



ESSENTIAL
HOSPITALS
INSTITUTE

Board of Directors Meeting

June 24, 2015
The Westin Gaslamp
San Diego, CA



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Institute Board of Directors Meeting

June 24, 2015

8 am - noon ET

Agenda

7:30–8 am	Breakfast	
8–8:05 am	Call to Order and Disclose Conflicts of Interest (Jacobs)	
8:05–8:10 am	Welcome New Board Member (Jacobs)	
8:10–8:15 am	Approve March 2015 Minutes (Jacobs)	ACTION
8:15–8:20 am	Approve New Committee Appointments (Roth)	ACTION
8:20–8:50 am	Expectations of Board Members (Jacobs)	
8:50–9:20 am	Institute Director Report (Engler)	
9:20–9:35 am	Treasurer's Report (Haley)	ACTION
9:35–9:55 am	Research Committee Report (Haley)	
9:55–10:15 am	Women's Leadership Academy Advisory Committee Report (Blouin)	
10:15 – 10:30 am	Education Committee Report (Finley)	
10:30 – 10:45 am	Break	
10:45 – 11:15 am	Member Engagement Index (Metter)	
11:15 – 11:45 am	REAL Module Update (Callahan)	
11:45 am – Noon	Board Photo	
Noon	Adjourn	



Essential Hospitals Institute Board of Directors 2014-2015

CHAIR

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

CHAIR-ELECT/SECRETARY

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

TREASURER

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

PAST CHAIR

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

RECORDING SECRETARY

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

MEMBER DIRECTORS

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

Dennis Keefe
President and CEO
Care New England 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, Chief Legal Officer
St. Luke's Health System

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

OUTSIDE DIRECTORS

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

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

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

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

EX-OFFICIO

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



Essential Hospitals Institute Board of Directors 2015-2016

CHAIR

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

Dennis D. Keefe
President and CEO
Care New England Health System

CHAIR-ELECT/SECRETARY

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Executive Associate Dean, Clinical Services, CMO
Emory Care Foundation
Grady Memorial Hospital

Christine Neuhoff, JD
System Vice President, Chief Legal Officer
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MEMBER DIRECTOR

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

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

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

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



Institute Board Meeting Dates

Tuesday, October 27, 2015

8 am – noon

Hyatt Regency Washington on Capitol Hill
Washington, DC

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

Tuesday, December 15, 2015

11 am – noon

Conference call

Tuesday, March 8, 2016

8 am – noon

America's Essential Hospitals Office
Washington, DC

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

Wednesday, June 15, 2016

8 am – noon ET

Seaport Hotel
Boston, MA

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

October 2016

America's Essential Hospitals Office
Washington, DC

December 2016 conference call - TBD



Essential Hospitals Institute
Board of Directors Meeting
March 17, 2015

Board Members Present (11): Delvecchio Finley, MPP Donald Goldmann, MD Leon Haley, MD, MHSA Caroline Jacobs, MPH, MSEd Dennis Keefe Erica Murray, MPA Reuven Pasternak, MD, MPH, MBA Anna Roth, RN, MS, MPH Bruce Siegel, MD, MPH Alan Weil, JD, MPP Winston Wong, MD, MS	Board Members Absent (5): Julie Cerese, RN, MSN Susan Moffatt-Bruce, MD, PhD Christine Neuhoff, JD Ann Scott Blouin, RN, PhD Cliff Wang, MD	Staff Present (9): Sarah Callahan, MHSA David Engler, PhD, MS Beth Feldpush, DrPH Caitlyn Furr Rhonda Gold Carl Graziano Kristine Metter Sneha Rangarao, MPH Katie Reid, MPH
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Agenda Items	Minutes
Call to Order and Disclosure of Conflicts of Interest (Jacobs)	<ul style="list-style-type: none">• Jacobs called the meeting to order at 8:08 am. She asked for any conflicts of interest; none were disclosed.• Jacobs welcomed Keefe to the board and members introduced themselves.
Approve December 2 Minutes (ACTION)	<i>Jacobs requested a motion to approve the December 2 conference call minutes. There was a motion, a second, and unanimous approval.</i>
Nominating Committee Report (Roth)	<ul style="list-style-type: none">• The nominating committee recommended Susan Moffatt-Bruce, MD, PhD, chief quality and patient safety officer of The Ohio State University Wexner Medical Center, as treasurer, and Sue Currin, RN, MS, CEO of San Francisco General Hospital and Trauma Center, to fill the member director vacancy.• The association board approved the nominations on March 16. The new board members will join the board meeting in June.
Institute Director Report (Engler)	<ul style="list-style-type: none">• Engler discussed the Institute's portfolio of work and upcoming challenges.• The Institute recently formed two new committees: the research committee and the executive women's leadership advisory council.

	<ul style="list-style-type: none"> The Fellows Program accepted 39 applications from 21 different organizations for the 2015-2016 class. The first three years of the Essential Hospital Engagement Network (EHEN) contract were evaluated by the Centers for Medicare & Medicaid Services' (CMS') external reviewers and considered a success. EHEN finished fifth out of 27 other engagement networks. The Institute will submit a new funding proposal in March with renewal expected beginning in June. The Institute is offering a webinar series on the Hospital Consumer Assessment of Healthcare Providers and Systems. It also developed the Race Ethnicity, and Language (REAL) module to help registration staff collect accurate data. Staff is working with The Joint Commission to expand REAL module's reach. The Institute has partnered with other organizations to address population health, equity, and delivery system reform projects. These three areas will guide the Institute's upcoming activities. The Institute has applied for a number of grants, totaling more than \$5 million, to broaden its revenue base., <i>Essential Hospitals Vital Data—Results of America's Essential Hospitals' Annual Characteristics Survey, FY 2013</i> will be on the website the week of March 23.
Research Committee Report (Haley)	<ul style="list-style-type: none"> Haley told the board that the research committee met for an introductory conference call on February 9. The committee identified three areas of focus: population health, health equity, and delivery system transformation. The board agreed that these should be the areas of focus, and stressed the need to focus on equity. The committee discussed the Institute's current work on population health and Medicaid waivers.
Women's Leadership Academy Advisory Council Report (Finley)	<ul style="list-style-type: none"> Finley told the board that the executive women's leadership advisory council has held three conference calls. The council has set a general trajectory for the year-long program and identified thematic elements. The program will include training on a variety of different skills, including finance and effective project planning. The program will include two face-to-face interactions between mentors and mentees, including one meeting at VITAL2015. The council is exploring potential funders. The program will launch at the end of 2015, and the council expects it to be small. The board said that the program must deliver measurable results and suggested the committee develop an action plan to show growth.
Education Committee Report (Finley)	<ul style="list-style-type: none"> Finley described the education committee's work to solicit and score the VITAL2015 call for proposals. He gave the board an overview of the VITAL2015 agenda.

	<ul style="list-style-type: none"> The 2015–2016 Fellows Program includes 39 fellows from 21 member organizations. Engler said that the association is trying to engage new members. The board discussed opportunities to keep fellows engaged with the association after they finish the program.
Population Health Manuscript (Taylor-Clark and Szekendi)	<ul style="list-style-type: none"> Engler introduced guest speakers Kalahn Taylor-Clark, PhD, MPH, and Marilyn Szekendi, PhD, RN, who presented their findings on the population health framework. The partnership formed between the Institute, GMU and UHC aimed to understand the future of population health. The researchers developed a framework around population health using 2012–2014 Gage Awards data and abstracts from UHC’s annual conference to identify population health initiatives at essential hospitals and academic medical centers. Key takeaways: <ul style="list-style-type: none"> Because of their missions, academic medical centers and essential hospitals have a responsibility to spearhead population health. They have a culture of multidisciplinary collaboration and tend to have strong relationships in their community to extend partnerships, which gives them the opportunity to act as innovators and early adopters. Population health requires an integrated approach that includes multidisciplinary staff, hospital systems, behavioral/mental health, etc. Programs must develop strategies to identify and access short- and long-term funding sources to be sustainable. Programs need to have measurable outcomes to show return on investment. The Institute produced two webinars on this research.
Membership Satisfaction Results (McKinley Advisors)	<ul style="list-style-type: none"> Metter introduced McKinley Advisors, who conducted and analyzed the member survey. The survey’s goal was to ensure that the association is aligned with member needs. Nearly 400 members responded, and more than half of member hospitals participated. This is a typical response rate for this type of survey. McKinley Advisors said that the overall survey results were positive for the association, with a net promoter score of 21 and 41 percent of respondents saying that membership value is greater than the cost of their dues. McKinley Advisors found that decision makers strongly favor the association, but the sentiment is weaker among non-decision makers. The association needs to look for opportunities to engage members outside of the C-suite. Decision makers most strongly value advocacy, while non-decision makers value tangible benefits, such as education. The board suggested engaging individuals at all levels of member organizations.

	<ul style="list-style-type: none"> The board agreed that the association should conduct a survey every other year.
Performance Improvement/Equity Update (Callahan)	<ul style="list-style-type: none"> Callahan updated the board on EHEN activities. The team is pursuing several additional grant opportunities. They will submit a proposal for HEN 2.0 at the end of March, with funding expected to begin in June. HEN 2.0 will focus on equity and engaging patients and families, and will include new harm measures for <i>Clostridium difficile</i> and sepsis. The team is focusing on equity in several ways and hopes to expand the REAL module nationally. The Institute will host a webinar series on the HCAHPS survey based on submissions and presentations from members.
KP-NACHC Project Report (Rangarao)	<ul style="list-style-type: none"> Rangarao told the board that the Institute is working on an equity project, which it will present to the board in June. Rangarao updated the board on the KP-NACHC project, which is in its third and final year. The Institute partnered with NACHC and George Washington University to facilitate collaboration among safety net providers and community health centers. The project built collaborations between hospitals and health systems that did not before exist. The communities are now working to engage local stakeholders and provide tangible deliverables. The Institute will host a summit for the participants in April
Results from <i>Essential Hospitals Vital Data</i> (Reid)	<ul style="list-style-type: none"> The Institute released <i>Essential Hospitals Vital Data</i>. Reid said that the analytics team received a high response rate from members. Graziano discussed the marketing and communications strategy for disseminating the report to the public. Next year's survey will be extended to all members.
2015 Revised Budget (Gold)	<ul style="list-style-type: none"> The Institute must revise its operating budget for 2015 due to the delay in the Partnership for Patients contract. The revised budget shows an operating deficit of \$847,000. The Institute's healthy net asset balance can support the deficit. <i>Jacobs requested a motion to approve the revised 2015 budget. There was a motion, a second, and unanimous approval.</i>
Office Move Update (Gold)	<ul style="list-style-type: none"> The association has signed the lease for 401 9th Street. The business terms are unchanged from what the board approved in October.
Adjourn	<ul style="list-style-type: none"> The meeting was adjourned at 12:11 pm

Submitted by:

Anna M. Roth, RN, MS, MPH
Secretary



DATE June 12, 2015
TO Board of Directors
FROM Anna Roth, RN, MS, MPH, Incoming Chair
RE New Committee Appointments

MEMORANDUM

The Essential Hospitals Institute bylaws require that all committee appointments be approved by the Institute's board of directors. As incoming chair, I recommend for board approval the following nominees for committee service.

