



AMERICA'S  
ESSENTIAL  
HOSPITALS

## Board of Directors Meeting

December 1, 2014  
Conference Call

[essentialhospitals.org](http://essentialhospitals.org)

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# AMERICA'S ESSENTIAL HOSPITALS

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# AMERICA'S ESSENTIAL HOSPITALS

## Association Board of Directors Meeting December 1, 2014 11 am – 12:30 pm ET Agenda

11 – 11:05 am	Call to Order and Roll Call (Walker)	
11:05 – 11:10 am	Approve October 28 Minutes (Walker)	ACTION
11:10 – 11:35 am	Review and Approve 2015 Proposed Budget (Coopwood/ Gold)	ACTION
11:35 – 12:05 pm	Policy Advisory Committee (Feldpush) • Review and Approve Principles of Equity of Care	ACTION
12:05 – 12:30pm	Advocacy Update (Feldpush)	
12:30 pm	Adjourn	



# 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

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

### CHAIR-ELECT

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

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

### PAST-CHAIR

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

Wright Lassiter III (2014–2015)  
CEO  
Alameda Health System

### SECRETARY

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

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

### TREASURER

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

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

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)  
CEO  
Virginia Commonwealth University Health System

Steven G. Gabbe, MD (2013–2015)  
Senior Vice President for Health Sciences, CEO  
The Ohio State University Wexner Medical Center

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

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

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 Association Board Meeting Dates

Monday, March 16, 2015

11 am – 5 pm

Westin Georgetown

Washington, DC

Held in conjunction with March 17–18, 2015, Policy Assembly

Tuesday, June 23, 2015

11 am – 5 pm

Westin Gaslamp Quarter

San Diego

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



Board of Directors Meeting  
October 28, 2014  
Washington, DC

Board Members Present (14)	Board Members Absent (3)	Staff Present (12)
Michael B. Belzer, MD Reginald W. Coopwood, MD Steven G. Gabbe, MD Michael Karpf, MD Wright L. Lassiter III Johnese M. Spisso, MPA, RN Thomas P. Traylor, MBA William B. Walker, MD By phone: Timothy M. Goldfarb George Hernandez, Jr., JD Santiago Muñoz, III Sheldon Retchin, MD, MSPH Donna K. Sollenberger, MA Roxane A. Townsend, MD	John M. Haupert Ramanathan Raju, MD, MBA Irene M. Thompson	Bruce Siegel, MD, MPH David Engler, PhD Beth Feldpush, DrPH Rhonda Gold, CPA Kristine Metter, CAE Sarah Callahan, MHSA Carl Graziano Shawn Gremminger, MPP Xiaoyi Huang, JD Alan Burk Katie Zimmerman Caitlyn Furr

Agenda Item	Minutes
Call to Order and Disclosure of Conflicts of Interest (Walker)	<ul style="list-style-type: none"><li>Walker called the meeting to order at 11 am and asked for conflicts of interest with the agenda; none was disclosed.</li></ul>
Approve Consent Agenda (Walker)	Members reviewed the June 24 meeting minutes.  Walker requested a motion to approve the consent agenda. There was a motion, a second, and unanimous approval of the consent agenda.
President's report (Siegel)	<ul style="list-style-type: none"><li>Siegel noted Ebola events have impacted many members, further demonstrating the essential role of member hospitals.</li><li>Spisso mentioned that University of Washington School of Medicine is a designated Ebola treatment center.</li></ul>

	<ul style="list-style-type: none"> <li>• Siegel reported on several association activities:           <ul style="list-style-type: none"> <li>◦ Risk adjustment for socioeconomic status (SES) remains on the association's agenda, with legislation in both houses of Congress.</li> <li>◦ The association added two new members, Interim LSU and Rhode Island Hospital; and lost University of Colorado.</li> <li>◦ Based on briefings with members, the association has found widespread support for dues restructuring.</li> <li>◦ The association will meet with Sen. Ron Wyden (D-OR) December 9 to discuss priorities for members of America's Essential Hospitals.</li> </ul> </li> </ul>
Nominating Committee Report (Spisso)	<ul style="list-style-type: none"> <li>• The board was asked to appoint a new secretary to fill the vacancy created by David Lopez's departure from the board. Karpf was nominated to fill this position. <i>Walker requested a motion to appoint Karpf as the new secretary of the board of directors. There was a motion, a second, and unanimous approval of Karpf's appointment.</i></li> <li>• The board was asked to appoint a new at-large director. University of Chicago Medicine President Sharon O'Keefe was nominated. <i>Walker requested a motion to appoint O'Keefe as the new at-large director. There was a motion, a second, and unanimous approval of O'Keefe's appointment.</i></li> <li>• The board was asked to appoint a new member director for the Essential Hospitals Institute board. Dennis Keefe, president and CEO of Care New England Health System, was nominated. <i>Walker requested a motion to appoint Keefe as the member director of the Institute board of directors. There was a motion, a second, and unanimous approval of Keefe's appointment.</i></li> </ul>
Finance Committee Report (Coopwood)	<ul style="list-style-type: none"> <li>• Coopwood asked Gold to present the financial update, Referencing materials in the board book, she reported these items:           <ul style="list-style-type: none"> <li>◦ America's Essential Hospitals' 2014 projected revenue is \$8.9 million, which is offset by \$7.19 million in expenses, before items funded from reserves, leaving an operating surplus of \$1.72 million.</li> <li>◦ The projected surplus is \$894,000 more than budget and \$700,000 better than last projected, in June. The increase is mostly a result of new membership dues.</li> <li>◦ A summary of significant budget variances.</li> </ul> </li> </ul> <p><i>Gold stated that the finance committee approved and recommended that the board set aside an additional \$100,000 in board-restricted net assets to fund the non-depreciable and non-amortizable costs for the office</i></p>

