



# Board of Directors Meeting

June 25, 2014

The Westin Riverwalk | San Antonio

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**Agenda**  
**Institute Board of Directors Meeting**  
**June 25, 2014**  
**8 am – noon**

8 – 8:05 am	Call to Order and Disclosure of Conflicts of Interest (Dr. Wang)	
8:05 – 8:10 am	Welcome New Board Members (Dr. Wang)	
8:10 – 8:15 am	Approve April 1 Minutes (Dr. Wang)	ACTION
8:15 – 8:45 am	Institute Director Report (Dr. Engler)	
8:45 – 9 am	Treasurer's Report (Ms. Roth) • Budget Update • Financial Reports	ACTION
9 – 9:30 am	Investment and Reserve Policy (Ms. Gold & Raffa Wealth Management) • Proposed Operating Reserve Policy • Proposed Investment Policy	ACTION
9:30 – 10 am	Forming a Research Committee (Dr. Wang)	ACTION
10 – 10:15 am	Break	
10:15 – 10:30 am	Education Committee Report (Ms. Jacobs)	
10:30 – 11 am	Defining Population Health (Dr. Perez and Ms. Reid)	
11 – 11:30 am	EHEN Case Studies (Ms. Callahan)	
11:30 – 11:45 am	Website Overview (Mr. Graziano)	
11:45 am – noon	Board Photo	

## Essential Hospitals Institute Board of Directors 2013-2014

**CHAIR**

Clifford Wang, MD  
Hospitalist, Division of Medicine  
Santa Clara Valley Medical Center

Susan Moffatt-Bruce, MD, PhD

Chief Quality and Patient Safety Officer  
The Ohio State University Wexner Medical  
Center

**SECRETARY**

Caroline M. Jacobs, MPH, MSEd  
Senior Vice President, Safety and Human  
Development  
New York City Health and Hospitals  
Corporation

Christine Neuhoff, JD

System Vice President, Chief Legal Officer  
St. Luke's Health System

**TREASURER**

Anna M. Roth, RN, MPH, MS  
CEO  
Contra Costa Regional Medical Center

Reuven Pasternak, MD, MPH, MBA

CEO  
Stony Brook University Hospital

**PAST CHAIR**

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Chief Health System Officer, UW Medicine  
VP for Medical Affairs, UW  
UW Medicine

**OUTSIDE DIRECTOR**

Ann Scott Blouin, PhD, RN  
Executive Vice President of Customer Relations  
The Joint Commission

**RECORDING SECRETARY/EX OFFICIO**

Bruce Siegel, MD, MPH  
President and CEO  
America's Essential Hospitals

Donald A. Goldmann, MD

Chief Medical and Scientific Officer  
Institute for Healthcare Improvement

**MEMBER DIRECTOR**

John W. Bluford, III, MBA  
President and CEO  
Truman Medical Centers

Erica Murray, MPA

President and CEO  
California Association of Public Hospitals and  
Health Systems

Leon L. Haley, Jr., MD, MHSA  
Executive Associate Dean, Clinical Services  
Grady Health System  
CMO, Emory Care Foundation

Alan Weil, JD, MPP

Editor-in-Chief  
*Health Affairs*

Winston F. Wong, MD, MS

Medical Director, Disparities Improvement and  
Quality Initiatives  
Kaiser Foundation Health Plans

**EX-OFFICIO**

Julie Cerese, MSN, RN  
Senior Vice President, Performance  
Improvement  
UHC

## Essential Hospitals Institute Board of Directors 2014-2015

### **CHAIR**

Caroline M. Jacobs, MPH, MSEd  
Senior Vice President, Safety and Human Development  
New York City Health and Hospitals Corporation

### **SECRETARY**

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President and CEO  
America's Essential Hospitals

### **MEMBER DIRECTOR**

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President and CEO  
Truman Medical Centers

Delvecchio S. Finley, MPP  
CEO  
Harbor-UCLA Medical Center

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

Christine Neuhoff, JD  
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### **EX-OFFICIO**

Julie Cerese, MSN, RN  
Senior Vice President, Performance Improvement  
UHC

**2014-2015**  
**Institute Board of Directors Meeting Dates**

**Tuesday, April 1, 2014**

8 am – noon

Westin Georgetown  
Washington, DC

Held in conjunction with Policy Assembly, April 1-2, 2014

**Wednesday, June 25, 2014**

8 am – noon

Westin Riverwalk  
San Antonio

Held in conjunction with VITAL2014, June 25-27, 2014

**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

## New Board Members

### Member Director

**Delvecchio S. Finley, MPP**  
**CEO**  
**Harbor-UCLA Medical Center**

Finley, appointed as CEO October 1, 2011, has extensive experience in health care, beginning as a division administrator at the University of California, San Francisco, where he was responsible for administrative and financial oversight of several medical subspecialties. Previously, he held several executive positions in other public hospitals, including associate administrator at San Francisco General Hospital and Trauma Center, and interim chief operating officer at Laguna Honda Hospital and Rehabilitation Center. Most recently, Finley was vice president of operations at California Pacific Medical Center (CPMC).

Finley holds a bachelor of science degree in chemistry from Emory University. He received his master of public policy degree from Duke University, where he also attended graduate certification in health policy, law, and management. Finley is board-certified in healthcare management and a fellow in the American College of Healthcare Executives (ACHE).

Finley has held several leadership roles in local and national professional organizations. He completed a three-year stint as ACHE regent for the California-Northern and Central region. He is past-president of the California Association of Healthcare Leaders and past-president of the Northern California chapter of the National Association of Health Services Executives.

Finley is also a graduate of the 2007-08 class of Leadership San Francisco and a 2008 fellow of America's Essential Hospitals. He frequently guest lectures at colleges and universities throughout Northern California and he has been published in major healthcare publications, including *Healthcare Executive* and the *Journal of Healthcare Management*. Finley has played an active role in the local community. He served as a big brother in Big Brothers/Big Sisters Organization. He was also a board member for Operation Access (an organization that connects medical volunteers, hospitals, and uninsured patients needing minor operations), and Out of Site Center for Arts Education. Finley is happily married to lawyer and entrepreneur Kelly Patrice Finley.

### Outside Directors

**Ann Scott Blouin, PhD, RN**  
**Executive Vice President of Customer Relations**  
**The Joint Commission**

Blouin focuses on building external customer and stakeholder relationships, primarily in the hospital and health system market. She gathers customer ideas and feedback, assisting in guiding business development and customer retention strategies. From 2008 to 2012, Blouin served as executive vice president for the Division of Accreditation and Certification Operations at The Joint Commission. Her responsibilities included executive leadership of accreditation and certification for more than 20,000 health care organizations and programs, including all activities related to surveys, eligibility and application processes, customer account

management, and federal deeming compliance requirements. The Hospital, Critical Access Hospital, and Laboratory programs reported through this division. Blouin also administered accreditation and certification policy development, surveyor education and development, survey technology, and the ongoing development and refinement of accreditation process components.

With more than 30 years of health care administration, consulting, and clinical nursing experience, Blouin has held positions of program administrator, vice president for nursing, and executive vice president for operations at two Chicago-area community teaching hospitals and a Chicago academic medical center. She has worked with multiple health systems across the United States to help them improve quality and patient safety, revenue management, and operating cost efficiency and effectiveness. Blouin has consulted with a large number of health care organizations, serving in leadership roles at consulting firms, such as Deloitte, Ernst & Young, Cap Gemini, and Huron Consulting Group.

Blouin has published and presented extensively on topics focused on health care, patient care quality and safety, and nursing, and served as an adjunct faculty member at several Chicago-area schools of nursing and medicine. She currently serves on the National Patient Safety Foundation board of directors, and as an editorial adviser for the *Journal of Nursing Administration* and *Journal of Biotechnology in Healthcare*.

Blouin earned her doctorate in nursing sciences and master of business administration from the University of Illinois at Chicago. She received her master's in nursing with honors in maternal/child nursing from Loyola University of Chicago; and her bachelor's in nursing with high honors from Lewis University, in Romeoville, Illinois. She is a fellow of the American College of Health Care Executives and member of the American Organization of Nurse Executives, American Nurses Association, and Sigma Theta Tau, the National Honor Society for Nurses.

**Erica Murray, MPA  
President and CEO  
CAPH-California Association of Public Hospitals and Health Systems**

CAPH is a statewide trade association with a mission to advance public policies that support the essential role of the public hospital safety net and improve access to care for low-income and uninsured patients. Before her 2013 appointment, Murray was CAPH senior vice president and, in that capacity, was responsible for leading the organization's policy and government relations efforts. She has worked at CAPH since 2005, with a focus on policies to support and strengthen public hospital systems' successful delivery system improvements, many of which have been fostered by CAPH's affiliate, the California Health Care Safety Net Institute (SNI). These improvements include chronic disease management, language access services, and outpatient service delivery efficiencies.

Before joining CAPH/SNI, Murray served as health policy legislative assistant for former U.S. Sen. John Edwards (D-NC). From 1997 to 1999, she served as a consultant to the U.S. Department of Health and Human Services, where she helped launch the AIDS Drug Assistance Program, a \$1.4 billion federal program that provides access to HIV/AIDS medications for uninsured, low-income individuals. Murray holds a master of public policy and administration from Columbia University, and received a bachelor's degree from McGill University, in Montreal, Quebec.



**Essential Hospitals Institute  
Board of Directors Meeting Minutes  
April 1, 2014**

<b>Board Members Present (12):</b> <ul style="list-style-type: none"><li>• Clifford Wang- (Chair)</li><li>• Caroline Jacobs - (Secretary)</li><li>• Anna Roth - (Treasurer)</li><li>• Bruce Siegel (Ex Officio)</li><li>• Leon Haley Jr</li><li>• Erica Murray</li><li>• Christine Neuhoff</li><li>• L. Reuven Pasternak</li><li>• Donald Goldmann</li><li>• Alan Weil</li><li>• Winston Wong</li><li>• Julie Cerese (Ex Officio)</li></ul>	<b>Board Members Absent (3):</b> <ul style="list-style-type: none"><li>• Johnese Spisso - (Past Chair)</li><li>• John Bluford</li><li>• Susan Moffat-Bruce</li></ul>	<b>Staff Present (13):</b> <ul style="list-style-type: none"><li>• Sarah Callahan</li><li>• David Engler</li><li>• Beth Feldpush</li><li>• Rhonda Gold</li><li>• Ricky Harrison</li><li>• Xiaoyi Huang</li><li>• Kristine Metter</li><li>• Bianca Perez</li><li>• Katie Reid</li><li>• Jummy Siwajuola</li><li>• Cassandra Blohowiak</li><li>• Katherine Susman</li></ul>
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Agenda Items	Minutes
Welcome and Call to Order (Wang)	<ul style="list-style-type: none"><li>• Call to order at 8:03 am</li></ul>
Approve Consent Agenda (Wang)	<ul style="list-style-type: none"><li>• Approve December 2013 meeting minutes</li><li>• Approve September 2013 meeting minutes</li></ul> <p><i>Wang requested a motion to approve the consent agenda. There was a motion, a second, and unanimous approval of the consent agenda.</i></p>
National Quality Forum Adjustment for Socioeconomic Status	<ul style="list-style-type: none"><li>• Siegel announced an additional agenda item: a board briefing on a recent National Quality Forum (NQF) development. To date, NQF has precluded socioeconomic status adjustments in quality and outcomes measurement. A recently assembled task force evaluated that policy and formally recommended changing it. As NQF directly advises the Centers for Medicare &amp; Medicaid Services (CMS), allowing social determinant adjustments would be a major change. The NQF proposal is open to public comment and America's Essential Hospitals has urged members to engage in the discourse (ending April 16). The group also discussed the arguments against this change, including risk of masked disparities and apprehension in the business community.</li></ul>

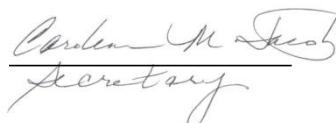
Treasurer's Report (Roth)	<ul style="list-style-type: none"> <li>• The Institute recently completed an audit, and financial statements will be distributed following the investment, audit and compliance committee's review.</li> <li>• The board reviewed the updated budget projections from 2013. Notably, after reviewing documentation from CMS, auditors reclassified 2012 and 2013 savings from deferred liability to earned revenue. This totals \$4.3 million and significantly impacted the ending net balance for the Institute budget. It was noted that the government does have the right to request the return of those funds. The organization will use the funds to develop and expand programs, and will present those plans to the board, once completed. In 2013, the Institute had unrestricted revenue of \$10.7 million, offset by \$4.89 million in expenses, leaving a surplus of \$4.78 million. Total net assets were \$7.74 million, with \$2 million temporarily restricted for existing grants. The ending 2013 net balance represents one year of operating expenses in reserve.</li> <li>• The board then reviewed the 2014 revised budget. Due to the CMS reclassification, \$485,000 of association support is no longer needed. The association will retain those funds for its programs, making this the first time the Institute is self-supporting—a long-standing organizational goal. The approved budget assumed \$5.17 million in renewal funding from CMS, though actual funding totaled \$5.5 million, offsetting the change in association support. Expense changes reflected in the revised budget include salary market adjustments recommended by external consultants and an additional staff position. These personnel changes total \$165,000. The revised budget now reflects an operating deficit of \$80,000, which can be more than supported by the \$5.66 million in unrestricted net assets.</li> </ul> <p><i>Wang requested a motion to revise the 2014 approved budget to reflect the elimination of \$485,000 in support from the association, and to approve the revised 2014 budget. There was a motion, a second, and unanimous approval of the revised 2014 budget.</i></p> <ul style="list-style-type: none"> <li>• The group then reviewed the long-term financial forecast, including the upcoming relocation of the association's offices. The move will happen before the end of 2015, when the current building will be demolished. There will likely be a 65 percent increase in square footage cost (in line with the DC market). The total cost of the move is estimated at \$4 million. The board reviewed projections for the next three years, using both the current dues structure and a proposed restructured system, which the board briefly discussed and on which the association board will vote in June. The new structure uses a tiered system based on expenses to provide more equity and growth across the organization's membership.</li> <li>• The board heard updates on fraud prevention and internal controls. The organization is consistently compliant with both Federal Information Security Management Act and Payment Card Industry guidelines.</li> </ul>
Education Committee Report (Jacobs)	<ul style="list-style-type: none"> <li>• Section 1115 Delivery System Reform Incentive Payment (DSRIP) waivers are now a significant component of the organization's educational programming.</li> <li>• The committee has helped prepare and plan for June's annual conference, VITAL2014, which will feature four tracks: executive leadership, clinical leadership, finance, and patient safety and quality. The conference will host new interest group meetings, Rapid-Fire sessions, and two post-conference workshops.</li> </ul>