I recommend these individuals to serve on the research committee:

- William B. Walker, MD
Director and Health Officer
Contra Costa Health Services
Research committee term: July 1, 2015 – June 30, 2016

- Alan Weil, JD, MPP
Editor-in-Chief
Health Affairs
Research committee term: July 1, 2015 – June 30, 2017

I recommend this individual to serve on the finance committee:

- Caroline Jacobs, MPH, MSEd
Senior Vice President, Safety & Human Development
New York City Health and Hospitals Corporation
Finance committee term: July 1, 2015 – June 30, 2016



2015 – 2016 Essential Hospitals Institute Committees

Finance Committee

FN	LN	Organization	City	ST	Term
Susan	Moffatt-Bruce	The Ohio State University Wexner Medical Center	Columbus	OH	Chair, 2015–2016
Leon	Haley	Grady Health System	Atlanta	GA	2015–2016
Caroline	Jacobs	NYC HHC	New York	NY	2015–2016
Reuven	Pasternak	Stony Brook University Hospital	Stony Brook	NY	2015–2017
Vacant					

Research Committee

FN	LN	Organization	City	ST	Term
Leon	Haley	Grady Health System	Atlanta	GA	Chair, 2015–2017
Ann Scott	Blouin	The Joint Commission	Chicago	IL	2015–2017
Donald	Goldmann	Institute for Healthcare Improvement	Cambridge	MA	2015–2017
Dennis	Keefe	Care New England Health System	Providence	RI	2015–2017
Susan	Moffatt-Bruce	The Ohio State University Wexner Medical Center	Columbus	OH	2015–2017
Katherine	Neuhausen	Virginia Commonwealth University Health System	Richmond	VA	2015–2017
Dean	Schillinger	San Francisco General Hospitals and Trauma Center	San Francisco	CA	2015–2017
Bill	Walker	Contra Costa	Martinez	CA	2015–2016
Alan	Weil	Health Affairs	Bethesda	MD	2015–2017
Irene	Yen	Alameda Health System	Oakland	CA	2015–2017

Executive Women's Leadership Academy Advisory Council

FN	LN	Organization	City	ST	Term
Ann Scott	Blouin	The Joint Commission	Chicago	IL	Chair, 2015–2017
Delvecchio	Finley	Harbor UCLA	Los Angeles	CA	2015–2017
Christine	Neuhoff	St. Luke's Health System	Boise	ID	2015–2017
Susan	Moffatt-Bruce	The Ohio State University Wexner Medical Center	Columbus	OH	2015–2017



DRAFT

Essential Hospitals Institute Board Member Expectations

Legal Duties for All Board Members¹

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

Expectations for All Board Members

- Provide organizational, strategic, and financial stewardship of the Institute
 - Read and understand the organization's bylaws and financial statements
- Consider issues brought before the board in the context of broader membership needs (not individual member needs)
 - Support the majority decision of the board
- Attend two out of three in-person board meetings annually
 - Prepare for meetings
 - Actively participate during meetings

Expectations for Member Directors

- Serve on one to two additional committees*
 - Attend conference calls and committee meetings
 - Serve as a liaison between the committee(s) and the board

- Make all reasonable efforts to attend at least one education or other in-person association meeting annually. For example:
 - Spring Policy Assembly (usually in March)
 - VITAL, the association's annual conference (usually in June)
 - Fall Policy Assembly (in October, or in December during election years)
- Encourage hospital staff to participate in association activities
 - Distance learning programs
 - Interest group sessions
 - In-person meetings
 - Fellows Program
 - Data collection efforts, (including the annual hospital characteristics survey)
- Assist with membership recruitment and retention activities
- Advocate issues important to our community of members to Congress, the administration, federal agencies, others in Washington, DC
- Support the Institute's public relations work on behalf of essential hospitals, including being available for media interviews

*Note that outside directors may serve on committees.

Expectations for Outside Directors

- Seek to find mutually beneficial collaborations between the association and/or Institute and the director's organization.

Additional Expectations of Officers

- Chair
 - Chair the board
 - Serve on nominating committee
 - Pass chair's gavel to incoming chair during VITAL
 - Participate in Gage Awards luncheon at during VITAL
 - Approve committee appointments
- Past-chair
 - Serve on nominating committee
- Chair-elect/Secretary
 - Chair the nominating committee
 - Receive chair's gavel at VITAL and give short address
 - Serve on finance committee
 - Review and sign minutes of each board meeting
- Treasurer
 - Chair finance committee
 - Serve on investment, audit, and compliance committee
 - Support preparation of the annual financial report
 - Support preparation of the annual audit

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



DATE June 12, 2015
TO Board of Directors
FROM David Engler, PhD
RE Institute Director's report

MEMORANDUM

Since the March 2015 board meeting, Essential Hospitals Institute completed the following work:

- As part of our work in the area of social determinants of health, the Institute is supporting member hospitals as they address the medical needs and social issues of homeless populations. In May 2015, the Institute held a webinar on how essential providers can partner with local organizations to create a comprehensive network for homeless patients. The Institute will soon publish a first-ever Quality Brief on the role essential hospitals play in health care for the homeless.
- The National Partnership hosted an in-person cross-community summit in Washington, DC on April 13 with members from the four community partners. The new partnership website, www.safetynetpartnership.org, was launched during the event, which featured best practice sharing and discussions on future policy and health care issues affecting providers filling a safety net role.
- This year's Innovations Summit will be held on October 15 and will focus on behavioral health integration. The meeting will feature essential hospitals members' work in this area. Staff is developing a research brief on innovative practices across five member hospitals for integrating behavioral health and primary care at essential hospitals. The brief will be released at the meeting. A webinar on this topic, featuring the work of Santa Clara Valley Health & Hospital System was presented to the membership on May 21.
- The research committee convened to discuss the Institute's future work around equity. The committee's discussions and recommendations will be presented at the June 24 board meeting.
- Our new class of 39 fellows will begin their first session during the week of VITAL2015.
- Program development is underway for the pilot class of the Essential Women's Leadership Academy. An advisory group of Institute board members has developed the curriculum and mentorship components of the program. The pilot class of 6 to 10 women

executives is scheduled to start in the fourth quarter of 2015. Funding requests have been sent to six foundations.

- To maintain the current Essential Hospitals Engagement Network (EHEN), staff held an “EHEN Readiness” webinar, with 46 participants on the call. Plans for the new contract – including new committees and new performance improvement efforts around C-Diff and Sepsis – were featured. More than 75 percent of the network has recommitted to another year. We await a decision on renewal by the Centers for Medicare & Medicaid Services (CMS).
- Work on the Ask Every Patient race, ethnicity, and language (REAL) project continues at a brisk pace. Five member hospitals have uploaded the e-learning module to their learning management systems. Outreach efforts to spread the module to more members are underway.
- The Patient Experience Forum, a four-part webinar series, kicked off on May 21 with 81 participants. Scheduled to run through November, the theme of the series is “sharing successful strategies to improve patient experience of care.”
- The Institute submitted a \$1.4-million, two-year proposal titled, “Accelerating Change in Essential Communities,” to the Robert Wood Johnson Foundation. The proposal envisions a comprehensive learning collaborative of safety net and non-safety net providers to accelerate reform implementation strategies. An advisory committee would oversee a re-granting component of this effort. The Institute partnered with Discern Health on key aspects of the work.
- The Institute is preparing for the launch of the 2014 Annual Hospital Characteristics Survey, which this year expands the data collection to include specialty hospitals within our membership. A robust orientation program has been developed, and a recruitment video has been filmed. Live and recorded webinar training sessions are planned for survey coordinators in addition to weekly office hours for questions and feedback.
- A half-page ad was published in *NewsPro*, a magazine for news professionals, to publicize Essential Hospitals Vital Data as the “go-to” source of data on Medicaid, social and economic barriers to care, and other issues affecting vulnerable patients.
- In May, research findings from the landscape review on population health in essential hospitals and academic medical centers were submitted for publication in the *Journal for HealthCare Quality*. The article, titled, “Advancing a Culture of Health: Population Health Programs in place at Essential Hospitals and Academic Medical Centers,” is a joint effort between the University Health Consortium (UHC), George Mason University, and the Institute.
- The Leadership Summit on State Medicaid Waivers will be held in Chicago on September 21. This second annual event will feature two tracks of programming for newcomers and seasoned waiver participants. CMS Director Wachino will be the keynote speaker.

Research Activities

Population Health Landscape Review

The Institute recently completed an ongoing initiative with partners at UHC and George Mason University. This effort included a large-scale evaluation of population health initiatives around the country based on an analysis of 121 hospital-led programs, sampled from submissions to America's Essential Hospitals Gage Awards and UHC poster presentations from 2012 to 2014. The project team analyzed this information and developed a conceptual framework for population health, particularly as it applies to essential hospitals and academic medical centers. Additionally, two webinars and stakeholder interviews were held to inform the analysis results and disseminate information to members. All findings were summarized in a scientific article, which was submitted for peer review in May 2015.

