network of women leaders who share mission and values.

A comprehensive literature review and landscape assessment was conducted to determine if there was a need for a leadership program targeting female leaders at America's Essential Hospitals. Based on the literature, it was found that women are significantly underrepresented in health care executive level positions. In addition, health care organizations in various sectors (hospital, association, academia, etc.) do provide opportunities to address the gender gap, but do so on a small scale. There is also a tremendous disparity within America's Essential Hospital's membership, such that only seven out of the association's nearly 250 organizations provide activities targeting women leaders.

The curriculum and program structure comprises four components which are based on evidence from the literature review. These include

- networking;
- mentorship opportunities;
- assessments and coaching; and
- didactic discussions and an in-person meeting.

Program planning and development will begin in 2015. During the second and third quarters, mentors will be recruited and trained. During the fourth quarter, mentees will be recruited. In 2016, the program begins, leading off with webinars and 360-degree assessments. An in-person meeting will be held in the second quarter. During the third and fourth quarters of 2016, the mentor-mentee pairs will hold check-in calls and mentees will visit mentor organizations.

Annual Hospital Characteristics Survey

In July, the association released its newly redesigned member characteristics report, Essential Hospitals Vital Data: Results of America's Essential Hospitals' Annual Hospital Characteristics Report, FY 2012. In a departure from previous report designs, the new report features an executive summary and high-impact infographics.

The report has been extremely well received by both members and the media, with coverage in Politico, Health Affairs, and Bloomberg Finance, among other publications. Currently, the fiscal year (FY) 2013 annual hospital characteristics survey is in its final stages. The survey responses have been validated and survey data is in the process of being finalized. Work is underway to publish the FY 2013 edition of Essential Hospitals Vital Data, with an expected January 2015 publication date.

We will send thank you emails to all CEOs, with copies to survey coordinators, acknowledging the remarkable work the survey coordinators and their staff did to complete the FY 2013 survey. The thank you messages will also include our first ever "feedback and satisfaction" survey. Through the very short questionnaire, we hope to better understand the time and resources needed for the survey coordinators to complete the survey, the preferred timeline for launch and deadlines, and the preferred survey platform. From the CEOs, we hope to better understand the ways they use the characteristics report and their view of the survey's importance.

We hope to use the data from the feedback and satisfaction survey to inform our development of the FY 2014 characteristics survey. This will be important, as we also hope to expand the survey to include the full membership of America's Essential Hospitals, not just acute care members. Given that many new survey coordinators will be recruited to complete the survey, we hope the feedback and satisfaction survey will allow us to make the FY 2014 survey the easiest, yet most comprehensive survey to date.



DATE October 21, 2014
TO Board of Directors
FROM Rhonda Gold, Chief Financial Officer
RE Financial Update

MEMORANDUM

This memorandum summarizes the 2014 financial projection compared with the projection presented to you in June and the approved budget; there is no action items requested from the board. The 2015 proposed budget will be presented on the December 2 scheduled board conference call.

Financial Projection

Columns 1 and 2 of attachment I present the 2014 approved budget and June projection; columns 3 and 4 present our updated financial projection; and column 5 reflects the budget variance. Projected unrestricted income (column 3) is \$7.51 million (including \$5.49 million from the Centers for Medicare & Medicaid Services for the Partnership for Patients contract) which is offset by \$7.63 million in expenses, leaving an unrestricted operating deficit of \$121,000. This projected deficit is \$41,000 more than budget (column 5) primarily due to a loss of tuition income (totaling \$65,000) from the Fellows Program.

After accounting for last year's beginning net assets, the 2014 projected unrestricted net assets are \$5.65 million (column 3), in addition to \$557,000 (column 4) in temporarily restricted assets, for a total of \$6.21 million. Under the operating reserve policy the board approved in June, the Institute now has two board-designated reserves as part of unrestricted net assets: board-designated operating reserves and non-operating board-designated funds. The board has set the target minimum board-designated operating reserve at \$900,000 to include all recurring, predictable expenses, such as salaries and benefits, rent, office, travel, program, and ongoing professional services. Under the policy, the board can also designate non-operating board-designated funds for developing new programs ("special purpose fund"), taking advantage of new opportunities ("opportunity fund"), and purchasing fixed assets ("building and capital asset reserve fund"). In June, the board approved an initial contribution of \$3.3 million to the board-designated special purpose fund to fund certain programs, activities or purposes that furthers the Institute's mission. These board-designated reserves are reflected on the bottom of attachment I.