	<i>move, for a total of \$450,000 in restricted net assets. There was a motion, a second, and unanimous approval.</i>
Office Relocation and Lease Terms (Gold)	<ul style="list-style-type: none"> <li>• Gold provided a brief office move update and introduced DTZ representatives Aaron Pomerantz and Cathy Jones.</li> <li>• Jones credited America's Essential Hospitals' staff with having foresight to enlist DTZ's services early on, which provided enough time and leverage to negotiate a good deal. He noted that when the process began, the market was fairly soft, but began to tighten over time.</li> <li>• DTZ outlined the lease acquisition process: <ul style="list-style-type: none"> <li>◦ Gold, Burk (HR director) and IT Director Mark Campbell visited 12 of 35 potential buildings. The list was further narrowed to three finalist sites, which the leadership team toured.</li> <li>◦ Characteristics considered included cost, location, access to public transportation, and space efficiency.</li> <li>◦ The selected space, at 401 9 St. NW, is a 14-year-old Class A Gold LEED building with amenities, including a rooftop terrace, a fitness center, and retail in the area and in the building. The building is three blocks from the association's current location, closer to Capitol Hill, and convenient to two subway stations.</li> <li>◦ America's Essential Hospitals will occupy the south side of the ninth floor under a 15-year lease. The team negotiated extensively and signed a lengthy, non-binding letter of intent with Boston Properties, the terms of which were shared with the finance committee. An attorney is reviewing the formal lease agreement.</li> <li>◦ Architects determined the association needs approximately 21,100 square feet of office space, including a conference room large enough to accommodate board meetings and space to accommodate staff growth.</li> <li>◦ In years 5 and 10, the organization will have a right to expand into 3,000 to 4,000 square feet of rentable contiguous space; however, if the first expansion option is not exercised, the second option will be forfeited. The association also has an ongoing first right of refusal to lease up to 5,000 square feet of space on the same floor, though this may not be contiguous space. The opportunity exists to sublease.</li> <li>◦ The negotiated rental cost, rent abatement, and tenant improvement allowance is more favorable than the real estate brokers' original estimate and substantially better than the assumptions previously communicated to the board.</li> <li>◦ The negotiated rent is \$67.25 per square foot (inclusive of operating expenses) with 14 months of free rent</li> </ul> </li> </ul>

- abatements, 2.5 percent annual rent increase, and a \$115 per square foot allowance for tenant improvement.
  - Staff's original estimates assumed a rental cost of \$70 per square foot for 20,000 square feet, an \$85 to \$95 per square foot tenant improvement allowance, and eight months of rent abatements. The rent abatement, which equates to a 7 percent to 8 percent cost reduction, can be converted to an additional tenant improvement allowance.
  - A four-month security deposit (approximately \$483,400) is required in the form of an irrevocable letter of credit, reducing over time, with only one month's deposit remaining after Year 4, assuming the association's revenues are at least \$8.5 million a year.
  - The lease will be in the name of the association only, as its revenue stream is (1) more consistent and reliable than the Institute's revenues based on grant and contract receipts; and (2) having two entities as co-tenants on a lease makes each entity jointly and severally liable for the entire amount of tenant obligations.
  - A financial analysis prepared by DTZ estimates annual rent of more than \$1.4 million, which will escalate by 2.5 percent per year in base rent plus operating expenses. The total cost over 15 years is estimated at \$25 million.
  - The total office move budget, including the office build-out, audiovisual, furniture, equipment, and artwork, is estimated at \$4.3 million, of which \$2.4 million will come from the tenant improvement allowance, for a net cost of approximately \$1.9 million (staff previously estimated a net cost of \$2.3 million).
  - Traylor asked how many more FTEs we could fit in the new space.
  - Gold responded that the new space will accommodate 70 employees, and staff total is now 58. There is some room for immediate growth plus the two expansion options for contiguous space in years 5 and 10.
  - Siegel mentioned that the association did not want to take more space than needed, despite its accelerated growth.
  - Gabbe said staff was sensitive to finding space consistent with the association's mission and that the choice is "A" space, but not "trophy" space.
  - Gold stated that the finance committee recommends approval of the terms, which would allow Siegel to enter into a binding contract in accordance with the terms of the non-binding letter of intent. All questions were addressed.
- Walker asked for a motion to provide board authorization for Siegel to enter into a formal lease agreement with Boston Properties for 401 9 St.*

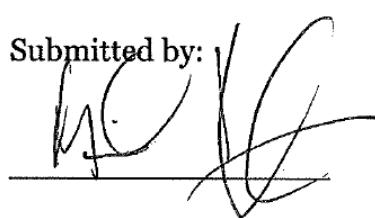
	<i>NW, assuming the lease terms do not differ in any significant way from the letter of intent. There was a motion, a second, and unanimous approval.</i>
Membership Committee Report (Traylor)	<ul style="list-style-type: none"> <li>• Traylor requested approval for a proposal to establish a corporate affiliate membership category. The membership committee vetted the proposal and recommended its approval.</li> <li>• America's Essential Hospitals now has two membership categories: full members and associate members. The association's bylaws allow for a corporate affiliate membership category to be created. The new category would allow vendors to work with the association on a more consistent, year-round basis.</li> <li>• There are \$5,000 per year or \$15,000 per year options for this membership category.</li> <li>• The association would not allow alcohol, gambling, firearms, or tobacco vendors to join, and corporate affiliates would be asked to sign a code of ethics.</li> <li>• Belzer asked for a census of associate members. Metter pointed to Central Health, in Texas, only, an indication the association is not likely to have a large number of associate members.</li> </ul> <p><i>Traylor asked for a motion to approve the creation of a corporate affiliate membership category. There was a motion, a second, and unanimous approval of the category.</i></p>
Board Member Expectations: Initial Discussion (Walker)	<ul style="list-style-type: none"> <li>• Walker and Siegel believe it would be beneficial to create clear expectations for board participation.</li> <li>• The expectations suggested include: informally helping to recruit and retain members; attend meetings; serve on committees; and encourage their hospital staff's involvement with the association.</li> <li>• They will create a formal set of expectations for use in assessing members' level of engagement against such expectations during reappointment.</li> <li>• Traylor mentioned political engagement with local representatives. Advocacy expectations would be good for potential board members to know up front.</li> <li>• Siegel said that the board would revisit expectations at its March 2015 meeting.</li> </ul>
Education Committee Report (Belzer)	<ul style="list-style-type: none"> <li>• The committee met in September at the association's offices and agreed that educational programs should be interactive.</li> <li>• The 2015 education programming will focus on Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS), Delivery System Reform Incentive Payment (DSRIP) Program waivers, and behavioral health.</li> <li>• The current Fellows Program class has gone through two sessions. This year's theme is adaptive leadership. Applications for the next</li> </ul>