Social Determinants of Health

In January, the Institute concluded a web series on the social determinants of health. The seven monthly web postings started in July 2014 and included an overview of the social determinants of health; topic pieces on social capital, food insecurity, housing and employment, neighborhoods and safety, and education; and a wrap-up piece discussing how these issues interconnect.

In addition to highlighting the importance of patients' social factors in medical care, the series showcased the innovative practices essential hospitals use in response to social determinants of health. The series featured these member hospitals:

- Boston Medical Center
- Santa Clara Valley Medical Center
- Harborview Medical Center
- Hennepin County Medical Center
- Bon Secours Baltimore Health System
- Health Care District of Palm Beach County
- Arrowhead Regional Medical Center
- Denver Health
- Contra Costa Health Services
- Henry Ford Health System

In April 2015, the Institute conducted a webinar for its members, focusing on the relationship between homelessness, housing, and health – and why these considerations are important for health care providers. Speakers discussed how essential hospitals can improve care for homeless patients and break down traditional care siloes, including providing tips for essential hospitals to partner with local homelessness services. Speakers for this webinar included:

- Peggy Bailey – senior policy advisor, Corporation for Supportive Housing; and
- Barbara DiPietro, PhD – director of policy, National Health Care for the Homeless Council.

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

Into its third year, the National Partnership has worked with each of its four partner communities to build and inform collaboration with key stakeholders, develop a strategic plan, and provide technical assistance. In addition, each partner community developed a comprehensive work plan to maintain momentum and accomplish goals.

In April 2015, the National Partnership launched a website (www.safetynetpartnership.org) that contains information about all Partnership and community activities as well as key resources on effective collaborations, Medicaid waivers, and other topics of relevance to our efforts.

On April 13, 2015, the National Partnership held an in-person, cross-community summit with members from all partner communities. The goals of the conference follow:

- Provide a networking opportunity for members of the National Partnership communities
- Discuss best practices and identify opportunities for further collaboration between federally qualified health centers (FQHCs) and hospitals
- Examine current and future policy and health care issues that affect providers filling a safety net role (e.g., Section 1115 waivers, Medicaid expansion, payment reforms)

The event was a tremendous success, including rich discussions and insights from all participants. Our funder from Kaiser Permanente, Cecilia Echeverria, was also involved in the summit and found it to be an engaging event.

In addition to these activities, the National Partnership has focused on sustainability and phase II of this project for the past three months. The National Partnership has gleaned a substantial amount of information from phase I on the scope, feasibility, and impact of activities. The group is now prepared to implement these learnings in phase II of this effort. Some of the key differences in the proposed model for phase II follow:

- Expanding the number of communities addressed from four to eight and implementing a systematic application and evaluation process for selecting the communities
- Focusing on two key areas of interest – readiness for value-based care and Medicaid innovations
- Developing a learning collaborative on specific topics of interest, driven by aggregate demand from communities, rather than providing individualized technical assistance

A concept paper is being developed for submission to our current funders at Kaiser Permanente. Phase II will go into effect in April 2016.

Effectiveness of Transitional Care

Project ACHIEVE (Achieving Patient-Centered Care and Optimized Health in Care Transitions by Evaluating the Value of Evidence), a three-year effort funded by the Patient-Centered Outcomes Research Institute (PCORI), focuses on the following objectives:

- Learn which transitional care outcomes matter most to patients
- Evaluate current efforts to improve care transitions
- Develop recommendations on best practices for patient-centered care transition interventions with guidance for scalability and large-scale dissemination

While this project includes a variety of partners and activities, our role centers around recruiting five to eight member hospitals to be involved in year two of this effort. Year two will focus on implementation efforts to further evaluate the effectiveness of care transition programs. This work will include retrospective and longitudinal comparative analyses of patient and caregiver experiences with specific transitional care components.

Since March 2015, our team has developed a draft recruitment plan for our member hospitals. Recruitment will begin during the summer of 2015.

Behavioral Health Integration and Primary Care Research

The research team is developing a research brief on innovative methods for integrating behavioral health and primary care at essential hospitals. This brief will focus on conducting an environmental scan of all innovative programs that have been implemented at essential hospitals on behavioral health and primary care integration. Based on this landscape review, the team will identify and describe the top five, exemplary programs across the United States.

This study is primarily qualitative, focused on understanding the design, development, and implementation of each exemplary program. In some cases, essential hospitals have gathered data on the impact of their innovative programs, which the Institute will analyze to better assess their effectiveness in addressing such elements as:

- poor care coordination and/or transition of vulnerable patients between physical and mental health care settings;
- avoidable hospitalizations;
- emergency department admissions; and
- readmission rates.

Through an initial scan of Gage Award submissions, peer-reviewed and gray literature, and health system/hospital websites, the team has identified exemplary integration practices at the following five member hospitals:

- Harris Health System
- NuHealth
- UMass Memorial Health Care
- University of Texas Medical Branch
- University of Washington Medical Center

Disparities Research

The team is currently developing a topic for a research brief on equity/disparity issues within essential hospitals. On May 26, 2015, we gathered insights from the Institute's board research committee regarding appropriate research questions to pursue for this brief. The committee

Chair, Dr. Leon Haley, will provide an update on these activities during the June board meeting. Our goals for this effort follow:

- Understand how our members work to address potential inequities
- Identify which interventions are most effective in addressing inequities and disparities among essential hospitals

We strive to reach these goals in order to affect policy change and ensure that all patients – regardless of race/ethnicity, socioeconomic status, etc. – are afforded the opportunity to receive high quality health care.

Analytics Update

The Institute is preparing to launch the fiscal year (FY) 2014 Annual Hospital Characteristics Survey, a key data source for *Essential Hospitals Vital Data*. There will be exciting changes in the FY 2014 survey. First, we will expand the survey to all hospitals within the association's membership, including specialty hospitals. Due to the significant increase in expected survey responses, we will launch a more robust orientation, training, and communications strategy, which will include the following elements:

- A recently recorded participation recruitment video targeting member CEOs to encourage their organization's participation
- Orientations with all new members to introduce them to the survey
- A live and recorded webinar training session for hospital survey coordinators who complete the survey
- A user group on the association website to give survey coordinators access to documents, a survey coordinator message board, and frequently asked questions
- Weekly office hours to give survey coordinators an opportunity to raise issues and ask questions

We have also adjusted the survey timeline and format in response to feedback from our survey coordinator satisfaction and feedback survey conducted in November. Responses indicated a desire for a later launch and deadline date. As such, the survey will now launch June 31, and the deadline will be October 31. Additionally, there was an almost 50-50 split among survey coordinators requesting that the format of the survey be in Excel or an Adobe Acrobat (pdf) fillable form. As such, we will now offer the survey in both formats, and survey coordinators can choose the option that works best for them.

In addition to work related to the Annual Hospital Characteristics Survey, analytics staff are preparing a research brief that will examine financial, utilization, and patient demographic trends of a matched set of member hospitals. The trend brief will include the past five years of characteristics and American Hospital Association data. Validation of data points is currently in progress, and the report is expected to be published in the fall.

Fellows Program

The third and final session of the 2014 Fellows Program was a culmination of the fellows' hard work and dedication. Fellows attended the association's semiannual Policy Assembly and met

with their congressional delegations to advocate on behalf of essential hospitals. In addition, each fellow presented their projects and shared leadership challenges, lessons learned, and successes. This work enforced the adaptive leadership framework, as each fellow incorporated the model in their presentations. A graduation ceremony and celebration was held in honor of the 32 fellows who completed the program. Evaluation results confirmed the success of the program, as it received an overall rating of 4.7 – the highest rating in the history of the program.

During session I of the 2015 Fellows Program, the new class will learn the overall adaptive leadership framework, developed by Harvard University's Ron Heifetz and Marty Linksy. They will begin to think about and discuss their organization's challenges, which will be the focus of their projects. The fellows will gain valuable feedback on their projects during peer-to-peer consulting sessions.

Essential Hospitals Women's Leadership Academy

The Essential Hospitals Women's Leadership Academy program development is in full swing. The advisory committee has met by telephone to design the details of the program timeline and the mentor/mentee recruitment and matching strategy. An announcement will be made at both the association and Institute board meetings to solicit mentee/mentor nominations from board members.

Performance Improvement

EHEN

The initial hospital engagement network (HEN) contract with the Partnership for Patients and CMS ended December 8, 2014. The announcement for an additional year of funding was released February 12, and we submitted a proposal on March 30, 2015. More than 75 percent of the original network has recommitted to participating in HEN 2.0. However, as yet, CMS has not made formal announcements about funding. We are optimistic about the proposal's success, given EHEN's leading role in health equity and the high evaluation marks EHEN received in August 2014.

Staff continues to support the EHEN network in their endeavors to reduce patient harm, reduce disparities, and improve patient and family engagement. Staff also provides feedback and reports to the network based on data submitted to the National Healthcare Safety Network and directly to the Institute. We have developed new reports stratified by race, ethnicity, age, and gender.

Health Equity

The Institute is involved in multiple efforts focusing on health equity, including work in performance improvement and research.

The Office of the Assistant Secretary (OASH) Office of Disease Prevention and Health Promotion (ODPHP) currently focuses on efforts to eliminate preventable adverse drug events (ADEs) and to reduce disparities in health care associated infections and readmissions. As part of this work, ODPHP engaged the MITRE Corporation to work with hospital engagement networks in a root-cause analysis to help the hospitals identify contributing factors to disparities related to ADEs. There is no additional federal funding; however, project results will be shared with all

participating hospitals and health systems. The Institute is working with MITRE and EHEN 1.0 hospitals to explore participation in this partnership, as ADEs and disparities remain a focus of HEN 2.0.

Work on the Ask Every Patient: REAL project continues. This tool, launched last fall, teaches registration staff and others how to collect patients' race, ethnicity, and language data in a culturally sensitive and effective way. The module dovetails with our Equity of Care coalition work. We are building on momentum to date, including use by members Arrowhead Regional Medical Center, Cook County Health & Hospitals System, Henry Ford Health System, Regional One Health, and University Health System. Staff has developed a marketing plan to reach out to all members and leadership to encourage adoption of the e-learning module.