For further detail, significant variances from budget within individual line items are described below (refer to column 5):

Grant income: Projected grant income is \$254,600 less than budget because the budget assumed \$250,000 in new grant funding, which has not yet been awarded. Positive feedback on our grant proposals by several potential funders gives us hope these awards will soon materialize. External funding sources included in the updated projection include the following awards:

- Kaiser Permanente's core funding of the Transformation Center: \$500,000 (grant ends December 2014)
- Kaiser Permanente collaboration with the National Association of Community Health Centers and The George Washington University School of Public Health and Health Services: \$726,000 (grant ends May 2016)
- Massachusetts Learning Collaborative: \$214,000 (grant ended June 2014)

Salaries and employee benefits: We project an overage of \$80,000 due to the allocation of more staff time spent on Institute projects.

Travel and meetings: We project savings of \$85,500 because of lower food costs at the spring governance meeting; and less travel and meeting costs for Transformation Center and research staff.

Consultants and subcontractors: We project savings of \$214,600, of which \$120,000 is due to unspent money in grants and contracts, and \$62,000 less in staff recruitment and other consulting costs for the Institute.

Investment Update

After the board approved the new investment policy statement, our financial advisers, Raffa Wealth Management (RWM) made their recommended investments, which align with the intermediate-term reserve policy, funded with \$3.3 million set aside in the board-designated special purpose fund. This portfolio targets an allocation of 30 percent to stocks and 70 percent to bonds.

At its June meeting, the board decided to prohibit the organization from investing in firms that derive revenue from tobacco or firearms. Because we could not reach a consensus on other possible restrictions, we agreed that RWM would develop a short survey to determine if there is a consensus on the board for restricting investment in other areas. This survey has been completed and RWM is in the process of finalizing its recommendations, which will be shared with the investment, audit and compliance committee and the Institute board. Additionally, we have added the following language to the approved investment policy statement to reflect a socially responsible mandate:

“Essential Hospitals Institute holds strongly its belief in its mission and desires to have that mission reflected in its investments. As a result, the Institute elects to avoid any direct or indirect investment, through mutual or exchange-traded funds, in companies that derive revenue from the sale of firearms or tobacco. This restriction is to be reflected across the total portfolio, including all asset allocations. The Institute believes these sectors run counter to the organization’s mission and do not wish to be involved with these companies in any way. The Institute board, staff, committee, and advisers will periodically review the portfolio to maintain this investment philosophy.”

The following summarizes funds in which the intermediate-term reserve is invested. The investment, audit and compliance committee has reviewed these investments and is comfortable with the adviser's recommendations.

- **Parametric Total U.S. Stock Market** seeks to purchase a broad and diverse range of U.S. securities, including large-, mid-, and small-cap stocks, as well as value and growth stocks in a market-neutral allocation. It excludes stocks of firms associated with firearms and tobacco. It has an annual fee of 0.57 percent.
- **Parametric Small Cap Value** seeks to purchase stocks of small companies and those that it determines to have a value orientation. It excludes stocks of firms associated with firearms and tobacco. It has an annual fee of 0.57 percent.
- **Parametric Total World ex-US** provides broad market-neutral exposure to the international developed market. It excludes stocks of firms associated with firearms and tobacco. It has an annual fee of 0.57 percent.
- **Parametric Total World ex-US Value** invests in what it determines to be value stocks in the international developed market space. It excludes stocks of firms associated with firearms and tobacco. It has an annual fee of 0.57 percent.
- **Breckinridge Intermediate Taxable Bond** invests in the broad U.S. fixed income market, including taxable muni, government, corporate, mortgage, and agency sectors. It excludes bonds of firms associated with firearms and tobacco. The portfolio will hold only bonds rated A- or better and will have an average credit quality of AA. The portfolio can hold bonds with maturities up to 15 years, but will have an average maturity of five years. It has an annual fee of 0.15 percent.
- **DFA World ex-US Fixed Income** fund invests in international government fixed income of highly rated countries. It has an average credit quality of AA and an average duration of 7.4. It has an expense ratio of 0.20 percent, which puts it in the top 1 percent for its asset category.
- **Vanguard Short Term Federal** fund invests in mortgages and government bonds. It has an average duration of 2.3 and an average credit quality of AAA. It has an expense ratio of 0.10 percent, which puts it in the top 2 percent for its asset category.