	<p>class of fellows will open in December and close in February, and repeat the theme of adaptive leadership.</p> <ul style="list-style-type: none"> <li>• The association opened a call for proposals for VITAL2015 presentations. Belzer asked board members to encourage colleagues to apply. The education committee will meet in December to review the proposals.</li> <li>• The association is developing an Essential Women's Leadership Academy mentoring and networking program for women. It is expected to begin in late 2015 or early 2016.</li> </ul>
Policy Advisory Committee Report (Haupert)	<ul style="list-style-type: none"> <li>• Feldpush presented the report in Haupert's absence.</li> <li>• The group is actively drafting principles around equity of care and reducing disparities to present to the board in December</li> <li>• Retchin asked if the principles address data on risk adjustment for readmissions rates. Feldpush said the principles address equity more broadly, but noted that the association supports risk adjustment of certain quality measures for patient SES status. Siegel said the board discussed risk adjustment at the last meeting, and America's Essential Hospitals has been vocal and uncompromising on the issue.</li> </ul>
Policy/Advocacy Update (Feldpush)	<ul style="list-style-type: none"> <li>• Feldpush provided an overview of the upcoming midterm election landscape.</li> <li>• The nation has experienced a dramatic increase in political polarization, both among policymakers and Americans in general, during the past 20 years.</li> <li>• There will be 36 governor races in the general election, with Republican victories likely.</li> <li>• All U.S. House of Representatives seats are up for election, most of which are safe for incumbents. Republicans may pick up a few seats, and already have a solid majority, and will likely keep that majority until the next census.</li> <li>• In the U.S. Senate, 36 seats are in play. Republicans need to net six additional seats to take a majority in the Senate, which looks likely to happen. Looking at past midterm elections, the president's party loses six seats, on average. Many of the races are close, and some are likely to go into runoffs. There is a possibility of three independents in the Senate, which could also tip the majority.</li> <li>• The opposite situation may occur in 2016. Republican seats will be open, providing momentum for a Republican president and a Democratic Senate.</li> <li>• Walker asked about the association's strategy for a Republican Senate.</li> <li>• Feldpush said that the first order of business after the election is the lame-duck session, during which Congress needs to pass a continuing resolution to continue funding the government.</li> </ul>

- Feldpush outlined a status update of legislative action important to the association:
  - Debt ceiling will come up in the spring, with the date uncertain, but hospital legislation may be attached.
  - Medicare sustainable growth rate (SGR) patch runs out in the spring. This is must-pass legislation, but momentum for a permanent fix has waned.
  - Children's Health Insurance Program (CHIP) reauthorization: Funding for CHIP expires September 30, 2015, so it will need to be addressed. The association is pushing for CHIP reauthorized this year because Sen. Orrin Hatch, (R-UT), who would become chair for the Senate Finance Committee, is developing some aggressive Medicaid reforms, and wants to attach them to the CHIP reauthorization legislation. The association is currently talking with his staff.
  - A plan created by Sens. Hatch, Richard Burr (R-NC), and Thomas Coburn (R-OK) would replace the Affordable Care Act (ACA) and alter Medicaid by making it a per-capita caps program. The association is providing feedback on the proposals, which lack detail.
- December 8 and 9 mark the association's next legislative fly-in. The lame-duck session will be a key time to talk about essential hospitals' concerns before the Hill tempo picks up in January.
- Issues at the forefront of the Hill discussions in December: the 340B Drug Pricing Program, risk adjustment, reducing disparities, CHIP reauthorization, Medicare disproportionate share hospital (DSH) payments, and the workforce. Of these, 340B will likely get more attention in the next Congress.
- Belzer asked about the association's strategy for reducing disparities.
- Feldpush responded that an idea is in development that would partner hospitals and the U.S. Department of Health and Human Services (HHS), with a focus on hospitals ready to accelerate work to reduce disparities. Under the plan, hospitals would get startup funding for creating programs to reduce disparities and ongoing funding as an incentive. Savings would accrue to the government because of better outcomes; those savings would pay for the program.
- The board discussed this concept and agreed that the degree to which hospitals are held accountable for a population's health will need to be carefully considered.
- Feldpush elaborated on the key issues facing Congress:
- 340B: Sources within the Health Resources and Services Administration (HRSA) indicate a decision is forthcoming on how to move forward on possible non-controversial provisions