	<ul style="list-style-type: none"> <li>The committee encouraged the organization to conduct a comprehensive analysis of distance learning participation across the membership. Initial data indicate that small- to medium-size hospitals are highly active, while larger institutions are less engaged. The organization will complete more analyses going forward to assess needs and tailor future programming.</li> <li>The 2014-2015 Fellows Program has 43 registrants from 18 organizations. Recent trends indicate that more hospitals are sending teams to the program, which will enhance the opportunity for fellows to sustain what they learn within their institutions. This year's program consultant is Cambridge Leadership Associates. The group discussed program growth and the desired balance between active participation and manageable size (50 fellows).</li> </ul>
Appoint Essential Hospitals Institute Director (Wang)	<ul style="list-style-type: none"> <li>Staff was excused so the board could discuss the Essential Hospitals Institute director appointment. Siegel formally recommended that the board appoint David Engler, PhD, senior vice president of leadership and innovation. Though not required by the bylaws, the Institute nominating committee vetted this recommendation to ensure transparency. The group discussed the personnel changes that preceded this appointment, noting that the departures of Jill Steinbruegge and Linda Cummings led leadership to unify research and leadership and innovation under Engler's position. The board then discussed its role in appointments and staff decisions as outlined in the bylaws and by historical precedent. The group underscored the need for strong research capacity and development in the integrated departments.</li> </ul> <p><i>Wang requested a motion to approve the appointment of David Engler as director of Essential Hospitals Institute. There was a motion, a second, and unanimous approval of the appointment.</i></p>
Institute Board Appointments (Wang)	<ul style="list-style-type: none"> <li>The Institute nominating committee met February 21 to consider candidates for the 2014-2015 board of directors. There are currently two vacant director positions with unexpired terms created by the retirement of Melissa Stafford Jones and the unfortunate passing of Jared Loeb. The nominating committee proposed Erica Murray, MPA, and Ann Scott Blouin, RN, PhD, fill those director positions, effective immediately.</li> </ul> <p><i>Wang requested a motion to approve the election of Erica Murray and Ann Scott Blouin to fill the director positions currently vacant and with unexpired terms. There was a motion, a second, and unanimous approval of the candidates.</i></p> <ul style="list-style-type: none"> <li>Staff returned to the room.</li> </ul>
PCORI Chronic Disease Management for the Underserved Project (Perez)	<ul style="list-style-type: none"> <li>The Patient-Centered Outcomes Research Institute (PCORI) asked Essential Hospitals Institute to conduct a landscape review on chronic disease management in the safety net. Throughout 2013, Essential Hospitals Institute staff reviewed and analyzed chronic care data through site visits to patient-centered medical homes, literature review, and interviews with providers at six hospitals.</li> <li>Staff identified five themes of effective chronic care management: cross-community multidisciplinary team care, communication/outreach tailored to vulnerable populations, customized and personalized care, addressing special populations' needs, and robust data and measurement. Essential Hospitals Institute staff presented these findings to the PCORI advisory board in January and published a final report in March.</li> <li>The board discussed facilitators and barriers to each of these components and discussed the implications for essential hospitals. The group expressed</li> </ul>

	<p>that this project is meaningful in showcasing safety net successes, rather than deficiencies.</p>
Partnerships with Community Health Centers Project (Harrison)	<ul style="list-style-type: none"> <li>• “Transforming Care Delivery in America’s Safety Net: Aligning Efforts to Improve Access and Care Coordination” is a partnership between Essential Hospitals Institute, the National Association of Community Health Centers (NACHC), and The George Washington University School of Public Health and Health Services (GW). The project is funded by Kaiser Permanente Community Benefit through state-level support to safety net hospitals and community health centers. The goal of this project is to develop support and document state-level collaboration around access and care coordination within the safety net. The role of the Institute and NACHC is to engage members, convene stakeholder and/or policy roundtable meetings, provide technical assistance, and disseminate analyses. GW’s role is to conduct research through interviews and develop case studies.</li> <li>• The partnership has conducted 65 interviews and identified key priorities for safety net organizations: Medicaid expansion, outreach and enrollment, government funding streams, workforce capacity, participation in qualified health plans, and payment/delivery system reform. Interview findings are also being used to guide initial support strategies and gauge what types of assistance will be most effective.</li> <li>• In 2014, the partnership will engage additional communities, create a clearinghouse of tools, hold five state-level meetings, and develop webinars and issue briefs to disseminate learning tools. In 2015, the project will continue to seek stakeholder support, and focus on sustainability and dissemination.</li> <li>• The group discussed the progression of this project in light of the changing health care climate and new delivery systems. It was noted that a fifth community will be found to replace one that stopped participating. The group noted the importance of active discourse throughout this project, including with other organizations seeking the same goal.</li> </ul>
EHEN Accomplishments, Current Work, and Future Goals (Callahan)	<ul style="list-style-type: none"> <li>• In December 2013, the Institute received a third year of funding for its Essential Hospitals Engagement Network (EHEN) from CMS. Throughout 2014, EHEN will continue to focus on sustaining improvement projects through leadership, and begin a new training program to teach hospital staff how to collect standardized race, ethnicity, and language (REAL) information. The organization has started working on CMS/Partnership for Patients (PfP)-identified target areas, including reductions in readmissions and catheter-associated urinary tract infections, and eliminating early elective deliveries. The board reviewed various charts showing EHEN’s progress, which is consistently positive and consistent with other hospital engagement networks. As of 2013, EHEN had prevented 2,200 harmful events and averted \$24 million in costs.</li> <li>• EHEN is currently looking at harm counts versus harm rates to reduce organizational harm and align quality improvement measures. An additional focus is analyzing REAL data to reduce care disparities within hospitals. EHEN is also continuing to enhance focus on patient and family engagement through research and distance learning events, working on specific goals set forth by the PfP.</li> <li>• The Institute hopes to continue its EHEN work in 2015 and take advantage of the next iteration of CMS/PfP-supported performance improvement work. Board members received a full 2013 EHEN annual report in their materials.</li> </ul>

	<ul style="list-style-type: none"> <li>The board discussed the process of hospital-reported progress to determine data, external evaluator scores, and standardization of metrics among HENs. The group also addressed EHEN incentive payments, which offer modest monetary support as reward for participation and achievement of goals.</li> </ul>
Works in Progress (Engler)	<ul style="list-style-type: none"> <li>The organization has developed programming on Section 1115 DSRIIP waivers, including a webinar series and research brief. The webinar series showcases hospital-specific experiences in three states. Presentations are shaped by 10 uniform questions to provide consistency and clear comparison throughout the series. The information from these webinars will contribute to a forthcoming research brief, to be published in September. The group discussed the growing importance of this topic in the policy world and the best way for the organization to serve all members in that capacity.</li> <li>Population health is a growing topic across the nation and the membership. The organization conducted an environmental scan on member activities in the field as the definition of population health continues to take shape. The Institute will present the results of the study in a research brief. The group discussed the difference between population health and population management, both of which play roles in essential hospitals.</li> <li>In February, America's Essential Hospitals held a joint meeting with the National Foundation to End Senior Hunger (NFESH), a nonprofit organization advocating on behalf of food-insecure seniors. The meeting convened representatives from health associations, corporations, and three association member hospitals. Staff is formulating next steps and assessing capacity for a systematic project in this area. America's Essential Hospitals will extend focus beyond seniors to include all age groups. Interest among members seems very strong.</li> </ul>
Adjourn	The meeting was adjourned at 11:56 am.

Submitted by:

 5/11/14  
Secretary

Caroline M. Jacobs, MPH, MSEd  
Secretary



DATE June 16, 2014  
TO Board of Directors  
FROM David Engler, PhD, Senior Vice President of Leadership and Innovation  
RE Activities Report: April–June 2014

MEMORANDUM

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The Institute has accomplished the following since the April board meeting:

- conducted a literature review and landscape review of members' activities in population health using Gage Awards applications from the past several years
- proposed two new research grants to the Patient Centered Outcomes Research Institute. The first grant was in partnership with The George Washington University (GW) to study the effectiveness of the patient-centered medical home model within the safety net. The second was in collaboration with a large consortium of researchers to study the effectiveness of transitional care
- initiated a study on cost sharing reduction under the Affordable Care Act in partnership with GW and the National Association of Community Health Centers (NACHC)
- completed the Massachusetts Learning Collaborative's final two learning collaborative sessions
- built on our national partnership work, engaging essential hospitals with community health centers in four cities across the country
- conducted the second in a three-part webinar series on Section 1115 Medicaid waivers and their impact on quality performance
- kicked off the Essential Hospital Engagement Network's work around race, ethnicity, and language (REAL), and Ask Every Patient: REAL
- launched a new annual hospital characteristics survey which streamlined and reduced reporting burden
- published comments supporting recommendations of an expert panel from the National Quality Forum (NQF) to include sociodemographic factors in risk adjustment used in accountability models, such as readmission penalties

- launched a new, 39-member Fellows Program class participating in adaptive leadership training

Details of each of these initiatives are described below.

#### Research Center

#### Population Health

The Institute is conducting a landscape review of population health in essential hospitals. The landscape review will include an extensive literature review and analysis of various population health definitions that have been put forth to date. The landscape review will also describe Gage Awards population health submissions from the past three years. Based on the findings of the Gage Awards analysis, approximately 10 hospitals will be selected to participate in semi-structured interviews to give us a more in-depth understanding of their motives for pursuing population health, as well as challenges and future plans. Findings will be summarized in a research brief in fall 2014. This brief will serve to formulate a definition and framework of population health in essential hospitals and identify the unique challenges and opportunities for achieving population health with vulnerable populations.

#### Improving Health Care Systems

In partnership with GW, we proposed a study that would examine the design, implementation, and effectiveness of the patient-centered medical home (PCMH) model within the safety net. The proposed study would focus on outcomes most relevant to low-income, underserved patients with multiple chronic conditions (MCC). We proposed that the study occur over the course of three years.

Year 1 will focus on creating a MCC Framework of Quality and MCC Patient Index. During this time, we will identify and enroll 10 PCMH safety net clinics and 10 non-PCMH clinics. After the initial enrollment period, patients participating in the study will be surveyed four times every six months regarding patient-centered outcomes identified in the study's preliminary stages. By Year 3, we will begin data analysis and draft a plan for dissemination and implementation of key findings. Through this patient data and site visits and interviews, we hope to better understand how the PCMH can be sustainably implemented in safety net settings to meet the needs of complex patients.

A number of stakeholders have already committed to participate in this study as co-investigators or members of the advisory board. These stakeholders include

- Gilbert Salinas, patient advocate;
- Jennifer Sweeney, National Partnership for Women & Families;
- Teresa Pasquini, caregiver/patient advocate;
- David McClure, MCC patient;
- Charles Preston, PhD, Santa Clara Valley Medical Center;
- Julie Bluhm, Hennepin Health;
- Sarah Anderson, PharmD, Denver Health;
- Steve Counsell, MD, Eskenazi Health;

- Katie Coleman, MSPH, MacColl Center; and
- Chris Farnitano, MD, Contra Costa Health Services.

### **Effectiveness of Transitional Care**

This project, known as Project ACHIEVE (Achieving Patient-Centered Care and Optimized Health In Care Transitions by Evaluating the Value of Evidence), seeks to learn which transitional care outcomes matter most to patients, rigorously evaluate current efforts at improving care transitions, and develop recommendations on best practices for patient-centered care transition interventions with guidance for scalability and large-scale dissemination.

The project will occur over the course of three years. Year 1 will focus on creating focus groups to identify the most important transitional care components and outcomes identified by patients and caregivers. Survey development will also take place during Year 1, and will be implemented in Year 2 to the cohort of patients and caregivers exposed to set care transition clusters. This will also include retrospective, longitudinal comparative analyses of patients experiencing transitional care components. In Year 3, 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 will primarily focus on hospital to home transitions. The project is headed by Mark Williams, of the University of Kentucky, and includes a consortium of research affiliates, including

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

### **Examining Cost Sharing Reduction Assistance under the Affordable Care Act (Partners: GW and NACHC)**

This four-month project aims to gain a greater understanding of how insurers apply cost-sharing reduction assistance and the implications of benefit design for health care access. The project premise is that the federal framework, instead of limiting the total exposure and shielding certain preventive services from cost-sharing exposure, gives plans considerable discretion over where they set cost-sharing limits for specific essential health benefits and

services. The basic question is how plans use this in relation to deductibles, copayments, and coinsurance.

The Institute's role will be to provide technical assistance to GW by selecting the qualified health plans from state exchanges in which the research will be conducted, assisting GW with the analysis of research findings, and assessing the potential impact of cost-sharing reduction plans on safety net health care providers and member coverage. Findings will be summarized in a policy brief in July 2014.