Should you have questions regarding these materials, please feel free to contact me at 202-585-0109 or rgold@essentialhospitals.org.

Attachments:

2014 Financial Projection Compared to Budget (Attachment I)

ATTACHMENT I

Statement of Functional Expenses: 2014 Fall Projection vs. June Projection and Budget

									column 1	column 2
	2014 Revised Budget/June Projection									
	<u>Grants</u>	<u>Partnership for Patients</u>	<u>Research</u>	<u>Transf Center & Fellows</u>	<u>Genl and Admin.</u>	<u>Total Programs: Unrestricted</u>		<u>Temporarily Restricted</u>		<u>Total</u>
REVENUE:										
Unrestricted Grant from UHC	\$ -	\$ -	\$ -	\$ -	\$ 350,000	\$ 350,000	\$ -	\$ -	\$ 350,000	
Grant Income	\$ 1,194,600	\$ -	\$ -	\$ 500,000	\$ -	\$ 1,694,600	\$ 250,000	\$ -	\$ 1,944,600	
Government Contract	\$ -	\$ 5,493,800	\$ -	\$ -	\$ -	\$ 5,493,800	\$ -	\$ -	\$ 5,493,800	
Fellows Program	\$ -	\$ -	\$ -	\$ 292,500	\$ -	\$ 292,500	\$ -	\$ -	\$ 292,500	
Net Assets Released from Donor Restrictions	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ (1,694,000)	\$ -	\$ (1,694,000)	
TOTAL REVENUE	\$ 1,194,600	\$ 5,493,800	\$ -	\$ 792,500	\$ 350,000	\$ 7,830,900	\$ (1,444,000)	\$ 6,386,900		
Salaries and employee benefits	\$ 375,800	\$ 1,958,300	\$ 263,000	\$ 638,400	\$ 714,500	\$ 3,950,000	\$ -	\$ -	\$ 3,950,000	
Office Supplies & Services	\$ -	\$ 106,000	\$ 20,000	\$ 34,000	\$ 154,300	\$ 314,300	\$ -	\$ -	\$ 314,300	
Rent	\$ -	\$ 220,000	\$ -	\$ -	\$ 129,500	\$ 349,500	\$ -	\$ -	\$ 349,500	
Travel & meetings	\$ 38,300	\$ 274,200	\$ 24,700	\$ 190,400	\$ 110,600	\$ 638,200	\$ -	\$ -	\$ 638,200	
Depr and amort.	\$ -	\$ -	\$ -	\$ -	\$ 41,000	\$ 41,000	\$ -	\$ -	\$ 41,000	
Consultants & sub-contracted svces	\$ 696,500	\$ 1,383,000	\$ 48,300	\$ 170,200	\$ 120,000	\$ 2,418,000	\$ -	\$ -	\$ 2,418,000	
Information Technology	\$ -	\$ -	\$ -	\$ -	\$ 70,900	\$ 70,900	\$ -	\$ -	\$ 70,900	
Misc., Taxes and Insurance	\$ -	\$ -	\$ -	\$ -	\$ 29,000	\$ 29,000	\$ -	\$ -	\$ 29,000	
Project Development	\$ -	\$ -	\$ -	\$ -	\$ 100,000	\$ 100,000	\$ -	\$ -	\$ 100,000	
Sub-total before grant overhead coverage	\$ 1,110,600	\$ 3,941,500	\$ 356,000	\$ 1,033,000	\$ 1,469,800	\$ 7,910,900	\$ -	\$ -	\$ 7,910,900	
Allocation of Overhead to Grants	\$ 84,000	\$ 1,145,100	\$ -	\$ 62,000	\$ (1,291,100)	\$ -	\$ -	\$ -	\$ -	
TOTAL EXPENSES	\$ 1,194,600	\$ 5,086,600	\$ 356,000	\$ 1,095,000	\$ 178,700	\$ 7,910,900	\$ -	\$ -	\$ 7,910,900	
CHANGE IN NET ASSETS	\$ -	\$ 407,200	\$ (356,000)	\$ (302,500)	\$ 171,300	\$ (80,000)	\$ (1,444,000)	\$ (1,524,000)		
Net Assets:										
Prior Year Net Assets	\$ 12,110	\$ 4,864,354	\$ 24,436	\$ 131,760	\$ 741,380	\$ 5,774,040	\$ 1,996,060	\$ 7,770,100		
Change in Net Assets	\$ -	\$ 407,200	\$ (356,000)	\$ (302,500)	\$ 171,300	\$ (80,000)	\$ (1,444,000)	\$ (1,524,000)		
Net Assets, End of Year	\$ 12,110	\$ 5,271,554	\$ (331,564)	\$ (170,740)	\$ 912,680	\$ 5,694,040	\$ 552,060	\$ 6,246,100		
Temporarily Restricted Net Assets	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 552,060	\$ 552,060		
Unrestricted Net Assets:										
Unrestricted Net Assets	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	
Board-Designated Operating Reserves	\$ 12,110	\$ 5,271,554	\$ (331,564)	\$ (170,740)	\$ 912,680	\$ 5,694,040	\$ -	\$ -	\$ 5,694,040	
Non-Operating Board Designated Reserves	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	
Total: Unrestricted & Board-Designated Reserves	\$ 12,110	\$ 5,271,554	\$ (331,564)	\$ (170,740)	\$ 912,680	\$ 5,694,040	\$ -	\$ 5,694,040		
Total Net Assets	\$ 12,110	\$ 5,271,554	\$ (331,564)	\$ (170,740)	\$ 912,680	\$ 5,694,040	\$ 552,060	\$ 6,246,100		

