



Board of Directors Meeting

April 1, 2014
Westin Georgetown
Washington, D.C.



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Board of Directors Meeting

April 1, 2014

8:00 am – 12:00 pm

Westin Georgetown
2350 M Street, NW
Washington, DC 20037

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Agenda
Board of Directors Meeting
April 1, 2014
8 am – noon

8:00 – 8:05 am	Welcome and Call to Order (Dr. Wang)	
8:05 – 8:10 am	Approve Consent Agenda (Dr. Wang)	ACTION
	• September 2013 Minutes	
	• December 2013 Minutes	
8:10 – 8:20 am	Treasurer's Report (Ms. Roth)	
	• Budget update	
	• Internal Controls	
8:20 – 8:35 am	Education Committee Report (Ms. Jacobs)	
8:35 – 8:45 am	Appoint Essential Hospitals Institute Director (Dr. Wang)	ACTION
8:45 – 8:55 am	Institute Board Appointments (Dr. Wang)	ACTION
8:55 – 9:25 am	PCORI Chronic Disease Management for the Underserved Project	
	• Highlights and Next Steps (Dr. Perez)	
9:25 – 9:55 am	Partnerships with Community Health Centers Project (Mr. Harrison)	
9:55 – 10:10 am	Break	
10:10 – 10:40 am	EHEN: Accomplishments, Current Work and Future Goals (Ms. Callahan)	
10:40 – noon	Work in Progress (Dr. Engler)	
	• Waivers	
	• Population Health	
	• Future Research	
Noon	Adjourn	



**Essential Hospitals Institute
Board of Directors
2013 – 2014**

OFFICERS

Chair

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

Secretary

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

Treasurer

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

Past-Chair

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

Recording Secretary (Ex Officio)

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

MEMBER DIRECTORS

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

Leon L. Haley Jr., MD, MHSA
Executive Associate Dean, Clinical Services Chief
Medical Officer
Grady Health System

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

Christine Neuhoff, JD
System Vice President and General Counsel
St. Luke's Health System

L. Reuven Pasternak, MBA, MD, MPH
CEO
Stony Brook University Hospital

OUTSIDE DIRECTORS

Donald A. Goldmann, MD
Chief Medical and Scientific Officer
Institute for Healthcare Improvement

Alan Weil, JD
Executive Director
National Academy for State Health Policy

Winston F. Wong, MD, MS
Medical Director, Disparities Improvement and
Quality Initiatives
Kaiser Foundation Health Plan

EX-OFFICIO

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



2014-2015 Institute Board 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



Board of Directors Meeting Minutes

Washington Marriot

Washington, D.C.

September 30, 2013

Board of Directors

Donald A. Goldmann, MD
Leon Haley, MD, MHS
Caroline Jacobs, MPH, MS Ed.
Richard P. Lofgren, MD, MPH
Susan Moffat-Bruce, MD, PhD
L. Reuven Pasternak, MBA, MD, MPH
Anna M. Roth, MPH, MS, RN
Bruce Siegel, MD, MPH
Clifford Wang, MD
Alan Weil, JD, MPP
Winston F. Wong, MD

Staff

Sarah Callahan, MHSA
Linda Cummings, PhD
David Engler, PhD
Rhonda Gold
Ricky Harrison, MPA,MS
Jane Hooker, RN, MSN
Brian Hurdle, MPH
Kristine Metter
Bianca Perez, PhD
Brian Roberson, MPA
Janelle Schrag, MPH

Minutes

Clifford Wang, MD, board chair, called the meeting to order at 1:03 pm and welcomed all in attendance. For the benefit of new members and first-time attendees, the board and staff introduced themselves. Bruce Siegel, America's Essential Hospitals president and CEO, extended thanks to Melissa Stafford Jones for her service on the Institute board, as she is leaving the California Association for Public Hospitals at the end of the year.

Dr. Wang gave an overview of the meeting agenda and heard a motion to approve the minutes from the June board meeting. Donald Goldmann, MD, so motioned and a second was heard. The motion passed unanimously. Dr. Wang then turned the floor over to Anna Roth.

Finance Committee Report

Ms. Roth explained the make-up and purpose of the Finance Committee and described the committee's duties and responsibilities. Ms. Roth suggested the following board members be confirmed to the Finance Committee for 2013-14 in accordance with the Institute's by-laws

1. Anna Roth, Chair, Ex Officio as Board Treasurer
2. Caroline Jacobs, Ex Officio as Board Secretary
3. Susan Moffat-Bruce
4. L. Reuven Pasternak
5. Alan Weil

Dr. Wang asked for a motion to approve the proposed finance committee members. Dr. Goldmann so motioned and a second was heard. The motion passed unanimously.



Treasurer's Report

Roth, board treasurer, reported on the most recent financial projection as compared to the approved budget. She stated that the Institute received a six month \$100,000 award from the Patient Centered Outcomes Research Institute (PCORI) since the June update. Projected unrestricted income is \$6.66 million, which is offset by projected expenses of \$6.5 million, leaving an unrestricted operating surplus of \$164,000. After taking into account last year's beginning net assets, total 2013 projected net assets (restricted and unrestricted) are \$2.2 million, including \$1.08 million in temporarily restricted assets and \$1.12 million in unrestricted net assets.

Dr. Wang asked for a motion to approve the treasurer's report. Dr. Pasternak so motioned and was seconded; the motion passed unanimously.

Education Committee Report

Ms. Jacobs delivered a report on the activities of the education committee. She expressed the committee's desire to ensure the Institute's educational activities align with the association's strategic plan and encompass enterprise-wide offerings. The committee suggested the annual conference include C-suite focused sessions, and that population health and Section 1115 Medicaid waivers be priority topics. She went on to say that the safety net focus will remain a priority. The committee suggested branding the 2014 annual conference as Vital2014. Jacobs also gave a brief overview of the proposed distance learning plan for 2014.

Ms. Jacobs stated that the committee requested the development of a regular Fellows Program e-newsletter for sponsors and that past Fellows serve as panelists and faculty in current programs. She also suggested that past and current Fellows introduce members at the annual conference session. The committee suggested that the Fellows program theme for 2014-2015 be "Innovative and Adaptive Leadership: Essential in Times of Change".

Dr. Wang opened the floor for questions. The board approved stressing the importance of empowering Fellows upon return to their home organizations. Discussion followed on adaptive leadership and the details of the Fellows program. The board raised questions around balancing a safety net focus with a focus on leaders in large organizations not in the safety net. The board noted that the program needs to recognize its end goal, and that goal should drive activities.

David Engler, PhD, senior vice president for leadership and innovation at America's Essential Hospitals, reported that 15 past Fellows have become C-suite staff in their organizations, and five have become CEOs. Two former Fellows have been employed in leadership positions by America's Essential Hospitals. The board asked about the prior training of Fellows, particularly those who went on to leadership roles. Dr. Engler agreed to analyze that data and to report to the board. The board questioned the functional difference in the 2014–2015 Fellows program theme and the themes of past years. Dr. Engler indicated that the curriculum would include an increased focus on effectiveness, nimbleness, and thoughtful leadership. Dr. Wang said that the education committee would like staff to define what "adaptive" and "innovative" mean.



Dr. Wang opened the floor to questions about the 2014 distance learning plan. The board inquired as to the method of selecting the number and topics of webinars. It was explained that all the topics and events link to the organization's strategic plan and goals.

Dr. Wang asked for a motion to approve the 2014 distance learning plan and the Fellows program theme. Dr. Winston Wong so motioned and the motion passed unanimously. Dr. Wang turned the floor over to Linda Cummings, PhD, vice president for research at America's Essential Hospitals and director of the Institute, for her update on the Research Center's activities.

Research Center Activities Update

Dr. Cummings opened her presentation by describing her involvement with the AcademyHealth Translation and Dissemination Institute. Dr. Cummings invited the board to provide feedback on the program.

Dr. Cummings then provided an agenda overview and discussed a new proposal to the Agency for Healthcare Research and Quality, submitted in partnership with AcademyHealth. Dr. Cummings explained that the proposal seeks to use the knowledge gained through the Gage Awards to disseminate those initiatives to other safety net members and to foster diffusion. A decision on the proposal is expected in the first quarter of 2014.

Dr. Cummings gave an update on the forthcoming website redesign, research brief streamlining, and the upcoming release of a data portal that members will be able to access.

Dr. Cummings turned the floor over to Dr. Wong to speak about Transforming Care Delivery in America's Safety Net: Aligning Efforts to Improve Access and Care Coordination, which staff refer to as the 2014 project. Dr. Wong explained that Kaiser Permanente's (KP's) support for this project stemmed from KP's long-standing support of America's Essential Hospitals and the National Association of Community Health Centers (NACHC), in addition to its interest in supporting collaboration to improve care for the population served by the members of both associations. Dr. Wong stated that KP saw the project as an opportunity to understand how community health centers and public hospitals will cooperate around patient access and care coordination, especially under implementation of the Affordable Care Act. Dr. Wong and Institute board member, Alan Weil, both serve on the project's advisory committee.

Dr. Cummings then turned the floor over to Ricky Harrison, senior research associate at America's Essential Hospitals, to give an update on the 2014 project. Mr. Harrison described the timeline and the goals of the project. He explained that America's Essential Hospitals has created a national partnership with NACHC and George Washington University (GWU). The role of America's Essential Hospitals and NACHC in this partnership is to engage members and provide technical support. The role of GWU is to provide research and evaluation support. Mr. Harrison described the composition and role of the project's advisory committee and the plan to target five key states for study. Mr. Harrison presented for board feedback key questions or issues to consider during the course of this project.



The board began by suggesting that the project team think about what it means to form a stakeholder group. Is this more about creating a coalition or action unit? The board cautioned that the technical assistance the project team brings to the local and regional teams is very important. The board suggested that the team look at past and current research and programs and attempt to avoid redundancy. The board suggested that the team study findings from other projects of this type and examine why these large types of initiatives have been unsustainable. It was also suggested that the patients may be a source of knowledge on this subject.

Dr. Cummings then turned the floor over to Bianca Perez, senior project manager at America's Essential Hospitals, for an update on the PCORI project. Dr. Perez explained the timeline and goals of the project. She shared the planned site visits to five member hospitals that either have an accountable care organization or patient-centered medical home. She went on to outline several of the key findings from the literature review. Dr. Perez ended her presentation by inquiring if the board had any further ideas for comparative effectiveness research.

Dr. Wang opened the questions to the board. Dr. Wong inquired as to whether the team had looked into risk adjustment models. The board suggested that an important issue may be the cost of providing a certain level of care. The board expressed concern that there is very little data around disparities. It was suggested that the team read Dr. Goldmann's article on how requests for grant proposals could ask for meaningful research around reducing disparities: *Meaningful Disparities Reduction Through Research and Translation Programs* (Marshall Chin, MD, MPH, and Don Goldmann, MD, *Journal of the American Medical Association*, January 26, 2011 – Vol. 305, No. 4).

Dr. Wang then turned the floor back to Dr. Cummings to talk about the two major areas of additional focus proposed for 2014: population health and Section 1115 Medicaid waivers. Dr. Cummings expressed the need for the organization to develop a shared definition of population health. Dr. Cummings said that staff will update the February 2013 research brief on Section 1115 Medicaid waivers to include added states and initiatives. She noted the opportunities for collaboration across the organization on webinars, policy, and advocacy issues. The board suggested that a PowerPoint format may be more useful for hospitals than a report or research brief.

Dr. Wang recessed for 15 minutes.

Transformation Center Activities Update

Dr. Wang turned the floor over to Dr. Engler to give an update on the activities of the Transformation Center (TC). Engler gave the board a recap of the TC's position within the organizational structure and how the work of the TC relates to the four pillars of America's Essential Hospitals' strategic plan. Dr. Engler spoke about the priority to align the work of the Research Center and the TC.



Dr. Engler presented infographic data on harm reduction in the Essential Hospitals Engagement Network (EHEN). The board voiced several concerns with the presentation of data in this graphic: the inclusion of all-cause readmissions in the graphic on prevented harm events, the colors of the graphic, and difficulty of counting. There was also a suggestion to separate readmissions from the graphic.

Dr. Engler explained that the TC will examine the following new areas: patient experience/patient and family centered care, cost and value, sustainability, and sepsis. He asked the board if these were directions into which the TC should move. The board noted that sustainability models are still unproven. Another board member posed a question as to how sustainability should be viewed in an environment of innovation and adaptation. A concern was raised that presenting patient experience and patient and family centered care as similar may be misleading. The board suggested that perhaps the TC should focus on fewer areas, prioritizing sustainability and patient experience. The board also raised a concern about the generic nature of these goals and the lack of connection to the underserved.

The board stated that hospitals filling a safety net role face greater challenges in residency programs. This situation may be an opportunity for focus. A board member raised a question as to how members in the EHEN are doing in comparison to our members in other hospital engagement networks. Staff informed the board that one could not stratify this aggregate data to answer that question.

Dr. Wang adjourned the meeting at 4:50 pm.

A handwritten signature in black ink that reads "Carol M. Salas". The signature is fluid and cursive, with "Carol M." on the top line and "Salas" on the bottom line.



Board of Directors Meeting Minutes

Monday, December 16, 2013

Meeting by Telephone

Attendees: Clifford Wang, MD; Caroline Jacobs MPH, MS Ed; Anna Roth, RN, MS, MPH; Johnese Spisso, RN, MPA; Bruce Siegel, MD; John Bluford, III; Leon Haley, MD, MHSA; Susan Moffatt-Bruce, MD, PhD; Melissa Stafford Jones

Excused: Christine Neuhoff, JD; Reuven Pasternak, MD; Donald Goldmann, MD; Alan Weil, JD; Winston Wong, MD; Richard Lofgren, MD, MPH

Staff: Linda Cummings, PhD; Rhonda Gold

Board of Directors Chair Wang called the meeting to order and stated that the agenda was for the board to review the 2013 year-end projection and approve the 2014 proposed budget. He turned the meeting to Roth, treasurer, for presenting financial materials.

Roth stated that the Institute finance committee reviewed and approved the 2013 financial projection and 2014 proposed budget. She reported that the Centers for Medicare & Medicaid Services (CMS) recently notified the Institute that the Partnership for Patients contract was renewed for option year 1. Roth said the 2013 projected financial update reflects projected unrestricted income of \$6.49 million, including \$4.14 million from CMS and \$6.36 million in expenses, leaving an unrestricted operating surplus of \$131,000. The projected surplus is \$33,000 less than last projected in October because of more uncovered staff time spent finalizing the Aetna grant. After taking into account last year's beginning net assets, staff projects total 2013 net assets of \$2.19 million, including \$1.09 million in temporarily restricted net assets. There were no questions asked.

Roth presented the 2014 proposed budget, which includes budgeted activities for 2014 to support the association's new, five-year strategic plan. She summarized the grant and contract awards reflected in the proposed budget, and stated that the budget does not include a four-year, \$910,000 proposal for a partnership with AcademyHealth. The proposed budget reflects unrestricted income of \$7.41 million and budgeted expenses of \$7.21 million, leaving an unrestricted operating surplus of \$196,000. Total budgeted net assets (restricted and unrestricted) are \$1.53 million, of which \$241,100 is temporarily restricted and \$1.28 million is unrestricted net assets. Gold offered to provide additional detail on individual budget line items.

Bluford asked the number of staff working solely on the Partnership for Patients contract, to which Gold responded 11 to 12 staff. He asked about the impact of the contract not being renewed in future years, to which Siegel responded that a contingency plan for Partnership for Patients



staffing was developed six months ago. Siegel noted the significance of CMS calling this renewal “option year 1,” which signals the agency’s possible intent to have future option years. Wang asked for a status update on the AcademyHealth proposal; Cummings responded that the Institute should be notified in late February to early spring. There were no other questions.

Spisso made a motion to accept the 2013 financial update, Bluford seconded the motion, and the board unanimously accepted the update. Haley made a motion to approve the 2014 proposed budget, Jacobs seconded the motion, and the board unanimously approved the 2014 proposed budget. Neuhoff and Pasternak voted by email.

Gold presented a long-range financial forecast through 2017 for the association and Institute. She said the purpose of the forecast was to project the amount of revenue enhancements or expense reductions the organization would need to maintain an annual 5 percent profit margin. She reviewed the budget assumptions and stated that to achieve an annual 5 percent profit margin through revenue enhancements, expense reductions, or a combination, approximately a 2 percent to 3 percent reduction in overall annual operating expenses would need to be achieved. Siegel said this information is a guide for the leadership team. Questions were addressed and the financial forecast and budget discussions were completed.

Wang noted Cummings’ retirement and thanked her for her hard work and service to the Institute. He stated that this will be Cummings’ last board meeting. Cummings thanked board members for their support.

Wang adjourned the meeting.

Submitted by:

A handwritten signature in black ink, appearing to read "Caroline Jacobs".

Caroline Jacobs, Secretary



DATE March 24, 2014
TO Board of Directors
FROM Rhonda Gold, CFO
RE Financial Update

MEMORANDUM

This memorandum updates you on the 2013 financial results compared with the last projection presented in December and, presents proposed revisions to the 2014 approved budget. Our audit fieldwork began on February 24; audited financial statements will be forwarded to you once the audit and compliance committee reviews and finalizes them. For your information, copies of the auditor's engagement and planning letters are included with this material.