### **Massachusetts Learning Collaborative**

In October 2012, six essential hospitals in Massachusetts began participating in a two-year learning collaborative developed by Essential Hospitals Institute as a Transformation Center initiative. The participating hospitals were Boston Medical Center, Cambridge Health Alliance, Holyoke Medical Center, Lawrence General Hospital, Mercy Medical Center, and Signature Healthcare Brockton. The learning collaborative was designed to help the six hospitals advance their projects related to the Massachusetts Delivery System Transformation Initiatives (DSTI) under the state's Medicaid waiver and to build sustainable transformation.

Specifically, the collaborative supported the work of the hospitals around three goals: (1) developing fully-integrated delivery systems; (2) improving health outcomes and quality; and (3) helping hospitals transition to value-based purchasing and alternative payment models. As of May 2014, the Institute held the last of eight learning meetings, which have included national expert speakers and peer-to-peer presentations for hospitals to learn strategies and best practices related to their DSTI projects. Three learning meetings took place this year and covered complex care management, care transitions, and preparing for alternative payment models.

The Institute is also working with the steering committee on a final report on the collaborative. The report highlights the most helpful delivery system reform lessons learned and shared through the collaborative. The Institute looks forward to working with the six hospitals again should the DSTI be renewed this year.

### **Transforming Care Delivery in America's Safety Net: Aligning Efforts to Improve Access and Care Coordination (Partners: GW and NACHC)**

The Institute, NACHC, and GW are partnering to improve vulnerable patients' access to and quality of care. One year after the launch of this project, funded by Kaiser Permanente Community Benefit, the partnership has engaged community health centers and essential hospitals in Atlanta, Cleveland, Denver, and Richmond around key ACA-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 inclusion in qualified health plans (Richmond).

Building on the key interview findings, the partnership has begun working with the four communities. Since April 2014, the partnership has worked with each community to facilitate and inform discussion and build and strengthen local strategies. For example, we are developing a compendium of promising practices around access to specialty services for Denver and plan to present this information in August at a Denver-based stakeholder meeting. The

partnership is also helping identify legislative and regulatory language that will be used to develop standards to ensure that essential community providers are included in Virginia's qualified health plans.

In addition, the partnership is working to identify opportunities to disseminate findings and progress within and beyond America's Essential Hospitals' and NACHC's members. The partnership plans to disseminate early findings on the issue of hospital-health center collaborations by the end of 2014.

### **Section 1115 Medicaid Waivers**

Essential hospitals in California, Massachusetts, and Texas are currently participating in Section 1115 Medicaid waiver demonstration projects. Other states are expected to join this movement. 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 is conducting in-depth case studies of waiver experiences in three health systems. The Institute has engaged Santa Clara Valley Medical Center (California), Boston Medical Center (Massachusetts), and UT Health Northeast (Texas) to share their stories through a webinar series and phone interviews.

The Institute has asked each hospital to address several key questions that will highlight successes and challenges related to waiver implementation, sustainability of waiver work, and lessons learned for other hospitals and states. A research brief will be released in September 2014.

### **Performance Improvement**

#### **Essential Hospitals Engagement Network (EHEN)**

In March, the EHEN kicked off Ask Every Patient: REAL, one of the special focuses of option year 1. This project aims to improve quality of care for all patients. This year, we are focusing on standardization in the collection of race, ethnicity, and language (REAL) information, so that hospitals can build a robust and accurate picture of the people served. 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 the e-learning 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 e-module will go live on the website in September.

In May, the EHEN fielded a best practices survey with the network. Our first organization assessment was done in spring 2012. This follow-up survey will provide comparison to 2012 and collect important information about remaining opportunities for targeted interventions by EHEN staff.

At the end of May, the EHEN participated in its regular leadership huddle with Partnership for Patients (PfP) co-directors Dennis Wagner and Paul McGann, MD. The call went extremely well, with the PfP asking the EHEN to help lead work around addressing disparities with the 25 other hospital engagement networks. The EHEN was asked to continue to work on recruiting new members to the network. Based on the evaluation group's feedback, the EHEN is well-positioned to receive additional funding if the Centers for Medicare & Medicaid Services offers a second option year.

We offered four webinars covering the PfP conditions, leadership, and health equity between April and June 2014. We attracted more than 200 participants, representing 19 EHEN hospitals (more than 80 percent of the network), 57 non-EHEN members, and seven 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.

### **Data Analytics**

#### **America's Essential Hospitals Annual Hospital Characteristics Survey**

The Essential Hospitals Institute staff has worked diligently over the past several months to redesign the report detailing the annual characteristics survey results. The new report, *Essential Hospitals, Vital Data: Results of America's Essential Hospitals Annual Hospital Characteristics Survey, FY 2012*, will be published shortly after Vital2014. In a departure from previous editions, the redesigned report will rely on infographics and high-level facts and figures to tell the story of America's Essential Hospitals.

Additionally, work is underway for the FY 2013 annual hospital characteristics survey. The survey, launched in early May, has been further refined and is much shorter in length, thanks to a new data sharing partnership with the American Hospital Association. The survey's primary deadline is June 30. A report of the survey's findings is expected to be released in December.

#### **Comments on National Quality Forum (NQF) Expert Panel Recommendations**

Staff submitted comments supporting an NQF expert panel's recommendation to include socioeconomic status (SES) factors in risk adjustment used in accountability models, such as readmission penalties.

Institute staff provided technical support to the panel members and helped solicit comments from the membership in support of the panel's eight recommendations. Institute staff also published on our website literature on SES' impact on health outcomes. If implemented, these recommendations would level the playing field, especially for providers who treat vulnerable populations.

## Fellows Program

During the third and final session of the 2013 Fellows Program, participants advocated to key legislators on Capitol Hill on behalf of America's Essential Hospitals. Fellows also had the opportunity to present leadership lessons from their year-long program projects.

During session I of the 2014 Fellows Program, the new class will strengthen the skills needed to lead adaptive change in complex environments. Participants will have 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.



DATE June 16, 2014  
TO Board of Directors  
FROM Rhonda Gold, CFO  
RE Financial Update

MEMORANDUM

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This memorandum summarizes the 2013 audited financial statements, a 2014 financial projection compared with budget, and a proposed Operating Reserve Policy and Investment Policy Statement. The attached materials have been reviewed with and accepted by the Institute's finance committee.

The following **action items** are requested from the board:

- Accept the Essential Hospitals Institute's 2013 audited financial statements as recommended by the investment, audit and compliance and finance committees.
- Accept the 2014 budget update.
- Approve the proposed Operating Reserve Policy.
- Approve the proposed Investment Policy Statement as presented by Raffa Wealth Management.

#### 2013 Audit

The investment, audit, and compliance and finance committees reviewed and accepted the attached 2013 audited financial reports. As reflected on the Statements of Financial Position, the Institute ended 2013 with total assets of \$8.45 million, including \$7.98 million in cash and other current assets; and \$689,000 in liabilities, mostly due to accrued grant expenses.

As reflected on the Statements of Activities and Changes in Net Assets, the Institute ended the year with \$10.7 million in unrestricted revenue, which was offset by \$5.95 million in expenses, leaving a \$4.81 million change in net assets ("operating surplus"). After accounting for last year's beginning net assets, total net assets are \$7.77 million, of which almost \$2 million is temporarily restricted for existing grants, leaving an operational reserve ("unrestricted") of \$5.77 million. The temporarily restricted net assets include \$1.8 million from Kaiser Permanente National Community Benefit Fund (KP) for "2014 Preparations by Community Health Centers and Safety Net Hospitals." These funds will be released as expenses are incurred. The ending 2013 net asset balance represents one year of operating expenses in reserves.

## 2014 Projection

The financial projection for the year is reflected in column 3 of Attachment I. Projected unrestricted revenue of \$7.83 million and an offset of \$7.91 million in projected expenses are on target to result in the budgeted operating deficit of \$80,000. There are no significant budget variances to report at this time.

## Proposed Operating Reserve Policy

Our current operating position plus the auditor's recognition of the unexpended 2012 and 2013 budget funds have led management staff to develop a new operating reserve policy for board action.

The Operating Reserve Policy designates a portion of these funds and provides guidelines for maintaining adequate reserves to ensure the Institute's long-term financial stability to carry out its mission. The operating reserve is intended to provide an internal source of funds for situations such as a sudden increase in expenses, one-time unbudgeted expenses, unanticipated losses in funding, or uninsured losses. Under the policy, board-designated funds will consist of board-designated operating reserves and non-operating board-designated funds.

The **board-designated operating reserve** is dynamic and is part of "unrestricted net assets," which are available for the operation of the Institute and include both internally designated and undesignated resources. The target minimum operating reserve established by the policy and funded with surplus unrestricted operating funds will be equal to **three months** of current budgeted operating expenses (initially set at \$900,000). This includes all recurring, predictable expenses, such as salaries and benefits, rent, office, travel, program, and ongoing professional services. Depreciation, in-kind, and other non-cash expenses are not included in the calculation, which also excludes pass-through programs, non-salary grant expenditures reflected in temporarily restricted net assets, one-time or unusual expenses, and capital purchases. The amount of the operating reserve target minimum will be calculated each year as part of the annual budget process, will be reported to the finance committee and board for approval, and will be included in the regular financial reports.

The board can also designate **non-operating board-designated funds** for the development of new programs, taking advantage of new opportunities, purchases of fixed assets, and/or other items as determined by the board. The Institute's first priority is to build an adequate board-designated operating reserve before building other, non-operating board designated funds. There are three types of non-operating board designated funds: (1) special purpose fund; (2) building and capital asset reserve fund; and (3) opportunity reserve.

The board-designated special purpose fund represents the portion of unrestricted net assets to fund certain programs, activities, or purposes that further the Institute's mission. The proposed policy assumes that the special purpose fund will be funded with an initial contribution of \$3.3 million, representing 80 percent of the unspent monies from the Centers for Medicare & Medicaid Services contract.

The building and capital asset reserve is intended to provide a ready source of funds for leaseholds, furniture, fixtures, technology, and equipment necessary for the effective operation of the organization and programs; and the opportunity reserve is intended to provide funds to

meet special targets of opportunity or need that further the Institute's mission that may or may not have specific expectation of incremental or long-term increased income. The building and capital assets reserve will be funded with special requests made by the Institute director and CFO; and the opportunity reserve fund will be funded with occasional special designations made by the board.

The attached policy specifies the required steps for the use of the reserves and for the reporting, monitoring, and reviewing of the policy.

#### **Investment Policy Statement**

The organization recently submitted a request for proposals for a new investment adviser. The investment, audit, and compliance committee has selected Raffa Wealth Management, LLC (RWM), a Registered Investment Advisor specializing in investment advisory services for nonprofit organizations. As part of its review process, RWM reviewed the Institute's financial documents (financial statements, budgets, cash flow projections) and interviewed key personnel to better understand the organization's operations, financial outlook, historical investing strategy, and segmentation of reserves. In addition, RWM conducted a risk tolerance survey with the Institute board chair, the investment, audit, and compliance committee, and institute finance committee to gain consensus on the objective, time frame, and tolerance for volatility of the reserves.

This data was used to develop the attached Investment Policy Statement (IPS), which will help form RWM's formal investment recommendations. The investment, audit and compliance and finance committees have reviewed this policy and recommend the board of director's approval. Mark Murphy, senior portfolio manager, will be present the survey findings and the proposed IPS, and address your questions, in San Antonio.

Should you have any questions regarding these materials, please contact me at 202-585-0109 or [rgold@essentialhospitals.org](mailto:rgold@essentialhospitals.org).

#### **Attachments:**

- 2013 Audited Financial Statements
- 2014 Financial Projection compared with Budget (Attachment I)
- Proposed Operating Reserve Policy
- Proposed Investment Policy Statement

Financial Statements

# Essential Hospitals Institute

For the Years Ended  
December 31, 2013 and 2012

## **ESSENTIAL HOSPITALS INSTITUTE**

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## INDEPENDENT AUDITOR'S REPORT

To the Board of Directors  
Essential Hospitals Institute  
Washington, D.C.

We have audited the accompanying financial statements of Essential Hospitals Institute, which comprise the statements of financial position as of December 31, 2013 and 2012, and the related statements of activities and changes in net assets, functional expenses and cash flows for the years then ended, and the related notes to the financial statements.

### **Management's Responsibility for the Financial Statements**

Management is responsible for the preparation and fair presentation of these financial statements in accordance with accounting principles generally accepted in the United States of America; this includes the design, implementation and maintenance of internal control relevant to the preparation and fair presentation of financial statements that are free from material misstatement, whether due to fraud or error.

### **Auditor's Responsibility**

Our responsibility is to express an opinion on these financial statements based on our audits. We conducted our audits in accordance with auditing standards generally accepted in the United States of America. Those standards require that we plan and perform the audits to obtain reasonable assurance about whether the financial statements are free of material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

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

## **Opinion**

In our opinion, the financial statements referred to above present fairly, in all material respects, the financial position of Essential Hospitals Institute as of December 31, 2013 and 2012, and the changes in its net assets and its cash flows for the years then ended in accordance with accounting principles generally accepted in the United States of America.

A handwritten signature in black ink that reads "Gelman Rosenberg & Freedman". The signature is cursive and fluid, with "Gelman" on the first line, "Rosenberg" on the second line, and "& Freedman" on the third line.