ATTACHMENT I

Statement of Functional Expenses: 2014 Fall Projection vs. June Projection and Budget

							column 3	column 4
	2014 Fall Projection							
	<u>Grants</u>	<u>Partnership for Patients</u>	<u>Research</u>	<u>Transf Center & Fellows</u>	<u>Genl and Admin.</u>	<u>Total Programs:</u>	<u>Temporarily Restricted</u>	<u>Total</u>
<u>REVENUE:</u>								
Unrestricted Grant from UHC	\$ -	\$ -	\$ -	\$ -	\$ 350,000	\$ 350,000	\$ -	\$ 350,000
Grant Income	\$ 940,000	\$ -	\$ -	\$ 500,000	\$ -	\$ 1,440,000	\$ -	\$ 1,440,000
Government Contract	\$ -	\$ 5,493,800	\$ -	\$ -	\$ -	\$ 5,493,800	\$ -	\$ 5,493,800
Fellows Program	\$ -	\$ -	\$ -	\$ 227,500	\$ -	\$ 227,500	\$ -	\$ 227,500
Net Assets Released from Donor Restrictions	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ (1,439,000)	\$ (1,439,000)
TOTAL REVENUE	\$ 940,000	\$ 5,493,800	\$ -	\$ 727,500	\$ 350,000	\$ 7,511,300	\$ (1,439,000)	\$ 6,072,300
Salaries and employee benefits	\$ 191,100	\$ 2,005,800	\$ 398,087	\$ 743,972	\$ 691,042	\$ 4,030,000	\$ -	\$ 4,030,000
Office Supplies & Services	\$ 750	\$ 150,000	\$ 27,550	\$ 13,100	\$ 92,100	\$ 283,500	\$ -	\$ 283,500
Rent	\$ -	\$ 220,000	\$ -	\$ -	\$ 115,700	\$ 335,700	\$ -	\$ 335,700
Travel & meetings	\$ 7,600	\$ 302,000	\$ 12,100	\$ 141,900	\$ 89,100	\$ 552,700	\$ -	\$ 552,700
Depr and amort.	\$ -	\$ -	\$ -	\$ -	\$ 31,000	\$ 31,000	\$ -	\$ 31,000
Consultants & sub-contracted svces	\$ 584,000	\$ 1,375,000	\$ 10,000	\$ 176,200	\$ 58,200	\$ 2,203,400	\$ -	\$ 2,203,400
Information Technology	\$ -	\$ -	\$ -	\$ -	\$ 67,000	\$ 67,000	\$ -	\$ 67,000
Misc, Taxes and Insurance	\$ -	\$ -	\$ -	\$ -	\$ 29,000	\$ 29,000	\$ -	\$ 29,000
Project Development	\$ -	\$ -	\$ -	\$ -	\$ 100,000	\$ 100,000	\$ -	\$ 100,000
Sub-total before grant overhead coverage	\$ 783,450	\$ 4,052,800	\$ 447,737	\$ 1,075,172	\$ 1,273,141	\$ 7,632,300	\$ -	\$ 7,632,300
Allocation of Overhead to Grants	\$ 49,300	\$ 1,054,200	\$ -	\$ 75,000	\$ (1,178,500)	\$ -	\$ -	\$ -
TOTAL EXPENSES	\$ 832,750	\$ 5,107,000	\$ 447,737	\$ 1,150,172	\$ 94,641	\$ 7,632,300	\$ -	\$ 7,632,300
CHANGE IN NET ASSETS	\$ 107,250	\$ 386,800	\$ (447,737)	\$ (422,672)	\$ 255,359	\$ (121,000)	\$ (1,439,000)	\$ (1,560,000)
<u>Net Assets:</u>								
Prior Year Net Assets	\$ 12,110	\$ 4,864,354	\$ 24,436	\$ 131,760	\$ 741,380	\$ 5,774,040	\$ 1,996,060	\$ 7,770,100
Change in Net Assets	\$ 107,250	\$ 386,800	\$ (447,737)	\$ (422,672)	\$ 255,359	\$ (121,000)	\$ (1,439,000)	\$ (1,560,000)
Net Assets, End of Year	\$ 119,360	\$ 5,251,154	\$ (423,301)	\$ (290,912)	\$ 996,739	\$ 5,653,040	\$ 557,060	\$ 6,210,100
Temporarily Restricted Net Assets	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 557,060	\$ 557,060
Unrestricted Net Assets:								
Unrestricted Net Assets	\$ 119,360	\$ 1,951,154	\$ (423,301)	\$ (290,912)	\$ 96,739	\$ 1,453,040	\$ -	\$ 1,453,040
Board-Designated Operating Reserves	\$ -	\$ -	\$ -	\$ -	\$ 900,000	\$ 900,000	\$ -	\$ 900,000
Non-Operating Board Designated Reserves	\$ -	\$ 3,300,000	\$ -	\$ -	\$ -	\$ 3,300,000	\$ -	\$ 3,300,000
Total: Unrestricted & Board-Designated Reserves	\$ 119,360	\$ 5,251,154	\$ (423,301)	\$ (290,912)	\$ 996,739	\$ 5,653,040	\$ -	\$ 5,653,040
Total Net Assets	\$ 119,360	\$ 5,251,154	\$ (423,301)	\$ (290,912)	\$ 996,739	\$ 5,653,040	\$ 557,060	\$ 6,210,100