Please note that staff is asking the board to vote on the following **action items**, as explained in this memo:

- Revise the 2014 approved budget to reflect the elimination of \$485,000 in support from the association.
- Approve the revised 2014 budget.

2013:

Presented in attachment I is an updated financial report compared with the last projection, as presented in December; attachment II reflects the 2014 approved and revised budget. Based on documentation received from the Centers for Medicare & Medicaid Services (CMS) acknowledging the change in scope for the Partnership for Patients initiative, the auditors have reclassified the unexpended 2012 and 2013 budget funds from a liability and recognized it as earned revenue in 2013. This reclassification amounts to \$4.3 million in revenue and is reflected in the ending net asset balance on the financial statements. The Institute's leadership team will develop proposals for spending these funds on new programs or expanding current ones. We plan to present these ideas to the board once they are developed.

For 2013, column 1 of attachment I reflects unrestricted revenue of \$10.7 million, which is offset by \$5.98 million in expenses, leaving an unrestricted operating surplus of \$4.78 million. This surplus is \$4.65 million more than last projected due to the recognition of the income from CMS. After taking into account last year's beginning net assets, total net assets are \$7.74 million, of which almost \$2 million is temporarily restricted for existing grants, leaving an operational reserve ("unrestricted") of \$5.74 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.

For informational purposes, a Statement of Financial Position is presented in Attachment VI.



2014 Revised Budget:

Attachment II presents the 2014 approved budget; Attachment III presents the revised budget. Because of the Institute's healthy net asset balance from 2013, the 2014 budgeted contribution (of \$485,000) from the association is no longer needed to support uncovered Institute labor and programmatic costs for research work and the Transformation Center. The association will retain these funds to support ongoing activities for advocacy, policy, communications, and member services. Therefore, the revised budget reflects this reduction in revenue.

Other budget changes affecting revenue include these:

- The approved budget assumed \$5.17 million in renewal funding from CMS for the Partnership for Patients initiative (December 9, 2013, to December 9, 2014); actual funding amounted to \$5.5 million for option year 1 (of which \$64,000 was spent in December 2013). This additional funding helps offset the elimination of support from the association. The net effect to budgeted 2014 revenue is an increase of \$323,300.
- The \$1.8 million award from KP for 2014 Preparations by Community Health Centers work includes \$1.26 million in subcontractor fees paid directly to The George Washington University and National Association of Community Health Centers. Since the Institute is the prime contractor on this award, the auditors reclassified the full award in 2013 to temporarily restricted net assets; the approved budget reflected these pass-through costs as a liability. Therefore, we have changed the presentation of these costs in the revised budget (increasing revenue and sub-contractor expenses by \$580,000). The budget now reflects the release of these funds from temporarily restricted net assets.

Budget changes affecting expenses include these:

- Staff salary market adjustments recommended by our outside consultant, RSC Advisory Group. After conducting a staff-wide compensation study (the most recent one was in 2010), the findings indicate that many positions were paid, on average, 10 percent below market. To retain and recruit talented staff, we tried to adjust staff salaries as much as possible.
- An unbudgeted position for a manager of innovation and partnerships. This position will report to the senior vice president of leadership and innovation, and be responsible for developing the Transformation Center's new initiatives in clinical transformation and innovation and expanding America's Essential Hospitals' non-dues revenue.

The budget implications for these personnel changes are \$165,000 in unbudgeted costs.

After accounting for these changes, the revised budget reflects an operating deficit of \$80,000, representing a reduction of \$276,000 from the approved operating surplus (of \$196,000). This deficit can be more than supported by the \$5.66 million in unrestricted net assets. **We are**



pleased to report that, for the first time in its history the Institute is self-supporting, thus accomplishing an organizational goal.

Long-term financial forecast:

As we refine the budget number for the association's move to new office space, we have found that it substantially exceeds our initial estimates. At this early juncture in the planning phase, our architects estimate an office space footprint of 17,000 to 20,000 square feet to accommodate a large board room and staff growth. Because our current rental rate is *significantly* below market, we can expect to see up to a 65 percent increase in the square footage cost (increasing our rent from \$42.50 to \$70 per square foot). Our annual rent expense could increase from \$780,000 to \$1.4 million, assuming a new office of 20,000 square feet. We are hopeful the landlord will offer an eight- to 10-month rent abatement to offset some of these costs. However, for financial statement purposes, this abatement is amortized over the length of the lease (10 years, 11 months).

We are estimating a total office move budget of \$4 million (for 20,000 square feet), of which \$1.7 million should be reduced by a landlord's tenant improvement allowance, for a net cost of \$2.3 million. This estimate includes build-out costs for the architect and construction, audio-video infrastructure, furniture, a telephone system, computers and office move expenses. Many of these expenses are depreciable over a three- to five-year period, while the space build-out is amortizable over the life of the lease (assuming 10 years). We will keep you apprised of this budget as we move forward, as these are very preliminary estimates.

To account for these costs, an updated financial forecast is presented in attachments IV and V for the association *and* Institute. Attachment IV presents our *current* dues structure, with two new members per year and 20,000 square feet of space. Attachment V reflects our *proposed* dues restructure with a net loss of two members in 2015, a net gain of two new members in 2016 and 2017, and 20,000 square feet of space.

The purpose of this forecast is to project the amount of revenue enhancements, expense reductions, or a combination that the organization would need to maintain an annual 5 percent profit margin. Because of the move and increased personnel costs, we will have to make some difficult decisions to meet a 5 percent profit margin. The last three columns (2015-2017) present scenarios for expense reductions or income increases (or combination) to maintain a 5 percent profit margin, under the following assumptions:

Revenue:

- dues revenue: 5 percent annual dues increase and net gain of two full members annually, under our current dues structure
- UHC dues and sponsorships: 2 percent annual increase
- external sponsorships: 2 percent annual increase
- grants and contracts:
 - 2015 assumes no Kaiser Permanente (KP) core funding of the Transformation Center (grant ends December 2014); \$428,000 for KP collaboration with the



- National Association of Community Health Centers; and \$258,000 in new funding.
- 2016 and 2017 assumes \$312,000 in grant funding.
- Our Partnership for Patients contract is assumed to be renewed each year
- program fees: 3 percent annual increase

Expenses:

- personnel: 4 percent merit increases; executive compensation changes based on market; 25 percent increase in health insurance premiums starting in 2015; and same FTEs as in 2014
- consultants/subcontractors (non-grant): 3 percent inflationary increase
- operations and programmatic expenses: 3 percent inflationary increase
- rent: 20,000 square feet at \$70 per square foot in 2016, increased by 4 percent in 2017. Assumes an eight-month rent abatement amortized over 10 years (\$86,000 per year)
- project development costs: \$200,000 per year
- Office build-out and relocation expenses of \$735,000 in 2015 and \$453,000 in 2016 and 2017; many of these expenses represent the depreciable or amortizable cost over three, five and 10 years.

To cover the additional rental costs and the build out, we would need to implement new revenue enhancements, expense reductions, or a combination. Under the existing dues structure, these measures would equate to an 8 percent to 9 percent reduction in overall annual operating expenses, revenue enhancements, or a combination. Under the dues restructure, these measures would equate to a 6 percent to 7 percent change.

We are hopeful that by recruiting new members, seeking additional non-dues revenue and grant funding opportunities, and reducing operating expenses, we will achieve our profit margin goal. As we have better budget estimates for the move, we will share those with you.

Attachment I:	2013 financial update
Attachment II:	2014 approved budget
Attachment III:	2014 revised budget
Attachment IV:	Three-year financial forecast under current dues structure
Attachment V:	Three-year financial forecast under dues restructure
Attachment VI:	Statement of Financial Position as of December 31, 2013

ATTACHMENT I

**Statement of Functional Expenses: 2013 Audit vs Prior Projection
For the Year Ended December 31, 2013**

		2013 Year-end Projection						2013 Audit						column 1			column 2		
		Total Programs: Unrestricted	Total Programs: Temporarily Restricted	Total Grants	Partnerships for Patients	Research	Transf. Center & Fellows	Gen. and Administrative	Total Programs: Unrestricted	Total Programs: Unrestricted	Total Temporarily Restricted	Total Unrestricted	Total Programs: Unrestricted	Total Temporarily Restricted	Total Unrestricted	Total Programs: Unrestricted	Total Temporarily Restricted	Total Unrestricted	Total
REVENUE:																			
Unrestricted Grant from UHC	\$ 350,000	\$ 1,057,300	\$ 350,000	\$ 350,000	\$ 1,746,100	\$ 1,065,049	\$ 7892,800	\$ 500,000	\$ 350,000	\$ 1,565,049	\$ 350,000	\$ 1,949,769	\$ 350,000	\$ 507,749	\$ 1,260,969	\$ -	\$ -	\$ 1,768,718	
Grant Income	\$ 4,144,000	\$ 240,000	\$ 4,144,000	\$ 240,000	\$ -	\$ -	\$ -	\$ 246,000	\$ -	\$ 246,000	\$ 9,118	\$ 9,118	\$ 246,000	\$ 6,000	\$ 9,118	\$ -	\$ 6,000	\$ 374,800	
Government Contract																			
Fellows Program																			
Investment Income																			
Miscellaneous																			
Contribution/Support from Association																			
Net Assets Released from Donor Restrictions	\$ 700,000	\$ -	\$ 700,000	\$ 700,000	\$ 1,082,000	\$ 1,082,000	\$ 490,000	\$ 210,000	\$ 700,000	\$ 700,000	\$ 700,000	\$ 700,000	\$ 700,000	\$ 700,000	\$ 200	\$ 200	\$ 200	\$ 200	200
TOTAL REVENUE	\$ 6,491,300	\$ 6,098,100	\$ (393,200)	\$ 1,065,049	\$ 7,492,800	\$ 490,000	\$ 956,000	\$ 359,318	\$ 10,763,167	\$ 504,693	\$ 112,677,860	\$ 4,271,867	\$ 897,893	\$ 5,169,160	\$ 363,076	\$ 363,076	\$ 363,076	\$ 363,076	\$ 363,076
Salaries and employee benefits	\$ 3,690,000	\$ 3,690,000	\$ 363,324	\$ 1,748,623	\$ 331,853	\$ 557,188	\$ 627,967	\$ 3,628,955	\$ 3,628,955	\$ 3,628,955	\$ 3,628,955	\$ 3,628,955	\$ 3,628,955	\$ 3,628,955	\$ 61,045	\$ -	\$ -	\$ 61,045	
Equipment and Furniture	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 16,440	\$ 16,440	\$ 16,440	\$ 16,440	\$ 16,440	\$ 16,440	\$ 16,440	\$ (30,382)	\$ -	\$ -	\$ (30,382)	
Office Supplies & Services	\$ 200,200	\$ 200,200	\$ 200,200	\$ 1,613	\$ 43,694	\$ 19,397	\$ 36,560	\$ 131,574	\$ 232,838	\$ 232,838	\$ 232,838	\$ 232,838	\$ 232,838	\$ 232,838	\$ (32,638)	\$ -	\$ -	\$ (32,638)	
Travel & meetings	\$ 334,900	\$ 630,400	\$ 334,900	\$ 630,400	\$ 36,472	\$ 252,380	\$ 112,936	\$ 29,086	\$ 352,851	\$ 352,851	\$ 352,851	\$ 352,851	\$ 352,851	\$ 352,851	\$ (28,398)	\$ -	\$ -	\$ (28,398)	
Dep't and a'mort.	\$ 107,600	\$ 1208,500	\$ 107,600	\$ 1208,500	\$ 558,606	\$ 67,383	\$ 42,613	\$ 67,253	\$ 30,023	\$ 97,406	\$ 97,406	\$ 97,406	\$ 97,406	\$ 97,406	\$ 10,194	\$ -	\$ -	\$ 10,194	
Consultants & sub-contracted svces	\$ 60,000	\$ 60,000	\$ 60,000	\$ 28,700	\$ 100,000	\$ 960,015	\$ 2,705,588	\$ 414,114	\$ 790,377	\$ 1,108,105	\$ 5,978,199	\$ 5,978,199	\$ 5,978,199	\$ 5,978,199	\$ 1213,191	\$ (4,691)	\$ -	\$ (4,691)	
Information Technology	\$ 28,700	\$ 100,000	\$ 100,000	\$ 6,360,300	\$ 6,360,300	\$ 86,217	\$ 613,564	\$ 65,617	\$ (765,338)	\$ 342,707	\$ 5,978,199	\$ 5,978,199	\$ 5,978,199	\$ 5,978,199	\$ 34,711	\$ 25,289	\$ -	\$ 25,289	
Misc. Taxes and Insurance	\$ -	\$ -	\$ -	\$ 6,360,300	\$ 6,360,300	\$ 3,219,152	\$ 414,114	\$ 855,994	\$ 504,693	\$ 16,611	\$ 4,784,958	\$ 4,784,958	\$ 4,784,958	\$ 4,784,958	\$ 24,567	\$ 24,567	\$ -	\$ 4,133	
Project Development	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 100,000	\$ -	\$ -	\$ 100,000	
Sub-total before grant overhead coverage	\$ 6,360,300	\$ -	\$ 6,360,300	\$ -	\$ 6,360,300	\$ -	\$ 6,360,300	\$ -	\$ 6,360,300	\$ -	\$ 6,360,300	\$ -	\$ 6,360,300	\$ -	\$ 382,101	\$ -	\$ -	\$ 382,101	
All location of Overhead to Grants																			
TOTAL EXPENSES	\$ 6,360,300	\$ -	\$ 6,360,300	\$ -	\$ 6,360,300	\$ -	\$ 6,360,300	\$ -	\$ 6,360,300	\$ -	\$ 6,360,300	\$ -	\$ 6,360,300	\$ -	\$ 382,101	\$ -	\$ -	\$ 382,101	
CHANGE IN NET ASSETS	\$ 131,000	\$ (393,200)	\$ (262,200)	\$ 18,817	\$ 4,273,648	\$ 75,886	\$ 100,006	\$ 16,611	\$ 4,784,958	\$ 504,693	\$ 5,289,661	\$ 4,653,968	\$ 4,653,968	\$ 4,653,968	\$ 897,893	\$ 897,893	\$ 5,551,861	\$ 5,551,861	
Net Assets:																			
Prior Year Net Assets	\$ 961,990	\$ 1,491,368	\$ 2,453,358	\$ (6,707)	\$ 290,706	\$ (51,450)	\$ 31,754	\$ 697,686	\$ 961,990	\$ 1,491,368	\$ 2,453,358	\$ 2,453,358	\$ 2,453,358	\$ 2,453,358	\$ 4,653,968	\$ 4,653,968	\$ 4,653,968	\$ 4,653,968	
Change in Net Assets	\$ 131,000	\$ 1,092,990	\$ 1,092,990	\$ (393,200)	\$ (262,200)	\$ 18,817	\$ 4,273,648	\$ 75,886	\$ 100,006	\$ 16,611	\$ 4,784,958	\$ 5,289,661	\$ 5,289,661	\$ 5,289,661	\$ 4,653,968	\$ 4,653,968	\$ 4,653,968	\$ 4,653,968	
Net Assets, End of Year	\$ 1,092,990	\$ 1,092,990	\$ 1,092,990	\$ 1,092,990	\$ 1,092,990	\$ 1,092,990	\$ 1,092,990	\$ 1,092,990	\$ 1,092,990	\$ 1,092,990	\$ 1,092,990	\$ 1,092,990	\$ 1,092,990	\$ 1,092,990	\$ 897,893	\$ 897,893	\$ 897,893	\$ 897,893	
Restricted Net Assets																			
Unrestricted Net Assets																			
Total Net Assets	\$ 1,092,990	\$ 1,092,990	\$ 1,092,990	\$ 1,092,990	\$ 1,092,990	\$ 1,092,990	\$ 1,092,990	\$ 1,092,990	\$ 1,092,990	\$ 1,092,990	\$ 1,092,990	\$ 1,092,990	\$ 1,092,990	\$ 1,092,990	\$ 743,019	\$ 743,019	\$ 743,019	\$ 743,019	