April 8, 2014

## EXHIBIT A

**ESSENTIAL HOSPITALS INSTITUTE**  
**STATEMENTS OF FINANCIAL POSITION**  
**AS OF DECEMBER 31, 2013 AND 2012**

	<b>ASSETS</b>	
	<b>2013</b>	<b>2012</b>
<b>CURRENT ASSETS</b>		
Cash and cash equivalents	\$ 6,844,285	\$ 5,055,895
Grants receivable, current portion (Note 2)	1,037,971	1,119,219
Contract receivable	64,740	92,874
Prepaid expenses	<u>34,770</u>	<u>46,004</u>
Total current assets	<u>7,981,766</u>	<u>6,313,992</u>
<b>FURNITURE, EQUIPMENT AND LEASEHOLD IMPROVEMENTS</b>		
Furniture and equipment	437,005	392,392
Leasehold improvements (Note 8)	<u>78,839</u>	<u>78,839</u>
	515,844	471,231
Less: Accumulated depreciation and amortization	<u>(402,218)</u>	<u>(284,683)</u>
Net furniture, equipment and leasehold improvements	<u>113,626</u>	<u>186,548</u>
<b>OTHER ASSETS</b>		
Grants receivable, net of current portion (Note 2)	<u>363,851</u>	<u>193,500</u>
<b>TOTAL ASSETS</b>	<b>\$ 8,459,243</b>	<b>\$ 6,694,040</b>
<b>LIABILITIES AND NET ASSETS</b>		
<b>CURRENT LIABILITIES</b>		
Accounts payable	\$ 522,332	\$ 593,203
Accrued salaries and related benefits	46,674	52,367
Current portion of deferred rent abatement (Note 8)	25,751	20,129
Deferred revenue	-	2,129,069
Due to America's Essential Hospitals (Note 5)	<u>55,007</u>	<u>1,388,241</u>
Total current liabilities	<u>649,764</u>	<u>4,183,009</u>
<b>LONG-TERM LIABILITIES</b>		
Deferred rent abatement, net of current portion (Note 8)	<u>39,349</u>	<u>57,674</u>
Total liabilities	<u>689,113</u>	<u>4,240,683</u>
<b>NET ASSETS</b>		
Unrestricted	5,774,070	961,991
Temporarily restricted (Note 3)	<u>1,996,060</u>	<u>1,491,366</u>
Total net assets	<u>7,770,130</u>	<u>2,453,357</u>
<b>TOTAL LIABILITIES AND NET ASSETS</b>	<b>\$ 8,459,243</b>	<b>\$ 6,694,040</b>

See accompanying notes to financial statements.

**ESSENTIAL HOSPITALS INSTITUTE**

**STATEMENTS OF ACTIVITIES AND CHANGES IN NET ASSETS  
FOR THE YEARS ENDED DECEMBER 31, 2013 AND 2012**

	2013		
	Unrestricted	Temporarily Restricted	Total
<b>REVENUE AND SUPPORT</b>			
Contracts (Note 7)	\$ 7,985,704	\$ -	\$ 7,985,704
Grants (Note 7)	526,869	1,800,000	2,326,869
Contributions (Note 5)	700,000	-	700,000
Tuition income	246,000	-	246,000
Miscellaneous	200	-	200
Interest	9,118	-	9,118
Net assets released from donor restrictions (Note 4)	<u>1,295,306</u>	<u>(1,295,306)</u>	<u>-</u>
Total revenue and support	<u>10,763,197</u>	<u>504,694</u>	<u>11,267,891</u>
<b>EXPENSES</b>			
Grants and Health Care	4,364,227	-	4,364,227
Transformation Center	855,996	-	855,996
Research and Education	414,114	-	414,114
General and Administrative	316,781	-	316,781
Total expenses	<u>5,951,118</u>	<u>-</u>	<u>5,951,118</u>
Changes in net assets	4,812,079	504,694	5,316,773
Net assets at beginning of year	<u>961,991</u>	<u>1,491,366</u>	<u>2,453,357</u>
<b>NET ASSETS AT END OF YEAR</b>	<b><u>\$ 5,774,070</u></b>	<b><u>\$ 1,996,060</u></b>	<b><u>\$ 7,770,130</u></b>

See accompanying notes to financial statements.

## EXHIBIT B

<u>2012</u>		
<u>Unrestricted</u>	<u>Temporarily Restricted</u>	<u>Total</u>
\$ 4,089,494	\$ -	\$ 4,089,494
350,000	2,016,000	2,366,000
700,000	-	700,000
246,000	-	246,000
500		500
4,476	-	4,476
<u>810,474</u>	<u>(810,474)</u>	<u>-</u>
<u>6,200,944</u>	<u>1,205,526</u>	<u>7,406,470</u>
4,099,144	-	4,099,144
714,248	-	714,248
358,156	-	358,156
<u>101,549</u>	<u>-</u>	<u>101,549</u>
<u>5,273,097</u>	<u>-</u>	<u>5,273,097</u>
927,847	1,205,526	2,133,373
<u>34,144</u>	<u>285,840</u>	<u>319,984</u>
<u>\$ 961,991</u>	<u>\$ 1,491,366</u>	<u>\$ 2,453,357</u>

See accompanying notes to financial statements.

**EXHIBIT C**

**ESSENTIAL HOSPITALS INSTITUTE**

**STATEMENT OF FUNCTIONAL EXPENSES  
FOR THE YEAR ENDED DECEMBER 31, 2013**

	<b>Grants and Health Care</b>	<b>Transformation Center</b>	<b>Research and Education</b>	<b>General and Administrative</b>	<b>Total Expenses</b>
Salaries and employee benefits (Note 6)	\$ 2,111,944	\$ 557,189	\$ 331,853	\$ 627,967	\$ 3,628,953
Equipment	6,541	16,440	-	15,499	38,480
Office supplies and services	37,791	33,841	19,397	127,404	218,433
Rent (Note 8)	237,270	-	-	78,819	316,089
Printing	975	1,216	-	6,673	8,864
Travel and meetings	190,084	118,408	20,251	27,181	355,924
Depreciation and amortization	81,329	-	-	36,206	117,535
Donations and sponsorships	-	1,500	-	-	1,500
Consultants and sub-contracted services	998,502	61,785	42,613	105,318	1,208,218
IT and computer	-	-	-	32,556	32,556
Miscellaneous	-	-	-	24,566	24,566
Sub-total	3,664,436	790,379	414,114	1,082,189	5,951,118
Allocation of overhead	699,791	65,617	-	(765,408)	-
<b>TOTAL</b>	<b>\$ 4,364,227</b>	<b>\$ 855,996</b>	<b>\$ 414,114</b>	<b>\$ 316,781</b>	<b>\$ 5,951,118</b>

See accompanying notes to financial statements.

**EXHIBIT D**

**ESSENTIAL HOSPITALS INSTITUTE**  
**STATEMENT OF FUNCTIONAL EXPENSES**  
**FOR THE YEAR ENDED DECEMBER 31, 2012**

	<b>Grants and Health Care</b>	<b>Transformation Center</b>	<b>Research and Education</b>	<b>General and Administrative</b>	<b>Total Expenses</b>
Salaries and employee benefits (Note 6)	\$ 1,897,835	\$ 478,180	\$ 219,997	\$ 440,399	\$ 3,036,411
Equipment	548	4,719	1,905	32,577	39,749
Office supplies and services	33,104	21,219	13,597	96,804	164,724
Rent (Note 8)	212,911	-	-	75,342	288,253
Printing	2,024	5,401	800	3,516	11,741
Travel and meetings	227,641	64,771	26,892	60,570	379,874
Depreciation and amortization	67,383	-	-	47,677	115,060
Donations and sponsorships	-	1,500	14,000	-	15,500
Consultants and sub-contracted services	966,407	75,209	80,964	47,125	1,169,705
IT and computer	-	-	-	38,658	38,658
Miscellaneous	-	-	-	13,421	13,421
 Sub-total	 3,407,853	 650,999	 358,155	 856,089	 5,273,096
Allocation of overhead	691,291	63,249	-	(754,540)	-
 <b>TOTAL</b>	 <b>\$ 4,099,144</b>	 <b>\$ 714,248</b>	 <b>\$ 358,155</b>	 <b>\$ 101,549</b>	 <b>\$ 5,273,096</b>

See accompanying notes to financial statements.

## EXHIBIT E

**ESSENTIAL HOSPITALS INSTITUTE**  
**STATEMENTS OF CASH FLOWS**  
**FOR THE YEARS ENDED DECEMBER 31, 2013 AND 2012**

	<u>2013</u>	<u>2012</u>
<b>CASH FLOWS FROM OPERATING ACTIVITIES</b>		
Changes in net assets	\$ 5,316,773	\$ 2,133,373
Adjustments to reconcile changes in net assets to net cash provided by operating activities:		
Depreciation and amortization	117,535	115,060
(Increase) decrease in:		
Grants receivable	(89,103)	(1,075,395)
Contribution receivable	-	250,000
Contract receivable	28,134	2,207
Prepaid expenses	11,234	(45,522)
Increase (decrease) in:		
Accounts payable	(70,871)	522,105
Accrued salaries and related benefits	(5,693)	52,367
Deferred rent abatement	(12,703)	77,803
Deferred revenue	(2,129,069)	2,129,069
Due to America's Essential Hospitals	<u>(1,333,234)</u>	<u>1,086,956</u>
Net cash provided by operating activities	<u>1,833,003</u>	<u>5,248,023</u>
<b>CASH FLOWS FROM INVESTING ACTIVITIES</b>		
Purchase of furniture and equipment	<u>(44,613)</u>	<u>(236,006)</u>
Net cash used by investing activities	<u>(44,613)</u>	<u>(236,006)</u>
Net increase in cash and cash equivalents	1,788,390	5,012,017
Cash and cash equivalents at beginning of year	<u>5,055,895</u>	<u>43,878</u>
<b>CASH AND CASH EQUIVALENTS AT END OF YEAR</b>	<b><u>\$ 6,844,285</u></b>	<b><u>\$ 5,055,895</u></b>

See accompanying notes to financial statements.

**ESSENTIAL HOSPITALS INSTITUTE  
NOTES TO FINANCIAL STATEMENTS  
DECEMBER 31, 2013 AND 2012**

**1. ORGANIZATION AND SIGNIFICANT ACCOUNTING POLICIES**

Organization -

Essential Hospitals Institute, formerly the National Public Health and Hospital Institute (NPHHI), was incorporated on October 1, 1987, primarily to foster and promote research and analysis relating to the more efficient and effective organization, delivery and financing of public hospitals and public health care; to educate the general public concerning the need to finance and provide access to quality care for all citizens; to sponsor programs and projects which are in furtherance of the charitable, scientific and educational goals of Essential Hospitals Institute and America's Essential Hospitals, its supported organization within the meaning of IRC Section 509(a)(3); and to serve as a source of expertise and knowledge to the general public in matters uniquely affecting public hospitals.

The accounting and reporting policies of Essential Hospitals Institute are in accordance with accounting principles generally accepted in the United States of America and reflect practices appropriate to non-profit organizations. The more significant of these policies are described below.

Basis of presentation -

The accompanying financial statements are presented on the accrual basis of accounting, and in accordance with FASB ASC 958, *Not-for-Profit Entities*.

Cash and cash equivalents -

Essential Hospitals Institute reports as cash and cash equivalents all cash and investments purchased with original maturities of less than three months.

Bank deposit accounts are insured by the Federal Deposit Insurance Corporation ("FDIC") up to a limit of \$250,000. At times during the year, Essential Hospitals Institute maintains cash balances in excess of the FDIC insurance limits. Management believes the risk in these situations to be minimal.

Receivables -

Grant, contribution and contract receivables approximate fair value. Management considers all amounts to be fully collectible. Accordingly, an allowance for doubtful accounts has not been established.

Furniture, equipment and leasehold improvements -

Furniture and equipment purchases over \$1,500 are capitalized and stated at cost. Furniture and equipment are being depreciated on the straight-line basis over the estimated useful lives of the related assets, generally three to five years. Furniture and equipment purchased for specific purposes under a contract are being depreciated over the life of the related contract. Leasehold improvements are amortized over the life of the lease using the straight-line basis. The cost of repairs and maintenance is recorded as expenses are incurred.

Contracts -

Contracts are considered to be available for unrestricted use, unless specifically restricted by the contractor. Revenue from cost reimbursable contracts is recognized to the extent that expenses have been incurred for the purpose specified by the contractor during the period.

**ESSENTIAL HOSPITALS INSTITUTE  
NOTES TO FINANCIAL STATEMENTS  
DECEMBER 31, 2013 AND 2012**

**1. ORGANIZATION AND SIGNIFICANT ACCOUNTING POLICIES (Continued)**

Contracts (continued) -

Revenue from fixed price contracts is recognized based on the work performed in correlation to the deliverables of the contract.

Essential Hospitals Institute received a fixed price contract from the Department of Health and Human Services during fiscal year 2011, in the amount of \$11,752,541. The contract period of performance is over 24 months, which ended on December 8, 2013. Essential Hospitals Institute was awarded one 12-month option period for an additional \$5,760,735 of funding. The purpose of the contract is to develop and possibly implement a campaign designed to decrease patient harm. During the years ended December 31, 2013 and 2012, Essential Hospitals Institute recorded contract revenue from this specific fixed price contract in the amounts of \$7,985,704 and \$4,089,494, respectively.

Contributions and grants -

Contributions and grants are recorded as revenue in the year notification is received from the donor. Contributions and grants are recognized as unrestricted support only to the extent of actual expenses incurred in compliance with the donor-imposed restrictions and satisfaction of time restrictions. Contributions and grants received in excess of expenses incurred are shown as temporarily restricted net assets in the accompanying financial statements.

Income taxes -

Essential Hospitals Institute is exempt from Federal income taxes under Section 501(c)(3) of the Internal Revenue Code. Accordingly, no provision for income taxes has been made in the accompanying financial statements. Essential Hospitals Institute is not a private foundation.

Uncertain tax positions -

For the years ended December 31, 2013 and 2012, Essential Hospitals Institute has documented its consideration of FASB ASC 740-10, *Income Taxes*, that provides guidance for reporting uncertainty in income taxes and has determined that no material uncertain tax positions qualify for either recognition or disclosure in the financial statements.

The Federal Form 990, *Return of Organization Exempt from Income Tax*, is subject to examination by the Internal Revenue Service, generally for three years after it is filed.

Use of estimates -

The preparation of the financial statements in conformity with accounting principles generally accepted in the United States of America requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities at the date of the financial statements and the reported amounts of revenue and expenses during the reporting period. Accordingly, actual results could differ from those estimates.