ATTACHMENT I

Statement of Functional Expenses: 2014 Fall Projection vs. June Projection and Budget

	2014 Budget Variance								column 5	
	<u>Grants</u>	<u>Partnership for Patients</u>	<u>Research</u>	<u>Transf Center & Fellows</u>	<u>Genl and Admin.</u>	<u>Programs:</u>	<u>Total</u>	<u>Temporarily Unrestricted</u>	<u>Restricted</u>	<u>Total</u>
<u>REVENUE:</u>										
Unrestricted Grant from UHC	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Grant Income	\$ (254,600)	\$ -	\$ -	\$ -	\$ -	\$ -	\$ (254,600)	\$ (250,000)	\$ (504,600)	
Government Contract	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Fellows Program	\$ -	\$ -	\$ -	\$ -	\$ (65,000)	\$ -	\$ (65,000)	\$ -	\$ (65,000)	
Net Assets Released from Donor Restrictions	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 255,000	\$ 255,000	
TOTAL REVENUE	\$ (254,600)	\$ -	\$ -	\$ (65,000)	\$ -	\$ (319,600)	\$ 5,000	\$ (314,600)		
Salaries and employee benefits	\$ 184,700	\$ (47,500)	\$ (135,087)	\$ (105,572)	\$ 23,458	\$ (80,000)	\$ -	\$ -	\$ (80,000)	
Office Supplies & Services	\$ (750)	\$ (44,000)	\$ (7,550)	\$ 20,900	\$ 62,200	\$ 30,800	\$ -	\$ -	\$ 30,800	
Rent	\$ -	\$ -	\$ -	\$ -	\$ 13,800	\$ 13,800	\$ -	\$ -	\$ 13,800	
Travel & meetings	\$ 30,700	\$ (27,800)	\$ 12,600	\$ 48,500	\$ 21,500	\$ 85,500	\$ -	\$ -	\$ 85,500	
Depr and amort.	\$ -	\$ -	\$ -	\$ -	\$ 10,000	\$ 10,000	\$ -	\$ -	\$ 10,000	
Consultants & sub-contracted svces	\$ 112,500	\$ 8,000	\$ 38,300	\$ (6,000)	\$ 61,800	\$ 214,600	\$ -	\$ -	\$ 214,600	
Information Technology	\$ -	\$ -	\$ -	\$ -	\$ 3,900	\$ 3,900	\$ -	\$ -	\$ 3,900	
Misc, Taxes and Insurance	\$ -	\$ -	\$ -	\$ -	\$ 0	\$ 0	\$ -	\$ -	\$ 0	
Project Development	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	
Sub-total before grant overhead coverage	\$ 327,150	\$ (111,300)	\$ (91,737)	\$ (42,172)	\$ 196,659	\$ 278,600	\$ -	\$ 278,600		
Allocation of Overhead to Grants	\$ 34,700	\$ 90,900	\$ -	\$ (13,000)	\$ (112,600)	\$ -	\$ -	\$ -	\$ -	
TOTAL EXPENSES	\$ 361,850	\$ (20,400)	\$ (91,737)	\$ (55,172)	\$ 84,059	\$ 278,600	\$ -	\$ 278,600		
CHANGE IN NET ASSETS	\$ 107,250	\$ (20,400)	\$ (91,737)	\$ (120,172)	\$ 84,059	\$ (41,000)	\$ 5,000	\$ (36,000)		