The Institute continues to work with its consultant to make the module available to all members and to explore ways to market it widely to all hospitals in partnership with The Joint Commission.

Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS)

Our four-part webinar series, Patient Experience Forum, kicked off on May 21 with a successful inaugural entry – including 64 participants on the web plus an additional 17 on the phone or in a room with a registered participant (81 in total), representing approximately 38 member organizations. The series concludes in November 2015. Member hospitals will share successful strategies and practices to improve patient experiences, as supported by Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey data. This 2015 series will be open to all members. Remaining offerings include the following:

- Applying Technology, Team Approaches to Enhance Patient Experience | The Ohio State University Wexner Medical Center and Ben Taub Hospital | July 29
- Improving Patient-Perceived Nurse Communication | Grady Health System | September 30
- Addressing Processes, Culture to Boost Patient Experience | Norwegian American Hospital and the University of Alabama at Birmingham (UAB) Hospital | November 18

Robert Wood Johnson Foundation (RWJF) Accelerating Payment and Delivery System Reform Efforts

On April 13, 2015 the Institute submitted a proposal titled, “Accelerating Change in Essential Communities (ACEC),” to RWJF to accelerate payment and delivery system reform. RWJF will conduct site visits to finalists in June, with an anticipated award announcement at the end of July. If successful, the project would start in October and last for two years.

ACEC will convene and support a comprehensive learning collaborative comprising safety net and non-safety net providers who represent a range of reform implementation efforts. This collaborative includes providers with demonstrated success, who will serve in mentorship and advisory roles; those who wish to further develop their models and share lessons learned; and five safety net providers suited for reform but lacking in adequate resources, who will receive re-granted funds. Key elements of success will be disseminated to a national audience through a public website, social media campaign, and formal reports.

The Institute proposes to partner with Discern Health for the ACEC project and will convene an advisory group of essential hospitals and stakeholders from various academic centers and provider/payer communities to guide the progress of the participants.

Transforming Clinical Practices Initiatives (TCPI)

TCPI is a new project that receives support from CMS. The initiative is designed to assist 150,000 clinician practices during the next four years to achieve large-scale health transformation.

TCPI is awarding two types of cooperative agreements: Practice Transformation Network (PTN) and Support and Alignment Network (SAN). The PTNs are learning networks of clinical practices applying best practices for positive change. The SANs provide resources and education that support workforce development among the PTNs. SANs will also help practices serving small, rural, and medically underserved communities.

The Institute submitted a proposal to serve as prime contractor for SAN and as subcontractor under UHC's proposal for a PTN. The awards were to be announced in early May; however, in early May CMS revised the anticipated announcement date to "late spring/early summer". If the Institute wins a TCPI-SAN award, it likely will add two new staff members. If UHC secures an award, existing staff would handle the Institute's subcontracted work.

Data Collection and UHC Subcontract

In December 2014 the EHEN subcontract with UHC to collect and analyze data required by the hospital engagement contract ended. We plan to renew that partnership for work under the next year of funding.



DATE June 12, 2015
TO Board of Directors
FROM Rhonda Gold, CFO
RE Budget Update

MEMORANDUM

This memorandum summarizes the 2014 audited financial statements, a 2015 financial projection compared with budget, and an investment update. The attached materials have been reviewed with and accepted by the Institute's finance committee.

The board is asked to:

- Accept the Essential Hospitals Institute's 2014 audited financial statements as recommended by the investment, audit, and compliance (IAC) and finance committees. We are pleased to report that there were no management letter comments.
- Accept the 2015 budget update.

2014 Audit

The Institute ended 2014 with total assets of \$8.52 million, of which \$8.08 million were in cash and other current assets; and \$1.11 million in liabilities, mostly due to the reimbursement due to the association for intercompany expenses ("due to America's Essential Hospitals") which was paid in January 2015.

As reflected on the Statements of Activities and Changes in Net Assets, the Institute had \$7.55 million in unrestricted revenue (including \$5.49 million from the Centers for Medicare & Medicaid Services (CMS) Partnership for Patients contract with Essential Hospitals Engagement Network (EHEN)), which was offset by \$6.5 million in expenses, leaving a \$1.05 million change in net assets ("operating surplus"). This represents a 14 percent profit margin. Total net assets are \$7.41 million, of which \$589,000 is temporarily restricted for existing grants, leaving an operational reserve ("unrestricted") of almost \$6.83 million.

The Institute board set aside \$4.2 million in "board designated" net assets, of which \$3.3 million is in a special purpose fund for programs and other activities that further the Institute's mission; and \$900,000 is reflected in an operating reserve to cover recurring expenses (e.g., salaries and benefits, rent, office, travel, program, and ongoing professional services). The remaining \$2.63 million is undesignated net assets.

Due to delays by CMS in releasing the request for proposals for renewal of hospital engagement network contracts, including the Institute's EHEN, the contract may not be funded until the summer. As presented to the board in March, this postponement presents significant financial

implications to the organization as personnel, rent, office equipment, and webinars normally budgeted under the contract will not be charged to the program until mid-year. During this transitional period, the board had approved using part of the net asset balance from prior years' unspent contract funds to cover the ongoing costs of our performance improvement work. We are hopeful the contract will be renewed in the near future.

2015 Projection

The financial projection for the year is reflected in column 8 of Attachment I. Because the board recently approved a revised budget, in March, there are no significant budget variances to report at this time. Projected revenue and expenses of \$5.87 million and \$6.72 million, respectively, are on target with budget; and the projected operating loss (change in net assets) is \$847,000. Projected net assets are \$5.97 million, of which \$4.2 million is board-designated and \$1.77 million is undesignated net assets.

External funding reflected in the budget and projection include the following awards and proposals:

Funder	Description	Term	Total Budget	2015 Income
CMS	Partnership for Patients	6/1/15-6/30/16	\$5.79 million	\$3.11 million
Kaiser Permanente	Collaboration with the National Association of Community Health Centers and The George Washington University for a study on 2014 Preparations by Community Health Centers and Safety Net Hospitals	4/1/13-4/1/16	\$1.8 million, split between the three organizations	\$438,000
DISTI 2.0	Learning collaborative on the Massachusetts care delivery system	1/1/15-12/31/17	\$859,816	\$274,400
Patient-Centered Outcomes Research Institute	Improving Care Transitions, a project led by the University of Kentucky; to	1/1/15-12/31/17	\$431,000	\$127,000

	discover care transition outcomes for importance to patients and evaluate current efforts for improving care transitions and interventions			
Kaiser Permanente Community Benefit	Core funding of the Institute's transformation center	8/1/15-7/31/17	\$592,300	\$343,000
Transforming Clinical Practice Initiative	Provide strategic support to Practice Transformation Networks through collaborative learning	5/1/15-4/30/19	\$1.97 million	\$320,000
	Total		\$11.4 million	\$4.61 million

The Institute recently submitted a two-year proposal for \$1.4 million to the Robert Wood Johnson Foundation to develop a learning collaborative for identifying key elements of success in payment and delivery system reform. This proposal is not reflected in the approved budget or financial projection.

Investment Update

This investment update was reviewed with and accepted by the investment, audit, and compliance committee on May 13. To summarize, Essential Hospitals Institute's intermediate term reserve is a moderately conservative portfolio tilted toward stability, invested 30 percent in stocks and 70 percent in bonds. The portfolio was in line with its target allocations as of April 30. The portfolio gained 1.7 percent, or \$57,000, for the year to date and is up 2.2 percent, or \$73,000, since the portfolio's inception on August 31, 2014. This compares with the portfolio benchmark, which was up 2.2 percent and 2.5 percent over the year to date and since inception, respectively. The portfolio slightly trailed the benchmark over the year to date due to the equity allocations trailing their benchmarks. Since inception, the portfolio trailed the benchmark as a result of weaknesses from the foreign stock allocation as the tilt towards value stocks was out of favor over the second half of 2014. The fixed income allocations outpaced their benchmarks, but not by enough to counter the weakness from the equity allocations.

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

Attachments:

2015 Financial Projection Compared with Budget (Attachment I)
2014 Audited Financial Statements for Essential Hospitals Institute