Functional allocation of expenses -

The costs of providing Essential Hospitals Institute's programs and administration have been summarized on a functional basis in the Statements of Activities and Changes in Net Assets. Accordingly, certain costs have been allocated among the programs benefited.

**ESSENTIAL HOSPITALS INSTITUTE  
NOTES TO FINANCIAL STATEMENTS  
DECEMBER 31, 2013 AND 2012**

**1. ORGANIZATION AND SIGNIFICANT ACCOUNTING POLICIES (Continued)**

Net asset classification -

The net assets are reported in two self-balancing groups as follows:

- **Unrestricted net assets** include unrestricted revenue and contributions received without donor-imposed restrictions. These net assets are available for the operation of Essential Hospitals Institute and include both internally designated and undesignated resources. It is the Board's intention to designate a material portion of the unrestricted net asset balance to be used for strategic and programmatic projects in accordance with the mission of Essential Hospitals Institute.
- **Temporarily restricted net assets** include revenue and contributions subject to donor-imposed stipulations that will be met by the actions of Essential Hospitals Institute and/or the passage of time. When a restriction expires, temporarily restricted net assets are reclassified to unrestricted net assets and reported in the Statements of Activities and Changes in Net Assets as net assets released from restrictions.

**2. GRANTS RECEIVABLE**

As of December 31, 2013 and 2012, contributors to Essential Hospitals Institute have made written promises to give totaling \$1,401,822 and \$1,312,719, respectively.

Grants are due as follows at December 31, 2013 and 2012:

	<b>2013</b>	<b>2012</b>
Less than one year	\$ 1,037,971	\$ 1,119,219
One to five years	363,851	193,500
<b>GRANTS RECEIVABLE</b>	<b>\$ 1,401,822</b>	<b>\$ 1,312,719</b>

**3. TEMPORARILY RESTRICTED NET ASSETS**

Temporarily restricted net assets consisted of the following at December 31, 2013 and 2012:

	<b>2013</b>	<b>2012</b>
<b>Time Restricted</b>	<b>\$ 1,996,060</b>	<b>\$ 1,491,366</b>

**4. NET ASSETS RELEASED FROM RESTRICTIONS**

The following temporarily restricted net assets were released from donor restrictions by the passage of time, which satisfied the restricted purposes specified by the donors:

	<b>2013</b>	<b>2012</b>
<b>Passage of Time</b>	<b>\$ 1,295,306</b>	<b>\$ 810,474</b>

**ESSENTIAL HOSPITALS INSTITUTE  
NOTES TO FINANCIAL STATEMENTS  
DECEMBER 31, 2013 AND 2012**

**5. RELATED PARTY TRANSACTIONS**

America's Essential Hospitals provides Essential Hospitals Institute with professional and administrative staffing, office space, equipment, furniture, office supplies and services, and other administrative support. Essential Hospitals Institute is a supporting organization to America's Essential Hospitals within the meaning of IRC Section 509(a)(3).

Costs are allocated between the two organizations based on actual expenditures or a percentage of salaries. Essential Hospitals Institute's allocation of expenses was 50% for 2013 and 2012. During 2013 and 2012, costs allocated to Essential Hospitals Institute were \$3,081,241 and \$3,433,660, respectively, and the amounts paid by Essential Hospitals Institute to America's Essential Hospitals totaled \$3,160,892 and \$2,045,420, respectively. Both 2013 and 2012 amounts include a \$700,000 contribution from America's Essential Hospitals to Essential Hospitals Institute to support uncovered Essential Hospitals Institute's labor and programmatic cost for research work and the Transformation Center.

At December 31, 2013 and 2012, Essential Hospitals Institute owed \$55,007 and \$1,388,241, respectively, to America's Essential Hospitals.

**6. PENSION PLAN**

Effective April 30, 1997, America's Essential Hospitals adopted a profit sharing and 401(k) plan covering all employees who are at least 21 years of age and have completed 1,000 hours of service during their first twelve months of employment. Employer contributions to the profit sharing plan vest over a three-year period from the date of eligibility. Contributions in 2013 and 2012 totaled \$417,200 and \$294,841, respectively. Of those amounts, \$211,523 and \$157,288, respectively, were allocated to Essential Hospitals Institute (see Note 5).

**7. CONCENTRATION OF REVENUE**

For the years ended December 31, 2013 and 2012, approximately 98% and 94% of contracts revenue, respectively, and 77% and 63% of grants revenue, respectively was derived from two organizations. Essential Hospitals Institute has no reason to believe that relationships with these organizations will be discontinued in the foreseeable future. However, any interruption of these relationships (i.e., the failure to renew grant agreements or withholding of funds) would adversely affect Essential Hospitals Institute's ability to finance ongoing operations.

**8. LEASE AGREEMENT**

In December 2011, America's Essential Hospitals, a related party organization (see Note 5), modified its existing lease agreement for additional office space to support the expansion of Essential Hospitals Institute activities. The agreement expires in December 2015 and provides for landlord-paid, leasehold improvements in the amount of \$78,839. The new space is fully occupied by Essential Hospitals Institute staff and accordingly, all related rent expenses have been allocated to Essential Hospitals Institute for the year ended December 31, 2013.

Accounting principles generally accepted in the United States of America require that the total rent commitment should be recognized on a straight-line basis over the term of the lease. Accordingly, the difference between the actual monthly payments and the rent expense being recognized for financial statement purposes is recorded as a deferred rent liability in the Statements of Financial Position.

**ESSENTIAL HOSPITALS INSTITUTE  
NOTES TO FINANCIAL STATEMENTS  
DECEMBER 31, 2013 AND 2012**

**8. LEASE AGREEMENT (Continued)**

Total rent expense for the years ended December 31, 2013 and 2012 was \$316,089 and \$288,253, respectively.

America's Essential Hospitals is committed for future minimum lease payments under the expansion agreement.

**9. SUBSEQUENT EVENTS**

In preparing these financial statements, Essential Hospitals Institute has evaluated events and transactions for potential recognition or disclosure through April 8, 2014, the date the financial statements were issued.

## ATTACHMENT I

## Statement of Functional Expenses: 2013 Audit, 2014 Revised Budget and June Projection

	2013 Audit		2014 Revised Budget & June Projection		column 1	column 2	column 3	column 4										
	Grants	Partnership for Patients	Research	Translational & Fellows	General Admin	Total Programs	Temporarily Restricted	Total	Grants for Patients	Partnership	Research	Translational & Fellows	General Admin	Total	Total Programs... Unrestricted	Temporarily Restricted	Total	
<b>REVENUE:</b>																		
Unrestricted Grant from UHC																		
Grant Income	\$ 1,065,049	\$ 7,892,800		\$ 500,000	\$ 350,000	\$ 3,500,000	\$ 1,565,049	\$ 1,949,769	\$ 3,514,818	\$ 1,194,569	\$ -	\$ -	\$ -	\$ 500,000	\$ 350,000	\$ 350,000	\$ 250,000	\$ 1,944,569
Government Contract																		
Fellows Program Income																		
Investment Income																		
Miscellaneous																		
Contribution/Support from Foundation & Association																		
Net Assets Released from Donor Restrictions																		
<b>TOTAL REVENUE</b>	<b>\$ 1,065,049</b>	<b>\$ 7,892,800</b>	<b>\$ 490,000</b>	<b>\$ 556,000</b>	<b>\$ 359,318</b>	<b>\$ 10,763,167</b>	<b>\$ 504,693</b>	<b>\$ 1,1267,860</b>	<b>\$ 1,194,569</b>	<b>\$ 5,493,800</b>	<b>\$ -</b>	<b>\$ 792,500</b>	<b>\$ 350,000</b>	<b>\$ 7,830,869</b>	<b>\$ (1,444,061)</b>	<b>\$ 6,366,868</b>		
Salaries and employee benefits	\$ 363,324	\$ 1,748,623	\$ 331,853	\$ 557,188	\$ 627,967	\$ 3,628,995	\$ 365,60	\$ 3,315,942	\$ 30,382	\$ 3,628,965	\$ 375,800	\$ 1,958,300	\$ 263,000	\$ 638,400	\$ 714,500	\$ 3,950,000	\$ -	\$ 3,950,000
Equipment and Furniture																		
Office Supplies & Services	\$ 1,613	\$ 43,694	\$ 19,397	\$ 16,440	\$ 13,942	\$ 131,542	\$ 32,806	\$ 32,806	\$ -	\$ 106,000	\$ 20,000	\$ 34,000	\$ 154,430	\$ 314,300	\$ -	\$ -	\$ 314,300	
Rent	\$ 36,472	\$ 232,380	\$ 154,106	\$ 20,251	\$ 112,936	\$ 65,709	\$ 31,089	\$ 31,089	\$ -	\$ 220,000	\$ 20,000	\$ -	\$ 129,500	\$ 349,500	\$ -	\$ -	\$ 349,500	
Travel & meetings																		
Dep. and amort.																		
Consultants & sub-contracted services	\$ 558,606	\$ 439,402	\$ 42,613	\$ 67,253	\$ 50,152	\$ 117,535	\$ 32,851	\$ 32,851	\$ 38,300	\$ 274,200	\$ 24,700	\$ 190,400	\$ 110,600	\$ 638,200	\$ -	\$ -	\$ 41,000	\$ -
Information Technology																		
Minic. Taxes and Insurance																		
Project Development																		
<b>Sub-total before grant overhead coverage</b>	<b>\$ 950,015</b>	<b>\$ 2,705,598</b>	<b>\$ 414,114</b>	<b>\$ 790,937</b>	<b>\$ 1,080,933</b>	<b>\$ 5,951,087</b>	<b>\$ -</b>	<b>\$ 5,951,087</b>	<b>\$ -</b>	<b>\$ 5,951,087</b>	<b>\$ 11,105,69</b>	<b>\$ 3,941,500</b>	<b>\$ 356,000</b>	<b>\$ 1,093,000</b>	<b>\$ 1,469,900</b>	<b>\$ 7,910,869</b>	<b>\$ -</b>	<b>\$ 7,910,869</b>
Allocation of Overhead to Grants	\$ 86,217	\$ 613,564	\$ 3,319,192	\$ 414,114	\$ 855,994	\$ 315,595	\$ 5,951,087	\$ -	\$ 5,951,087	\$ 84,000	\$ 11,115,100	\$ -	\$ 62,000	\$ 120,000	\$ 2,417,969	\$ -	\$ 70,900	
<b>TOTAL EXPENSES</b>	<b>\$ 1,046,232</b>	<b>\$ 3,319,192</b>	<b>\$ 414,114</b>	<b>\$ 855,994</b>	<b>\$ 315,595</b>	<b>\$ 5,951,087</b>	<b>\$ -</b>	<b>\$ 5,951,087</b>	<b>\$ -</b>	<b>\$ 5,951,087</b>	<b>\$ 11,194,569</b>	<b>\$ 5,086,600</b>	<b>\$ 356,000</b>	<b>\$ 1,095,000</b>	<b>\$ 17,700</b>	<b>\$ 7,910,869</b>	<b>\$ -</b>	<b>\$ 7,910,869</b>
<b>CHANGE IN NET ASSETS</b>	<b>\$ 18,817</b>	<b>\$ 4,573,648</b>	<b>\$ 75,886</b>	<b>\$ 100,006</b>	<b>\$ 43,773</b>	<b>\$ 4,812,080</b>	<b>\$ 504,693</b>	<b>\$ 5,316,773</b>	<b>\$ -</b>	<b>\$ 407,200</b>	<b>\$ 356,000</b>	<b>\$ (302,500)</b>	<b>\$ 171,300</b>	<b>\$ (80,000)</b>	<b>\$ (1,444,061)</b>	<b>\$ (1,524,061)</b>		
<b>Net Assets:</b>																		
Prior Year Net Assets	\$ (6,707)	\$ 290,706	\$ (51,450)	\$ 31,754	\$ 697,686	\$ 961,990	\$ 1,991,368	\$ 2,453,358	\$ 12,110	\$ 4,864,354	\$ 24,436	\$ 12,110	\$ 4,864,354	\$ 24,436	\$ 131,760	\$ 741,409	\$ 5,774,070	\$ 1,996,061
Change in Net Assets	\$ 18,817	\$ 4,573,648	\$ 75,886	\$ 100,006	\$ 43,773	\$ 4,812,080	\$ 504,693	\$ 5,316,773	\$ -	\$ 407,200	\$ 356,000	\$ (302,500)	\$ 171,300	\$ (80,000)	\$ (1,444,061)	\$ (1,524,061)		
Net Assets End of Year	\$ 12,110	\$ 4,864,354	\$ 24,436	\$ 131,760	\$ 741,409	\$ 5,774,070	\$ 1,996,061	\$ 5,316,773	\$ -	\$ 407,200	\$ 356,000	\$ (302,500)	\$ 171,300	\$ (80,000)	\$ (1,444,061)	\$ (1,524,061)		
<b>Restricted Net Assets</b>	<b>\$ 12,110</b>	<b>\$ 4,864,354</b>	<b>\$ 24,436</b>	<b>\$ 131,760</b>	<b>\$ 741,409</b>	<b>\$ 5,774,070</b>	<b>\$ 1,996,061</b>	<b>\$ 5,316,773</b>	<b>\$ -</b>	<b>\$ 407,200</b>	<b>\$ 356,000</b>	<b>\$ (302,500)</b>	<b>\$ 171,300</b>	<b>\$ (80,000)</b>	<b>\$ 5,694,070</b>	<b>\$ 5,694,070</b>		
<b>Unrestricted Net Assets</b>	<b>\$ 12,110</b>	<b>\$ 4,864,354</b>	<b>\$ 24,436</b>	<b>\$ 131,760</b>	<b>\$ 741,409</b>	<b>\$ 5,774,070</b>	<b>\$ 1,996,061</b>	<b>\$ 5,316,773</b>	<b>\$ -</b>	<b>\$ 407,200</b>	<b>\$ 356,000</b>	<b>\$ (302,500)</b>	<b>\$ 171,300</b>	<b>\$ (80,000)</b>	<b>\$ 5,694,070</b>	<b>\$ 5,694,070</b>		
<b>Total Net Assets</b>	<b>\$ 12,110</b>	<b>\$ 4,864,354</b>	<b>\$ 24,436</b>	<b>\$ 131,760</b>	<b>\$ 741,409</b>	<b>\$ 5,774,070</b>	<b>\$ 1,996,061</b>	<b>\$ 5,316,773</b>	<b>\$ -</b>	<b>\$ 407,200</b>	<b>\$ 356,000</b>	<b>\$ (302,500)</b>	<b>\$ 171,300</b>	<b>\$ (80,000)</b>	<b>\$ 5,694,070</b>	<b>\$ 5,694,070</b>		



## Essential Hospitals Institute Policy Statement: Board-Designated Funds Operating Reserve Fund

### Statement of Purpose

The purpose of this policy is to provide guidelines for maintaining adequate reserves. The general purpose of the board-designated operating reserve fund [“operating reserve”] is to ensure the long-term financial stability of the Essential Hospitals Institute [“Institute”] and position it to respond to varying economic conditions and changes affecting the organization’s financial position and the ability of the organization to continuously carry out its mission. The operating reserve is intended to provide an internal source of funds for situations such as a sudden increase in expenses, one-time unbudgeted expenses, unanticipated losses in funding, or uninsured losses.