DATE October 21, 2014
TO Board of Directors
FROM Delvecchio Finley, Education Committee Liaison to the Board
RE Education Committee Report

MEMORANDUM

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

Section 1115 Delivery System Reform Incentive Payment (DSRIP) Waivers

America's Essential Hospitals focused this year on a series of educational activities on DSRIP waivers. The series, which included two briefs, three distance-learning programs, sessions at the annual conference, and a one-day Leadership Summit, is now complete. The summit, held September 29, drew 80 participants and a 4.1 overall satisfaction score. Based on the success of this year's program, staff are considering the option of holding a one-day summit again in 2015.

Innovations Summit

The 2014 Innovations Summit is scheduled for October 29. This year's summit focuses on population health and social networks. Nicholas Christakis, MD, PhD, MPH, author of Connected, will be this year's keynote speaker. Rapid-fire presentations by four of our member hospitals and a panel discussion will round out programming for this year's summit.

Fellows Program

Thirty-four fellows from 19 member hospitals have completed the first two sessions of the 2014 Fellows Program, built on a theme of "Adaptive Leadership." We have expanded our consulting panel to include consultants from Cambridge Leadership to teach the fellows on the Heifetz model of adaptive leadership versus technical solutions to operational challenges. The fellows' projects are well underway, as are the individual coaching sessions conducted by webinar. CEO and sponsor updates are routinely being emailed to keep the sponsors informed of fellows' work progress and expectations.

Applications for the Fellows Program class of 2015-2016 will open on December 1 and will close on January 31, 2015. As discussed at the June board meeting, a new enrollment process is being put into place this year to ensure sponsors and fellows understand their obligations and financial commitments.

VITAL2015

Planning for VITAL2015, the association's annual conference, is well underway. The program will largely stay the same as in 2014, but of note is that the association is conducting a call for proposals (CFP) this year to help fill a portion of the conference program. The education committee believes the CFP will enhance member engagement and help to uncover innovative programs within the membership that should be shared with others. The proposal deadline is November 14 and the education committee will review and select proposals in mid-December.

2015 Educational Programming

Educational programming in 2015 will again feature distance learning and in-person events. In addition to the usual broad swath of current topics that are important to member hospitals, staff plans deep dives into three topics: Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS), behavioral health, and DSRIIP waivers.

Also in the 2015 work plan is the development and launch of the **Essential Women's Leadership Academy**. During its September meeting, the education committee reviewed a staff recommendation to launch this program, which seeks to increase aspirations and executive competencies of female leaders in essential hospitals. The Essential Women's Leadership Academy has four components: mentorship, assessments and coaching, didactic webinars and meetings, and networking. The education committee reviewed and discussed ideas for the mentorship component of the program, including mentors' roles, responsibilities, and time commitments, as well as strategies for matching mentees to mentors.