Attachment I

Essential Hospital Institute

2015 Revised Budget and Vital 2015 Projection

	Research			Analytics			Performance Improvement			Fellows			Innovation and Partnerships			G&A			Total: 2015 REVISED Budget & Projection				
	Funded	Unfunded	Total	Unfunded	Funded	Unfunded	Total	Unfunded	Funded	Unfunded	Total	G&A	Funded	Unfunded	Unrestricted	Total:	Temp Restricted	Total					
INCOME:																							
Unrestricted Grant from UHC	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 400,000	\$ -	\$ 400,000	\$ 400,000	\$ -	\$ 400,000	\$ -	\$ 400,000				
Grant Income	\$ 840,000	\$ -	\$ 840,000	\$ -	\$ 320,000	\$ 320,000	\$ -	\$ 344,000	\$ 344,000	\$ -	\$ -	\$ 1,504,000	\$ -	\$ -	\$ 1,504,000	\$ 5,276,300	\$ 6,780,300						
Government Contract	\$ -	\$ -	\$ -	\$ -	\$ 3,113,000	\$ 3,113,000	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 3,113,000	\$ -	\$ -	\$ 3,113,000	\$ -	\$ 3,113,000						
Tuition Income	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 262,500	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 262,500	\$ 262,500	\$ -	\$ 262,500						
Contribution/Support from AEH	\$ -	\$ 190,000	\$ 190,000	\$ 242,000	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 163,000	\$ -	\$ 595,000	\$ 595,000	\$ -	\$ 595,000						
Net Assets Released from Donor Restrictions	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ (1,502,000)	\$ (1,502,000)					
TOTAL INCOME	\$ 840,000	\$ 190,000	\$ 1,030,000	\$ 242,000	\$ 3,433,000	\$ -	\$ 3,433,000	\$ 262,500	\$ 344,000	\$ -	\$ 344,000	\$ 563,000	\$ 4,617,000	\$ 1,257,500	\$ 5,874,500	\$ 3,774,300	\$ 9,648,800						
Personnel	\$ 324,300	\$ 151,500	\$ 475,800	\$ 191,000	\$ 1,417,400	\$ 716,000	\$ 2,133,400	\$ 129,000	\$ 270,000	\$ 190,000	\$ 460,000	\$ 795,800	\$ 2,011,700	\$ 2,173,300	\$ 4,185,000	\$ -	\$ 4,185,000						
Consultants & sub-contracted svces	\$ 391,400	\$ -	\$ 391,400	\$ -	\$ 299,500	\$ -	\$ 299,500	\$ 142,300	\$ 5,000	\$ 15,000	\$ 20,000	\$ 77,500	\$ 695,900	\$ 234,800	\$ 930,700	\$ -	\$ 930,700						
Equipment	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 30,000	\$ -	\$ 30,000	\$ -	\$ -	\$ 30,000	\$ -	\$ 30,000	\$ -	\$ 30,000					
Office Supplies & Services	\$ 3,800	\$ 25,900	\$ 29,700	\$ 40,600	\$ 54,400	\$ 1,700	\$ 56,100	\$ 13,300	\$ 2,900	\$ 2,000	\$ 4,900	\$ 98,000	\$ 61,100	\$ 181,500	\$ 242,600	\$ -	\$ 242,600						
Rent	\$ -	\$ -	\$ -	\$ -	\$ 118,700	\$ -	\$ 118,700	\$ -	\$ -	\$ -	\$ -	\$ 235,300	\$ 118,700	\$ 235,300	\$ 354,000	\$ -	\$ 354,000						
Travel & meetings	\$ 29,400	\$ 12,600	\$ 42,000	\$ 10,400	\$ 418,500	\$ 500	\$ 419,000	\$ 116,100	\$ 5,100	\$ 500	\$ 5,600	\$ 141,000	\$ 453,000	\$ 281,100	\$ 734,100	\$ -	\$ 734,100						
Depr and amort.	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 21,600	\$ -	\$ 21,600	\$ -	\$ 21,600	\$ -	\$ 21,600					
Information Technology	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 82,500	\$ -	\$ 82,500	\$ 82,500	\$ -	\$ 82,500						
Misc, Taxes and Insurance	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 41,000	\$ -	\$ 41,000	\$ 41,000	\$ -	\$ 41,000						
Project Development	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 100,000	\$ -	\$ 100,000	\$ 100,000	\$ -	\$ 100,000						
Sub-total before grant overhead coverage	\$ 748,900	\$ 190,000	\$ 938,900	\$ 242,000	\$ 2,308,500	\$ 718,200	\$ 3,026,700	\$ 400,700	\$ 283,000	\$ 207,500	\$ 490,500	\$ 1,622,700	\$ 3,340,400	\$ 3,381,100	\$ 6,721,500	\$ -	\$ 6,721,500						
Allocation of Overhead to Grants	\$ 91,100	\$ -	\$ 91,100	\$ -	\$ 894,500	\$ -	\$ 894,500	\$ -	\$ 61,000	\$ -	\$ 61,000	\$ (1,046,600)	\$ 1,046,600	\$ (1,046,600)	\$ -	\$ -	\$ -						
Total Expenses	\$ 840,000	\$ 190,000	\$ 1,030,000	\$ 242,000	\$ 3,203,000	\$ 718,200	\$ 3,921,200	\$ 400,700	\$ 344,000	\$ 207,500	\$ 551,500	\$ 576,100	\$ 4,387,000	\$ 2,334,500	\$ 6,721,500	\$ -	\$ -	\$ 6,721,500					
Operating Net Income (Loss)	\$ -	\$ -	\$ -	\$ -	\$ 230,000	\$ (718,200)	\$ (488,200)	\$ (138,200)	\$ -	\$ (207,500)	\$ (207,500)	\$ (13,100)	\$ 230,000	\$ (1,077,000)	\$ (847,000)	\$ 3,774,300	\$ 2,927,300						
Net Assets:																							
Prior Year Net Assets	\$ 108,333	\$ (299,017)	\$ (190,684)	\$ (125,600)	\$ 6,070,992	\$ (235,294)	\$ 5,835,698	\$ 46,884	\$ -	\$ (61,826)	\$ (61,826)	\$ 1,317,310	\$ 6,179,325	\$ 642,456	\$ 6,821,781	\$ 589,760	\$ 7,411,541						
Change in Net Assets	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 230,000	\$ (718,200)	\$ (488,200)	\$ (138,200)	\$ -	\$ (207,500)	\$ (207,500)	\$ (13,100)	\$ 230,000	\$ (1,077,000)	\$ (847,000)	\$ 3,774,300	\$ 2,927,300					
Net Assets, End of Year	\$ 108,333	\$ (299,017)	\$ (190,684)	\$ (125,600)	\$ 6,300,992	\$ (953,494)	\$ 5,347,498	\$ (91,316)	\$ -	\$ (269,326)	\$ (269,326)	\$ 1,304,210	\$ 6,409,325	\$ (434,544)	\$ 5,974,781	\$ 4,364,060	\$ 10,338,841						
Restricted Net Assets:																							
Special Purpose Fund	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 3,300,000	\$ -	\$ 3,300,000					
Board Designated Operating Reserve	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 900,000	\$ -	\$ 900,000					
Total Restricted Net Assets	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 4,200,000	\$ -	\$ 4,200,000					
Unrestricted Net Assets	\$ 108,333	\$ (299,017)	\$ (190,684)	\$ (125,600)	\$ 6,300,992	\$ (953,494)	\$ 5,347,498	\$ (91,316)	\$ -	\$ (269,326)	\$ (269,326)	\$ 1,304,210	\$ 6,409,325	\$ (434,544)	\$ 1,774,781	\$ 4,364,060	\$ 6,138,841						
Total Net Assets	\$ 108,333	\$ (299,017)	\$ (190,684)	\$ (125,600)	\$ 6,300,992	\$ (953,494)	\$ 5,347,498	\$ (91,316)	\$ -	\$ (269,326)	\$ (269,326)	\$ 1,304,210	\$ 6,409,325	\$ (434,544)	\$ 5,974,781	\$ 4,364,060	\$ 10,338,841						

GELMAN, ROSENBERG & FREEDMAN

CERTIFIED PUBLIC ACCOUNTANTS



May 13, 2015

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

We have audited the financial statements of Essential Hospitals Institute for the year ended December 31, 2014, and have issued our report thereon dated May 13, 2015. Professional standards require that we provide you with information about our responsibilities under generally accepted auditing standards, as well as certain information related to the planned scope and timing of our audit. We have communicated such information in our letter to you dated November 21, 2014.

Professional standards also require that we communicate to you the following information related to our audit.

- **Qualitative Aspects of Accounting Practices**

Management is responsible for the selection and use of appropriate accounting policies. The significant accounting policies used by Essential Hospitals Institute are described in Note 1 to the financial statements. No new accounting policies were adopted and the application of existing policies was not changed during the year ended December 31, 2014. We noted no transactions entered into by Essential Hospitals Institute during the year for which there is a lack of authoritative guidance or consensus. All significant transactions have been recognized in the financial statements in the proper period.

Accounting estimates are an integral part of the financial statements prepared by management and are based on management's knowledge and experience about past and current events and assumptions about future events. Certain accounting estimates are particularly sensitive because of their significance to the financial statements and because of the possibility that future events affecting them may differ significantly from those expected.

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The most sensitive estimate affecting the financial statements was management's estimate of the allocation of expenses to programs and to Essential Hospitals Institute's related entity, which is based on an allocation of the actual time spent on each program. We evaluated the key factors and assumptions used to develop the allocation in determining that it is reasonable in relation to the financial statements taken as a whole.

The disclosures in the financial statements are neutral, consistent and clear. Certain financial statement disclosures are particularly sensitive because of their significance to financial statement users.

The most sensitive disclosure affecting the financial statements was the disclosure of related party transactions in Note 6 to the financial statements.

- **Difficulties Encountered in Performing the Audit**

We encountered no significant difficulties in dealing with management in performing and completing our audit.

- **Corrected and Uncorrected Misstatements**

Professional standards require us to accumulate all misstatements identified during the audit, other than those that are clearly trivial, and communicate them to the appropriate level of management. Management has corrected all such misstatements. In addition, none of the misstatements detected as a result of audit procedures and corrected by management were material, either individually or in the aggregate, to the financial statements taken as a whole.

We proposed five adjusting journal entries that decreased the net assets by approximately \$1,320. The most significant of these was to reverse an accrual related to 2015 expenses.

- **Disagreements with Management**

For purposes of this letter, a disagreement with management is a financial accounting, reporting, or auditing matter, whether or not resolved to our satisfaction, that could be significant to the financial statements or the auditor's report. We are pleased to report that no such disagreements arose during the course of our audit.

- **Planned Scope and Timing of the Audit**

We performed our audit according to the planned scope and timing previously communicated to you in our engagement letter and our other letter on planning of the engagement dated November 21, 2014.

- **Management Representations**

We have requested certain representations from management that are included in the management representation letter dated May 13, 2015.

- **Management Consultations with Other Independent Accountants**

In some cases, management may decide to consult with other accountants about auditing and accounting matters, similar to obtaining a "second opinion" on certain situations. If a consultation involves application of an accounting principle to Essential Hospitals Institute's financial statements or a determination of the type of auditor's opinion that may be expressed on those statements, our professional standards require the consulting accountant to check with us to determine that the consultant has all the relevant facts. To our knowledge, there were no such consultations with other accountants.

- **Other Audit Findings or Issues**

We generally discuss a variety of matters, including the application of accounting principles and auditing standards, with management each year prior to retention as Essential Hospitals Institute's auditors. However, these discussions occurred in the normal course of our professional relationship and our responses were not a condition to our retention.