ESSENTIAL HOSPITALS INSTITUTE

ATTACHMENT II

Statement of Functional Expenses For the Year Ended December 31, 2014

2014 Approved Budget

	2014 Approved Budget							
	Grants	Partnership for Patients	Research	Transf Center & Fellows	Gen'l and Admin.	Total Programs: Unrestricted	Temporarily Restricted	Total
REVENUE:								
Unrestricted Grant from UHC	\$ -	\$ -	\$ -	\$ -	\$ 350,000	\$ 350,000	\$ -	\$ 350,000
Grant income	\$ 612,000	\$ -	\$ -	\$ 500,000	\$ -	\$ 1,112,000	\$ 250,000	\$ 1,362,000
Government Contract	\$ -	\$ 5,170,500	\$ -	\$ -	\$ -	\$ 5,170,500	\$ -	\$ 5,170,500
Fellows Program	\$ -	\$ -	\$ -	\$ 292,500	\$ -	\$ 292,500	\$ -	\$ 292,500
Contribution/Support from Association	\$ -	\$ -	\$ 360,000	\$ 125,000	\$ -	\$ 485,000	\$ -	\$ 485,000
Net Assets Released from Donor Restrictions	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ (1,107,000)	\$ (1,107,000)
TOTAL REVENUE	\$ 612,000	\$ 5,170,500	\$ 360,000	\$ 917,500	\$ 350,000	\$ 7,410,000	\$ (857,000)	\$ 6,553,000
Salaries and employee benefits								
Office Supplies & Services	\$ 371,700	\$ 1,956,000	\$ 330,000	\$ 492,000	\$ 635,300	\$ 3,785,000	\$ -	\$ 3,785,000
Rent	\$ -	\$ 106,000	\$ 20,000	\$ 34,000	\$ 154,300	\$ 314,300	\$ -	\$ 314,300
Travel & meetings	\$ -	\$ 220,000	\$ -	\$ -	\$ 129,500	\$ 349,500	\$ -	\$ 349,500
Depr and a amort.	\$ 31,700	\$ 327,000	\$ 24,600	\$ 190,400	\$ 110,500	\$ 684,200	\$ -	\$ 684,200
Consultants & sub-contracted svcs	\$ -	\$ -	\$ -	\$ -	\$ 41,000	\$ 41,000	\$ -	\$ 41,000
Information Technology	\$ 128,600	\$ 1,373,000	\$ 48,300	\$ 170,200	\$ 120,000	\$ 1,840,100	\$ -	\$ 1,840,100
Misc, Taxes and Insurance	\$ -	\$ -	\$ -	\$ -	\$ 70,900	\$ 70,900	\$ -	\$ 70,900
Project Development	\$ -	\$ -	\$ -	\$ -	\$ 29,000	\$ 29,000	\$ -	\$ 29,000
Sub-total before grant overhead coverage	\$ 532,000	\$ 3,982,000	\$ 422,900	\$ 886,600	\$ 1,390,500	\$ 7,214,000	\$ -	\$ 7,214,000
Allocation of Overhead to Grants	\$ 80,000	\$ 804,000	\$ -	\$ 62,000	\$ (946,000)	\$ -	\$ -	\$ -
TOTAL EXPENSES	\$ 612,000	\$ 4,786,000	\$ 422,900	\$ 948,600	\$ 444,500	\$ 7,214,000	\$ -	\$ 7,214,000
CHANGE IN NET ASSETS	\$ -	\$ 384,500	\$ (62,900)	\$ (31,100)	\$ (94,500)	\$ 196,000	\$ (857,000)	\$ (661,000)
Net Assets:								
Prior Year Net Assets	\$ 12,110	\$ 4,864,354	\$ 24,436	\$ 131,760	\$ 714,297	\$ 5,746,958	\$ 1,996,061	\$ 7,743,019
Change in Net Assets	\$ -	\$ 384,500	\$ (62,900)	\$ (31,100)	\$ (94,500)	\$ 196,000	\$ (857,000)	\$ (661,000)
Net Assets, End of Year	\$ 12,110	\$ 5,248,854	\$ (38,464)	\$ 100,660	\$ 619,797	\$ 5,942,958	\$ 1,139,061	\$ 7,082,019
Restricted Net Assets	\$ -	\$ 5,248,854	\$ (38,464)	\$ 100,660	\$ 619,797	\$ 5,942,958	\$ -	\$ 5,942,958
Unrestricted Net Assets	\$ 12,110	\$ 5,248,854	\$ (38,464)	\$ 100,660	\$ 619,797	\$ 5,942,958	\$ 1,139,061	\$ 7,082,019
Total Net Assets	\$ 12,110	\$ 5,248,854	\$ (38,464)	\$ 100,660	\$ 619,797	\$ 5,942,958	\$ 1,139,061	\$ 7,082,019

ATTACHMENT III

**Statement of Functional Expenses: 2014 Revised Budget
For the Year Ended December 31, 2014**

	2014 Revised Budget										Change in Budget		
	<u>Grants</u>	<u>Partnership for Patients</u>	<u>Research</u>	<u>Transf Center & Fellows</u>	<u>Gen Land Admin.</u>	<u>Total Programs: Unrestricted</u>	<u>Total Programs: Restricted</u>	<u>Total Temporarily Restricted</u>	<u>Total Temporarily Unrestricted</u>	<u>Total Programs: Unrestricted</u>	<u>Total Temporarily Restricted</u>	<u>Total</u>	
REVENUE:													
Unrestricted Grant from UHC	\$ 1,194,569	\$ -	\$ -	\$ -	\$ 500,000	\$ 350,000	\$ 1,694,569	\$ 250,000	\$ 350,000	\$ 1,944,569	\$ 582,569	\$ -	
Grant Income	\$ -	\$ 5,493,800	\$ -	\$ -	\$ -	\$ 5,493,800	\$ 5,493,800	\$ 292,500	\$ 292,500	\$ 5,201,300	\$ 323,300	\$ -	
Government Contract	\$ -	\$ -	\$ -	\$ -	\$ 292,500	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	
Fellows Program	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	
Contribution/Support from Association	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	
Net Assets Released from Donor Restrictions	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ (1,694,061)	\$ (1,694,061)	\$ (485,000)	\$ (485,000)	\$ -	
TOTAL REVENUE	\$ 1,194,569	\$ 5,493,800	\$ -	\$ 792,500	\$ 350,000	\$ 7,830,869	\$ (1,444,061)	\$ 6,386,808	\$ 420,869	\$ (587,061)	\$ (166,192)		
Salaries and employee benefits	\$ 375,800	\$ 1,958,300	\$ 263,000	\$ 638,400	\$ 714,500	\$ 3,950,000	\$ -	\$ -	\$ 3,950,000	\$ (165,000)	\$ -	\$ (165,000)	
Office Supplies & Services	\$ -	\$ 106,000	\$ 20,000	\$ 34,000	\$ 154,300	\$ 314,300	\$ -	\$ -	\$ 314,300	\$ -	\$ -	\$ -	
Rent	\$ -	\$ 220,000	\$ -	\$ -	\$ 129,500	\$ 349,500	\$ -	\$ -	\$ 349,500	\$ -	\$ -	\$ -	
Travel & meetings	\$ 38,300	\$ 274,200	\$ 24,700	\$ 190,400	\$ 110,600	\$ 638,200	\$ -	\$ -	\$ 638,200	\$ 46,000	\$ -	\$ 46,000	
Depr and amort.	\$ -	\$ -	\$ -	\$ -	\$ 41,000	\$ 41,000	\$ -	\$ -	\$ 41,000	\$ -	\$ -	\$ -	
Consultants & sub-contracted svces	\$ 696,469	\$ 1,383,000	\$ 48,300	\$ 170,200	\$ 120,000	\$ 2,417,969	\$ -	\$ -	\$ 2,417,969	\$ (577,869)	\$ -	\$ (577,869)	
Information Technology	\$ -	\$ -	\$ -	\$ -	\$ 70,900	\$ 70,900	\$ -	\$ -	\$ 70,900	\$ -	\$ -	\$ -	
Misc, Taxes and Insurance	\$ -	\$ -	\$ -	\$ -	\$ 29,000	\$ 29,000	\$ -	\$ -	\$ 29,000	\$ -	\$ -	\$ -	
Project Development	\$ -	\$ -	\$ -	\$ -	\$ 100,000	\$ 100,000	\$ -	\$ -	\$ 100,000	\$ -	\$ -	\$ -	
Sub-total before grant overhead coverage	\$ 1,110,569	\$ 3,941,500	\$ 356,000	\$ 1,033,000	\$ 1,469,800	\$ 7,910,869	\$ -	\$ 7,910,869	\$ (696,869)	\$ -	\$ -	\$ (696,869)	
Allocation of Overhead to Grants	\$ 84,000	\$ 1,145,100	\$ -	\$ 62,000	\$ (1,291,100)	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	
TOTAL EXPENSES	\$ 1,194,569	\$ 5,086,600	\$ 356,000	\$ 1,095,000	\$ 178,700	\$ 7,910,869	\$ -	\$ 7,910,869	\$ (696,869)	\$ -	\$ -	\$ (696,869)	
CHANGE IN NET ASSETS	\$ -	\$ 407,200	\$ (356,000)	\$ (302,500)	\$ (80,000)	\$ 171,300	\$ (1,444,061)	\$ (1,444,061)	\$ (276,000)	\$ (587,061)	\$ (863,061)		
Net Assets:													
Prior Year Net Assets	\$ 12,110	\$ 4,864,354	\$ 24,436	\$ 131,760	\$ 714,297	\$ 5,746,958	\$ 1,996,061	\$ 7,743,019	\$ -	\$ -	\$ -	\$ (587,061)	
Change in Net Assets	\$ -	\$ 407,200	\$ (356,000)	\$ (302,500)	\$ 171,300	\$ (80,000)	\$ (1,444,061)	\$ (1,444,061)	\$ (276,000)	\$ (587,061)	\$ (863,061)		
Net Assets, End of Year	\$ 12,110	\$ 5,271,554	\$ (331,564)	\$ (170,740)	\$ 885,597	\$ 5,666,958	\$ 552,000	\$ 552,000	\$ 552,000	\$ 5,666,958	\$ (276,000)	\$ (863,061)	
Restricted Net Assets	\$ 12,110	\$ 5,271,554	\$ (331,564)	\$ (170,740)	\$ 885,597	\$ 5,666,958	\$ 552,000	\$ 552,000	\$ 552,000	\$ 5,666,958	\$ (276,000)	\$ (863,061)	
Unrestricted Net Assets	\$ 12,110	\$ 5,271,554	\$ (331,564)	\$ (170,740)	\$ 885,597	\$ 5,666,958	\$ 552,000	\$ 552,000	\$ 552,000	\$ 5,666,958	\$ (276,000)	\$ (863,061)	
Total Net Assets	\$ 12,110	\$ 5,271,554	\$ (331,564)	\$ (170,740)	\$ 885,597	\$ 5,666,958	\$ 552,000	\$ 552,000	\$ 552,000	\$ 5,666,958	\$ (276,000)	\$ (863,061)	

ATTACHMENT IV

CURRENT DUES STRUCTURE
 Two new member per year, 5% dues increase
 assumes 20,000 sq ft for new space

- Assumptions:**
 - New Lobbyist and 2 new research positions and Manager of Innovations
 - Current Dues Structure with 2 new members per year
 Goal of 5% profit margin

Revenue:	Dues	existing dues structure					Expense Reduction	Income Increase	Expense Reduction	Income Increase
		2013 actuals	2014 revised	2015	2016	2017				
Revenue:										
Dues	\$ 4,627,383	\$ 5,153,100	\$ 5,471,708	\$ 5,872,963	\$ 6,300,663	\$ 6,741,228				
UHC (note 2)	\$ 3,431,400	\$ 3,500,000	\$ 3,570,000	\$ 3,641,400	\$ 3,714,998	\$ 3,785,996				
Sponsorships (note 2)	\$ 204,495	\$ 245,000	\$ 249,900	\$ 254,898	\$ 261,000	\$ 268,000				
Grants (note 3)	\$ 1,665,050	\$ 1,694,569	\$ 686,505	\$ 317,000	\$ 5,692,500	\$ 5,787,000				
Gov. Contract (note 4)	\$ 3,584,687	\$ 5,493,800	\$ 468,341	\$ 399,991	\$ 411,991	\$ 424,991				
Gov. Contract (note 4) - release of deferred revenue	\$ 4,308,143	\$ 416,953								
Program Fees (note 5)	\$ 454,700									
Total Revenue	\$ 18,138,111	\$ 16,541,169	\$ 16,138,954	\$ 16,273,252	\$ 16,795,878	\$ 16,200,000	\$ 17,600,000	\$ 18,000,000	\$ 16,300,000	\$ 18,525,000
rev enhancements										
Expenses:										
Personnel (note 6), incl manager of innov.	\$ 7,016,795	\$ 8,090,000	\$ 8,700,000	\$ 9,048,000	\$ 9,409,920	\$ 9,409,920				
Retainer/Consultants/Subcontractors, non-contract (note 7)	\$ 652,512	\$ 655,000	\$ 674,650	\$ 694,890	\$ 715,736	\$ 715,736				
Operations (note 8)	\$ 656,900	\$ 1,014,500	\$ 1,044,935	\$ 1,076,283	\$ 1,108,572	\$ 1,108,572				
Rent (new space in 2016 for 20kst @ \$70 psf) (note 9)	\$ 702,581	\$ 733,800	\$ 777,300	\$ 1,400,000	\$ 1,456,000	\$ 1,456,000				
Rent abatement (8 mos)-amortized over 10yrs										
Grants/contracts, non-personnel (note 10)	\$ 1,301,276	\$ 2,527,646	\$ 2,067,864	\$ 1,812,700	\$ 1,772,700	\$ 1,772,700				
Research, TCA Fellows, non-personnel (note 11)	\$ 315,450	\$ 457,800	\$ 471,534	\$ 485,680	\$ 500,250	\$ 500,250				
Polio/Advocacy/Connex (note 11)	\$ 764,040	\$ 1,010,200	\$ 1,040,507	\$ 1,071,722	\$ 1,103,874	\$ 1,103,874				
Mem. Svcs/Events (note 11)	\$ 647,562	\$ 842,600	\$ 887,878	\$ 914,514	\$ 941,950	\$ 941,950				
Rebranding	\$ 166,322	\$ 100,000	\$ 100,000	\$ -	\$ 200,000	\$ 200,000				
Project Development	\$ -	\$ 200,000	\$ 200,000	\$ 200,000	\$ 200,000	\$ 200,000				
Total Expenses, excl office move	\$ 12,223,428	\$ 15,631,546	\$ 15,964,668	\$ 16,617,635	\$ 17,122,848	\$ 17,122,848				
Net surplus/(loss) before space buildout & move	\$ 5,914,683	32.61%	\$ 909,623	5.50%	\$ 174,286	1.08%	\$ (344,383)	(2.12%)	\$ (326,970)	(1.95%)
Office build-out and office relocation expenses:										
Amortization of space buildout										
Depreciation on new furniture and telephones										
Signage/Office moves/consultants										
Office move related expenses	\$ -	\$ 212,000	\$ 735,034	\$ 453,654	\$ 453,654	\$ 453,654				
Total Expenses, including office move	\$ 12,223,428	\$ 15,843,546	\$ 16,699,702	\$ 17,071,289	\$ 17,576,502	\$ 17,576,502	\$ 15,360,000	\$ 16,699,702	\$ 15,475,000	\$ 17,071,289
exp reductions										
Net surplus/(loss) after space buildout & move	\$ 5,914,683	32.61%	\$ 697,623	4.22%	\$ (560,749)	(3.47%)	\$ (798,037)	(4.90%)	\$ 640,000	5.12%
Profit Margin Goal										
5.00%	5.00%	5.00%	5.00%	5.00%	5.00%	5.00%	5.00%	5.00%	5.00%	5.00%
Net surplus/(loss) after space buildout & move	\$ 5,914,683	32.61%	\$ 697,623	4.22%	\$ (560,749)	(3.47%)	\$ (798,037)	(4.90%)	\$ 640,000	5.12%
Profit Margin Goal										
5.00%	5.00%	5.00%	5.00%	5.00%	5.00%	5.00%	5.00%	5.00%	5.00%	5.00%

Expense Reductions on expenses necessary for 5% profit margin:	
2015	(\$1,339,702) -8%
2016	(\$1,546,289) -9%
2017	(\$1,601,502) -%

ATTACHMENT V

DUES RESTRUCTURE
NET LOSS Of 2 MEMBERS IN 2015; NET GAIN Of 2 NEW MEMBERS THEREAFTER
 calculation of rent cost to maintain 5% profit margin (20,000 sf)

Assumptions:

- New lobbyist and 2 new research positions and Manager of Innovations
- Dues restructure with \$65k and below immediately phased in; others over 2 year phase in by 2016
- 4 LOSSES resulting from the restructure in 2015, offset by GAIN of 2 NEW members (net loss of 2 members in '15)
- 2 NEW members resulting from dues restructure starting in 2016 and continuing into out-years
- Goal of 5% profit margin