	<p>with interpretive guidance. Congress will likely be more active on 340B in the next year. The Pharmaceutical Research and Manufacturers of America (PhRMA) is mounting an aggressive media campaign against 340B. However, the campaign is having little impact on independent thinkers. America's Essential Hospitals will try to reframe the issue: If Congress wants to scale back the program, it will take resources away from essential hospitals and increase costs to taxpayers.</p> <ul style="list-style-type: none"> <li>• Ebola preparedness: The association has been in regular contact with the Centers for Disease Control and Prevention and HHS and has been pushing out information to members, including through a webpage dedicated to Ebola resources.</li> <li>• Feldpush said the association is getting questions from Congress about what hospitals need. The chief idea is to fully fund the Hospital Preparedness Program, which has been cut by 50 percent over the past decade. There will be an Ebola hearing by the Senate Appropriations Committee on November 12.</li> <li>• Sollenberger said The University of Texas Medical Branch (UTMB) is designated in Texas as an Ebola receiving hospital because Galveston National Lab is on its campus and studies emerging diseases, and the hospital has waste disposal facilities on site. UTMB calculated construction costs to build an Ebola isolation unit would be about \$2 million per bed.</li> <li>• Sollenberger will soon have a list of all costs for staffing, training, and building.</li> <li>• Karpf said the country needs to develop a coherent plan for containing outbreaks, as there are sure to be other emerging microbes after Ebola.</li> <li>• Spisso said hospitals need more funding for personal protective equipment.</li> <li>• Feldpush will reach out to board members individually before the hearings.</li> </ul>
Executive Session	<ul style="list-style-type: none"> <li>• The board went into executive session at 2:56 pm and the meeting was adjourned.</li> </ul>

Submitted by:



Michael Karpf, MD  
Secretary



DATE December 1, 2014  
TO Board of Directors  
FROM Finance Committee  
RE 2015 Proposed Budget

MEMORANDUM

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There is a scheduled conference call with the board of directors on **Monday, December 1, at 11 am ET**, to review the association's proposed 2015 budget. To access the call, please enter the following:

Dial in #: 1-877-668-4493  
Attendee #: 23295891

The finance committee has reviewed the attached 2015 budget materials and recommends the board's review and approval. The finance committee is asking the board of directors to vote on the following **action item**:

- Approve the 2015 proposed budget.

The proposed budget reflects ongoing activities that support the organization's 2013–2018 strategic plan. The budgeted advocacy activities focus on preserving funding for essential hospitals as the health care delivery system continues to transform. Policy activities focus on preparing members for future changes—including the potential for further delivery system reform. And budgeted communications-related activities focus on maintaining and expanding outreach to policymakers, opinion leaders, other health care organizations, and the media.

Activities relating to research, analytics, performance improvement, the Fellows Program, and innovations and partnerships are reflected in the Institute's budget.

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#### Financial Summary

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. Of the budgeted \$10.2 million in revenue, \$6.6 million represents membership dues, including dues from six new full members (two for the full year, two at half-year, and two at quarter-year).

UHC dues and sponsorships are budgeted to increase by 2 percent, for a total of \$3.57 million in revenue (\$3.17 million to the association and \$400,000 to support the Institute). Budgeted

revenue also includes \$200,000 in external sponsorships and \$260,000 in conference registration fees.

Budgeted expenses of \$8.8 million include a \$595,000 contribution to Essential Hospitals 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). Budgeted expenses, excluding the \$595,000 contribution, are 15 percent (or \$1 million) more than the 2014 projection and 8 percent (or \$618,000) more than the 2014 budget.

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. On a consolidated basis, the 2015 association and Institute budgets reflect a 5 percent operating margin (after taking into account the nondepreciable and nonamortizable office move expenses) and 7 percent before office move expenses.

The budget justification for each line item is detailed in this memo. This proposed budget will be reviewed with you during the scheduled call, but please do not hesitate to contact Rhonda Gold at [rgold@essentialhospitals.org](mailto:rgold@essentialhospitals.org) or 202-585-0109 should you have questions prior to the call.

Attachment I: 2015 proposed budget

## 2015 BUDGET JUSTIFICATION

### INCOME

**Membership Dues:** The budget proposes \$6.61 million in membership dues under the new tiered dues structure, including six new full members (two for the full year, two at half-year, and two at quarter-year). The budget also reflects a reduction of \$266,000 as bad debt expense for the potential deactivation of four members, as 2015 will be the first year of the new dues structure.

The proposal reflects the conversion of two of the three existing associate members (Natividad Medical Center and the Health Care District of Palm Beach County) to full members. Central Health will continue as an associate member, along with one potential new recruit. Under the bylaws, associate members are other health care providers that are not general acute care providers or other health systems that are not being considered for full membership but share some characteristics with the association's full members and therefore have some similar needs.

Under the affiliate membership category, only two existing state alliances (Georgia and Florida) will continue as affiliate members. Corporate sponsors will be converted to the new corporate affiliate membership category. This proposed membership category, as recommended by the membership committee, will include organizations providing products and services for essential hospitals. An organization may choose to become a corporate affiliate member rather than sponsor a particular activity or event to gain year-long visibility in the association. The budget reflects the reclassification of \$80,000 from sponsorship income to membership dues.

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.

While the budget reflects some potential deactivations, additional membership losses could occur once dues are invoiced despite the positive feedback regarding the dues change the association has received from member CEOs. We will be monitoring this item closely.

**UHC Dues and Sponsorships:** Under the memorandum of understanding with UHC, membership dues, sponsorships, and support to the Institute from UHC are 2 percent more than the 2014 projected and budgeted levels. UHC will also be providing a \$400,000 unrestricted grant to the Institute to help cover general and administrative costs.

In addition to UHC sponsorships, the budget reflects \$200,000 in corporate sponsorships from other organizations. This is a reduction of \$40,000 (or 17 percent) from the 2014 projected level (and 18 percent less than 2014 budget). This reduction is due to the reclassification of \$80,000 to the proposed corporate affiliate membership category, of which \$40,000 is offset by new budgeted sponsorship revenue.