- **Independence and Non-Audit Services Provided by Audit Firm**

In accordance with professional standards, during the fiscal year and currently, all members of our firm were independent with respect to Essential Hospitals Institute.

During the year under audit, we provided corporate tax preparation services (IRS Form 990) and additional tax advice. All other time and expenses incurred by us were in connection with our annual audit.

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



May 13, 2015

GELMAN, ROSENBERG & FREEDMAN

CERTIFIED PUBLIC ACCOUNTANTS



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

In planning and performing our audit of the financial statements of Essential Hospitals Institute as of and for the year ended December 31, 2014, in accordance with auditing standards generally accepted in the United States of America, we considered Essential Hospitals Institute's internal control over financial reporting (internal control) as a basis for designing our auditing procedures, for the purpose of expressing our opinion on the financial statements, but not for the purpose of expressing an opinion on the effectiveness of Essential Hospitals Institute's internal control. Accordingly, we do not express an opinion on the effectiveness of Essential Hospitals Institutes internal control.

Our consideration of Essential Hospitals Institute's internal control was for the limited purpose described in the preceding paragraph and was not designed to identify all deficiencies in Essential Hospitals Institute's internal control that might be significant deficiencies or material weaknesses and therefore, there can be no assurance that all such deficiencies have been identified. However, as discussed below, we identified certain matters involving the internal control and other operational matters that are presented for your consideration. This letter does not affect our report dated May 13, 2015 on the financial statements of Essential Hospitals Institute. We will review the status of these comments during our next audit engagement. Our comments and recommendations, all of which have been discussed with appropriate members of management, are intended to improve the internal control or result in other operating efficiencies. We will be pleased to discuss these comments in further detail at your convenience, perform any additional study of these matters, or assist you in implementing the recommendations. Our comments are summarized as follows:

OTHER RECOMMENDATIONS

Fixed Price Contract

Prior Year Comment: At our recommendation, Essential Hospitals Institute did receive written notification that the Federal government was aware of the change in scope of work from the budget estimate of 66 hospitals to the final 30 participating hospitals. The fixed price contract with the government ended in December 2013. As a result of the reduction in scope, Essential Hospitals Institute has recognized a profit on this contract. An audit entry of approximately \$4,300,000 was posted to recognize the deferred revenue/profit from this contract. While the government approved the change in scope, we want to alert management that the Federal government still has the right to come back and request certain funds be reimbursed to them if they would deem this unreasonable.

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Current Year Status: The contract was extended for an additional one year option for a price of approximately \$5.5 million. The grant work was completed with no outstanding receivable or deferred balances, and accordingly, the full amount of the award was recognized to revenue during the year. We continue to note that the government approved the change in scope for work under the original grant and subsequent options.

Timesheet Approvals

Prior Year Status: We noted two (2) of the four (4) randomly selected timesheets lacked supervisory approval. While the controls around the timesheet system appear to be in place, the lack of approvals resulted from transition to the new system. We strongly recommend Essential Hospitals Institute ensure the current procedures are implemented, including an oversight process, with the respect to the approval process with the new electronic timesheet system to ensure all timesheets are adequately approved.

Current Year Status: Employee timesheets are currently being reviewed and approved. We consider this comment adequately addressed.

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



May 13, 2015

FINANCIAL STATEMENTS

ESSENTIAL HOSPITALS INSTITUTE

**FOR THE YEARS ENDED
DECEMBER 31, 2014 AND 2013**

ESSENTIAL HOSPITALS INSTITUTE

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GELMAN, ROSENBERG & FREEDMAN

CERTIFIED PUBLIC ACCOUNTANTS



INDEPENDENT AUDITOR'S REPORT

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

We have audited the accompanying financial statements of Essential Hospitals Institute, which comprise the statements of financial position as of December 31, 2014 and 2013, and the related statements of activities and changes in net assets, functional expenses and cash flows for the years then ended, and the related notes to the financial statements.

Management's Responsibility for the Financial Statements

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

Auditor's Responsibility

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

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

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

Opinion

In our opinion, the financial statements referred to above present fairly, in all material respects, the financial position of Essential Hospitals Institute as of December 31, 2014 and 2013, and the changes in its net assets and its cash flows for the years then ended in accordance with accounting principles generally accepted in the United States of America.

May 13, 2015

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

ESSENTIAL HOSPITALS INSTITUTE
STATEMENTS OF FINANCIAL POSITION
AS OF DECEMBER 31, 2014 AND 2013

	ASSETS	
	2014	2013
CURRENT ASSETS		
Cash and cash equivalents	\$ 4,778,303	\$ 6,844,285
Investments (Notes 2 and 12)	3,304,425	-
Grants receivable, current portion (Note 3)	365,134	1,037,971
Contracts receivable	-	64,740
Prepaid expenses	<u>33,961</u>	<u>34,770</u>
Total current assets	<u>8,481,823</u>	<u>7,981,766</u>
FURNITURE, EQUIPMENT AND LEASEHOLD IMPROVEMENTS		
Furniture and equipment	420,914	437,005
Leasehold improvements (Note 11)	<u>78,839</u>	<u>78,839</u>
	499,753	515,844
Less: Accumulated depreciation and amortization	<u>(453,427)</u>	<u>(402,218)</u>
Net furniture, equipment and leasehold improvements	<u>46,326</u>	<u>113,626</u>
OTHER ASSETS		
Grants receivable, net of current portion (Note 3)	-	363,851
TOTAL ASSETS	\$ 8,528,149	\$ 8,459,243
LIABILITIES AND NET ASSETS		
CURRENT LIABILITIES		
Accounts payable	\$ 94,433	\$ 522,332
Accrued salaries and related benefits	44,239	46,674
Current portion of deferred rent abatement (Note 11)	39,349	25,751
Due to America's Essential Hospitals (Note 7)	<u>932,272</u>	<u>55,007</u>
Total current liabilities	<u>1,110,293</u>	<u>649,764</u>
LONG-TERM LIABILITIES		
Deferred rent abatement, net of current portion (Note 11)	-	39,349
Total liabilities	<u>1,110,293</u>	<u>689,113</u>
NET ASSETS		
Unrestricted:		
Undesignated	2,628,038	5,774,070
Board designated (Note 6)	<u>4,200,000</u>	-
Total unrestricted	<u>6,828,038</u>	<u>5,774,070</u>
Temporarily restricted (Note 4)	<u>589,818</u>	<u>1,996,060</u>
Total net assets	<u>7,417,856</u>	<u>7,770,130</u>
TOTAL LIABILITIES AND NET ASSETS	\$ 8,528,149	\$ 8,459,243

See accompanying notes to financial statements.

ESSENTIAL HOSPITALS INSTITUTE
STATEMENTS OF ACTIVITIES AND CHANGES IN NET ASSETS
FOR THE YEARS ENDED DECEMBER 31, 2014 AND 2013

	2014		
	Unrestricted	Temporarily Restricted	Total
REVENUE AND SUPPORT			
Contracts (Notes 9 and 10)	\$ 5,493,808	\$ -	\$ 5,493,808
Grants (Notes 9 and 10)	355,000	-	355,000
Contributions (Note 7)	-	-	-
Tuition income	221,000	-	221,000
Miscellaneous	55,500	-	55,500
Investment income (Note 2)	23,427	-	23,427
Net assets released from donor restrictions (Note 5)	<u>1,406,242</u>	<u>(1,406,242)</u>	<u>-</u>
Total revenue and support	<u>7,554,977</u>	<u>(1,406,242)</u>	<u>6,148,735</u>
EXPENSES			
Grants and Health Care	5,100,544	-	5,100,544
Transformation Center	981,089	-	981,089
Research and Education	403,162	-	403,162
General and Administrative	<u>16,214</u>	<u>-</u>	<u>16,214</u>
Total expenses	<u>6,501,009</u>	<u>-</u>	<u>6,501,009</u>
Changes in net assets	1,053,968	(1,406,242)	(352,274)
Net assets at beginning of year	<u>5,774,070</u>	<u>1,996,060</u>	<u>7,770,130</u>
NET ASSETS AT END OF YEAR	<u>\$ 6,828,038</u>	<u>\$ 589,818</u>	<u>\$ 7,417,856</u>

See accompanying notes to financial statements.

2013		
Unrestricted	Temporarily Restricted	Total
\$ 7,985,704	\$ -	\$ 7,985,704
526,869	1,800,000	2,326,869
700,000	-	700,000
246,000	-	246,000
200		200
9,118	-	9,118
<u>1,295,306</u>	<u>(1,295,306)</u>	<u>-</u>
<u>10,763,197</u>	<u>504,694</u>	<u>11,267,891</u>
4,364,227	-	4,364,227
855,996	-	855,996
414,114	-	414,114
<u>316,781</u>	<u>-</u>	<u>316,781</u>
<u>5,951,118</u>	<u>-</u>	<u>5,951,118</u>
4,812,079	504,694	5,316,773
<u>961,991</u>	<u>1,491,366</u>	<u>2,453,357</u>
\$ 5,774,070	\$ 1,996,060	\$ 7,770,130

See accompanying notes to financial statements.

ESSENTIAL HOSPITALS INSTITUTE
STATEMENT OF FUNCTIONAL EXPENSES
FOR THE YEAR ENDED DECEMBER 31, 2014

	Grants and Health Care	Transformation Center	and Education	General and Administrative	Total Expenses
Salaries and employee benefits (Notes 6 and 7)	\$ 1,944,710	\$ 608,612	\$ 361,329	\$ 731,616	\$ 3,646,267
Equipment	-	-	-	18,002	18,002
Office supplies and services	26,833	9,315	13,865	53,394	103,407
Rent (Note 9)	218,833	-	-	93,200	312,033
Printing	-	-	1,050	174	1,224
Travel and meetings	781,371	142,462	13,346	47,689	984,868
Depreciation and amortization	-	-	-	51,209	51,209
Consultants and sub-contracted services	988,319	149,384	6,677	61,065	1,205,445
IT and computer	111,978	-	-	27,256	139,234
Investment fees	-	-	-	8,562	8,562
Miscellaneous	-	-	6,895	23,863	30,758
 Sub-total	 4,072,044	 909,773	 403,162	 1,116,030	 6,501,009
Allocation of overhead	1,028,500	71,316	-	(1,099,816)	-
 TOTAL	 \$ 5,100,544	 \$ 981,089	 \$ 403,162	 \$ 16,214	 \$ 6,501,009

See accompanying notes to financial statements.