DATE October 21, 2014
TO Board of Directors
FROM Bianca Perez, Research Committee Liaison to the Board
RE Research Committee Appointments

MEMORANDUM

Non-Board Member Research Committee Nominees

Dean Schillinger, MD, is founding director of the Center for Vulnerable Populations at San Francisco General Hospital. The Center's mission is to carry out research to prevent chronic disease in vulnerable populations. Schillinger carries out research related to health care for vulnerable populations and is an internationally recognized expert in health communication science, health literacy, and chronic disease prevention and management. (Term: 2015-2017)

Sample publications include:

1. Pandit AU, Bailey SC, Curtis LM, et al. Disease-related distress, self-care and clinical outcomes among low-income patients with diabetes. *Journal of Epidemiology & Community Health*. 2014; 68(6):557-64.
2. Barton JL, Trupin L, Tonner C.. English language proficiency, health literacy, and trust in physician are associated with shared decision making in rheumatoid arthritis. *The Journal of Rheumatology*. July 2014; 41(7):1290-7.
3. Sarkar U, Lyles CR, Parker MM, et al. Use of the refill function through an online patient portal is associated with improved adherence to statins in an integrated health system. *Medical Care*. March 2014; 52(3):194-201.
4. Brach C, Dreyer BP, Schillinger D. Physicians' roles in creating health literate organizations: A call to action. *Journal General Internal Medicine*. Feb 2014; 29(2):273-5.
5. Wu JR, Dewalt DA, Baker DW, et al. A single-item self-report medication adherence question predicts hospitalization and death in patients with heart failure. *Journal Clinical Nursing*. December 20, 2013.

Irene Yen, PhD, is research director for the department of medicine at Alameda County Medical Center. Her areas of research include social determinants of health, neighborhood environments, childhood social and economic experiences, and race and class inequalities. She served as principal investigator on a multi-year National Institutes of Health grant investigating key social and environmental mechanisms that create racial/ethnic and socio-economic disparities among older adults. (Term: 2014-2016)

Sample publications include:

1. Shariff-Marco S, Yang J, John EM, et al. Impact of neighborhood and individual socioeconomic status on survival after breast cancer varies by race/ethnicity: The neighborhood and breast cancer study. *Cancer Epidemiology, Biomarkers & Prevention*. May 2014; 23(5):793-811.
2. Yen IH, Gregorich S, Cohen AK, Stewart A. A community cohort study about childhood social and economic circumstances: racial/ethnic differences and associations with educational attainment and health of older adults. *BMJ Open*. 2013; 3(4).
3. Kersten E, Laraia B, Kelly M, Adler N, Yen IH. Small food stores and availability of nutritious foods: A comparison of database and in-store measures, Northern California, 2009. *Preventing Chronic Disease*. 2012; 9:E127.
4. Kochtitzky CS, Freeland AL, Yen IH. Ensuring mobility-supporting environments for an aging population: Critical actors and collaborations. *Journal of Aging Research*. 2011; 2011:138931.
5. Weir RC, Tseng W, Yen IH, Caballero J. Primary health-care delivery gaps among medically underserved Asian American and Pacific Islander populations. *Public Health Reports*. Nov.-Dec. 2009; 124(6):831-40.

Katherine Neuhausen, MD, director of delivery system reform at Virginia Commonwealth University's Office of Health Innovation, has studied the impact of the Affordable Care Act (ACA) on the financial stability of hospitals. She also served as an investigator for a Commonwealth study to identify the facilitators and barriers to developing integrated care systems for low-income populations. Neuhausen also worked with researchers at the Robert Graham Center to identify models of how community health centers access specialty care. She also serves as an adviser to the Centers for Medicare & Medicaid Services on the design and implementation of Texas' Delivery System Reform Incentive Payment program. (Term: 2015-2017)

Sample publications include:

1. Neuhausen K, Davis AC, Needleman J, Brook RH, Zingmond D, Roby DH. Disproportionate-share hospital payment reductions may threaten the financial stability of safety-net hospitals. *Health Affairs*. 2014; 33(6):988-96.
2. Rieselbach RE, Crouse BJ, Neuhausen K, Nasca TJ, Frohna JG. Academic Medicine: A key partner in strengthening the primary care infrastructure via teaching health centers. *Academic Medicine*. 2013; 88(12):1835-43.
3. Bergman J, Neuhausen K, Chamie K, Scales CD, Carter S, Kwan L, Lerman SE, Aronson W, Litwin MS. Building a medical neighborhood in the safety net: An innovative technology improves hematuria workups. *Urology*. 2013; 82(6):1277-82.
4. Neuhausen K, Grumbach K, Bazemore A, Phillips RL. Integrating community health centers into organized delivery systems can improve access to subspecialty care. *Health Affairs*. 2012; 31(8):1708-16.
5. Neuhausen K, Katz MH. Patient satisfaction and safety-net hospitals: carrots, not sticks, are a better approach. *Archives of Internal Medicine*. 2012; 172 (16):1202-3.