**Conference Registration Fees:** The 2015 budget assumes \$260,000 in registration fees, of which \$151,000 is for the annual conference, VITAL2015. Included in the budget is \$34,000 in registration fees for an expanded in-person waiver meeting and \$75,000 in tuition fees for the

Government Relations Academy. The 2015 budgeted fees are \$92,300 (or 55 percent) more than 2014 projected because the Government Relations Academy occurs every other year.

## EXPENSES

**Salaries and Fringes:** Budgeted at \$4.48 million, an increase of \$530,000 (or 13 percent) from the 2014 projected level and 8 percent from the 2014 budget.

The salary and fringe line reflects a salary and merit increase pool of an average of 3.5 percent, which is consistent with other nonprofit organizations in the Washington, DC, market. It also includes three new budgeted positions- a quality/policy analyst, senior accountant, and marketing coordinator.

The new quality/policy analyst will track hospital quality measures at the National Quality Forum (NQF), support Bruce Siegel in his role on the NQF board, and handle performance incentive programs, including the Hospital Value-Based Purchasing Program, the Hospital Readmissions Reduction Program, and the Hospital Acquired Conditions Program. This position will be the key point person working with the Centers for Disease Control and Prevention, The Joint Commission, and other stakeholders on quality-related policy issues. At this time, America's Essential Hospitals is the only national hospital association without a dedicated quality/policy staff person.

The senior accountant—funded from the Partnership for Patients, Essential Hospitals Engagement Network (EHEN) contract—will oversee the EHEN contract, track expenditures, and monitor the budget. This previously budgeted position was filled and vacated earlier this year and replaced with a junior-level staff accountant. The finance team recognizes a need for a higher-level accounting professional to oversee the EHEN contract while the junior-level position handles the day-to-day accounting functions.

The marketing coordinator will assist staff as they handle the expanded volume of programs and events. Duties will include the Gage Awards Program, membership recruitment, and speaker management for association and Institute events.

The budget reflects a 25 percent increase in health insurance premiums that was recently assessed by Carefirst and 10 percent increases in other insurance benefits. Total budgeted salary and fringe costs for the association and Institute is \$8.5 million, of which \$4 million is allocated to the Institute. The allocation split in the 2015 budget is approximately the same (50/50) as the 2014 projection.

**Support to Institute:** Budgeted at \$595,000, this line reflects the budgeted uncovered salary, fringe, and programmatic costs for Institute staff working on research and analytics work.

**Policy:** Budgeted at \$294,000, 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 budget also includes a retainer with Health Policy Alternatives (of \$42,000) for

the drafting of special bulletins, comment letters, and policy briefs. The budget for amicus briefs (of \$25,000) was increased by \$5,000, as staff anticipates legal action related to the 340B Drug Pricing Program and ongoing efforts relating to challenges to the Affordable Care Act. An in-person advisory committee meeting (\$17,000) and outside conferences and meetings (\$13,000) were budgeted at the same level as 2014.

**Advocacy:** Budgeted at \$653,000, an increase of \$191,200 (or 41 percent) from the 2014 projected level, and an increase of \$197,000 (43 percent) from the 2014 budget.

The budget includes the hosting 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). The increase from the 2014 projection and budget is due to the reclassification of the Coalition to Protect America's Healthcare contribution (of \$50,000) from the communications budget line to advocacy and higher budgeted speaker fees and food costs for the policy assembly meetings. Furthermore, the budget reflects \$94,300 for the Government Relations Academy, a new expense for 2015 since this program occurs every other year.

**Member Services:** Budgeted at \$244,700, a reduction of \$4,500 (2 percent) from the 2014 projected amount, an increase of \$12,200 (5 percent) from the 2014 budget.

The budget reflects site visits for membership recruitment and retention activities (\$50,000), awards and education committee expenses (\$30,000), membership materials and mailings (\$16,000), sponsorships to other organizations (\$138,000), and conference site visit travel (\$10,000). The membership committee is not scheduled to meet in person, as the bulk of their work was completed in 2014 and no new initiatives are planned for 2015.

**Conferences:** Budgeted expenses of \$637,000, an increase of \$183,000 (or 40 percent) from the 2014 projected amount and 4 percent from the 2014 budget.

Budgeted conferences and meetings include the VITAL2015 annual conference (\$427,200 in expenses), fall innovations summit (\$51,000), governance meetings (\$125,000), and a waiver summit (\$33,800). The board governance meetings will continue to be held in conjunction with a major event (spring and fall policy assemblies and VITAL2015). Bundled 2015 events will be scheduled three times during the year: March, June, and fall.

The increase from 2014 is due to the following assumptions:

- Budgeted food costs for VITAL2015 are 30 percent (\$100,000) higher than VITAL2014 due to the San Diego location and a projected 50-person increase in attendees (budgeted at \$29,000).
- The budgeted cost of 2015 governance meetings is higher than the 2014 projected amount (by \$44,000) because the budget assumes full board attendance at the three planned board meetings and includes a new strategic planning committee meeting.
- The waiver summit assumes increased attendees in 2015.

**Communications:** Budgeted at \$231,000, a reduction of \$52,700 (or 19 percent) from the 2014 projected amount and a 25 percent decrease from the 2014 budget.

Budgeted costs are less than the 2014 projection and budget because of the reclassification of the Coalition to Protect America's Healthcare contribution (of \$50,000) to the advocacy line.

The 2015 communications budget maintains the association's relationship with Neimand Collaborative (at \$50,000) as primary consultant for creative direction on advocacy and other campaigns. In 2015, staff expect to renew a campaign to ensure sufficient and sustainable funding for essential hospitals. The budget includes ongoing website support (at \$58,000); branding, design work, and publications (at \$31,000); dues and subscriptions (at \$20,400) for social media management and various services, associations, and publications relevant to communications work; media and advertising campaigns (at \$53,500); and \$12,000 for a robust media monitoring and tracking service and materials for a new media library and electronic magazine (ezine).