ESSENTIAL HOSPITALS INSTITUTE
STATEMENT OF FUNCTIONAL EXPENSES
FOR THE YEAR ENDED DECEMBER 31, 2013

	Grants and Health Care	Transformation Center	Research and Education	General and Administrative	Total Expenses
Salaries and employee benefits (Notes 6 and 7)	\$ 2,111,944	\$ 557,189	\$ 331,853	\$ 627,967	\$ 3,628,953
Equipment	6,541	16,440	-	15,499	38,480
Office supplies and services	37,791	33,841	19,397	127,404	218,433
Rent (Note 9)	237,270	-	-	78,819	316,089
Printing	975	1,216	-	6,673	8,864
Travel and meetings	190,084	118,408	20,251	27,181	355,924
Depreciation and amortization	81,329	-	-	36,206	117,535
Donations and sponsorship	-	1,500	-	-	1,500
Consultants and sub-contracted services	998,502	61,785	42,613	105,318	1,208,218
IT and computer	-	-	-	32,556	32,556
Miscellaneous	-	-	-	24,566	24,566
Sub-total	3,664,436	790,379	414,114	1,082,189	5,951,118
Allocation of overhead	699,791	65,617	-	(765,408)	-
TOTAL	\$ 4,364,227	\$ 855,996	\$ 414,114	\$ 316,781	\$ 5,951,118

See accompanying notes to financial statements.

ESSENTIAL HOSPITALS INSTITUTE
STATEMENTS OF CASH FLOWS
FOR THE YEARS ENDED DECEMBER 31, 2014 AND 2013

	<u>2014</u>	<u>2013</u>
CASH FLOWS FROM OPERATING ACTIVITIES		
Changes in net assets	\$ (352,274)	\$ 5,316,773
Adjustments to reconcile changes in net assets to net cash provided by operating activities:		
Depreciation and amortization	51,209	117,535
Unrealized loss	18,594	-
Capitalized items reallocated towards contract	20,199	-
(Increase) decrease in:		
Grants receivable	1,036,688	(89,103)
Contracts receivable	64,740	(2,100,935)
Prepaid expenses	809	11,234
Increase (decrease) in:		
Accounts payable	(427,899)	(70,871)
Accrued salaries and related benefits	(2,435)	(5,693)
Deferred rent abatement	(25,751)	(12,703)
Due to America's Essential Hospitals	<u>877,265</u>	<u>(1,333,234)</u>
Net cash provided by operating activities	<u>1,261,145</u>	<u>1,833,003</u>
CASH FLOWS FROM INVESTING ACTIVITIES		
Purchase of furniture and equipment	(4,108)	(44,613)
Purchase of investments	<u>(3,323,019)</u>	<u>-</u>
Net cash used by investing activities	<u>(3,327,127)</u>	<u>(44,613)</u>
Net (decrease) increase in cash and cash equivalents	(2,065,982)	1,788,390
Cash and cash equivalents at beginning of year	<u>6,844,285</u>	<u>5,055,895</u>
CASH AND CASH EQUIVALENTS AT END OF YEAR	\$ 4,778,303	\$ 6,844,285

See accompanying notes to financial statements.

ESSENTIAL HOSPITALS INSTITUTE

NOTES TO FINANCIAL STATEMENTS DECEMBER 31, 2014 AND 2013

1. ORGANIZATION AND SIGNIFICANT ACCOUNTING POLICIES

Organization -

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

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

Basis of presentation -

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

Cash and cash equivalents -

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

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

Investments -

Investments are recorded at their readily determinable fair value. Realized and unrealized gains and losses are included in investment income on the Statements of Activities and Changes in Net Assets.

Receivables -

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

Furniture, equipment and leasehold improvements -

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

ESSENTIAL HOSPITALS INSTITUTE

NOTES TO FINANCIAL STATEMENTS DECEMBER 31, 2014 AND 2013

1. ORGANIZATION AND SIGNIFICANT ACCOUNTING POLICIES (Continued)

Contracts -

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

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

Essential Hospitals Institute received a fixed price contract from the Department of Health and Human Services during fiscal year 2011, in the amount of \$11,752,541. The contract period of performance is over 24 months, which ended on December 8, 2013. Essential Hospitals Institute was awarded one 12-month option period for an additional \$5,760,735 of funding. The purpose of the contract is to develop and possibly implement a campaign designed to decrease patient harm. During the years ended December 31, 2014 and 2013, Essential Hospitals Institute recorded contract revenue from this specific fixed price contract in the amounts of \$5,493,808 and \$7,985,704, respectively.

Contributions and grants -

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

Income taxes -

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

Uncertain tax positions -

For the years ended December 31, 2014 and 2013, Essential Hospitals Institute has documented its consideration of FASB ASC 740-10, *Income Taxes*, that provides guidance for reporting uncertainty in income taxes and has determined that no material uncertain tax positions qualify for either recognition or disclosure in the financial statements.

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

Use of estimates -

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

Functional allocation of expenses -

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

ESSENTIAL HOSPITALS INSTITUTE

NOTES TO FINANCIAL STATEMENTS DECEMBER 31, 2014 AND 2013

1. ORGANIZATION AND SIGNIFICANT ACCOUNTING POLICIES (Continued)

Net asset classification -

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

- **Unrestricted net assets** include unrestricted revenue and contributions received without donor-imposed restrictions. These net assets are available for the operation of Essential Hospitals Institute and include both internally designated and undesignated resources.
- **Temporarily restricted net assets** include revenue and contributions subject to donor-imposed stipulations that will be met by the actions of Essential Hospitals Institute and/or the passage of time. When a restriction expires, temporarily restricted net assets are reclassified to unrestricted net assets and reported in the Statements of Activities and Changes in Net Assets as net assets released from restrictions.

Risks and uncertainties -

Essential Hospitals Institute invests in various investment securities. Investment securities are exposed to various risks such as interest rates, market and credit risks. Due to the level of risk associated with certain investment securities, it is at least reasonably possible that changes in the values of investment securities will occur in the near term and that such changes could materially affect the amounts reported in the accompanying financial statements.

Fair value measurements -

Essential Hospitals Institute adopted the provisions of FASB ASC 820, *Fair Value Measurement*. FASB ASC 820 defines fair value, establishes a framework for measuring fair value, establishes a fair value hierarchy based on the quality of inputs (assumptions that market participants would use in pricing assets and liabilities, including assumptions about risk) used to measure fair value, and enhances disclosure requirements for fair value measurements. Essential Hospitals Institute accounts for a significant portion of its financial instruments at fair value or considers fair value in their measurement.

2. INVESTMENTS

Investments consisted of the following at December 31, 2014. There were no investments at December 31, 2013.

	<u>Fair Value</u>
Money market funds	\$ 96,452
Mutual funds - bond funds	737,121
Equities	964,959
Fixed income	<u>1,505,893</u>
	 <u>\$ 3,304,425</u>

Included in investment income are the following:

	<u>2014</u>	<u>2013</u>
Interest and dividends	\$ 42,021	\$ 9,118
Unrealized loss	<u>(18,594)</u>	-
Total investment income	<u>\$ 23,427</u>	<u>\$ 9,118</u>

ESSENTIAL HOSPITALS INSTITUTE
NOTES TO FINANCIAL STATEMENTS
DECEMBER 31, 2014 AND 2013

3. GRANTS RECEIVABLE

As of December 31, 2014 and 2013, contributors to Essential Hospitals Institute have made written promises to give totaling \$365,134 and \$1,401,822, respectively.

Grants are due as follows at December 31, 2014 and 2013:

	2014	2013
Less than one year	\$ 365,134	\$ 1,037,971
One to five years	-	363,851
GRANTS RECEIVABLE	\$ 365,134	\$ 1,401,822

4. TEMPORARILY RESTRICTED NET ASSETS

Temporarily restricted net assets consisted of the following at December 31, 2014 and 2013:

	2014	2013
Time Restricted	\$ 589,818	\$ 1,996,060

5. NET ASSETS RELEASED FROM RESTRICTIONS

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

	2014	2013
Passage of Time	\$ 1,406,242	\$ 1,295,306

6. BOARD DESIGNATED NET ASSETS

As of December 31, 2014, net assets have been designated by the Board of Directors for the following purposes. There were no designated net assets as of December 31, 2013.

	2014	2013
Special purpose fund	\$ 3,300,000	\$ -
Operating reserve	900,000	-
BOARD DESIGNATED NET ASSETS	\$ 4,200,000	\$ -

7. RELATED PARTY TRANSACTIONS

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

ESSENTIAL HOSPITALS INSTITUTE

NOTES TO FINANCIAL STATEMENTS DECEMBER 31, 2014 AND 2013

7. RELATED PARTY TRANSACTIONS (Continued)

Costs are allocated between the two organizations based on actual expenditures or a percentage of salaries. Essential Hospitals Institute's allocation of expenses was 50% for 2014 and 2013. During 2014 and 2013, costs allocated to Essential Hospitals Institute were \$3,960,347 and \$3,081,241, respectively, and the amounts paid by Essential Hospitals Institute to America's Essential Hospitals totaled \$3,083,082 and \$3,160,892, respectively. The 2013 amounts include a \$700,000 contribution from America's Essential Hospitals to Essential Hospitals Institute to support uncovered Essential Hospitals Institute's labor and programmatic cost for research work and the Transformation Center. There was no such contribution for the year ended December 31, 2014.

At December 31, 2014 and 2013, Essential Hospitals Institute owed \$932,272 and \$55,007, respectively, to America's Essential Hospitals.