	Dues	2013	2014 revised	with dues restructure				2015	2016	2017	Maintain 5% Margin	Expense Reduction	Income Increase															
				2015	2016	2017	Maintain 5% Margin																					
Revenue:																												
Dues	\$ 4,627,383	\$ 5,153,100	\$ 5,705,304	\$ 6,475,250	\$ 6,942,338	\$ 7,414,228	\$ 7,942,338																					
UHC (note 2)	\$ 3,431,400	\$ 3,500,000	\$ 3,570,000	\$ 3,601,400	\$ 3,641,400	\$ 3,681,400	\$ 3,714,228																					
Sponsorships (note 2)	\$ 245,000																											
Grants (note 3)	\$ 1,585,050	\$ 1,694,469	\$ 686,505	\$ 517,000	\$ 224,000																							
Gov. Contract (note 4)	\$ 3,584,687	\$ 5,493,800	\$ 5,682,500	\$ 5,787,000	\$ 5,885,000																							
Gov. Contract (note 4) - release of deferred revenue	\$ 4,308,143																											
Program Fees (note 5)	\$ 416,953																											
Total Revenue	\$18,138,111	\$ 16,541,169	\$ 16,372,550	\$ 16,875,539	\$ 17,437,552	\$ 16,372,550	\$ 17,970,000	\$16,875,539	\$ 17,600,000	\$ 17,970,000	\$16,875,539	\$ 17,437,552	\$ 18,520,000	\$ 17,970,000	\$ 17,437,552	\$ 18,520,000	\$ 17,970,000	\$ 17,437,552	\$ 18,520,000	\$ 17,970,000	\$ 17,437,552	\$ 18,520,000	\$ 17,970,000	\$ 17,437,552	\$ 18,520,000	\$ 17,970,000	\$ 17,437,552	\$ 18,520,000
Reenhancements																												
Expenses:																												
Personnel (note 6), incl manager of innovations	\$ 7,016,785	\$ 8,090,000	\$ 8,700,000	\$ 9,048,000	\$ 9,409,920	\$ 9,649,920	\$ 9,715,736																					
Consultants/Subcontractors, non-contract (note 7)	\$ 632,512	\$ 655,000	\$ 674,650	\$ 694,890	\$ 715,736																							
Operations(note 8)	\$ 656,900	\$ 1,014,900	\$ 1,044,335	\$ 1,076,283	\$ 1,108,572																							
Rent (new space in 2016 for 20ksf @ \$70psf) (note 9)	\$ 702,581	\$ 733,800	\$ 777,300	\$ 1,400,000	\$ 1,456,000																							
Rent abatement (8 mos)-amortized over 10yrs	\$ -																											
Grants/contracts, non-personnel (note 10)	\$ 1,301,276	\$ 2,527,646	\$ 2,067,864	\$ 1,812,700	\$ 1,772,700																							
Research, TC & Fellows, non-personnel (note 11)	\$ 315,450	\$ 457,800	\$ 471,534	\$ 485,680	\$ 500,250																							
Policy/Advocacy/Comm's (note 11)	\$ 764,040	\$ 1,010,200	\$ 1,040,507	\$ 1,071,722	\$ 1,103,874																							
Mem Svcs/Events (note 11)	\$ 647,562	\$ 842,600	\$ 887,878	\$ 914,514	\$ 941,950																							
Rebranding	\$ 166,322	\$ 100,000	\$ 100,000	\$ -	\$ -																							
Project Development	\$ -	\$ 200,000	\$ 200,000	\$ 200,000	\$ 200,000																							
Total Expenses, excl office move	\$12,223,428	\$ 15,631,546	\$ 15,964,668	\$ 16,617,635	\$ 17,122,848																							
Net surplus/(loss) before space buildout & move	\$5,914,683	32.61%	\$ 909,623	5.50%	\$ 407,882	2.49%	\$ 257,904	1.33%	\$ 314,704	1.80%																		
Office build-out and office relocation expenses:																												
Amortization of space buildout																												
Depreciation on new furniture and telephones																												
Signage/Office movers/consultants																												
Office move related expenses	\$ -	\$ 212,000	\$ 735,034	\$ 453,654	\$ 453,654																							
Total Expenses, including office move	\$12,223,428	\$ 15,843,546	\$ 16,699,702	\$ 17,071,289	\$ 17,576,502																							
exp reductions																												
Net surplus/(loss) after space buildout & move	\$ 5,914,683	32.61%	\$ 697,621	4.22%	\$ (327,152)	(2.00%)	\$ (195,750)	(-1.16%)	\$ (138,950)	(-0.80%)	\$ 5,02%	\$ 822,550	5.00%	\$ 50,539	5.12%	\$ 50,539	5.12%	\$ 50,539	5.12%	\$ 50,539	5.12%	\$ 50,539	5.12%	\$ 50,539	5.12%	\$ 50,539	5.12%	
Profit Margin Goal	\$623	5.00%																										

Expense Reductions on expenses necessary for 5% profit margin:	
2015	(\$1,149,702) -7%
2016	(\$1,046,289) -6%
2017	(\$1,026,502) -6%

**ATTACHMENT VI**

ESSENTIAL HOSPITALS INSTITUTE
STATEMENT OF FINANCIAL POSITION
As OF DECEMBER 31, 2013

ASSETS	2013
CURRENT ASSETS	
Cash and cash equivalents	\$ 6,781,243
Grants Receivable	\$ 1,401,810
Contract Receivable	\$ 463,221
Due from EHEN	\$ 48,113
Prepaid Expenses	<u>\$ 32,625</u>
Total current assets	<u>\$ 8,727,012</u>
FURNITURE, EQUIPMENT AND LEASEHOLD IMPROVEMENTS	
Furniture, Equipment & Software	\$ 437,005
Leasehold and improvement	<u>\$ 78,839</u>
Less Accumulated depreciation and amortization	<u>\$ 515,844</u>
Net furniture, equipment and leasehold improvements	<u>\$ 86,541</u>
Other Assets	
Deposits	<u>\$ 2,145</u>
Total Other Assets	<u>\$ 2,145</u>
TOTAL ASSETS	<u>\$ 8,815,698</u>
LIABILITIES AND NET ASSETS	
CURRENT LIABILITIES	
Accounts Payable	\$ 459,290
Due to Association	\$ 55,007
Due from EHEN	\$ 48,113
Accrued Expenses	\$ 46,674
Deferred Grant Income	\$ 398,499
Rent Abatement	<u>\$ 65,100</u>
Total current liabilities	<u>\$ 1,072,683</u>
Total Liabilities	<u>\$ 1,072,683</u>
NET ASSETS	
Unrestricted	\$ 5,746,957
Temp Restricted	<u>\$ 1,996,058</u>
Total Net Assets	<u>\$ 7,743,015</u>
Total Liabilities and Net Assets	<u>\$ 8,815,698</u>



**GELMAN, ROSENBERG
& FREEDMAN**

CERTIFIED PUBLIC ACCOUNTANTS



February 19, 2014

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

We are engaged to audit the financial statements of the Essential Hospitals Institute (EHI) for the year ended December 31, 2013. Professional standards require that we provide you with the following information related to our audit. If you have any questions or concerns regarding your audit, please feel free to contact us and we can arrange a meeting or conference call to discuss this information in further detail.

Our Responsibility under U.S. Generally Accepted Auditing Standards

As stated in our engagement letter dated January 29, 2014, our responsibility, as described by professional standards, is to express an opinion about whether the financial statements prepared by management with your oversight are fairly presented, in all material respects, in conformity with U.S. generally accepted accounting principles. Our audit of the financial statements does not relieve you or management of your responsibilities.

Our responsibility is to plan and perform the audit to obtain reasonable, but not absolute, assurance that the financial statements are free of material misstatement. As part of our audit, we considered the internal controls of EHI. Such considerations were solely for the purpose of determining our audit procedures and not to provide any assurance concerning such internal control. We are responsible for communicating significant matters related to the audit that are, in our professional judgment, relevant to your responsibilities in overseeing the financial reporting process. However, we are not required to design procedures specifically to identify such matters. We are also responsible for communicating particular matters required by law, regulation, agreement or other requirements applicable to the engagement.

4550 MONTGOMERY AVENUE, SUITE 650 NORTH, BETHESDA, MARYLAND 20814
(301) 951-9090 • FAX (301) 951-3570 • WWW.GRFCPA.COM

MEMBER OF CPAmerica INTERNATIONAL, AN AFFILIATE OF HORWATH INTERNATIONAL
MEMBER OF THE AMERICAN INSTITUTE OF CERTIFIED PUBLIC ACCOUNTANTS' PRIVATE COMPANIES PRACTICE SECTION



**Essential Hospitals Institute
Audit Engagement – December 31, 2013**

-2-

Planned Scope and Timing of the Audit

An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements; therefore, our audit will involve judgment about the number of transactions to be examined and the areas to be tested.

Our audit will include obtaining an understanding of EHI and its environment, including internal control, sufficient to assess the risks of material misstatement of the financial statements and to design the nature, timing, and extent of further audit procedures. Material misstatements may result from (1) errors, (2) fraudulent financial reporting, (3) misappropriation of assets, or (4) violations of laws or governmental regulations that are attributable to the entity or to acts by management or employees acting on behalf of EHI. We will generally communicate our significant findings at the conclusion of the audit. However, some matters could be communicated sooner, particularly if significant difficulties are encountered during the audit where assistance is needed to overcome the difficulties or if the difficulties may lead to a modified opinion. We will also communicate any internal control related matters that are required to be communicated under professional standards.

We expect to begin our audit on February 24, 2014 and complete your audit and information returns and issue at the conclusion of the audit and tax process.

This information is intended solely for the use of the Board of Directors and management of the Essential Hospitals Institute and is not intended to be, and should not be, used by anyone other than these specified parties.

Gelman Rosenberg & Freedman

February 19, 2014



GELMAN, ROSENBERG & FREEDMAN

CERTIFIED PUBLIC ACCOUNTANTS



January 29, 2014

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

Dear Ms. Gold:

We are pleased to confirm our understanding of the services we are to provide for Essential Hospitals Institute for the year ended December 31, 2013.

We will audit the statement of financial position of Essential Hospitals Institute as of December 31, 2013, and the related statements of activities and change in net assets, functional expenses and cash flows for the year then ended.

We will also prepare Essential Hospitals Institute's Federal Form 990, Return of Organization Exempt from Income Tax, for the year ended December 31, 2013.

Audit Objective

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

Audit Procedures

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

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**Essential Hospitals Institute
Audit Engagement – December 31, 2013**

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

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

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

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

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



**Essential Hospitals Institute
Audit Engagement – December 31, 2013**

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Management Responsibilities

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

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

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

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

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

Engagement Administration, Fees and Other

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



**Essential Hospitals Institute
Audit Engagement – December 31, 2013**

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

We estimate that our fee for these services will be \$26,000. We will bill you only for the time expended, plus out-of-pocket costs such as travel, report production, typing, postage, etc. Additional expenses are estimated to be \$500. The fee estimate is based on anticipated cooperation from your personnel and the assumption that unexpected circumstances will not be encountered during the audit. Our invoices will be rendered each month as work progresses and are payable on presentation. If we elect to terminate our services for nonpayment, our engagement will be deemed to have been completed upon written notification of termination, even if we have not completed our report. You will be obligated to compensate us for all time expended and to reimburse us for all out-of-pocket expenditures through the date of termination.

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

Sincerely,

GELMAN, ROSENBERG & FREEDMAN

Amy Boland

Amy Boland
Certified Public Accountant

RESPONSE:

This letter correctly sets forth the understanding of Essential Hospitals Institute.

J. Mandel, DMD

Officer Signature

CFO

Title

2/4/14

Date



DATE March 24, 2014
TO Board of Directors
FROM Caroline Jacobs, Education Committee Co-Chair
RE Education Committee Report

MEMORANDUM

On behalf of the education committee, I am pleased to share the following update on 2014 educational programming.

1115 Delivery System Reform Incentive Payment (DSRIP) Waivers

Staff has organized a comprehensive educational work plan focusing on section 1115 waivers to include a webinar series, sessions at the annual conference, two written products, and possible one-day workshop.

2014 Webinar Series	VITAL2014 Breakout Sessions
December 17, 2013 “Medicaid Payments to Incentivize Delivery System Reform” Attendance: 64 Avg. Satisfaction Score: 4.47 (on a 5-point scale)	June 26, 2014 10:45 am - Noon “Learn from Experience: Texas DSRIP Hospitals Share”
February 11, 2014 “DSRIP Waiver Implementation: One Hospital’s Experience” Featured Member: Santa Clara Valley Medical Center in California Attendance: 76 Avg. Satisfaction Score: 4.2 (on 5-point scale)	June 26, 2014 2:25 – 2:45 pm “Recent Trends in DSRIP Waivers”
April 24, 2014 Featured Member: Boston Medical Center	June 26, 2014 3:00 – 3:30 pm “Clinical Improvement through DSRIP Waivers”
July 23, 2014 Featured Member: UT Health Northeast, Texas	



VITAL2014

- **Keynote Speakers**
Confirmed keynote speakers include **Stephen Johnson**, bestselling author, *Where Good Ideas Come From* and *Future Perfect*; and **Rebecca Onie**, co-founder and CEO, Health Leads
- **Post-Conference Workshops**

Sustaining the Gains: How to Maintain Quality Improvement

Current estimates show that as many as 70 percent of improvement projects fail to be sustained. Understanding the 10 factors that impact sustainability is critical to succeeding in today's changing environment.

Lynne Maher, PhD, director of innovation at [Ko Awatea](#) and associate honorary professor of nursing at the University of Auckland, will teach participants how to evaluate their organizational improvement projects and identify actions that will help increase sustainability. Maher will base her discussion on a sustainability model built during her tenure at the National Health Service.

Audience: Clinical leadership

Leading Through the Second Curve: Managing Transformation

Health care leaders are increasingly supporting the push to transition our health care system into one that values high-quality, comprehensive care over volume-driven, episodic care. But they struggle with making this transition.

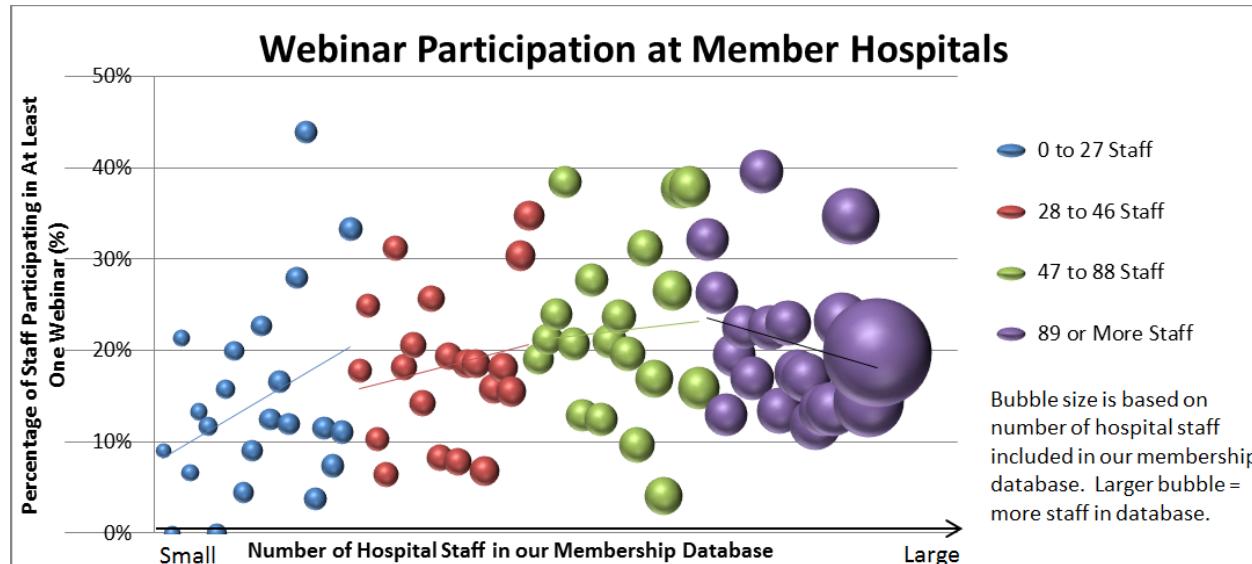
James B. Conway, MS, adjunct lecturer, Department of Health Policy and Management at the Harvard School of Public Health, will review core content on leading and managing change, specifically focusing on adaptive change and navigating through the emerging “second curve” of health care. Driven by the audience, content will include issues on which attendees are specifically focused, including active engagement with the patient, family, public, and community.

Previously, Conway served as senior vice president, Institute for Healthcare Improvement; and executive vice president and chief operating officer, Dana Farber Cancer Institute

Audience: Executive and clinical leadership

2013 Webinar Participation Analysis

In 2013, America's Essential Hospitals and Essential Hospitals Institute conducted 56 distance learning programs (webinars). Of the more than 5,000 people in our database who work for a member hospital or health system, 20 percent participated in at least one webinar in 2013.



Methodology:

A bubble chart helps visually identify trends in data. For this model, the member hospitals were sorted based on their size, from smallest to largest number of staff in our membership database. Then, each hospital was assigned a numerical ID (e.g., 1, 2, 3, etc.) based on size—values ranged from 1 to 81. Quartile measurements on staff size were then used to create four groups of hospital sizes. A bubble chart was created using the assigned numerical value for the x-axis value and the percentage of staff participating in at least one webinar on the yaxis. Bubble size was determined using the actual number of staff at each hospital, with small bubbles representing smaller hospital staff size and larger ones representing hospitals with more staff.

Interpretation of Results:

- Groups 1, 2 and 3: For each of these groups, as the number of staff in the membership database increases, so, too, does the webinar participation. However, as noted by the trend lines, the trend levels off as the number of staff increases.
- Group 4: While participation in the members with the largest number of staff in the database is on par with the other groups, the trend seen in groups 1 to 3 reverses, with participation dropping off as the hospital staff size gets larger.



2014-2015 Fellows Program

Session I June 23-27, 2014 San Antonio Adaptive Leadership: Mobilizing for Change Session Objective: Participants will strengthen the leadership skills needed to mobilize their organization to adapt and thrive in challenging environments.	Session II October 8-10, 2014 Long Beach, California Adaptive Leadership: Leading at the Speed of Trust Session Objective: Participants will gain a heightened sense of self- awareness and understanding regarding diversity issues of self and others.	Session III March 18-20, 2015 Washington, DC Your Essential Hospital Leadership Legacy Session Objective: Participants will gain important communications strategies to formally advocate on behalf of essential hospitals, apply leadership lessons learned through work on projects, and identify techniques for increasing resilience to stress.
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About Cambridge Leadership Associates (CLA)

CLA is an international leadership development practice and the home of Adaptive Leadership™.