**Consulting/Professional Fees:** Budgeted at \$117,500, a decrease of \$4,500 (or 4 percent) from the 2014 projected amount and 13 percent from the 2014 budget.

Included in this line are auditing and 990 tax return fees (\$30,000), recruitment and human resource consulting fees (\$42,500), legal fees for non-retainer related issues (\$23,000), and unspecified consulting services (\$22,000).

This budget line does not reflect an exhaustive list of 2015 consultants. Consulting costs for policy and advocacy are reflected in their own budget lines, writers and other public relations consultants are budgeted in communications, member services consultants are budgeted in member services, and computer consultants are reflected in the information technology (IT) line.

**Retainer:** Budgeted at \$350,000, a reduction of \$50,000 (or 13 percent) from 2014.

As a result of cutting back on the retainer, America's Essential Hospitals will utilize internal staff to handle policy development work, including writing comment letters, tracking issues, and responding to requests for information.

**IT:** Budgeted at \$111,300, a decrease of \$9,700 (or 8 percent) from the 2014 projected amount and 2 percent less than the 2014 budget.

Included in this budget line are the costs associated with the hiring of computer consultants (\$21,000), support agreements and licenses (\$14,300), membership database consultants and fees (\$42,000), cloud fees (\$18,500), and computer supplies (\$15,500).

In addition to the \$111,300 reflected in the association budget, \$69,300 in shared IT costs is reflected in the Institute's budget.

**Rent:** Budgeted at \$385,000, an increase of \$9,000 (or 2 percent) from the 2014 projected amount and the same as the 2014 budget.

The budget reflects a 2 percent increase to the base rent for the advocacy, policy, communications, member services, and finance and administrative staff. The rent for the suite housing the Institute staff is reflected in the institute's budget (an additional \$354,000). The office relocation is anticipated to occur in mid-December.

**Office Expenses and Equipment Rental:** Budgeted at \$212,500, an increase of \$29,400 (or 16 percent) from the 2014 projected amount and 5 percent less than the 2014 budget.

This budgeted line item reflects general office expenses, including telephone, supplies, advertising and recruitment, dues and subscriptions, temporary help, and printing expenses. This line also includes leasing fees associated with the copiers and telephone system (totaling \$53,000). The increase from the 2014 projected amount is due to a new \$20,000 expense for an e-scanning service to eliminate paper financial and human resource documents before the office move.

**Travel and Professional Development:** Budgeted at \$180,000, an increase of \$52,500 (or 41 percent) from the 2014 projected amount and 43 percent from the 2014 budget.

The significant change in this line item is due to increased staff professional development opportunities to include continuing education and professional certification classes, new staff training initiatives, a one-night site visit for 15 staff to visit a member hospital, licenses for online professional development videos, and budgeted training opportunities as recommended by the leadership team. The budget also assumes a 10 percent increase in travel costs relating to staff airfare, food, and hotel expenses.

**Taxes/Insurance/Miscellaneous:** Budgeted at \$87,000, an increase of \$18,000 (or 26 percent) from the 2014 projected amount and budget.

Budgeted line item costs include general liability, commercial and directors and officers liability insurance (\$28,600); bank and credit card processing fees (\$13,000); a bank line of credit fee (\$15,000); administrative fees for employee benefit plans (\$15,000); a web-based third-party payable administrator (\$7,800); and licenses and property and use taxes (\$7,500). The budgeted increase is for higher line of credit bank fees associated with the move.

**Depreciation/Amortization:** Budgeted at \$157,000, an increase of \$126,400 from the 2014 projected amount and 108 percent more than the 2014 budget.

The significant change in this line item is due to the reclassification of \$93,000 in depreciation for the new website from the rebranding line funded from reserves to an ongoing expense funded from operations.

The 2015 fixed asset budget (of \$63,500) includes costs for new computer hardware and software programs and office enhancements, which are depreciable over a three-year period. Furniture and equipment costs for the move are reflected in the move budget, which will be funded from reserves.

**Project Development:** Budgeted at \$100,000, no change from 2014.

As additional funding resources are sought, a fund of \$100,000 has been budgeted at the same level as the 2014 budget to support consultants to evaluate the risk and returns for new business proposals.

**Office Move (Funded from Reserves):** Budgeted at \$435,000.

Included in this line are the nondepreciable and nonamortizable moving costs that will be expensed in 2015 (e.g., moving services, architectural and engineering fees, furniture consultants, new copier lease, stationary, kitchen and office supplies)