The operating reserve is not intended to replace a permanent loss of funds or eliminate an ongoing budget gap. It is the intention of the Institute’s operating reserve to be used and replenished within a reasonably short period of time. This Operating Reserve Fund Policy will be implemented in concert with the other governance and financial policies of America’s Essential Hospitals and the Essential Hospitals Institute, and is intended to support goals and strategies contained in these related polices and in strategic and operational plans.

### Definitions and Goals

Board-designated funds for the Institute consist of board-designated operating reserves and non-operating board-designated funds.

### Board-Designated Operating Reserve

The board-designated operating reserve is part of “unrestricted net assets” that are available for the operation of the Institute and includes both internally designated and undesignated resources. The minimum amount designated by the board as operating reserves will be established in an amount sufficient to maintain ongoing operations and programs measured for a set period of time, measured in months. The operating reserve is dynamic and will be reviewed and adjusted in response to both internal and external changes.

The Institute’s target minimum operating reserve is equal to three months of current budgeted operating expenses. The calculation of average monthly operating expenses includes all recurring, predictable expenses such as salaries and benefits, occupancy, office, travel, program, and ongoing professional services. Depreciation, in-kind, and other non-cash expenses are not included in the calculation. The calculation of average monthly expenses also excludes pass-

through programs, non-salary grant expenditures reflected in temporarily restricted net assets, one-time or unusual expenses, and capital purchases.

The amount of the operating reserve target minimum will be calculated each year as part of the annual budget process, will be reported to the finance committee and board for approval, and will be included in regular financial reports.

### **Non-Operating Board-Designated Funds**

The board will designate non-operating board-designated funds for development of new programs, taking advantage of new opportunities, purchases of fixed assets, and/or other items as determined by the board. The Institute's first priority is to build an adequate board-designated operating reserve before building other, non-operating board-designated funds.

- Special Purpose Fund

The board-designated special purpose fund represents the portion of unrestricted net assets to fund a certain program, activity, or purpose that furthers the Institute's mission.

- Building and Capital Asset Reserve

The building and capital asset reserve is intended to provide a ready source of funds for leaseholds, furniture, fixtures, technology, and equipment necessary for the effective operation of the organization and programs.

- Opportunity Reserve

The opportunity reserve is intended to provide funds to meet special targets of opportunity or need that further the Institute's mission that may or may not have specific expectation of incremental or long-term increased income. It is also intended as a source of internal funds for organizational capacity building, such as staff development, research and development, or investment in infrastructure that will build long-term capacity.

### **Accounting for Reserves**

The board-designated reserve funds will be listed separately in the net assets section of the organization's statement of financial position as "board-designated reserves" and longer-term borrowings from the reserve will be shown as a liability, ["due to operating reserve"] in internal financial reports. The reserve will be funded and available in cash or cash equivalent funds and will be commingled with the general cash and investment accounts of the organization.

### **Funding of Reserves**

The operating reserve fund will be funded with surplus unrestricted operating funds. The board may from time to time direct that a specific source of revenue be set aside for operating reserves. Examples could include one-time gifts or special grants.

The special purpose fund will be funded with an initial contribution of \$3.3 million.

The building and capital assets reserve will be funded with special requests made by the Institute director and chief financial officer (CFO).

The opportunity reserve fund will be funded with occasional special designations made by the board.

### **Use of Reserves**

Use of the reserves requires three steps:

- 1. Identification of appropriate use of reserve funds**

The Institute director and CFO will identify the need for accessing reserve funds and confirm that the use is consistent with the purpose of the reserves as described in this policy. This step requires analysis of the reason for the shortfall, the availability of any other sources of funds before using reserves, and evaluation of the time period that the funds will be needed and replenished.

- 2. Authority to use reserves**

Authority for use of reserves is delegated to the Institute director and CFO in consultation with the finance committee. The proposed use of reserves will be reported to the board at its next scheduled meeting, accompanied by a description of the analysis and determination of the use of funds and plans for replenishment to restore the operating reserve to the target minimum amount.

- 3. Reporting and monitoring**

The Institute director and CFO is responsible for assuring that the reserve funds are maintained and used only as described in this policy. Upon approval for the use of reserve funds, the Institute director and CFO will maintain records of the use of funds and plan for replenishment, if required. The finance committee will receive reports of the board-designated reserve funds at its regular meetings, and the treasurer will report the status of the funds to the board as part of the regular treasurer's report.

In the event operating reserves are less than the targeted reserve levels, this deficit will be eliminated in a minimum of three years. If the operating reserves exceed the targeted reserve level for three consecutive years, the excess should be made available for current use.

### **Review of Policy**

The finance committee will review this policy every three years or sooner if warranted by internal or external events or changes. Changes to the policy will be recommended by the finance committee to the board.



## Statement of Investment Policy: Board-Designated Funds

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## **Statement of Purpose**

The purpose of this Investment Policy Statement (together with its Appendix, the “statement”) is to set forth the policies and procedures that shall guide the investment, audit, and compliance committee (the “IAC”) and the board of directors (the “board”) of Essential Hospitals Institute in supervising and monitoring the management of the organization’s investable assets (the “fund”).

## **Roles and Responsibilities**

If the board elects to oversee investment matters directly, it shall undertake the roles and responsibilities prescribed for the IAC herein. Otherwise, the IAC shall implement the management process and monitor the fund in accordance with this statement.

The IAC, acting pursuant to this statement and to instructions from the board, shall have direct responsibility for the oversight and management of the fund and for the establishment of investment policies and procedures.

The IAC shall, as more fully described herein, manage the fund via a set of asset allocation targets and ranges for the portfolio.

## **General Principles**

Essential Hospitals Institute shall diversify the investments of the fund unless the board and, if applicable, the IAC, after appropriate deliberation, reasonably determine that because of special circumstances the purposes of the fund are better served without diversification.

The fund shall be managed in accordance with high standards of fiduciary duty and in compliance with applicable laws and regulations.<sup>1</sup>

Standards for return, asset allocation and diversification shall be determined from a strategic perspective and measured over successive market cycles.

This statement shall be reviewed annually by the IAC and any recommendations for changes presented to the board.

In fulfilling its responsibilities under this statement, the committee shall, among other activities, recommend to the board the hiring and dismissal of investment managers, fiscal agents, and other advisers.

Reports on the fund shall be provided at least three times per year to the IAC. The Financial Advisor shall be responsible to the committee for maintaining detailed records of all invested funds and for carrying out the investment policies and procedures established by the board and the IAC.

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<sup>1</sup> Including but not limited to the version of the Uniform Prudent Management of Institutional Funds Act enacted in this state, if applicable.

## **Goals and Objectives**

### **Investment Objectives of the Fund:**

The fund (hereby referred to “collectively” as the operating and reserve funds) has a long-term investment horizon. The primary investment objectives of the fund are these:

1. maintain the real purchasing power of the fund after inflation, costs and spending
2. provide a stable source of liquidity and financial support for the organization’s mission

### **Investment Philosophy:**

While acknowledging the importance of preserving capital, the board also recognizes the necessity of accepting risk if the fund is to be able to meet its long-term investment goals. It is the view of the board that choices made with respect to asset allocation will be the major determinants of investment performance. The IAC shall seek to ensure that the risks taken are appropriate and commensurate with the fund’s goals.

### **Investment Operating Guidelines and Procedures**

The fund shall be managed in accordance with the operating guidelines described in this section. The fund’s target asset allocation and range for each asset class or investment strategy, together with the applicable guidelines and restrictions, are outlined in Appendix A. Taken together, these guidelines constitute a framework to assist America’s Essential Hospitals and its investment managers in achieving the fund’s investment objectives at a level of risk consistent with the parameters set forth in this statement.

Once the operating guidelines have been approved by the board, the IAC shall have the authority to manage the fund within the operating guidelines without further authorization from the board.

Investments in mutual funds or commingled funds shall be reviewed and approved by the IAC on a case-by-case basis and, if approved, may vary from this statement. For each such mutual or commingled fund, the prospectus, offering memorandum or declaration of trust documents of the respective fund will govern the investment policies of the fund investments. While the IAC understands that such funds have their own stated guidelines which cannot be changed for individual investors, those guidelines should be similar in principle and spirit to the guidelines stated herein. To the extent that a mutual or commingled fund departs from any or all of such guidelines, the IAC shall make itself aware of the possible consequences and be confident that the investment manager thoroughly understands the risks being taken, has demonstrated expertise in such investment strategies and has guidelines in place for monitoring their risk-adjusted performance.

The fund shall be diversified both by asset class and within asset classes. Within each asset class, investments shall be diversified further among economic sector, industry, quality, and size. The purpose of this diversification is to provide a reasonable assurance that no single security or class of securities will have a disproportionate impact—positive or negative—on the overall performance of the fund.

## **Investment Policy**

**Asset allocation:** The IAC shall, consistent with the above sections, invest the fund using an asset allocation, as set forth in Appendix A, that is designed to meet the fund's long-term goals. The allocation will be based on the objectives of the fund as set forth above.

**Targets and ranges:** The asset allocation shall be implemented using a policy portfolio as set forth in Appendix A, with target allocations and ranges for each investment strategy. Due to the need for diversification and the longer funding periods for certain investment strategies, the IAC recognizes that an extended period of time may be required to fully implement the asset allocation plan.

**Rebalancing:** The purpose of rebalancing is to maintain the fund's policy asset allocation within the targeted ranges, thereby ensuring that the fund does not incur additional risks as a result of having deviated from the policy portfolio. It is expected that market value fluctuations will cause deviations from the target allocations to occur. However, if any target allocation moves outside of the target range the portfolio will be rebalanced. Other events that may trigger a rebalance include large deposits or withdrawals and significant market movements. Regardless of activity, the portfolio will be reviewed on a quarterly basis at a minimum to assure the balance is adequately maintained. In order to minimize transaction costs, the Designated Investment Advisor will evaluate the benefit of rebalancing relative to the transaction cost.

**Illiquid investments:** Because of their long-term nature, investments in and commitments to illiquid investment strategies, including but not limited to private capital, private equity real estate, natural resources, distressed debt, and other similar private investments, shall be analyzed and discussed by the IAC separately.

**Standard of conduct:** In managing and investing the fund, the IAC shall:

- act in good faith and with the care an ordinarily prudent person in a like position would exercise under similar circumstances;
- make a reasonable effort to verify facts relevant to the management and investment of the fund;
- consider the following factors, if relevant:
  - (a) general economic conditions;
  - (b) the possible effect of inflation or deflation;
  - (c) the expected tax consequences, if any, of investment decisions or strategies;
  - (d) the role that each investment or course of action plays within the overall investment portfolio of the fund;
  - (e) the expected total return from income and the appreciation of investments;
  - (f) other resources of America's Essential Hospitals;
  - (g) the needs of America's Essential Hospitals and the fund to make distributions and to preserve capital;
- make management and investment decisions about an individual asset not in isolation, but rather in the context of the fund's portfolio of investments as a whole and as a part of the organization's overall investment strategy, including the risk and return parameters set forth in this statement.

**Delegation:** Subject to any specific limitation set forth in a gift instrument, the IAC may delegate to an external agent the management and investment of all or part of the fund to the extent that America's Essential Hospitals could prudently delegate under the circumstances. The IAC shall act in good faith, with the care that an ordinarily prudent person in a like position would exercise under similar circumstances in: (1) selecting an agent; (2) establishing the scope and terms of the delegation, consistent with the purposes of America's Essential Hospitals and the fund; and (3) periodically reviewing the agent's actions in order to monitor the agent's performance and compliance with the scope and terms of the delegation.

In this regard, the IAC shall engage qualified external professional investment managers that have demonstrated competence in their respective investment strategies. These managers shall have full discretion and authority for determining investment strategy, security selection and timing of purchases, and sales of assets subject to the guidelines specific to their allocation.

**Designated Investment Advisor:** Will be responsible for implementing the investment strategy outlined in this policy statement by selecting investments and external managers that meet the investment criteria within this policy statement. The Designated Investment Advisor will be charged with recommending investments, transacting approved purchases and sales of investments, and timely reporting of investment performance to the Essential Hospitals Institute. The Designated Investment Advisor is also required to perform all normal due diligence in selecting external investment managers, including a review of their ability to operate within the investment guidelines and restrictions outlined in this policy. The Designated Investment Advisor is responsible for selecting other appropriate parties as needed to implement this policy, including attorneys, custodians, and broker/dealers.