Adaptive Leadership emerged from 30-plus years of research at Harvard University by Dr. Ron Heifetz and Marty Linsky, defining the frontier of leadership training and development. Adaptive Leadership provides the framework, skills, and tools for responding to today's unrelenting, adaptive pressures of complexity, uncertainty, and constant change.

CLA generates rapid and measurable impact on organizational agility and leadership effectiveness. Working with companies, government agencies, non-profits, and individuals, CLA is committed to helping them identify their most significant challenges, generate new solutions, and exercise the leadership required to bring them to scale.

Today, CLA comprises a team of experienced consultants working around the globe and skilled in the practical application of Adaptive Leadership.



DATE March 24, 2014
TO Board of Directors
FROM Bruce Siegel, MD, MPH, President and CEO
RE Institute Director

MEMORANDUM

With the retirement of Linda Cummings, PhD, we have an opening for the position of Institute director. Below is the language in our bylaws related to this position.

The Institute Director shall be appointed by the Board of Directors in consultation with the Association President and CEO. The Institute Director shall report to the Association President and CEO. The Institute Director shall serve the role of the president of the Institute and exercise overall management and day to day supervision over the affairs of the Institute; shall discharge the duties of the Chair in the event of the Chair's absence or disability for any cause whatsoever; shall serve as a nonvoting, ex officio member of each committee of the Board; and shall have such other powers and perform such other duties as may be prescribed from time to time by the Board of Directors. The person serving as Institute Director shall not simultaneously serve as Secretary.

I recommend to the board, David Engler, PhD, as Institute director. As you know, he joined America's Essential Hospitals last year as senior vice president for leadership and innovation and provides vision, strategic direction, and oversight for activities supporting its members as they transform into integrated health systems that deliver quality and access to the most vulnerable populations.

His experience lies in quality improvement and safety initiatives in the health care industry. He also is nationally recognized for performance improvement and clinical informatics solutions that lead to improved outcomes and reduced harm. He previously served as vice president at the Ohio Hospital Association, in Columbus, where he led the association's strategic initiatives in quality and safety. He received a bachelor's degree in natural sciences from Case Western Reserve University, in Cleveland, and a master's in preventative medicine and doctorate in economics, both from Ohio State University.

Action: Appoint David Engler as Institute director



DATE March 24, 2014
TO Board of Directors
FROM Caroline Jacobs, Chair, Institute Nominating Committee
RE Board Vacancies

MEMORANDUM

The Institute's nominating committee met February 21 to consider the slate for the annual board elections. The committee also considered candidates for two board vacancies created by the retirement of Melissa Stafford Jones and the unfortunate passing of Jared Loeb. Under our bylaws, such vacancies are filled by a board majority vote.

The committee recommends the following people to fill these unexpired terms:

Erica Murray, President and CEO, California Association of Public Hospitals and Health Systems

Erica Murray serves as president and CEO for the California Association of Public Hospitals and Health Systems (CAPH). 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. Prior to her 2013 appointment, Murray was 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 masters of public policy and administration from Columbia University, and received a bachelor's degree from McGill University, in Montreal, Quebec.

Ann Scott Blouin, Executive Vice President of Customer Relations, The Joint Commission
Ann Scott Blouin, RN, PhD, FACHE, is executive vice president of customer relations at The Joint Commission. In this position, she focuses on building external customer and stakeholder relationships, primarily in the hospital and health system market. Blouin 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.

Action: Vote to approve Erica Murray and Ann Scott Blouin to fill the two board vacancies.



Essential Hospitals Research and Education Activities
Board of Directors Meeting
April 1, 2014

DATE March 24, 2014
TO Board of Directors
FROM David Engler, PhD, Senior Vice President for Leadership and Innovation
RE Activities Report: October 2013–February 2014

MEMORANDUM

Essential Hospitals Institute is the research arm of America's Essential Hospitals. The Institute conducts primary and secondary research on system delivery reform, engages in performance improvement activities, builds leadership capacity through our Fellows Program, supports educational programming, and conducts analytics in support of Americas Essential Hospitals. The Institute communicates to external audiences the vital role member hospitals and health systems have in providing high-quality care to all, especially the most vulnerable.

These are the highlights of the Institute's work since the last meeting of the Institute Board, in September:

- Completed and published the results of the Patient-Centered Outcomes Research Institute (PCORI)-funded grant into chronic care management for the underserved.
- Launched a Kaiser Permanente-funded research project, in partnership with the National Association of Community Health Centers and The George Washington University.
- Secured a third year of funding from the Centers for Medicare & Medicaid Services to continue and expand the work of the Essential Hospitals Engagement Network, with an emphasis on across-the-board harm reduction and equity.
- Developed and implemented a work plan, including webinars and research briefs on Delivery System Reform Incentive Payment (DSRIP) waivers and their impact on quality of care.
- Developed a new curriculum on adaptive leadership for the Fellows class of 2014–2015.
- Conducted analyses on the financial impact that readmissions penalties and value-based purchasing have on our members.
- Continued and expanded our work in the learning collaboratives.

Details about each of these are described in the attached activities report.

We look forward to seeing you in Washington, DC, April 1.



Research Center

Chronic Disease Management in the Safety Net (Contract with PCORI and subcontract with The George Washington University)

PCORI asked Essential Hospitals Institute to conduct a landscape review as part of the development of new request for proposals on chronic disease management in the safety net. From July through December 2013, the Institute reviewed several approaches to delivering care to chronically ill populations, including patient-centered medical homes and accountable care organizations. A literature review, site visits, and interviews with providers at six member hospitals highlighted a wide variety of challenges and facilitators to caring for vulnerable patients with chronic disease.

Specifically, integration of the interview findings and literature reviews revealed five major factors that characterize effective chronic disease care models for vulnerable patients: communication tailored to vulnerable populations, team-based care, customized and personalized care, addressing special populations' needs, and use of data and measurement. The report also highlighted research gaps and made recommendations for future research, which will be called out in PCORI's request for proposals. The findings were presented in January at PCORI's Advisory Meeting on Addressing Disparities, and the final report was published on PCORI's website. In addition, a research brief was published in March 2014.

Transforming Care Delivery in America's Safety Net: Aligning Efforts to Improve Access and Care Coordination

Essential Hospitals Institute, the National Association of Community Health Centers, and The George Washington University (GW) School of Public Health and Health Services are partnering in a commitment to improve vulnerable patients' access and quality of care. With the launch of "Transforming Care Delivery in America's Safety Net: Aligning Efforts to Improve Access and Care Coordination," funded by Kaiser Permanente Community Benefit, the partnership is currently focused on identifying strategies for collaboration between essential hospitals and community health centers, as well as identifying effective models of integration and care coordination across different settings and communities.

Between October 2013 and January 2014, the Partnership completed more than 60 interviews across 32 states to obtain baseline information about partnerships between essential hospitals and community health centers, and their readiness for 2014 health reforms. In addition, the partnership identified five communities in five states where essential hospitals and community health centers would collaborate around relevant policy issues: Atlanta, Cleveland, Denver, Detroit, and Richmond.

The interviews also identified six areas of potential work within the communities, including Medicaid expansion, outreach and enrollment, government funding streams, workforce capacity, qualified health plans, and payment and delivery system reforms. The partnership has engaged each of the communities and will support the local collaborations by providing funding and



technical assistance throughout their two-year projects. GW will evaluate this work and lead the development of case studies, which will highlight successes, challenges, and lessons learned through hospital-health center collaborations.

Behavioral Health

Essential Hospitals Institute is conducting a study on the integration of behavioral and physical health in essential hospitals. The Institute interviewed providers and staff at Contra Costa Health Services, New York City Health and Hospitals Corporation, Hennepin County Medical Center, and Eskenazi Health (formerly Wishard Health Services) between October and December 2013.

The Institute found that each of the hospitals and health systems use innovative strategies and practices to integrate physical and behavioral health, such as ambulatory intensive care for patients with addiction and persistent mental health needs; an evidence-based care model for integration of services, with each stage providing progressively more intensive behavioral health services; staff training; and flexibility in service integration with specialty and community clinics. The interviews and literature review will identify a set of factors that support the integration of behavioral and physical health. Findings will be published in a research brief, to be released in June.

1115 Medicaid Waivers

Recently, essential hospitals in California, Massachusetts, and Texas have participated in Medicaid 1115 waiver demonstration projects, and other states are expected to join this movement. In March 2013, Essential Hospitals Institute released its first brief on this topic, describing the 1115 waiver work occurring in these states. As a follow-up to this brief, the Institute will conduct 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. The Institute will supplement webinar findings and follow-up interviews with data obtained in waiver progress reports. A research brief will be released in September 2014.

Population Health

The Institute is conducting a landscape review on population health management (PHM) by essential hospitals. Research staff will engage in several activities: collect and analyze existing definitions of PHM; survey and interview member hospitals about their approaches to PHM, their specific PHM activities, and barriers and facilitators to advancing their PHM work; and formulate a PHM definition and framework addresses the challenges of serving low-income, underserved populations. Hospital participants will be identified from pools of Gage Award applicants, internet searches, and other outlets identified by research staff. The results of the study will inform the development of a research brief that discusses what PHM means to



essential hospitals, provides an overview of PHM work in essential hospitals, and outlines successes and challenges of taking on organization-wide PHM endeavors.

Massachusetts Learning Collaborative

In October 2012, six essential hospitals in Massachusetts began participation in a two-year learning collaborative developed by Essential Hospitals Institute as a Transformation Center initiative: Boston Medical Center, Cambridge Health Alliance, Holyoke Medical Center, Lawrence General Hospital, Mercy Medical Center, and Signature Healthcare Brockton. The learning collaborative is 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 supports the work of the hospitals around three DSTI 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. To date, the Institute has held six in-person learning meetings involving national expert speakers, as well as peer-to-peer presentations for hospitals to learn strategies and best practices related to their DSTI projects. Earlier this year, the collaborative held its sixth learning meeting on complex care management. The final two meetings will occur this spring to conclude the collaborative, and will focus on improving care transitions and preparing for alternative payment models.

Performance Improvement

Essential Hospitals Engagement Network (EHEN)

In December, America's Essential Hospitals was awarded a third year of EHEN funding. Staff continue the primary work of the Centers for Medicare & Medicaid Services (CMS) contract: supporting hospital improvement teams that work to reduce the Partnership for Patients' (PfP's) 10 targeted hospital-acquired conditions and readmissions, collecting data, and coaching hospitals as they implement improvement cycles. In 2014, we will continue our focus on building leadership capacity to support and sustain the improvement projects and on our patient and family engagement (PFE) work, in addition to kicking off a new training program for hospital staff on how to collect standardized race, ethnicity, and language (REAL) information. We have also started laying the groundwork to sustain the improvements we make.

Between October and December 2013, we finished our second round of site visits, traveling to six hospitals in our network. After receiving the new contract in December, we kicked off the new year of work with hospitals leaders, sharing the special-emphasis targets CMS identified: acceleration of reductions in readmissions and Catheter-Associated Urinary Tract Infection (CAUTI) and eliminating early elective deliveries. CMS also charged HENs with broadening attention to maternal harm and adverse drug events, as well as spreading the work beyond individual units to the entire hospital.

In mid-2013, we kicked off a new collaborative focusing on health equity with a special distance learning event, which attracted both members and non-members of America's Essential



Hospitals. We continued to build on this webinar series with new events since October. These webinars continue to attract EHEN participants and garner interest from the larger membership. In 2014, we kicked-off a new project, “Ask Every Patient: REAL.” The ultimate outcome of this project is to improve quality of care for all patients. During this year, we will focus on standardizing the collection of REAL information so hospitals can build a robust and accurate picture of the people they serve. That information will also help hospitals identify where disparities in care and outcomes exist. The collection of REAL information is the first crucial step hospitals can take that will enable them to align their improvement efforts and address disparities in a more thoughtful and effective manner.

We continue to enhance our focus on patient and family engagement, working on specific goals articulated by the PfP and coordinating with existing Institute efforts. We formed a partnership with the Institute for Patient- and Family-Centered Care (IPFCC) and the National Partnership for Women and Families in August 2013 to offer technical assistance to four member hospitals to build or augment their patient and family programs, and that partnership will continue through 2014. This work is well aligned with our webinar series on engaging patients and families in the hospitals using five PfP-specified metrics to monitor progress.

Between October 2013 and March 2014, we offered 12 webinars covering the PfP conditions, leadership, health equity, and patient and family engagement.

You can see results of the project in the 2013 annual report submitted to CMS, attached as an appendix to this report.

Data Collection and UHC Subcontract

The EHEN subcontracts with UHC to collect and analyze data required under the hospital engagement contract. Data collection has been challenging for the project; however, the entire network reports data through one or more of our data streams now, with more than 80 percent reporting through UHC and 100 percent sharing information through the Centers for Disease Control and Prevention's National Healthcare Safety Network. We began work in January with UHC to provide the necessary business associates agreement updates to ensure that our hospitals meet the omnibus rule requirements by the September deadline.

Ask Every Patient: REAL – Standardizing race, ethnicity and language information

Project Goal:

America’s Essential Hospitals will work with hospitals to take the first step toward increasing health equity for the most vulnerable and disadvantaged patients through the collection of standardized race, ethnicity, and language (REAL) information to build a robust, accurate picture of the people served. The “Ask Every Patient: REAL” project will support this effort through the development of materials that support the consistent and meaningful collection and use of REAL data.

- Hospital categories will be OMB consistent categories, and hospitals will utilize patient self-reporting methodology.



- Hospitals will train essential staff in REAL data collection best practices.

Project Components:

- Building Equity Action Team: tapping our EHEN hospitals to provide skills and knowledge from the field as our advisers
- survey of EHEN hospitals
- e-learning module development (for training registration staff)
- distribution of e-learning module
 - website
 - to hospital learning management systems (approximately 200 hospitals)
- hospital staff educational webinars
 - for registration and training leads
 - for information technology leads
 - for quality leads
- EHEN learning collaborative to focus on REAL data collection best practices and findings among early adopters
- communications
 - communications with hospitals regarding various aspects of the initiative

Timeline:

initial call/kick-off	March
assessment/module refinement	April-May
training	May-Oct

2013 Fellows Program

During the second session of the 2013 Fellows Program in October, fellows learned how to become leaders of high-performing organizations and to cultivate a culture of excellence. Fellows received their Hospital Leadership Quality Assessment Tool (HLQAT) results and determined current leadership structures, processes, and activities, as well as opportunities for improvement. Fellows explored the levers of cultural change and used their Myers Briggs Type Indicator (MBTI) results to better understand and manage others. In addition, the fellows visited University of California Davis, a top-performing essential hospital, to meet with the hospital's leaders and learn best practices. After the second session, the fellows participated in monthly, hour-long group coaching webinars, which supported fellows' project work.

During the third and final session, fellows will advocate on behalf of America's Essential Hospitals to key legislators on Capitol Hill. Fellows will also have the opportunity to hear and present leadership lessons learned through the work on their year-long program projects.

Hand Hygiene Learning Network

In partnership with The Joint Commission Center for Transforming Healthcare, America's Essential Hospitals launched phase 1 of the Hand Hygiene Learning Network, which began in June 2013 and will end in December 2013. The collaborative includes six webinars that aim to



help participating hospitals reduce hospital-acquired infections by improving hand hygiene compliance.

The two-part program leverages the Targeted Solutions Tool (TST), an evidence-based tool, developed by The Joint Commission Center for Transforming Healthcare, that guides health care organizations through a step-by-step process to accurately measure performance and identify barriers and solutions.

In the first part of the program, each organization assesses baseline hand hygiene compliance in one unit, applies best practice strategies to increase compliance, and evaluates the interventions' impacts. In the second part, organizations will implement successful interventions on a hospital wide basis.

Phase 2 is an entirely new program derived from the work and the identified needs of the first cohort, and seeks to guide these facilities through a wider application of the tool. As this has never been done before, the series has been designed entirely to meet the needs of the hospitals. Potential outcomes include improved hand hygiene compliance in the pilot units, as well as members' recognized autonomy in their ability to implement this work after the cohort is complete.

Participating members are Alameda Health System, Truman Medical Centers (three facilities), Natividad Medical Center, and Jackson Health System (three facilities). Woodhull Medical Center, Lincoln Medical Center, and Metropolitan Hospital Center, of the New York Health and Hospital Corporation, joined for phase 2, as well.

Silvia Munoz-Price, MD, medical director for infection control at Jackson Memorial Hospital, is the physician champion for the project. Cleveland-based MetroHealth System was highlighted as an organizational role model, as they successfully have used the TST to improve hand hygiene compliance and reduce infections.

HCAHPS Learning Network: Year 3 Patient Experience College

The Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) Patient Experience College kicked off February 12, offering eight webinars and guided quality improvement work for the duration of the calendar year. The webinars feature Carrie Brady, JD, MA, and Terry Rusconi, of the University of Kansas Medical Center, as content experts. This year, webinar content has transitioned from passive learning to active quality improvement work within the membership. The college has 24 participating teams, with projects that include work in staff communication, pain management, and quietness at night.