**Attachment I**

**2014 Projection and 2015 Proposed Budget**

	col 1	col 2	col 5	col 6	col 7		
	2014 Revised Budget	2014 Fall Projection	2015 Proposed Budget	2015 vs 2014 proj	2015 vs '14 proj % change	2015 vs 2014 budget	2015 vs '14 budget % change
<b>REVENUE:</b>							
Membership Dues	\$ 5,153,100	\$ 5,379,800	\$ 6,612,000	\$ 1,232,200	23%	\$ 1,458,900	28%
UHC Membership Dues and Sponsorships	\$ 3,150,000	\$ 3,150,000	\$ 3,170,000	\$ 20,000	1%	\$ 20,000	1%
Other sponsorships	\$ 245,000	\$ 240,000	\$ 200,000	\$ (40,000)	-17%	\$ (45,000)	-18%
Conferences	\$ 162,200	\$ 167,700	\$ 260,000	\$ 92,300	55%	\$ 97,800	60%
Publication Sales/Misc.	\$ -	\$ 3,500	\$ -	\$ (3,500)	-100%	\$ -	100%
<b>TOTAL REVENUE</b>	<b>\$ 8,710,300</b>	<b>\$ 8,941,000</b>	<b>\$ 10,242,000</b>	<b>\$ 1,301,000</b>	<b>15%</b>	<b>\$ 1,531,700</b>	<b>18%</b>
<b>EXPENSE:</b>							
Personnel Labor & Fringes	\$ 4,140,000	\$ 3,950,000	\$ 4,480,000	\$ (530,000)	-13%	\$ (340,000)	-8%
Contribution /Support to Institute	\$ -	\$ -	\$ 595,000	\$ (595,000)	100%	\$ (595,000)	100%
Policy	\$ 246,700	\$ 268,000	\$ 294,000	\$ (26,000)	-10%	\$ (47,300)	-19%
Advocacy	\$ 456,000	\$ 461,800	\$ 653,000	\$ (191,200)	-41%	\$ (197,000)	-43%
Member Services	\$ 232,500	\$ 249,200	\$ 244,700	\$ 4,500	2%	\$ (12,200)	-5%
Conferences	\$ 612,200	\$ 454,000	\$ 637,000	\$ (183,000)	-40%	\$ (24,800)	-4%
Communications	\$ 307,600	\$ 283,700	\$ 231,000	\$ 52,700	19%	\$ 76,600	25%
Consulting/Prof Fees	\$ 135,000	\$ 122,000	\$ 117,500	\$ 4,500	4%	\$ 17,500	13%
Retainer	\$ 400,000	\$ 400,000	\$ 350,000	\$ 50,000	13%	\$ 50,000	13%
Information Technology	\$ 114,000	\$ 121,000	\$ 111,300	\$ 9,700	8%	\$ 2,700	2%
Rent	\$ 384,200	\$ 376,000	\$ 385,000	\$ (9,000)	-2%	\$ (800)	0%
Office expenses/equipment rental	\$ 223,100	\$ 183,100	\$ 212,500	\$ (29,400)	-16%	\$ 10,600	5%
Travel and Prof Development	\$ 125,500	\$ 127,500	\$ 180,000	\$ (52,500)	-41%	\$ (54,500)	-43%
Taxes, Insurance and Misc.	\$ 69,000	\$ 69,000	\$ 87,000	\$ (18,000)	-26%	\$ (18,000)	-26%
Depreciation/Amortization	\$ 75,500	\$ 30,600	\$ 157,000	\$ (126,400)	-413%	\$ (81,500)	-108%
Project Development	\$ 100,000	\$ 100,000	\$ 100,000	\$ -	0%	\$ -	0%
<b>TOTAL EXPENSE</b>	<b>\$ 7,621,300</b>	<b>\$ 7,195,900</b>	<b>\$ 8,835,000</b>	<b>\$ (1,639,100)</b>	<b>-23%</b>	<b>\$ (1,213,700)</b>	<b>-16%</b>
<b>Changes in Net Assets before funding from reserves</b>	<b>\$ 1,089,000</b>	<b>\$ 1,745,100</b>	<b>\$ 1,407,000</b>	<b>\$ 2,940,100</b>		<b>\$ 2,745,400</b>	
<b>Other Items funded from Reserves:</b>							
Rebranding (including depreciation on website)	\$ (100,000)	\$ (93,000)	\$ -	\$ 93,000		\$ 100,000	
Office Move	\$ (212,000)	\$ (60,000)	\$ (435,000)	\$ (375,000)		\$ (223,000)	
<b>Changes in Net Assets, after funding from reserves (operating surplus) &amp; before non-operating income</b>	<b>\$ 777,000</b>	<b>\$ 1,592,100</b>	<b>\$ 972,000</b>	<b>\$ 2,658,100</b>		<b>\$ 2,622,400</b>	
<b>Non-Operating Income:</b>							
Interest/Dividend Income	\$ 50,000	\$ 20,000	\$ -	\$ (20,000)		\$ (50,000)	
Realized Capital Gains/(Losses)	\$ -	\$ 559,000	\$ -	\$ (559,000)		\$ -	
Unrealized Gains/(Losses)	\$ -	\$ (450,000)	\$ -	\$ 450,000		\$ -	
<b>Total Non-Operating Income/(Loss)</b>	<b>\$ 50,000</b>	<b>\$ 129,000</b>	<b>\$ -</b>	<b>\$ (129,000)</b>		<b>\$ (50,000)</b>	
<b>Changes in Net Assets, after Non-Operating Income</b>	<b>\$ 827,000</b>	<b>\$ 1,721,100</b>	<b>\$ 972,000</b>	<b>\$ 2,529,100</b>		<b>\$ 2,572,400</b>	