Marshall Chin, MD, MPH, is a general internist, section chief and director of research at the University of Chicago. He has extensive experience improving the care of vulnerable patients with chronic disease. He has worked to advance diabetes care and outcomes on Chicago's South Side through health care system and community interventions. Chin also serves on the editorial board of Health Services Research and the advisory committee for Robert Wood Johnson Foundation's Aligning Forces for Quality.

Sample publications include:

1. Baig AA, Benitez A, Locklin CA, et al. Community health center provider and staff's Spanish language ability and cultural awareness. *Journal of Health Care for the Poor and Underserved*. 2014;25 (2):527-45.
2. Laiteerapong N, Kirby J, Gao Y., et al. Health care utilization and receipt of preventive care for patients seen at federally funded health centers compared to other sites of primary care. *Health Services Research Journal*. April 30, 2014.
3. Peek ME, Ferguson M, Bergeron N, Maltby D, Chin MH. Integrated community-healthcare diabetes interventions to reduce disparities. *Current Diabetes Reports*. March 2014; 14(3):467.
4. Quinn MT, Gunter KE, Nocon RS. Undergoing transformation to the patient-centered medical home in safety net health centers: Perspectives from the front lines. *Ethnicity & Disease*. 2013; 23(3):356-362.
5. Nundy S, Dick JJ, Goddu A, et al. Using mobile health to support the chronic care model: Developing an institutional initiative. *International Journal of Telemedicine and Applications*. 2013. Epub.



DATE October 21, 2014
TO Board of Directors
FROM Anna Roth, Chair, Institute Nominating Committee
RE Nominating Committee Report

MEMORANDUM

The Essential Hospitals Institute nominating committee met September 30 to consider one opening on the board, created by the retirement of John Bluford. The committee considered two candidates for the open slot and recommended Dennis Keefe to complete Bluford's term, which runs through June 30, 2015. His biography:

Dennis Keefe, MBA
President and CEO
Care New England Health System

Dennis Keefe serves as president and CEO of the Care New England (CNE) Health System, based in Providence, Rhode Island. Keefe has occupied this position since August 2011. CNE comprises four hospitals—Butler, Women & Infants, Kent and Memorial (effective September 2013)—and the visiting nurse association of Care New England, with combined revenues of \$1 billion annually. Recent accomplishments include the acquisition of Memorial Hospital of Rhode Island, a new Academic Affiliation with Brown University School of Medicine, an affiliation with The Providence Center for Behavioral Health, and an innovative strategic partnership with Blue Cross/Blue Shield of Rhode Island.

Keefe previously served as CEO of Cambridge Health Alliance (CHA) and the commissioner of public health for the City of Cambridge, Massachusetts, from 2002-2011. CHA grew significantly under Keefe's leadership, becoming a more than \$1 billion integrated health care delivery system. While at CHA, Keefe led the organization through a significant service reconfiguration plan, which helped to stabilize the foundation of CHA to serve its employees and patients in the future.

Keefe also served as chair of the Massachusetts Hospital Association (MHA). Additionally, he has served on the executive committee of America's Essential Hospitals and as board chair of Essential Hospitals Institute.

In 2008, Keefe was honored with a Lifetime Achievement Award from the Massachusetts advocacy organization, Health Care for All, for his efforts to improve access to medical care in Massachusetts. In 2009, he received the American College of Healthcare Executives' Massachusetts Healthcare Executive of the Year Award.

Keefe is a highest honors graduate of Northeastern University, where he received the Dean's Citation Award as the top student in the Health Sciences Program. Keefe also earned a master's

degree in business administration, with a focus in health care administration, from Northeastern University, and was honored as the 2005 Alumnus of the Year by Northeastern University.

As outlined in the Institute bylaws, vacancies on the Institute board are approved by the association board. On October 28, the association board of directors will meet and will be asked to approve the Institute nominating committee's recommendation. Keefe will begin his term of service immediately upon appointment by the association board.