The webinars provide general HCAHPS improvement steps, led by Carrie Brady, and featuring a member from within the cohort who is doing outstanding work in the project. Participants will also have access to domain-specific coaching calls with Carrie Brady and staff at America's Essential Hospitals, to share best practices specific to certain work. A closed portal has also been



created on the website to facilitate discussion among participants, sharing of resources, and a community for members doing this work.

Participants received several benefits for participation, including a free copy of *The HCAHPS Handbook*, by the Studer Group. Participants will also receive access to the Institute for Healthcare Improvement Open School to facilitate their improvement projects, and continuing education units from the National Association of Healthcare Quality.

Gage Awards 2014

Our members submitted 67 applications for the 2014 Gage Awards. We received 40 applications in the quality category and 27 applications in the population health category. Assisting staff in judging the applications this year was an expert panel of judges chaired by Karen Adams, vice president of national priorities for the National Quality Forum (note: Adams served as chair, but did not review applications). Adams was assisted by the following members of the Gage Awards selection committee:

- Lawrence Antonucci, MD, MBA, chief operating officer, Lee Memorial Health System
- Courtney Forward, MBA, patient family experience advisor, The Ohio State University Wexner Medical Center
- Barton Hill, MD, vice president and chief quality officer, St. Luke's Health System
- Joshua D. Lenchus, DO, RPh, president, Jackson Health System Medical Staff, Jackson Memorial Hospital
- Deborah M. Nadzam, PhD, RN, director, CMS Partnership for Patients Hospital Engagement Network, Joint Commission Resources
- Anthony Patterson, RN, MSHA, interim CEO, UAB Hospital
- Terry Rusconi, vice president, performance improvement, The University of Kansas Hospital
- Lucy A. Savitz, PhD, MBA, director, research and education, Intermountain Institute for Health Care Delivery Research
- Rhonda A. Scott, PhD, RN, executive vice president and chief nursing officer, Grady Health System

Other Institute Activities

Analytics Report

Work to build the capacity of the data center and warehouse within America's Essential Hospitals was started in 2013 and will continue throughout the year. The organization has now formed an analytics team that includes a manager of analytics and two data analysts responsible for overseeing the data warehouse and performing analytics in support of the organization's research, performance improvement, and policy and advocacy efforts. Recent accomplishments of the Analytics team include these:



- **Purchase of SQL server management studio:** This has resulted in improved data warehousing and management capabilities, much beyond those previously utilized through Microsoft Access. Utilizing SQL to warehouse the data allows for more complex and speedier data analyses, as well as greatly increases the data storage capacity for future expansion.
- **Improved data security:** All data housed in the SQL server is now restricted to read-only access by all staff outside of the analytics team. Additionally, sensitive data will be available only to those who have gone through appropriate data privacy trainings and have been granted rights to view that information.
- **Two in-depth impact studies:**
 - Readmissions penalty impact study: This study examined the impact that Medicare's readmissions rule changes would have on our member hospitals and health systems. The analysis found that members are more than twice as likely to incur a readmissions penalty as other hospitals across the country, and 67 percent of members were penalized at a higher rate than the national median. However, members did reduce their penalty payments from \$17.8 million in fiscal year (FY) 2013 to \$14.8 million in FY 2014, a reduction of 16.5 percent.
 - Value-based purchasing (VBP) program impact study: This study examined the total financial impact of the Medicare VBP program on our member hospitals in its first two years (FY 2013 and FY 2014). The analysis determined that, while members lost money under the VBP program in both years, the first two years of the program had only a modest financial impact on members. Estimated dollar impact was \$5.3 million in FY 2013, which declined to \$3.8 million in FY 2014. Members continued to improve HCAHPS and process domain scores, although still perform under the national average and median. However, members performed better than the national average and median for the outcomes domain.
- **America's Essential Hospitals annual hospital characteristics survey, FY 2012:** The association's annual hospital characteristics survey, FY 2012, was launched in March 2013 to 96 member hospitals and health systems. Of the 96 members invited to participate in the survey, 83 members responded (86 percent response rate), representing 99 acute care hospitals across the United States. The results will be published in a newly redesigned report called *Essential Hospitals, Vital Data: Results of America's Essential Hospitals Annual Hospital Characteristics Survey, FY 2012*. The report, which features the most important facts and figures from the survey analysis, as well as supporting facts and figures, will be released in the spring.
- **Formation of data sharing partnerships:** In 2013, the annual hospital characteristics survey was redesigned, including the removal of data elements that were available and purchased from the American Hospital Association (AHA) Annual Survey of Hospitals. Unfortunately, this did not include the removal of items that AHA collected in its annual survey but did not include in the purchased survey database—primarily revenue



information. To eliminate duplication of work by our member hospitals and greatly reduce the time needed to respond to the survey, Essential Hospitals Institute formed a data sharing partnership with AHA. The Institute will work over the next few months to collect signed data sharing agreements with member hospitals, which will allow AHA to provide us with all data supplied by member hospitals to the AHA annual survey.

- **America's Essential Hospitals annual hospital characteristics survey, FY 2013:** Members of the analytics team are currently working to further streamline this year's characteristics survey, thanks to the newly formed partnership with AHA. The survey will be launched to members in the spring.



America's Essential Hospitals Membership

Alameda Health System (Oakland CA)

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

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)

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)

GACH-Georgia Alliance of Community Hospitals (Tifton GA)

Columbus Regional Healthcare System (Columbus GA)
Doctors Hospital (Columbus Georgia)
Floyd Medical Center (Rome GA)
Georgia Regents Health System (Augusta GA)
Hughston Hospital (Columbus GA)
John D. Archbold Memorial Hospital (Thomasville GA)
Medical Center of Central Georgia (Macon GA)
Medical College of Georgia (Augusta GA)
Phoebe Putney Memorial Hospital (Albany GA)
University Hospital (Augusta GA)

Georgia Hospital Safety Net Coalition (Atlanta GA)

Grady Health System (Atlanta GA)

Lindbergh Women's & Children's Center (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 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)

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)

MetroHealth System (Cleveland OH)
MetroHealth Medical Center-Main Campus (Cleveland OH)

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

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 and 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)

Sinai Health System (Chicago IL)

Holy Cross Hospital (Chicago IL)
Mount Sinai Hospital (Chicago IL)
Schwab Rehabilitation Hospital (Chicago IL)
Sinai Children's Hospital (Chicago IL)

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)

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

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 Missouri Health Care (Columbia MO)
Missouri Psychiatric Center (Columbia MO)
Missouri Rehabilitation Center (Mount Vernon 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)

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)



APPENDIX

Essential Hospitals Engagement Network 2013 Annual Report

Contract Number: HHSM-500-2012-00019C

Sponsoring Agency: CMS

November 29, 2013

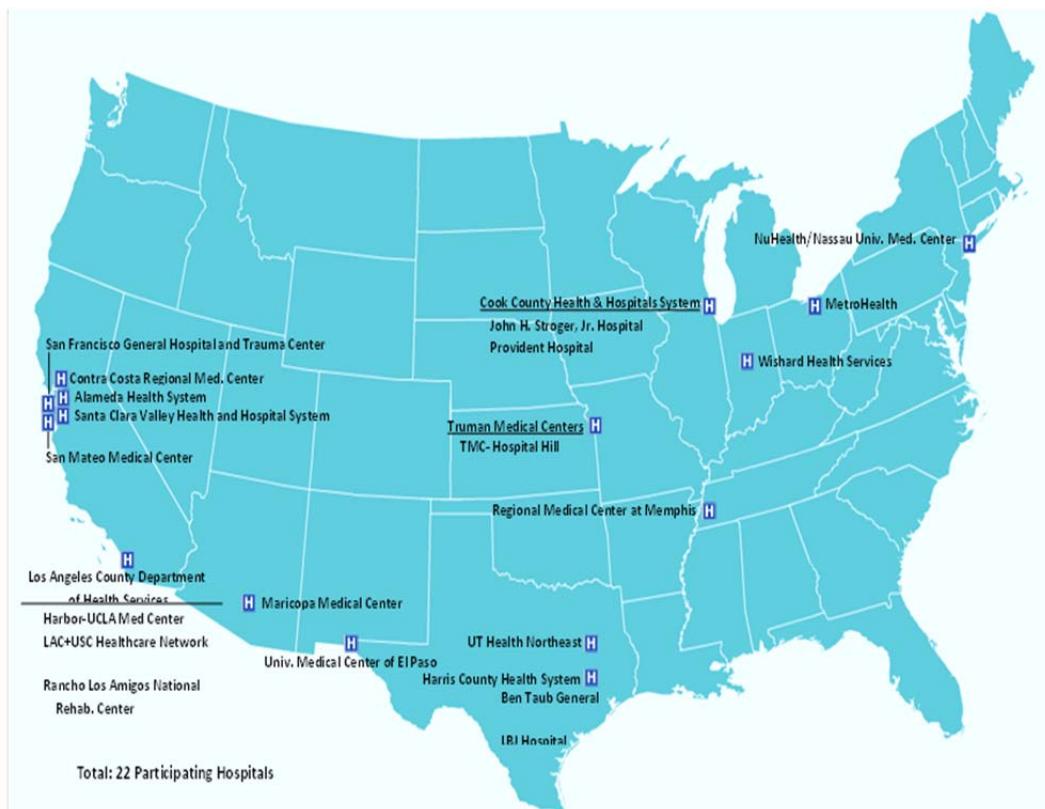
Overview: Our Hospitals, Our Patients

Fundamental changes are re-shaping the nation's health care system—from purchaser and payer demands for greater quality and value to new legislative and regulatory requirements, such as the landmark Affordable Care Act (ACA). Hospitals that care for society's most vulnerable, regardless of ability to pay, have contributed much to the goals of reform through innovative practices born of a need to do more with less.

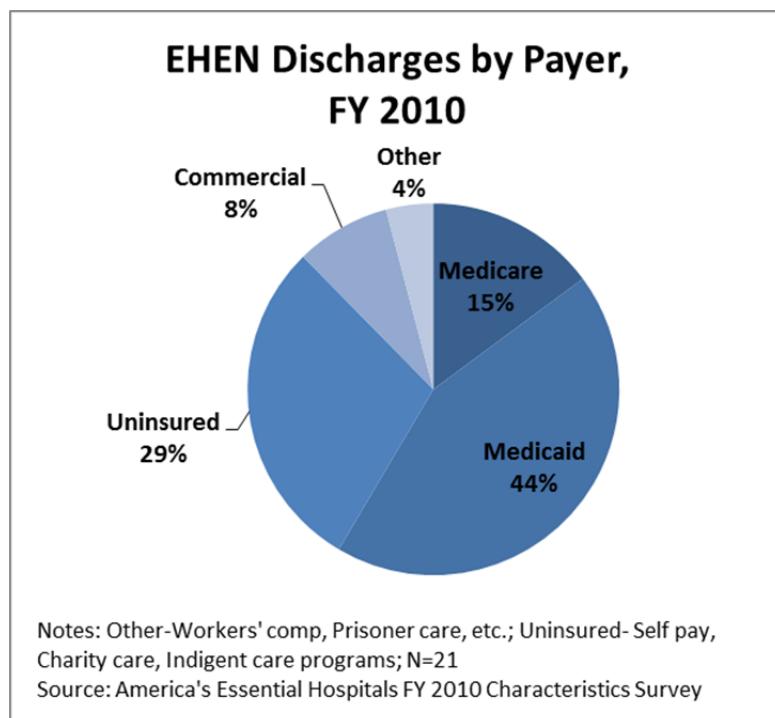
Central to this commitment to the disadvantaged and underserved has been an emphasis on ensuring that patients need not compromise on quality and safety for access to affordable health care. It was in this spirit that the Essential Hospitals Institute, formerly the National Public Health and Hospital Institute, created a hospital engagement network (HEN) for members through the Partnership for Patients (PfP) initiative.

In October 2011, the Centers for Medicare & Medicaid Services (CMS) awarded one of 26 HEN contracts to the Essential Hospitals Institute, the research affiliate of America's Essential Hospitals (formerly NAPH), and with it established the Essential Hospitals Engagement Network (EHEN), formerly the NAPH Safety Network. Like other HENs, the EHEN aims to reduce nine hospital-acquired conditions by 40 percent and preventable readmissions by 20 percent by the end of 2013. These are critical goals—especially for vulnerable patients, who face cultural and socioeconomic challenges that can contribute to a higher likelihood of hospitalization and poor outcomes.

ESSENTIAL HOSPITALS ENGAGEMENT NETWORK



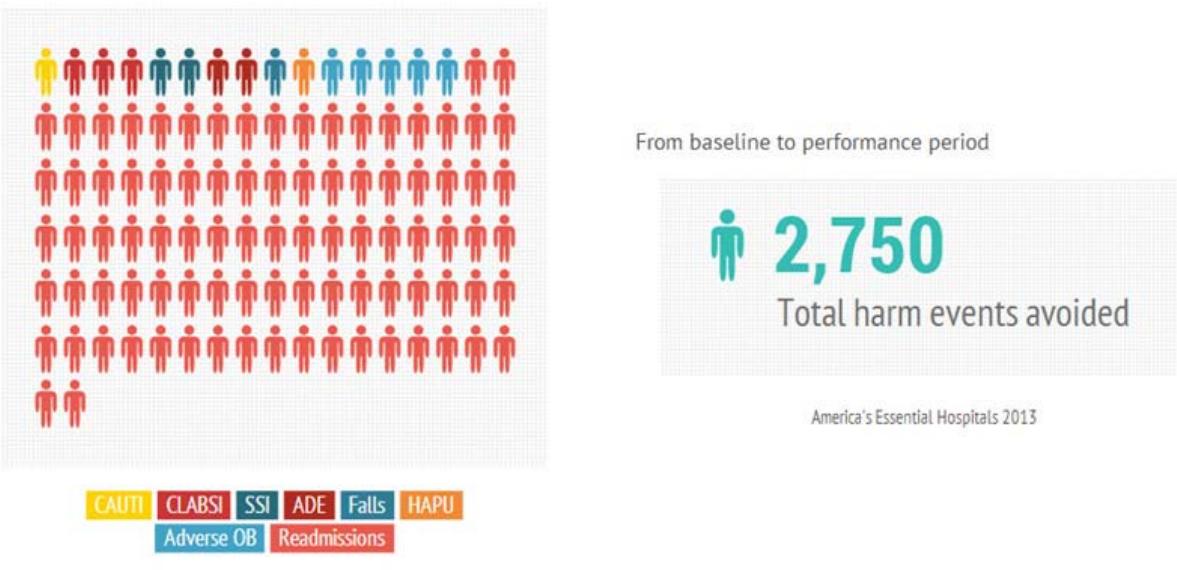
The EHEN is the only hospital engagement network composed entirely of essential hospitals—those with a safety net role in their communities—and serves as a link between such hospitals and a national quality improvement infrastructure. The network comprises 22 hospitals in 10 states and represents a mix of small and large hospitals that have committed to serving the most vulnerable in their communities.



Building on the accomplishments of its first year, the EHEN continued to make impressive strides to improve quality and reduce costs. During its second year, the EHEN conducted site visits to all of its hospitals, convened two more leadership workshops, launched new collaboratives on health equity, patient and family engagement, and organizational harm, and fortified data streams with all of its hospitals. However, its most noteworthy achievements are seen from the patient's perspective:

- dramatically reduced rates of adverse events in EHEN hospitals, including catheter-associated urinary tract infections, falls and trauma, and central line-associated bloodstream infections
- sustained low rates of early elective deliveries, falls with injury, and post-operative cases of venous thromboembolism

Overall, the EHEN estimates that during the project's first two years, participating hospitals prevented 2,750 harmful events and saved approximately \$27.2 million.



The Essential Hospitals Institute laid the groundwork for these accomplishments in less than five months and ahead of the project's timeline, building a new team and improvement program from the ground up. Leveraging this infrastructure, the EHEN used a two-pronged approach to reduce harm by simultaneously coaching and educating frontline clinical staff and training hospitals' executive teams to foster a culture of patient safety. The EHEN also owes its success, in part, to hospital leaders who provided staff with needed resources, removed barriers to their work, and allowed flexibility to make rapid tests of change.

The Essential Hospitals Institute set the bar high for the work of its HEN—and the network's participating hospitals rose to the challenge. Along the way, they also learned important lessons that will serve to improve their work and that of other safety collaboratives, including about economic and structural barriers to hospital participation, the importance of clinical leaders to the network's success, and data collection and sharing challenges.

The EHEN and its hospitals look forward to Option Year 1, during which the network will continue work to reduce hospital-acquired conditions and avoidable readmissions, as well as focus on patient and family engagement, health equity, and sustainability.

Improving health care quality and safety, especially for vulnerable populations, must remain a national priority. Through the work of the EHEN and other PfP partners, we can make a difference in the lives of millions and build a stronger—and safer—health care system.

About America's Essential Hospitals

America's Essential Hospitals, formerly the National Association of Public Hospitals and Health Systems, is the leading association and champion for hospitals and health systems dedicated to high-quality care for all, including the most vulnerable. Since 1981, America's Essential Hospitals has initiated, advanced, and preserved programs and policies that help these hospitals ensure access to care. It supports members with advocacy, policy development, research, and education.