**Investment Manager:** Investment managers will be any party the Designated Investment Advisor selects to invest funds on behalf of the Essential Hospitals Institute. For purposes of this policy, Investment Managers include mutual fund managers, exchange traded fund managers, separate account managers, money market fund managers, and any other party that the Investment Manager contracts to invest funds on behalf of the Essential Hospitals Institute. The Investment Advisor is responsible for assuring that any Investment Manager selected is investing funds in a manner consistent with the eligible investments and restrictions outlined in this policy.

**Investment manager reporting and evaluation:** The Designated Investment Advisor responsible for the investment of the fund's assets shall report on their performance at least three times per year. Reports shall include, at a minimum, (1) comparative returns for the fund assets under management against a portfolio benchmark and the performance of each underlying fund or separately managed account in the portfolio against a style and size specific benchmark; (2) a complete accounting of all transactions involving the fund during the reporting period; and (3) the current portfolio allocation compared to the target asset allocation.

When possible, the IAC shall monitor and compare the fund's performance relative to its (1) absolute return objectives for the fund; (2) the respective benchmarks for each asset class or strategy in which the fund is invested, as set forth in the asset allocations in Appendix A; and (3) a representative group of peer investment managers.

## Appendix A: Operating Guidelines

### Definitions of Allowable Investments

**Equity Securities:** The purpose of equity investments, both domestic and international, in the fund is to provide capital appreciation, growth of income, and current income. This asset class carries the assumption of greater market volatility and increased risk of loss, but also provides a traditional approach to meeting portfolio total return goals. This component includes domestic and international common stocks, American Depository Receipts (ADRs), preferred stocks, and convertible stocks traded on the world's stock exchanges or over-the counter markets.

Public equity securities shall be restricted to high-quality, readily marketable securities of corporations that are traded on the major stock exchanges, including NASDAQ, and have the potential for meeting return targets. Equity holdings must generally represent companies meeting a minimum market capitalization requirement of respective asset class profiles with reasonable market liquidity where customary. Decisions as to individual security selection, number of industries and holdings, current income levels and turnover are left to manager discretion, subject to the standards of fiduciary prudence.

Within the above guidelines and restrictions, the fund's investment managers shall have complete discretion over the selection, purchase, and sale of equity securities.

**Fixed Income Securities:** Domestic and international fixed-income investments are intended to provide diversification and a dependable source of current income. Fixed-income investments should reduce the overall volatility of the fund's assets and provide a deflation or inflation hedge, where appropriate.

The fixed-income asset class includes the fixed-income markets of the United States and the world's other developed economies. It includes, but is not limited to, U.S. Treasury and government agency bonds, non-U.S. dollar denominated securities, public and private corporate debt, mortgages and asset-backed securities, and non-investment grade debt. Also included are money market instruments such as commercial paper, certificates of deposit, time deposits, bankers' acceptances, repurchase agreements, and U.S. Treasury and agency obligations. The investment managers shall take into account credit quality, sector, duration, and issuer concentrations in selecting an appropriate mix of fixed income securities. Investments in fixed income securities shall be managed actively to pursue opportunities presented by changes in interest rates, credit ratings, and maturity premiums.

Within the above guidelines and restrictions, the fund's investment managers shall have complete discretion over the selection, purchase, and sale of fixed-income securities.

For the purposes of this document, short-term fixed income is defined as fixed income with a maturity of five years or shorter. Intermediate-term fixed income is defined as fixed income with a maturity between 5 and 10 years.

**Cash and Equivalents:** The fund's investment managers may invest in the highest quality commercial paper, repurchase agreements, U.S. Treasury Bills, certificates of deposit, and money market funds to provide income, liquidity for expense payments, and preservation of the fund's

principal value. Investments in the obligations of a single issuer shall not at time of investment exceed 5 percent of the fund's total market value, with the exception of the U.S. Government and its agencies.

Since the IAC does not consider short-term cash equivalent securities to be appropriate investment vehicles for long-term portfolios, uninvested cash reserves shall be kept to a minimum except where needed to comply with the fund's liquidity parameters. However, such vehicles are considered appropriate (i) as a depository for income distributions from longer-term investments; (ii) as needed for temporary placement of funds directed for future investment to longer-term investment strategies; and (iii) for contributions to the current fund or for current operating cash.

Within the above guidelines and restrictions, the investment managers shall have complete discretion over the selection, purchase, and sale of cash equivalent securities.

**Investment Restrictions:** The IAC may waive or modify any of the restrictions in these guidelines in appropriate circumstances. Any such waiver or modification shall be made only after a thorough review of the investment manager and investment strategy involved. An addendum supporting such waiver or modification shall be maintained as a permanent record of the IAC. All such waivers and modifications shall be reported to the board at the meeting immediately following the granting of the waiver or modification.

Adherence to the restrictions in these guidelines shall be measured as of the time of initial investment. It is recognized that subsequent market action may result in the investment or strategy ceasing to adhere to these restrictions, through no fault of Essential Hospitals Institute's staff or the respective outside manager. In such a situation, the organization and the manager shall make reasonable attempts to bring the investment or strategy back within adherence to these restrictions, bearing in mind the long-term interests of the organization and the fund and the desirability of avoiding harmful forced sales of assets.

**Diversification:** (1) No more than 5 percent of the portfolio combined may be in the securities of any one issuer with the exception of obligations of the U.S. Government and its agencies, and federally insured instruments. (2) No more than 20 percent of the portfolio combined may be in the securities of a particular industry.

#### Intermediate Term Reserve Fund

**Purpose:** To improve investment returns on the funds for future expenditures of Essential Hospitals Institute. This can include fixed income securities and equities.

**Investment Objectives:** (1) capital appreciation and (2) preservation of purchasing power.

**Cash Flow Expectations:** This portfolio is expected to be used to fund mission-related investments annually. As such, a sufficient amount of funds will be held in cash and fixed income investments to cover this funding need.

### Target Allocations

	Minimum	Target	Maximum
Cash Equivalents	0%	1%	2%
U.S. Equities	15%	19.5%	23.5%
International Equities	8.5%	10.5%	12.5%
Fixed Income	55%	69%	83%

The fixed income asset class will target a weighted average maturity of eight years or less and a weighted average credit quality of no lower than AA.

The domestic and international equity assets classes will reflect an allocation to all nine style boxes based on market capitalization (large, mid, small) and style (value, blend, growth.) The allocation to international equity will also include exposure to both developed and emerging markets.

**Benchmarking:** The portfolio will be compared to a benchmark comprising the Russell 3000 Index, FTSE All World Ex-U.S. Index, Barclays Capital Aggregate Bond Index, Barclays Capital Gov. 1-5 Year Bond Index, and the Merrill Lynch Three Month US Treasury Bill Index. Weights will be applied to each index based on the target allocation to each broad asset class.



DATE June 16, 2014  
TO Board of Directors  
FROM Clifford Wang, MD  
RE Research Committee Charter

MEMORANDUM

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I am pleased to share the following update on creating a research committee.

#### Membership

The research committee will consist of nine members: four member directors from the board, two outside directors from the board and three non-board members from the America's Essential Hospitals membership. The board chair will nominate members for approval by the Institute board for terms not exceeding two years.

#### Committee Operations

The committee will meet once per quarter by phone call and one per year in person, with additional work to be conducted electronically. The committee will report regularly to the board.

#### Responsibilities

The committee will have the responsibility of providing guidance to the Institute on the following matters:

- establishing a set of principles that will guide the Institute's scope of research activities
- identifying issues where the Institute's research can help essential hospitals
- developing strategies for engaging member hospitals in research projects
- identifying innovative and effective ways of disseminating findings to member hospitals and more broadly



DATE June 16, 2014  
TO Board of Directors  
FROM Caroline Jacobs, MPH, MSEd, Education Committee Co-Chair  
RE Education Committee Report

**MEMORANDUM**

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

**Annual Conference**

• **VITAL2014**

One of the committee's goals for this conference was to broaden participation. In support of the goal, this year's annual conference features several new session formats, including 30-minute mini-sessions that feature focused case studies, and five-minute Rapid-Fire presentations. All programming is organized into four tracks: executive leadership, clinical leadership, finance, and quality and patient safety.

Another committee goal for the conference was to provide avenues for focused networking. You will see new name badge ribbons available to designate various groups within the membership and provide a visible mechanism to connect with other attendees. We also have in-person interest group meetings on Wednesday afternoon for participants to gather around the topics of philanthropy, medical leadership, and the 340B Drug Pricing Program. Also on Wednesday, the opening reception will feature designated areas for segments of the membership to network in an informal setting.

During this year's conference, the education committee is taking on two new roles and raising the visibility of the volunteers. First, committee members in attendance will serve as moderators for select breakout sessions. Second, committee members will serve as ambassadors to first-time attendees, providing the new participants with an orientation to the association and the conference.

As of June 3, 216 individuals were registered for the conference. An updated registration count will be provided during the board meeting.

• **VITAL2015**

Next year's annual conference will be in San Diego, June 24-26. As planning for the conference begins, the committee supports staff's suggestion to conduct a call for

proposals (CFP) process that will solicit members for presentation proposals to be considered for the program. The CFP will lead to more engaged members, the surfacing of new topics and case studies, and a more robust program. It is anticipated that about half the program will come from the CFP and half the program will be invited panels. Staff will accept proposals between mid-September and mid-November and the committee will evaluate and select proposals in mid-December.

### **Section 1115 Delivery System Reform Incentive Payment (DSRIP) Waivers**

As reported during the last board meeting, staff has organized a comprehensive educational work plan focusing on Section 1115 waivers to include a webinar series, several sessions during the annual conference, and two written products: a policy brief and a research brief. The waiver webinar series has been organized as case studies around the impact of waivers on quality improvement at hospitals in three waiver states. Additionally, an in-person meeting has been scheduled for September 29 at the Hilton Chicago O'Hare Airport. This fee-based, one-day program targets chief medical officer/chief financial officer teams and will feature presentations on waiver trends, financing, and clinical improvement. More details on the program will be available during the board meeting.

### **Innovations Summit**

The 2014 Innovations Summit is scheduled for October 29, in Washington, DC. This year's summit focuses on population health and social networks. The confirmed keynote speaker is Dr. Nicholas Christakis, MD, PhD, a physician and social scientist who directs the Human Nature Lab at Yale University. His research focuses on how social networks affect health and health care and implications for policy and public health. He is the co-author of *Connected: The Surprising Power of Our Social Networks and How They Shape Our Lives*. The program will also feature Rapid-Fire sessions from five or six essential hospitals showcasing their efforts to improve population health in their communities.

### **Fellows Program**

During the third and final session of the 2013 Fellows Program, participants advocated to key legislators on Capitol Hill on behalf of America's Essential Hospitals. Fellows also had the opportunity to present and hear from each other's leadership lessons learned through the work on their year-long program projects.

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

### **Webinars**

The 2014 schedule of webinars continues to be robust. For the second half of the year, topics will include the 340B program, patient and family centered care, HCAHPs, Medicaid expansion, and chronic disease management.

## America's Essential Hospitals Membership

### **Alameda Health System** (Oakland, CA)

Alameda Hospital (Alameda, CA)  
Fairmont Hospital (San Leandro, CA)  
Highland Hospital (Oakland, CA)  
John George Psychiatric Hospital (San Leandro, CA)  
San Leandro Hospital (Oakland, CA)

### **Arrowhead Regional Medical Center** (Colton, CA)

### **Bergen Regional Medical Center** (Paramus, NJ)

### **Bon Secours Baltimore Health System** (Baltimore, MD)

### **Boston Medical Center** (Boston, MA)

### **Broadlawns Medical Center** (Des Moines, IA)

### **Broward Health** (Fort Lauderdale, FL)

Broward Health Coral Springs (Coral Springs, FL)  
Broward Health Imperial Point (Fort Lauderdale, FL)  
Broward Health Medical Center (Fort Lauderdale, FL)  
Broward Health North (Deerfield Beach, FL)  
Chris Evert Children's Hospital (Fort Lauderdale, FL)

### **Cambridge Health Alliance** (Cambridge, MA)

Cambridge Hospital Campus (Cambridge, MA)  
Somerville Hospital Campus (Somerville, MA)  
Whidden Hospital Campus (Cambridge, MA)

### **Care New England Health System (CNE)** (Providence, RI)

Butler Hospital (Providence, RI)  
Kent County Memorial Hospital (Warwick, RI)  
Memorial Hospital of Rhode Island (Pawtucket, RI)  
Women & Infants Hospital of Rhode Island (Providence, RI)

### **Central Health** (Austin, TX)

### **City and County of San Francisco Department of Public Health** (San Francisco, CA)

Laguna Honda Hospital and Rehabilitation Center (San Francisco, CA)  
San Francisco General Hospital and Trauma Center (San Francisco, CA)

### **Contra Costa Health Services** (Martinez, CA)

Contra Costa Regional Medical Center (Martinez, CA)

### **Cook County Health & Hospitals System** (Chicago, IL)

John H. Stroger, Jr. Hospital of Cook County (Chicago, IL)  
Oak Forest Health Center (Oak Forest, IL)  
Provident Hospital of Cook County (Chicago, IL)

### **Denver Health Medical Center** (Denver, CO)

### **East Alabama Medical Center** (Opelika, AL)

### **Einstein Healthcare Network** (Philadelphia, PA)

Belmont Behavioral Health-Center for Comprehensive Treatment (Philadelphia, PA)  
Einstein Medical Center Elkins Park (Elkins Park, PA)  
Einstein Medical Center Montgomery (East Norriton, PA)  
Einstein Medical Center Philadelphia (Philadelphia, PA)  
MossRehab (Elkins Park, PA)