**Attachment I**

**2014 Projection and 2015 Proposed Budget**

**(continued)**

	<b>2014 Revised Budget</b>	<b>2014 Fall Projection</b>	<b>2015 Proposed Budget</b>	<b>2015 vs 2014 proj</b>	<b>2015 vs '14 proj % change</b>	<b>2015 vs 2014 budget</b>	<b>2015 vs '14 budget % change</b>
<b>NET ASSETS:</b>							
<b>Prior Year Net Assets</b>	\$ 6,759,350	\$ 6,759,350	\$ 8,480,450	\$ 1,721,100		\$ 1,721,100	
<b>Change in Net Assets</b>	\$ 827,000	\$ 1,721,100	\$ 972,000	\$ (749,100)		\$ 145,000	
<b>Total Net Assets after funding of special projects</b>	<b>\$ 7,586,350</b>	<b>\$ 8,480,450</b>	<b>\$ 9,452,450</b>	<b>\$ 972,000</b>	<b>\$ -</b>	<b>\$ 1,866,100</b>	<b>\$ -</b>
<b>Contribution to Restricted Net Assets:</b>							
Office Relocation (restricted net assets)	\$ (100,000)	\$ (200,000)	\$ -	\$ 200,000		\$ 100,000	
<b>Total Contribution to Restricted Net Assets</b>	<b>\$ (100,000)</b>	<b>\$ (200,000)</b>	<b>\$ -</b>	<b>\$ 200,000</b>	<b>\$ -</b>	<b>\$ 100,000</b>	<b>\$ -</b>
<b>Summary of Total Net Assets:</b>							
<b>Unrestricted Net Assets</b>	<b>\$ 7,236,350</b>	<b>\$ 8,030,450</b>	<b>\$ 9,002,450</b>	<b>\$ 972,000</b>		<b>\$ 1,766,100</b>	
<b>Restricted Net Assets for office relocation</b>	<b>\$ 350,000</b>	<b>\$ 450,000</b>	<b>\$ 450,000</b>	<b>\$ -</b>		<b>\$ 100,000</b>	
<b>Total Net Assets</b>	<b>\$ 7,586,350</b>	<b>\$ 8,480,450</b>	<b>\$ 9,452,450</b>	<b>\$ 972,000</b>	<b>\$ -</b>	<b>\$ 1,866,100</b>	<b>\$ -</b>



DATE December 1, 2014  
TO Board of Directors  
FROM John Haupert, Chair, Policy Advisory Committee  
RE Policy/Advocacy Update

**MEMORANDUM**

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On behalf of the policy advisory committee (PAC), I provide this update of the committee's activities and present an action item for the board's consideration.

Over the past several months, the committee has examined issues of equity of care and reducing health disparities. At this time, I ask the board to approve a set of draft principles on equity of care.

A commitment to reduce disparities in health and health care is inherent in the mission of the members of America's Essential Hospitals and the association itself. America's Essential Hospitals' *Vital Data* member characteristics report indicates that more than half our patients are minorities. And, as leaders in serving the most vulnerable, we are uniquely positioned to pave the way to reducing disparities.

We are often called on, in our role as an industry voice, to support actions to reduce disparities in health and health care. However, as a policy issue, we do not have formal position statements on the goal of reducing disparities in care. This topic is currently playing out prominently at the national level in the discussion of whether certain quality measures—in particular, those for hospital readmissions—should be risk-adjusted for sociodemographic factors.

America's Essential Hospitals has long supported the inclusion of sociodemographic and socioeconomic factors in the risk-adjustment models of outcomes measures when there is scientific evidence these factors influence health outcomes. As debate on this issue continues nationally and on Capitol Hill, in discussions of risk-adjusted quality measures, it would be helpful to have well-crafted principles and position statements association staff may share during the ongoing discussions and debate.

The equity of care principles are attached to this memo (Attachment A) and will be presented to you during the December 1 call for your review and approval.

## **Attachment A**

### **Draft Principles on Equity of Care**

**Policy Advisory Committee  
America's Essential Hospitals  
October 2014**

Members of America's Essential Hospitals provide high-quality care for all, including the most vulnerable. These essential hospitals not only shoulder a disproportionate share of the nation's uncompensated care, they are also at the forefront of cutting-edge medical research and innovation that continues to improve the quality of care received by all patients. And through their work with underserved populations, essential hospitals have uniquely focused on the needs and challenges of vulnerable patient populations, most of whom are of diverse racial or ethnic origins, are low-income, and struggle with social issues such as food, transportation, or housing insecurity. This commitment to promote equity of care and eliminate disparities for the underserved places these hospitals in a unique position within the health care delivery system. As policymakers discuss improvements to innovative pay-for-performance programs, we urge them to consider the following principles:

1. As a country, we must remain committed to eliminating disparities in health and health care. And health care providers should strive to achieve equity of care for all patients, regardless of the patients' socioeconomic and socio-demographic characteristics.
2. The broader community, including governmental entities, health care providers, social service and community organizations, academic institutions, employer groups, and all individuals, must be involved in developing and implementing solutions to effectively eliminate disparities.
3. Health care providers should proactively assess their communities to better understand and address the health care and social needs of those who live and work in the community. Efforts to promote equity of care and eliminate disparities must recognize the community's distinctive needs.
4. Patient engagement must be a core component of a health care provider's efforts to address disparities and ensure equity of care. Such engagement should include directly involving patients and their families in decisions about their own care and should be in line with patients' expectations for the health care encounter and how it relates to their overall health goals.
5. Communities must be served by a health care workforce that possesses competencies to address the needs of diverse populations. In addition, the cultural backgrounds of the health care workforce must parallel those who live and work in the community. The health care workforce pipeline also must include future professionals who reflect the population in the communities these professionals will serve.

6. Innovative and novel approaches, as well as evidence-based best practices for addressing disparities, should be embraced, practiced, supported, and shared. At the broader community level, investments should be made in conducting and translating research into successful practices, replicating such practices, and disseminating findings.
7. All health care professionals must have ongoing cultural competency training to better serve patients in their communities.
8. There is a need for accurate data on patients' socioeconomic and socio-demographic characteristics, including, but not limited to, self-reported race, ethnicity, and preferred language. All health care professionals and others working in the delivery system must be trained on collecting accurate socioeconomic and socio-demographic data and educating patients on why such data are being collected.
9. To successfully eliminate disparities, all health care professionals need an accurate, reliable and real-time business intelligence infrastructure to analyze the socio-economic data collected from their patients and translate into practice the learnings from that analysis.
10. Incentives across the health care delivery and payment system need to be aligned to promote equity of care and eliminate disparities.
11. In designing new payment systems, special recognition and financial support should be given to providers who disproportionately deliver care to disadvantaged populations with health and healthcare disparities.