Our more than 200 members are vital to their communities, providing primary care through trauma care, disaster response, health professionals training, research, public health programs, and other services. They innovate and adapt to lead the broader health care community toward more effective and efficient care. Visit EssentialHospitals.org to learn more.

About the Essential Hospitals Institute

Essential Hospitals Institute, formerly the National Public Health and Hospital Institute, researches and promotes evidence-based best practices and specializes in programs that promote the health of vulnerable people and underserved communities. The Institute uses data analysis and lessons learned to help members and the broader health care community achieve high-quality, cost-efficient care for all people.

Key topics of study include patient safety, quality improvement, care disparities, and other issues important to hospitals that serve high volumes of vulnerable patients. In addition to conducting research, the Institute educates and trains senior administrators and clinical leaders. It accomplishes this work through a Research Center and the Transformation Center, a catalyst for innovative change to improve quality and safety. Established in 1988, Essential Hospitals Institute is the research affiliate of America's Essential Hospitals. Learn more at EssentialHospitalsInstitute.org.

Establishing the EHEN and Early Achievements

In less than five months after the October 2011 award of its HEN contract—and ahead of the project’s timeline—Essential Hospitals Institute created a team and built an improvement program where one had not previously existed. We reached out to hospitals for the first six months of 2012, identifying essential organizations from CMS’ “orphan hospital” list and encouraging their participation in the EHEN.

Three objectives guided learning sessions at the Leadership Summits:

- enable leaders to see the extent of patient harm in their hospitals
- ensure that leaders own the problem—that is, assume responsibility for patient harm
- empower leaders to solve the problem—to reduce harm rates rapidly and effectively

In-Person Training

To launch improvement work in network hospitals, the EHEN convened Regional Collaboratives and Leadership Summits in Chicago, Houston, and Los Angeles during July and August 2012. The events together drew 165 participants, including improvement teams and leaders from more than 90 percent of network hospitals, and offered didactic presentations, inter-organizational learning, and networking. The collaboratives grouped the 10 targeted conditions as hospital-acquired infections (HAIs), hospital-acquired conditions (HACs), obstetrical adverse events (OB), and readmissions, allowing hospitals to leverage common solutions across multiple conditions.

Meanwhile, at the Leadership Summits, C-suite hospital executives and board leaders learned key leadership practices to improve the oversight of quality and patient safety and align all members of the organization with the PfP goals. In discussions led by consultant James Reinertsen, MD, leaders drew inspiration and practical knowledge from success stories of hospitals that made leaps in patient safety and quality.

Distance Learning

After the in-person regional events, the EHEN engaged hospital leaders in monthly assignments to apply leadership practices taught by Dr.

A Busy First Year for the EHEN

The EHEN rapidly ramped up in its first year and quickly established a strong network with its participating hospitals. In 2012, it:

- completed hospital and staff recruitment;
- conducted two initial assessments to optimize the network and customize approaches to the participating hospitals;
- executed three, two-day Regional Collaborative events around the 10 conditions;
- engaged senior leaders and board members with Leadership Summits;
- developed and launched a series of webinars;
- developed a data collection process, including two reporting systems;
- established relationships between our network hospital improvement teams and improvement coaches; and
- completed seven site visits, where EHEN coaches analyzed hospitals’ progress in reducing patient harm.

Reinertsen during the summits. They also have shared their experiences in monthly conference calls facilitated by Dr. Reinertsen and now continue those discussions in regular webinars.

Year 1 Results: Safer, Higher-Quality Patient Care

In the first year of its HEN, the Essential Hospitals Institute shared on its website and in other formats 20 success stories from 14 hospitals (48 percent of the network), showcasing achievements by essential hospitals to reduce harm and improve the quality of care. These “bright spots” highlighted achievements in catheter-associated urinary tract infections (CAUTI), central line-associated bloodstream infections (CLABSI), EEDs, falls, pressure ulcers, preventable readmissions, surgical site infections (SSI), ventilator-associated pneumonia (VAP), and venous thromboembolism (VTE). For example, University Medical Center of El Paso reduced its EED rate from 27 percent in 2010 to zero in 2012 and has maintained a zero rate since. Harris Health System has reduced its VAP rate from 11.4 percent in 2010 to zero in 2012 and has maintained zero for nine consecutive months.

Year 2: Building on Success

In its second year, the EHEN continued working with network hospital improvement teams to achieve the PfP goals by addressing frontline and leadership issues—a two-pronged strategy bolstered by distance learning events, coaching calls, site visits, monthly data reports, and leadership conference calls.

We continue to host condition-specific distance learning events for our hospitals’ improvement teams, and have expanded our educational offerings to include broader topics, such as patient and family engagement, harm across the board, and health equity. Meanwhile, to complement these efforts, we provide leadership training that offers simple, straightforward practices that encourage awareness and accountability for patient safety, which have percolated throughout the leadership cohorts within and across our network hospitals.

Year 1: EHEN Action Period

Milestones

- 100 percent engagement by hospitals and their improvement coaches
- Action plans from more than 70 percent of EHEN hospitals.
- NHSN data submission by 93 percent of EHEN hospitals
- September launch of monthly webinars on all 10 conditions. In second month, more than 70 percent of network hospitals participate and rate these sessions highly.

Busy Second Year for the EHEN

- visited all network hospitals
- continued our monthly distance learning events
- offered two Leadership for Safety workshops in June and October
- celebrated EHEN success at America’s Essential Hospitals national annual conference, showcasing essential hospitals
- strengthened our data collection process, which includes two reporting systems
- continued to broaden our established relationships between our network hospital improvement teams and improvement coaches
- kicked off health equity work
- kicked off patient and family engagement focus

Year 2: Key Accomplishments

- retained more than 70 percent of the original network despite severe financial and environmental challenges to safety net providers
- achieved more than 60 percent of the network regularly sharing data
- met interim PfP goals, including having more than half the network reporting data and showing improvements in six of the 10 conditions
- achieved quantifiable cost savings by improving patient safety and avoiding harm

These efforts helped the EHEN meet the critical PfP milestones in July of having more than half the network regularly sharing data on targeted conditions and showing decreased harm in at least six areas. We believe six innovative approaches in particular helped propel our network toward success, especially in the first half of Year 2:

1. Data infrastructure: Through our partnership with UHC, we have helped essential hospitals build data and reporting systems—where little or none existed previously—so they are now able to collect and proactively use their data to identify opportunities for improvement and implement patient safety best practices. This will help sustain the valuable information stream necessary to measure results of quality improvement work.

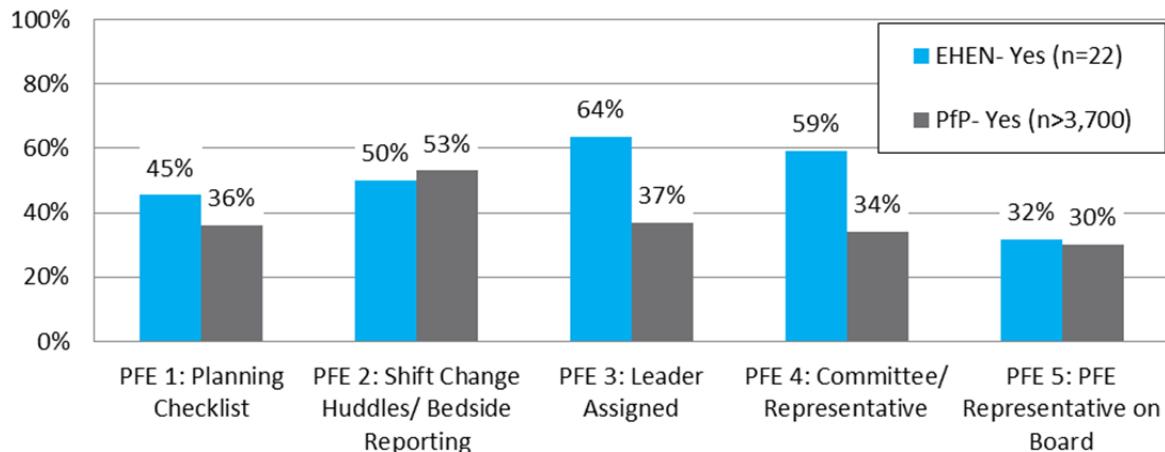
2. Leadership: We created an effective and impactful leadership program—so successful, in fact, that we are seeing it spread from hospitals' executive

and senior leadership to lower levels of management. We believe keys to the program's success, detailed below, include

- simple, straightforward leadership practices that encourage awareness and accountability;
 - a leadership model that succinctly and clearly summarizes core leadership for safety practices; and
 - webinars to reinforce safety leadership practices taught in in-person workshops and to create a community of shared learning.
3. Reporting harm counts instead of rates: We have employed a unique and innovative approach in this project: We focus on the number of patients harmed (discrete events) instead of the harm rate to align efforts across frontline improvement teams and senior leaders. We are the only HEN to adopt this approach and, in doing so, have made a significant contribution to the field of quality improvement. Presenting harm in this way resonates with boards, consumers, and frontline providers because it is easier to understand and visualize. This, in turn, continually elevates the importance of transparency and patient safety by making harm events personal. In short, it puts a face on the work of harm reduction. To ensure harm reduction is not an artifact of changes in either volume of admissions or exposure to events, we monitor the population or exposure group for our measures.

4. **Health equity**: As the only safety net-focused HEN in the PfP, we are uniquely positioned to raise awareness of health disparities and help our hospitals efficiently and effectively collect and use race, ethnicity, and language (REAL) data to improve quality and patient safety. Research shows that while collecting accurate REAL data is essential to reducing health care disparities, U.S. hospitals do not consistently collect this data for quality improvement. In May, the U.S. Department of Health and Human Services' Office of Minority Health invited the EHEN to submit a concept paper outlining how we would engage a small group of HENs around the collection and use of REAL data to identify and address disparities in the targeted PfP conditions. While we still are awaiting feedback, we believe we are well-positioned to take on a leadership role in this work. Meanwhile, in June 2013, the EHEN launched a health equity collaborative, which aims to engage our hospital leaders and educate their staffs about how to use REAL data in their PfP improvement activities.
5. **Patient and family engagement (PFE)**: The EHEN in its second year sharpened its focus on patient and family engagement by partnering with PfP's patient and family engagement subcontractor and launching its own PFE collaborative. Teams of patient advisers and hospital staff from two EHEN hospitals attended an intense, three-day conference and committed to comprehensive work plans to quickly spread patient- and family-centered care principles throughout their hospitals. We are optimistic this approach will ignite the will to rapidly accomplish the PfP PFE goals and will be replicable in other EHEN hospitals. For example, one of the EHEN hospitals, accompanied by a patient adviser, now is presenting harm scores in a town hall forum. In addition, one of our improvement coaches is co-leading the PFE affinity group's vulnerable patients workgroup, which published a comprehensive inventory of tools for engaging patients and families. In July 2013, the workgroup spearheaded an online pacing event that highlighted the impressive work at several EHEN hospitals and elsewhere to ensure high quality, equitable care. Last, EHEN staff organized and hosted webinars for member hospitals to provide educational content and subject matter expertise to accelerate change. To make our PFE offerings as valuable as possible, we are working to create a patient and family advisers work group to provide direct input when we plan, deliver, and evaluate our PFE events.
6. **Network engagement**: We have successfully engaged—and continue to engage—a cohort of essential hospitals in an ambitious patient safety initiative, overcoming challenges posed by the group's varied governance structures, limited experience with the improvement model, nascent data capabilities, and limited financial resources.

Patient and Family Engagement Metrics- EHEN vs. PfP



Source: Project Evaluation Activity in Support of Partnership for Patients: Task 1 Monthly Formative Feedback Report. July 2013.

In Year 2, the EHEN also emphasized incorporating participant feedback into its curriculum. A network survey found that hospitals rate site visits by an EHEN improvement coach as the most effective intervention. Based on these results, we increased the number of site visits and returned to hospitals in person sooner than we originally planned. Meanwhile, to boost efficiency and accelerate progress toward the PfP goals, we sharpened our focus on helping our hospitals embrace the concept of “harm across the board” to align their current patient safety improvement initiatives, an area our hospitals also said they wanted to address.

Showcasing results: Safer, higher-quality patient care

In two years, EHEN shared on its website and in other formats 27 success stories from 80 percent of the network, showcasing achievements by safety net hospitals to reduce harm and improve the quality of care. These “bright spots” highlight achievements in reducing the 10 conditions PfP is targeting, as well as improvement in patient and family engagement (see attachments).

COLLABORATE
[Essential Hospitals Engagement Network](#)
[About Our Members](#)
[Success Stories](#)
[2012 Annual Report](#)
[Staff](#)
[Hospital-Acquired Infections](#)
[Hospital-Acquired Conditions](#)
[Obstetrical Adverse Events](#)
[30-Day Readmissions](#)
[Patient and Family Engagement](#)
[Health Equity](#)
[Leadership](#)
[Data Collection](#)
[Upcoming Events](#)
[Tools](#)
SUCCESS STORIES

Each month, the Essential Hospitals Engagement Network asks member hospitals to submit stories and run charts to highlight successful interventions and document improvement results across time.

Tell your story: To showcase your successes, please email Project Analyst Arielle Gorstein.

 | [Share](#)
SPOTLIGHT

'Here for You:' Multifaceted approach leads to drop in falls rate

After logging an average of 64 falls per quarter in 2010, Wishard staff implemented a multifaceted and interdisciplinary falls prevention strategy that reduced falls by 40 percent from their 2010 baseline to the second quarter of 2013.


Make it personal: UT Health Northeast tailors patient discharges to cut readmissions

After the Centers for Medicare & Medicaid Services made reducing readmissions a national priority through the Affordable Care Act, UT Health Northeast took major steps to curb hospitalizations in its own community.


From CEO to Nurse, Teamwork Helps Santa Clara Cut CLABSI

Collaboration among physicians and nurses, executive leadership, and front line staff helped the hospital increase compliance with its central line insertion practices bundle from 29 percent to 82 percent.

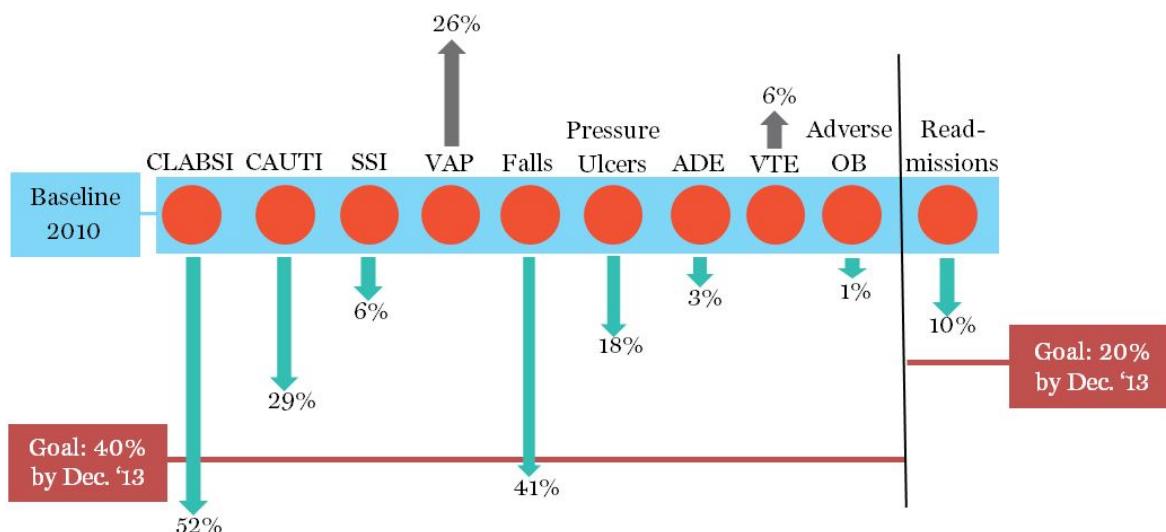

Replicating Results: How One LAC+USC Unit Became a Model in Pressure Ulcer Prevention

One ICU's success started a ripple effect throughout the organization, leading to an impressive improvement in patient safety.

DISCOVER MORE STRATEGIES
Access Archived Success Stories

Stories highlight sustained improvements in conditions including CAUTI, readmissions, SSI, VAP and more.

EHEN Progress Towards PfP Goals as of May-July '13 Performance Period



Note: For all measures, UHC Claims Database is the source and the baseline is Jan '10 to Dec '10. Each measure has >75% of the network included. Adverse OB is episiotomy.

The attention these success stories have received in the monthly EHEN newsletter has underscored the importance of sharing and celebrating our hospitals' work. It also highlights the important collaborative nature of this work and the need for the EHEN to not only work with improvement teams at the hospital level, but to also connect them to successful peers in the "all teach, all learn" approach modeled by the PfP and NCD.