### **Erie County Medical Center** (Buffalo, NY)

### **Erlanger Health System** (Chattanooga, TN)

Children's Hospital at Erlanger (Chattanooga, TN)  
Erlanger Baroness Campus (Chattanooga, TN)  
Erlanger Bledsoe Campus (Pikeville, TN)  
Erlanger East Campus (Chattanooga, TN)  
Erlanger North Campus (Chattanooga, TN)

**Georgia Hospital Safety Net Coalition** (Atlanta, GA)

**Grady Health System** (Atlanta, GA)

**Halifax Health** (Daytona Beach, FL)

Halifax Health Medical Center (Daytona Beach, FL)  
Halifax Health Medical Center Port Orange  
(Port Orange, FL)

**Harris Health System** (Houston, TX)

Ben Taub Hospital (Houston, TX)  
Lyndon B. Johnson General Hospital (Houston, TX)  
Quentin Mease Hospital (Houston, TX)

**Health and Hospital Corporation of Marion County** (Indianapolis, IN)

Eskenazi Health (Indianapolis, IN)  
Sidney and Losi Eskenazi Hospital (Indianapolis, IN)

**Health Care District of Palm Beach County** (Palm Springs, FL)

Lakeside Medical Center (Belle Glade, FL)

**Hennepin County Medical Center** (Minneapolis, MN)

**Henry Ford Health System** (Bingham Farms, MI)

Henry Ford Hospital (Detroit, MI)  
Henry Ford Kingswood Hospital (Ferndale, MI)  
Henry Ford Macomb Hospital (Clinton Township, MI)  
Henry Ford Macomb Hospital-Mt. Clemens Campus  
(Warren, MI)  
Henry Ford Macomb Physical Rehabilitation Center  
(Warren, MI)  
Henry Ford West Bloomfield Hospital  
(West Bloomfield, MI)  
Henry Ford Wyandotte Hospital (Wyandotte, MI)

**Howard University Hospital** (Washington, DC)

**Hurley Medical Center** (Flint, MI)

**Jackson Health System** (Miami, FL)

Holtz Children's Hospital (Miami, FL)  
Jackson Behavioral Health Hospital (Miami, FL)  
Jackson Memorial Hospital (Miami, FL)  
Jackson North Medical Center (Miami, FL)

Jackson Rehabilitation Hospital (Miami, FL)

Jackson South Community Hospital (Miami, FL)

**JPS Health Network** (Fort Worth, TX)

John Peter Smith Hospital (Fort Worth, TX)

**Kern Medical Center** (Bakersfield, CA)

**Lee Memorial Health System** (Fort Myers, FL)

Cape Coral Hospital (Cape Coral, FL)  
Golisano Children's Hospital of Southwest Florida (Fort Myers, FL)  
Gulf Coast Medical Center (Fort Myers, FL)  
HealthPark Medical Center (Fort Myers, FL)  
Lee Memorial Hospital (Fort Myers, FL)  
The Rehabilitation Hospital (Fort Myers, FL)

**LibertyHealth System** (Jersey City, NJ)

LibertyHealth/Jersey City Medical Center (Jersey City, NJ)

**Los Angeles County Department of Health Services** (Los Angeles, CA)

Harbor-UCLA Medical Center (Torrance, CA)  
High Desert Health System Multi-Service Ambulatory Care Center (Lancaster, CA)  
LAC+USC Medical Center (Los Angeles, CA)  
Olive View-UCLA Medical Center (Sylmar, CA)  
Rancho Los Amigos National Rehabilitation Center (Downey, CA)

**Maricopa Integrated Health Systems (MIHS)** (Phoenix, AZ)

Maricopa Medical Center (Phoenix, AZ)

**Martin Luther King, Jr. Community Hospital** (Los Angeles, CA)

**Memorial Healthcare System** (Hollywood, FL)

Joe DiMaggio Children's Hospital (Hollywood, FL)  
Memorial Hospital Miramar (Miramar, FL)  
Memorial Hospital Pembroke (Pembroke Pines, FL)  
Memorial Hospital West (Pembroke Pines, FL)  
Memorial Regional Hospital (Hollywood, FL)  
Memorial Regional Hospital South (Hollywood, FL)

**Memorial Hospital at Gulfport** (Gulfport, MS)

**Metropolitan Nashville Hospital Authority**  
(Nashville, TN)  
Nashville General Hospital at Meharry (Nashville, TN)

**Natividad Medical Center** (Salinas, CA)

**New York City Health and Hospitals Corporation**  
(New York, NY)

Bellevue Hospital Center (New York, NY)  
Coler-Goldwater Specialty Hospital and Nursing Facility (New York, NY)  
Coney Island Hospital (Brooklyn, NY)  
Dr. Susan Smith McKinney Nursing and Rehabilitation Center (Brooklyn, NY)  
Elmhurst Hospital Center (Elmhurst, NY)  
Harlem Hospital Center (New York, NY)  
Jacobi Medical Center (Bronx, NY)  
Kings County Hospital Center (Brooklyn, NY)  
Lincoln Medical and Mental Health Center (Bronx, NY)  
Metropolitan Hospital Center (New York, NY)  
North Central Bronx Hospital (Bronx, NY)  
Queens Hospital Center (Jamaica, NY)  
Sea View Hospital Rehabilitation Center and Home (Staten Island, NY)  
Woodhull Medical and Mental Health Center (Brooklyn, NY)

**Norwegian American Hospital** (Chicago, IL)

**NuHealth** (East Meadow, NY)

**Oklahoma State University Medical Trust** (Tulsa, OK)

**Orlando Health** (Orlando, FL)

Arnold Palmer Hospital for Children (Orlando, FL)  
Dr. P. Phillips Hospital (Orlando, FL)  
Health Central Hospital (Orlando, FL)  
Orlando Regional Medical Center (Orlando, FL)  
South Lake Hospital (Clermont, FL)  
South Seminole Hospital (Longwood, FL)  
Winnie Palmer Hospital for Women and Babies (Orlando, FL)

**Parkland Health & Hospital System** (Dallas, TX)

**Regional One Health** (Memphis, TN)

**Riverside County Regional Medical Center**  
(Moreno Valley, CA)

**San Joaquin General Hospital** (French Camp, CA)

**San Mateo Medical Center** (San Mateo, CA)

**Santa Clara Valley Health & Hospital System** (San Jose, CA)  
Santa Clara Valley Medical Center (San Jose, CA)

**SNHAF-Safety Net Hospital Alliance of Florida** (Tallahassee, FL)

**St. Luke's Health System** (Boise, ID)

St. Luke's Children's Hospital (Boise, ID)  
St. Luke's Elmore Medical Center (Mountain Home, ID)  
St. Luke's Jerome (Jerome, ID)  
St. Luke's Magic Valley Medical Center (Twin Falls, ID)  
St. Luke's McCall Medical Center (McCall, ID)  
St. Luke's Meridian Medical Center (Meridian, ID)  
St. Luke's Regional Medical Center (Boise, ID)  
St. Luke's Wood River Medical Center (Ketchum, ID)

**SUNY-State University of New York** (Albany, NY)

Stony Brook University Hospital (Stony Brook, NY)  
SUNY Downstate Medical Center (Brooklyn, NY)  
SUNY Upstate Medical University (Syracuse, NY)

**Swedish Covenant Hospital** (Chicago, IL)

**Tampa General Hospital** (Tampa, FL)

**Temple University Health System** (Philadelphia, PA)

Episcopal Hospital (Philadelphia, PA)  
Jeanes Hospital (Philadelphia, PA)  
Temple University Hospital (Philadelphia, PA)

**The MetroHealth System** (Cleveland, OH)

MetroHealth Medical Center-Main Campus (Cleveland, OH)

**The Ohio State University Wexner Medical Center** (Columbus, OH)

OSU Harding Hospital (Columbus, OH)  
Richard M. Ross Heart Hospital (Columbus, OH)  
University Hospital (Columbus, OH)

University Hospital East (Columbus, OH)

**The University of Arizona Health Network**  
(Tucson, AZ)

The University of Arizona Medical Center-South Campus (Tucson, AZ)  
The University of Arizona Medical Center-University Campus (Tucson, AZ)

**The University of Kansas Hospital** (Kansas City, KS)

**The University of Texas Medical Branch**  
(Galveston, TX)

Children's Hospital (Galveston, TX)  
John Sealy Hospital (Galveston, TX)

**Truman Medical Centers** (Kansas City, MO)

TMC Behavioral Health (Kansas City, MO)  
TMC Hospital Hill (Kansas City, MO)  
TMC Lakewood (Kansas City, MO)

**UK HealthCare** (Lexington, KY)

Kentucky Children's Hospital (Lexington, KY)  
UK Albert B. Chandler Hospital (Lexington, KY)  
UK Good Samaritan Hospital (Lexington, KY)

**UMass Memorial Health Care** (Worcester, MA)

Clinton Hospital (Clinton, MA)  
HealthAlliance Hospital (Leominster, MA)  
Marlborough Hospital (Marlborough, MA)  
UMass Memorial Medical Center (Worcester, MA)  
Wing Memorial Hospital (Palmer, MA)

**United Medical Center** (Washington, DC)

**University Health System** (San Antonio, TX)

University Hospital (San Antonio, TX)

**University Hospital** (Newark, NJ)

**University Medical Center of El Paso** (El Paso, TX)

**University Medical Center of Southern Nevada**  
(Las Vegas, NV)

Children's Hospital of Nevada at UMC (Las Vegas, NV)

**University of Alabama at Birmingham**  
(UAB Health System) (Birmingham, AL)

Callahan Eye Hospital (Birmingham, AL)  
Spain Rehabilitation Center (Birmingham, AL)  
UAB Hospital (Birmingham, AL)  
UAB Hospital-Highlands (Birmingham, AL)  
Women & Infants Center (Birmingham, AL)

**University of Arkansas for Medical Sciences (UAMS)** (Little Rock, AR)

**University of California** (Oakland, CA)

Mattel Children's Hospital UCLA (Los Angeles, CA)  
Resnick Neuropsychiatric Hospital at UCLA (Los Angeles, CA)  
Ronald Reagan UCLA Medical Center (Los Angeles, CA)  
UC Davis Medical Center (Sacramento, CA)  
UC Irvine Medical Center (Orange, CA)  
UC San Diego Health System (San Diego, CA)  
UCLA Medical Center Santa Monica (Santa Monica, CA)  
UCSF Benioff Children's Hospital (San Francisco, CA)  
UCSF Medical Center at Mount Zion (San Francisco, CA)

**University of Colorado Health** (Aurora, CO)

Anschutz Inpatient Pavilion (Aurora, CO)  
Children's Hospital Colorado at Memorial Hospital (Cascade, CO)  
Children's Hospital of Colorado (Aurora, CO)  
Medical Center of the Rockies (Loveland, CO)  
Memorial Hospital Central (Colorado Springs, CO)  
Memorial Hospital North (Colorado Springs, CO)  
Mountain Crest Behavioral Healthcare Center (Fort Collins, CO)  
Poudre Valley Hospital (Fort Collins, CO)  
University of Colorado Hospital (Aurora, CO)

**University of Florida Health** (Gainesville, FL)

UF Health Jacksonville (Jacksonville, FL)  
UF Health Shands Children's Hospital (Gainesville, FL)  
UF Health Shands Hospital (Gainesville, FL)  
UF Health Shands Psychiatric Hospital (Gainesville, FL)  
UF Health Shands Rehab Hospital (Gainesville, FL)

**University of Illinois Hospital & Health Sciences System** (Chicago, IL)

**University of Mississippi Health Care** (Jackson, MS)

Batson Children's Hospital (Jackson, MS)

Holmes County Hospital and Clinics (Lexington, MS)

University of Mississippi Medical Center (Jackson, MS)

Wallace R. Conerly Critical Care Hospital  
(Jackson, MS)

Winfred L. Wiser Hospital for Women and Infants  
(Jackson, MS)

**University of Missouri Health Care** (Columbia, MO)

Missouri Psychiatric Center (Columbia, MO)

Missouri Rehabilitation Center (Mount Vernon, MO)

The Missouri Orthopaedic Institute (Columbia, MO)

University Hospital (Columbia, MO)

University of Missouri Children's Hospital  
(Columbia, MO)

University of Missouri Women's and Children's  
Hospital (Columbia, MO)

**University of South Alabama Medical Center**  
(Mobile, AL)

University of South Alabama Children's and  
Women's Hospital (Mobile, AL)

**University of Utah Health Care** (Salt Lake City, UT)

**UNM Health Sciences Center** (Albuquerque, NM)

UNM Carrie Tingley Hospital (Albuquerque, NM)

UNM Children's Hospital (Albuquerque, NM)

UNM Children's Psychiatric Center (Albuquerque, NM)

UNM Hospitals (Albuquerque, NM)

UNM Psychiatric Center (Albuquerque, NM)

UNM Sandoval Regional Medical Center (Rio Rancho, NM)

**UT Health Northeast** (Tyler, TX)

**UW Medicine** (Seattle, WA)

Harborview Medical Center (Seattle, WA)

Northwest Hospital & Medical Center (Seattle, WA)

UW Medical Center (Seattle, WA)

Valley Medical Center (Renton, WA)

**Ventura County Health Care Agency** (Ventura, CA)

Santa Paula Hospital (Santa Paula, CA)

Ventura County Medical Center (Ventura, CA)

**Virginia Commonwealth University Health System** (Richmond, VA)

Children's Hospital of Richmond (Richmond, VA)

MCV Hospitals (Richmond, VA)

VCU Pauley Heart Center (Richmond, VA)

**West Virginia University Hospitals, Inc.** (Morgantown, WV)

Chestnut Ridge Center (Morgantown, WV)

City Hospital (Martinsburg, WV)

Jefferson Memorial Hospital (Ranson, WV)

Ruby Memorial Hospital (Morgantown, WV)

WVU Children's Hospital (Morgantown, WV)

**Westchester Medical Center** (Valhalla, NY)

MidHudson Regional Hospital of Westchester (Poughkeepsie, NY)