8. RETIREMENT PLAN

Effective April 30, 1997, America's Essential Hospitals adopted a profit sharing and 401(k) plan covering all employees who are at least 21 years of age and have completed 1,000 hours of service during their first twelve months of employment. Employer contributions to the profit sharing plan vest over a three-year period from the date of eligibility. Contributions in 2014 and 2013 totaled \$511,000 and \$417,200, respectively. Of those amounts, \$254,408 and \$211,523, respectively, were allocated to Essential Hospitals Institute (see Note 7).

9. CONCENTRATION OF REVENUE

For the years ended December 31, 2014 and 2013, approximately 100% and 98% of contracts revenue, respectively, and 99% and 77% of grants revenue, respectively, was derived from two organizations. Essential Hospitals Institute has no reason to believe that relationships with these organizations will be discontinued in the foreseeable future. However, any interruption of these relationships (i.e., the failure to renew grant agreements or withholding of funds) would adversely affect Essential Hospitals Institute's ability to finance ongoing operations.

10. COMMITMENTS

Essential Hospitals Institute is committed under an agreement for meeting space through the year 2015. The total commitments under the agreement are not determinable as it depends upon attendance and other unknown factors. There are cancellation penalties that would be due if the agreement were cancelled prior to the event date. The amount of the cancellation penalties increase through the date of the event.

11. LEASE AGREEMENT

In December 2011, America's Essential Hospitals, a related party organization (see Note 7), modified its existing lease agreement for additional office space to support the expansion of Essential Hospitals Institute activities. The agreement expires in December 2015, and provides for landlord-paid leasehold improvements in the amount of \$78,839. The new space is fully occupied by Essential Hospitals Institute staff and accordingly, all related rent expenses have been allocated to Essential Hospitals Institute for the year ended December 31, 2014.

ESSENTIAL HOSPITALS INSTITUTE

NOTES TO FINANCIAL STATEMENTS DECEMBER 31, 2014 AND 2013

11. LEASE AGREEMENT (Continued)

On March 4, 2015, America's Essential Hospitals entered into a fifteen-year agreement to lease new office space. Base rent is \$1,449,977, increasing by a factor of 2.5% per year. The lease includes fourteen months of abated rent in the the first two years of the lease.

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

Total rent expense for the years ended December 31, 2014 and 2013 was \$312,033 and \$316,089, respectively.

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

12. FAIR VALUE MEASUREMENT

In accordance with FASB ASC 820, *Fair Value Measurement*, Essential Hospitals Institute has categorized its financial instruments, based on the priority of the inputs to the valuation technique, into a three-level fair value hierarchy. The fair value hierarchy gives the highest priority to quoted prices in active markets for identical assets or liabilities (Level 1) and the lowest priority to unobservable inputs (Level 3). If the inputs used to measure the financial instruments fall within different levels of hierarchy, the categorization is based on the lowest level input that is significant to the fair value measurement of the instrument. Investments recorded in the Statements of Financial Position are categorized based on the inputs to valuation techniques as follows:

Level 1. These are investments where values are based on unadjusted quoted prices for identical assets in an active market Essential Hospitals Institute has the ability to access.

Level 2. These are investments where values are based on quoted prices for similar instruments in active markets, quoted prices for identical or similar instruments in markets that are not active, or model-based valuation techniques that utilize inputs that are observable either directly or indirectly for substantially the full-term of the investments.

Level 3. These are investments where inputs to the valuation methodology are unobservable and significant to the fair value measurement.

Following is a description of the valuation methodology used for investments measured at fair value.

- *Money market funds* - The fair value is equal to the reported net asset value of the fund.
- *Mutual funds* - The fair value is equal to the reported net asset value of the fund, which is the price at which additional shares can be obtained.
- *Equities* - Valued at the closing price reported on the active market in which the individual securities are traded.
- *Fixed income* - Fair value is based upon current yields available on comparable securities of issuers with similar ratings, the security's terms and conditions, and interest rate and credit risk.

ESSENTIAL HOSPITALS INSTITUTE

NOTES TO FINANCIAL STATEMENTS DECEMBER 31, 2014 AND 2013

12. FAIR VALUE MEASUREMENT (Continued)

The table below summarizes, by level within the fair value hierarchy, Essential Hospitals Institute's investments as of December 31, 2014:

Asset Class:	Level 1	Level 2	Level 3	Total December 31, 2014
Money market funds	\$ 96,452	\$ -	\$ -	\$ 96,452
Mutual funds - bond funds	737,121	-	-	737,121
Equities	964,959	-	-	964,959
Fixed income	-	1,505,893	-	1,505,893
TOTAL	\$ 1,798,532	\$ 1,505,893	\$ -	\$ 3,304,425

Essential Hospitals Institute did not have any investments as of December 30, 2013.

13. SUBSEQUENT EVENTS

In preparing these financial statements, Essential Hospitals Institute has evaluated events and transactions for potential recognition or disclosure through May 13, 2015, the date the financial statements were issued.



DATE June 12, 2015
TO Board of Directors
FROM Ann Scott Blouin, MD, Women's Leadership Academy
Advisory Committee Liaison to the Board
RE Women's Leadership Academy Advisory Committee Report **MEMORANDUM**

On behalf of the Women's Leadership Academy Advisory Committee, I am pleased to share the following update.

Since the last report in March, the advisory committee has held two planning calls focusing on program components, evaluation, and mentorship recruitment and matching.

Program Components

The program will include the following components:

- Leadership assessments: Participants will complete an assessment to determine their leadership strengths and opportunities. From these results, they will work with a professional coach and their mentors to develop a career plan. The committee is considering several assessments, including a short 360-degree assessment, the Myers-Briggs Type Indicator, the DiSC personal assessment tool, and the FIRO-B assessment.
- Staff are investigating the cost of having an executive coach available to meet with participants at the in-person meeting.
- Staff will invite a keynote speaker to the in-person meeting. A panel of female leaders from inside and outside of America's Essential Hospitals' membership will also be invited to discuss their leadership journeys and philosophies.
- Staff will conduct pre- and post-tests to evaluate whether the program met participants' expectations.
- Staff will reach out to mentors after each mentorship check-in call to continuously evaluate the match.
- Staff will outline clear expectations for sponsors. Participants will set up a meeting with their sponsor to discuss whether the program met the participant's objectives.

Mentor/Mentee Recruitment and Matching

The first class will be launched as a pilot program with a cohort of 6 to 10 participants. Each participant will be assigned to a mentor. As a soft launch of the pilot board members will be asked to consider nominating mentors and mentees from their organizations. Staff will also reach out to select members not currently serving on boards, including former board members, for suggestions. Staff will launch a formal mentee application in September.

After mentors and mentees have been selected, staff will send mentee applications, resumes, and background information to mentors. Mentor resumes and background information will also be sent to mentees. Mentees and mentors will rank their top three choices and staff will make final matches and send to mentors for their approval. The advisory committee will review and validate each match. Before the in-person meeting, each pair will conduct a meet and greet phone call to confirm a good match.

Program Funding Update

To financially support the program, staff have submitted letters of inquiry (LOI) to six organizations that prioritize women's issues, equality, leadership, education, and women's empowerment. Staff are also working on submitting more LOIs to various organizations. The organizations include these:

Submitted:

- The Compton Foundation – waiting for response
- Oak Foundation USA – waiting for response
- The Josiah Macy Foundation – LOI not accepted
- George Family Foundation – LOI not accepted
- RGK Foundation – LOI not accepted
- Ford Foundation – LOI not accepted

Estimated submit date: 6/20/15

- Columbus Foundation (Limited brands)
- Mazda Foundation
- Alfred P. Sloan Foundation

In addition to potential support from grants, staff will also seek sponsorship opportunities. Staff have developed a sponsorship package which will allow sponsors to support either the entire program or certain events and activities (webinars, in-person meetings, etc.). The package will be sent to potential sponsors in July and August.



DATE June 12, 2015
TO Board of Directors
FROM Delvecchio Finely, MPP, Education Committee Member
RE Education Committee Report

MEMORANDUM

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

Annual Conference

- **VITAL2015**

As of June 8, 261 individuals had registered for the conference. Staff will provide an updated registration count during the board meeting.

This year's program features several sessions on state Medicaid waivers, as well as a variety of sessions on sociodemographic factors, including treating the homeless, food insecurity, gender and sexual diversity, and race, ethnicity, and language (REL).

- **VITAL2016**

Next year's annual conference will be in Boston, June 15 to 17. To support program development, we again will conduct a call for proposals (CFP) this fall. The committee and staff have identified a few minor modifications based on this year's successful CFP.

State Medicaid Waivers

Throughout 2015, the association is conducting a multipronged work plan focused on state Medicaid waivers, including these initiatives:

- development of a national message that makes the case for waivers and their benefit to delivery system reform and payment models
- enhanced visibility on the association's website with a "one-stop shop" landing page of waiver resources.
- three breakout sessions at VITAL2015
- a one-day summit, September 21, in Chicago, to include two tracks on Medicaid waiver activities and a featured speaker from the Centers for Medicare & Medicaid Services (CMS)
- a five-part distance learning series with a special emphasis on hospital and community health centers, developments from CMS, and other trends

- a research brief on the key elements of success in waivers, especially the positive impact on lives saved and costs avoided

Fellows Program

Thirty-nine fellows from 21 organizations are enrolled in the 2015-2016 Fellows Program. A new fellows orientation session was held on May 12. Fellows have been given pre-class assignments and will meet with their sponsors before the program's first session, at VITAL2015, in San Diego. A site visit has been scheduled for UC San Diego Health (Hillcrest Medical Center).

Innovations Summit

The Innovations Summit showcases for policymakers and influencers innovative member programs. This year's summit will be October 15, in Washington, DC, and the program will focus on the integration of behavioral health and primary care. Staff have confirmed Linda Rosenberg, president and CEO of the National Council for Behavioral Health, as the program's opening keynote speaker. The event will feature member programs, including at UMass Memorial Health Care, in Worcester, Massachusetts, and Harris Health System, in Houston.

Also at the summit, Essential Hospitals Institute will release a research brief featuring five member programs:

- Harris Health System
- NuHealth
- UMass Memorial Health Care
- University of Texas Medical Branch.
- University of Washington

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

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

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

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

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

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

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

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

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

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

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

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