Each faced with its own unique challenges, all EHEN hospitals – large and small, teaching and community – have excelled in particular areas. A few notable examples are:

- **UT Health Northeast** is a 123-bed teaching hospital, whose patient population is 9 percent uninsured patients and 49 percent Medicare recipients (as of FY 2009). Since joining the EHEN in 2012, UT Health has restructured its discharge process to make it more personalized and to prevent patients from "getting lost." Highlighted in an April 9 success story, UT Health Northeast reduced readmissions by 20 percent, from 9.3 percent in August 2012 to about 6 percent in February 2013, according to their internal metrics. According to EHEN data, the hospital has continued on this downward trend, showing a total reduction of 44.3 percent from our 2010 baseline to the performance period of April-June 2013.
- **Eskenazi Health (formerly Wishard Health Services)** is a 316-bed level I trauma center where 70 percent of patients are either uninsured or on Medicaid (as of FY 2009). In its August 12 success story, Eskenazi shared the strategies it used to reduce its fall count by 40 percent, from an average of 64 falls per month in 2010 to 39 in the second quarter of 2013. A key intervention that led to this achievement was hourly care rounds for all staff, including volunteers, environmental services, nutritionists, and nursing. Leveraging patient, family, and staff engagement strategies, Eskenazi has sustained these results and looks forward to further improvement.
- **Santa Clara Valley Medical Center** is a 554-bed hospital offering a broad range of services, such as a burn center and a Level I trauma center. Of Santa Clara's yearly 23,988 discharges, 76 percent are either Medicaid or uninsured (as of FY 2009). Using a collaborative approach between physicians, nurses, executive leadership, and front line staff, Santa Clara reduced its yearly CLABSI count by 50 percent between 2011 and 2012, and has since kept its SIR well below 1.0.

For more details on these success stories and others, see the appendix.

Leadership Successes

Over the past two years, the EHEN's Leadership for Safety program has engaged 103 leaders from 38 hospitals, including 20 EHEN organizations and the Nevada HEN organization. The program has helped EHEN hospitals improve their safety cultures—affecting everyone from the governance board to frontline staff. Many hospitals have shown notable improvements in Hospital Leadership Quality Assessment Tool scores, a survey that measures leadership activities, structures, and processes associated with high performance in clinical quality.

The Leadership for Safety program kicked off in 2012 with three regional, in-person workshops led by Dr. Reinertsen, who taught CEOs, board members, and other senior leaders a series of core leadership practices for reducing patient harm. The EHEN held two additional workshops in 2013. The workshops have been highly engaging and interactive, and have encouraged participating leaders to publicly articulate specific, time-bound goals for improving safety, thereby committing to carry out specific leadership for safety practices on a routine basis.

The program offers simple, straightforward practices that encourage leaders to become acutely aware of the magnitude of patient harm in their organizations and their responsibility for that and all other aspects of their organization.

The success of the Leadership for Safety program largely reflects its effective structure and delivery. First, it organizes leadership practices within a framework that succinctly captures what leaders must do to improve safety: *See the problem, own the problem, solve the problem*. Second, monthly webinars have reinforced the leadership practices and created a forum for leaders to discuss challenges, successes, and best practices. During the webinars, participants hear about, and often recommend broader dissemination of, tools and resources peers use to achieve safety.

The Leadership for Safety program has not only improved leaders' approaches to safety, it also has impacted organizational cultures and put safety at the forefront of their priorities. For example, the CEO of San Francisco General Hospital has been actively engaged throughout the program and has formed a team of 17 leaders who champion leadership for safety practices in their hospital. The CEO and her team spend 30 minutes before each webinar reviewing the current leadership practice of the month and 30 minutes after each webinar planning for the following month's leadership practice. In a recent interview, the CEO said that as a result of the Leadership for Safety program, she is now "improving safety in areas that previously defied their best efforts."

We continue to work with our hospitals around Partnership for Patients leadership metrics:

- Hospitals have a regular quality review aligned with the PfP goals.

EHEN Leadership Program: CEO Feedback

Leadership webinars have "provided direction on how to move forward" and encouraged their leadership team to "go into the field and see firsthand what is going on out there."

--*Tom Holton, MS, RN
Patient Safety Officer
San Francisco General Hospital*

"Very impactful and powerful."

--*Kerin Bashaw
Vice President for Quality
Alameda Health System*

"I always take away a point or two [from webinars] to bring back and share with my teams."

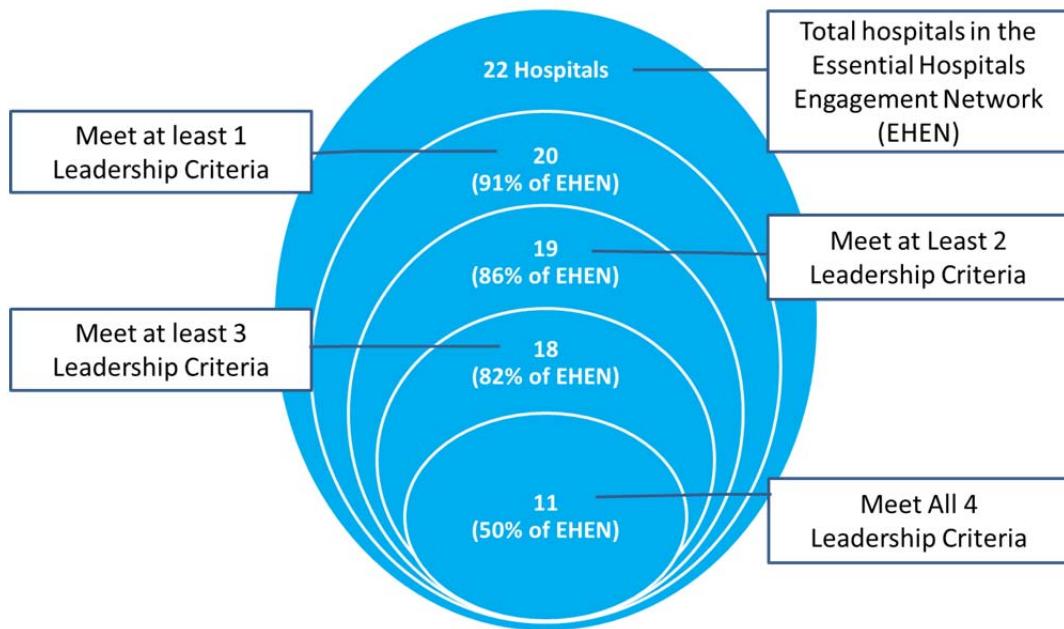
--*David Coultas, MD
Chief Medical Officer
UT Tyler*

"The in-person events were amazing and immensely valuable, and I'm speaking for myself and others. They have really changed the organization's approach to safety."

--*Krishna Das, MD
Interim System Director of Quality
Cook County Health and Hospitals System*

- They have a public commitment to safety improvement with transparency in sharing more than CORE measurement data with the public.
- All, or nearly all, hospital staff members have a role or perceived goal in patient safety.
- The hospital board of trustees establishes a quality committee to regularly review patient safety data and review and analyze risk events.

PfP Leadership Criteria Among the EHEN



The EHEN also has been quantifying the success of the Leadership for Safety program using the Hospital Leadership and Quality Assessment Tool (HLQAT), an evidence-based tool that not only reveals opportunities for organizational improvement, but also provides concrete “first steps” for taking action based on each organization’s results. Specifically, the HLQAT consists of two surveys—one for C-suite leaders and one for clinical leaders—that assess perceptions of a hospital’s progress in 12 domains that correlate to high clinical performance in quality:

1. knowledge-seeking organizations
2. effective communication process
3. adequate resource allocation to quality improvement (QI)
4. non-punitive culture
5. established quality goals and priorities
6. public reporting of quality and safety data
7. clearly defined QI leadership roles
8. monitoring and evaluation of QI progress
9. QI education for all staff
10. employee rewards/recognition for achieved goals

11. collaboration across functions and levels
12. clinical management tools, techniques, and processes

We have invited each of our hospitals to complete the survey twice throughout the project, with the latest survey being completed in August 2013. Hospitals that completed both HLQAT iterations saw improvements across 11 of the 13 categories for the C-suite; clinical leaders saw improvements in eight categories.

Gaining access to the most recent survey results has allowed us to paint a more complete picture of how our hospitals function and approach improvement, as well as helped us identify where we can help our hospitals align quality improvement efforts already underway at the leadership and frontline levels.

Challenges and Lessons Learned

Hospital Engagement

Hospital engagement was a challenge for the Essential Hospitals Institute, particularly during the first year. Although 66 hospitals initially indicated a willingness to participate in the EHEN, 22 ultimately followed through. We later discovered that some hospital leaders who expressed interest in the EHEN “hedged their bet” and submitted letters of support to at least two (and, in some cases, as many as four) organizations that submitted proposals. Because the EHEN was unaware of this activity, we underestimated the attrition rate.

The Essential Hospitals Institute then launched a second round of recruitment that targeted members of America’s Essential Hospitals that were not enrolled in a HEN, as well as orphan safety net hospitals that did not belong to other HENs. As a result of the renewed outreach, the EHEN enrolled 30 hospitals.

The challenging economic environment, however, strained many EHEN hospitals financially in Year 2 and prompted them to withdraw from the network. For example, a lack of funding caused one hospital to close its inpatient services, while another hospital system was privatized after its state cut Medicaid payments by 25 percent. Other hospitals reorganized their leadership, which made it more difficult to engage an executive sponsor in frontline improvement work.

These events taught EHEN the importance of thoroughly assessing each hospital’s status and outlook when planning, during both the recruitment and execution phases of the project. In addition, we learned the importance of leadership engagement in quality improvement. Frontline staff at hospitals with less-engaged leaders tend to have a more difficult time securing the financial and human resources required to achieve sustained enhancements in patient safety.

Data Collection

Essential hospitals struggle with a lack of data infrastructure. Originally, only a third of EHEN hospitals participated with our data subcontractor UHC and submitted data through UHC's Clinical Data Base (CDB). The EHEN worked diligently throughout the first year and into the second to prepare the remainder of the network to create files that allow them to extract claims data and submit it to UHC through a "CDB Lite" system. CDB Lite captures outcomes measure data for all conditions. Meanwhile, hospitals reported their process measure data monthly through the EHEN's Web Data Entry Portal, which also allows each hospital to stratify its data by race, ethnicity, and language information, if available.

Helping hospitals build a data reporting infrastructure proved more complex than expected. We learned that our hospitals' diverse governance structures made paperwork for sharing data and assigning IT and quality staff to build data files time-consuming and difficult.

There is a critical difference between hospitals with private boards, accountable only to the hospital, and those with publicly elected or politically appointed boards that govern multiple agencies within a larger county structure. In the latter, we encountered unforeseen challenges when working with county legal counsels who had limited experience with hospital quality improvement work or data-sharing agreements among three entities (i.e., UHC as the Essential Hospitals Institute's subcontractor, the EHEN, and the hospital). Working with different county lawyers to review data-sharing agreements was staff-intensive work, both at the hospital level and at the HEN level, which we did not foresee.

In addition, we overestimated our hospitals' ability to allocate staff to work with EHEN and UHC to build data reporting capability. Several of our hospitals are implementing electronic health record (EHR) systems, which has overwhelmed their staff resources. For example, some hospitals had assigned one person to work on EHR implementation, as well as to build files for EHEN data submission. In several hospitals that underwent severe budget cuts, the lead data/IT person working with the EHEN left the position, with no one to pick up the work. As a result, the submission of complete data from all hospitals has lagged behind our initial projections, as hospitals refocus their IT priorities.

Recognizing the challenges that data collection presents for many of our hospitals, we moved quickly to form a group within the National Healthcare Safety Network (NHSN), which provides data on all of the HAIs (CAUTI, CLABSI, SSI, and VAP) to expedite submission of that data to CMS. The EHEN worked with each hospital to help them join the group as quickly as possible; the effort was extremely successful, with 95 percent of the network joining EHEN's group.

While the network's data lag was lengthy—we underestimated the resource burden on hospitals and the number of legal challenges we would face—we constructed a targeted plan to work with each hospital to build their data reporting streams. While working through that phase, we identified NHSN as an alternative data source that most hospitals already reported to. We learned that we should have engaged each hospital's chief information officer at the

beginning of the project, in tandem with the CEO, asking them specifically for a commitment to work on the conditions and report data.

Despite these data challenges, after two years we now are able to determine the areas at each hospital that need the most improvement, which helps us appropriately tailor our coaching and educational efforts.

Overall lessons

Other lessons the EHEN has gleaned from the first two years of the project include these:

Goal setting We learned that each phase of our work should begin with a clear aim and that we should help each hospital understand its starting point and operating environment and how our project fits with other initiatives. This overall picture can help hospitals take advantage of synergies across multiple efforts, including those with the EHEN, QIOs, and state waivers.

Communication Clear, concise, two-way communication is critical to keeping hospital staff engaged. It is the HEN's responsibility to present improvement work in a compelling, helpful, and digestible fashion to hospital staff. We've learned that our network prefers regular digests of EHEN updates so all related information can be found in one communication.

Feedback Seeking feedback regularly from improvement teams is important for determining what does or doesn't work and identifying potential barriers to improvement. We have altered our coaching approach based on network feedback, which called for more frequent site visits and coaching calls, and webinars covering certain topics.

Leadership engagement Any improvement effort requires engaged leadership to succeed. We have found that CEOs respond to peers and can often provide mutual support to encourage continued work toward PfP goals.

Option Year 1: The road ahead

Looking forward to a third year, we will continue to work with our network to achieve the 40/20 reduction goal and will help hospitals move from a condition-by-condition improvement strategy to one that targets organizational harm. To do this, we will offer distance learning events that highlight the importance of addressing harm across the board, provide strategies for aligning improvement initiatives across hospital departments, and celebrate successes within the EHEN. To make the most of our improvement work on patient safety, we will focus on helping hospitals identify successful, unit-level improvement strategies that can be replicated in other parts of the hospital.

While leaders at EHEN hospitals remain committed to the PfP project, we will ask them to reaffirm their support to work on all 10 conditions, and also ask them to commit to focusing on readmissions and CAUTI to accelerate improvements in those areas. Recognizing that there is an opportunity for the PfP to expand its reach in Option Year 1, the EHEN will seek to engage

members of America's Essential Hospitals that currently are not linked to the national quality improvement infrastructure.

We also will support our hospitals as they interact with other patient safety and quality improvement groups, including their QIO and state Medicaid waiver. To achieve better outcomes for patients, the EHEN works with frontline hospital teams to promote greater alignment of improvement efforts.

A special focus on health equity

Starting in 2013, and continuing through 2014, we will focus on improving health equity in our network. We plan to expand work on collection of REAL data by creating deliverables that hospitals can use to collect and act on this data using the same framework as the EHEN Leadership for Safety program – *to see, own, and solve the problem of disparities* in their hospitals. To do this, we propose to partner with two to four other HENs whose hospitals collect data that can be analyzed by REAL.

- *See the problem:* Through data and stories about how disparities affect an organization's quality, efficiency, and patient experience, we will impress upon hospital leaders the importance of collecting and acting on REAL data.
- *Own the problem:* Meaningful action requires accurate data, so patient registration staff must be trained to collect standardized, patient-reported REAL.
- *Solve the problem:* Analyzing PfP conditions by REAL to identify disparities will allow hospitals to develop and implement improvement plans. We will provide technical assistance to HENs and hospitals to stratify process and outcomes data for the PfP conditions by REAL to identify disparities.

As a national leader in promoting health equity, Essential Hospitals Institute is uniquely qualified to spearhead work within the Partnership for Patients to reduce disparities. We look forward to collaborating with other HENs around this important issue and look forward to expanding our scope of work in Option Year 1.

Maintaining Momentum—Sustainability

Sustaining gains made by our EHEN members is critical to the success of the PFP. Estimates show that close to 70 percent of quality improvement projects fail to survive, often because an organization fails to integrate a project into work flow. Our goal is that the process changes our members make to improve outcomes and reduce harm across the board become the new norm. To accomplish this, we will integrate a 10-step sustainability model developed and now used by the United Kingdom's National Health Service. We will do this in two steps: training and implementation. We have already identified a lead consultant who will train our staff on the NHS Sustainability Model and tools for deployment. Subsequently, we will train our EHEN hospitals on the model through distance learning and in-person meetings. Once hospitals learn

the model, they can incorporate it into new and existing performance improvement projects and greatly improve the chances of sustaining gains.

Additional 2014 goals

The Essential Hospitals Engagement Network looks forward to continuing its work into Option Year 1 and to working with our hospitals to improve patient safety and health equity. In 2014, the EHEN will showcase our hospitals' achievements at the America's Essential Hospitals June annual conference, VITAL2014, and on the EHEN and America's Essential Hospitals websites.

We know our hospitals are engaging patients and families, as many are working with the Essential Hospitals Institute to improve their Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey results. In 2014, the EHEN will continue to work explicitly with its network hospitals on fully engaging patients and families.

The EHEN also will continue the Leadership for Safety program, looking to engage new leaders and to consider how to engage affinity groups of senior leaders (chief medical officer, chief nursing officer, chief quality officer, etc.). The EHEN will also host a conference to celebrate the accomplishments of the network and to focus on sustainability—specifically, how hospitals can continue to reduce harm and maintain their improvements after this project ends.

The continuing support from the PfP is critical to understanding how to improve care for underserved populations. Like other hospitals with a safety net role, EHEN participants face unique challenges: they serve the most vulnerable patients in an environment of constrained resources and complex governance structures. We view our successes in the past two years in light of the challenges our hospitals face and are proud that the 22 hospitals we carried into 2013 continue to be highly engaged in achieving the PfP goals.