

ESSENTIAL
HOSPITALS
INSTITUTE

Board of Directors Meeting

March 17, 2015
The Westin Georgetown

essentialhospitalsinstitute.org

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Institute Board of Directors Meeting

March 17, 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	Approve December 2014 Minutes (Jacobs)	ACTION
8:10 – 8:15 am	Nominating Committee Report (Roth)	
8:15 – 8:45 am	Institute Director Report (Engler)	
8:45 – 9 am	Research Committee Report (Haley)	
9 – 9:20 am	Women's Leadership Academy Advisory Committee Report (Finley)	
9:20 – 9:35 am	Education Committee Report (Finley)	
9:35 – 9:50 am	Break	
9:50 – 10:35 am	Population Health Manuscript (Taylor-Clark and Szekendi)	
10:35 – 11:05 am	Member Satisfaction Survey Results (McKinley Advisors)	
11:05 – 11:20 am	Performance Improvement/Equity Update (Callahan)	
11:20 – 11:35 am	KP-NACHC Project Report (Rangarao)	
11:35 – 11:50 am	Results from <i>Essential Hospitals Vital Data</i> (Reid)	
11:50 am – noon	2015 Revised Budget and Office Move (Gold)	ACTION
noon	Adjourn	



Essential Hospitals Institute Board of Directors 2014-2015

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EX-OFFICIO

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



2015 Institute Board Meeting Dates

Wednesday, June 24, 2015

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

Tuesday, October 27, 2015

8 am – noon
Hyatt Regency Washington on Capitol Hill
Washington, DC
Held in conjunction with October 27-28 Policy Assembly

December 2015 Conference Call – TBD

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
Seaport Hotel
Boston
Held in conjunction with June 15-17 2016 Vital 2016

October 2016 - TBD

December 2016 conference call - TBD



Board of Directors Meeting Minutes
Tuesday, December 2, 2014
Meeting by Telephone

Board Members Present (12): Julie Cerese, RN, MSN Delvecchio Finley, MPP Leon Haley, MD, MHSA Caroline Jacobs, MPH, MSEd Erica Murray, MPA Christine Neuhoff, JD Reuven Pasternak, MD, MPH, MBA Anna Roth, RN, MS, MPH Ann Scott Blouin, PhD, RN Bruce Siegel, MD, MPH Alan Weil, JD, MPP Winston Wong, MD, MS	Board Members Absent (4): Donald Goldmann, MD Dennis Keefe Susan Moffatt-Bruce, MD, PhD Cliff Wang, MD	Staff Present (4): David Engler, PhD, MS Rhonda Gold Kristine Metter Caitlyn Furr
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Agenda Items	Minutes
Call to Order	<ul style="list-style-type: none">• Jacobs called the meeting to order at 11:04 am.
Approve October 30 Minutes (ACTION)	Members reviewed the October 30 meeting minutes. <i>Jacobs requested a motion to approve the October 30 meeting minutes. There was a motion, a second, and unanimous approval of the minutes.</i>
Review and Approve 2015 Proposed Budget (Haley/Gold)	<ul style="list-style-type: none">• Gold reviewed the 2015 proposed budget, which was approved by the finance committee on November 20. The budgeted activities for 2015 are in line with the 2013-2018 strategic plan and will focus on quality, innovation, and adaptation.• The 2015 proposed budget includes a \$595,000 contribution from the association to offset costs of operating the analytics and research departments. With the association's contribution, the Institute's budgeted deficit is \$80,000.• It is still unclear whether or not the Centers for Medicare & Medicaid Services (CMS) will continue funding the Partnership for Patients. However, staff is optimistic, and the Essential Hospitals Engagement Network (EHEN) ranked third out of 26

	<p>engagement networks. Therefore, the 2015 budget assumes renewal of the contract, but at a lower funding level.</p> <ul style="list-style-type: none"> • The 2015 budget also assumes funding from Kaiser Permanente's Community Benefit arm to address food insecurity. This is a two-year contract, and staff has budgeted \$249,000 for 2015. • Jacobs asked if the Institute is seeking additional funding for what is being lost this year. Engler and Gold responded that the Institute would like to broaden its financial base and is looking for additional mission-driven opportunities. The Institute has developed and put forth seven funding proposals in the last seven months, and Engler described each. The board was given a summary of outstanding proposals. • The personnel cost is the largest expense in the 2015 budget. The proposed budget includes more than \$4 million for Institute staff. \$2.16 million is funded, while \$1.85 million is unfunded. This budget reflects a 25 percent health insurance premium that was recently assessed by Carefirst. Gold explained that because the staff census at the time period requested by Carefirst was less than 50 full-time staff, the organization was rated in the small business sector which has less opportunities to be competitive within the insurance marketplace. • The Fellows Program is budgeted to break-even for direct costs, but does not include staff time. • Rent is budgeted at \$134,000, in addition to \$220,000 that is covered by the EHEN contract. This is rent in the current office space as the office move will not occur until December 2015. • Total unrestricted income is \$7 million, which is offset by \$7.48 million, for a slight budgeted operating deficit of \$80,000. Total budgeted unrestricted net assets are \$5.69 million, in addition to temporarily restricted net assets of \$552,000, for total net assets of \$5.75 million, in addition to temporarily restricted net assets of \$1.56 million, for total budgeted net assets of \$7.13 million. Of this, \$3.3 million is restricted in a special purpose fund. The Institute will be restricting another \$900,000 in accordance with the board's approved reserve policy. • Gold and Engler stated that the Institute is holding back money from the current EHEN contract to help bridge EHEN staff salaries until CMS makes a final decision. The \$3.3 million held in a special purpose fund is money not spent from last year's EHEN contract.
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	<p><i>Haley asked for a motion to approve the Institute's 2015 proposed budget. There was a motion, a second, and the motion passed unanimously.</i></p>
Institute Updates (Engler)	<ul style="list-style-type: none"> • Engler updated the board on activities the Institute is focusing on. • The Institute is scheduling advisory committee calls to gain feedback on the Executive Women's Leadership Academy. Staff is working on a letter of intent to the Josiah Macy, Jr. Foundation, which they will submit by January 16. Staff expects to hear back in March. • The first of two webinars on population health was held December 2 and had more than 100 registrants. The webinars share results of population health research by University HealthSystem Consortium (UHC), George Mason University, and the Institute. • The Institute plans to focus on the integration of behavioral health and primary care in 2015. The research department is developing briefs on the topic. The project will feature four case studies from members that have implemented successful programs. • The analytics team is expanding the characteristics survey. The team will publish a trends book in July 2015 with all of the data. Jacobs asked about the dissemination plan. Staff will be engaging the communications team and using a YouTube announcement to engage more members submitting data. • The performance improvement team is wrapping up EHEN option year one, which has been very successful. The collaborative prevented more than 4,000 harm events and led to a significant cost savings. • The Race, Ethnicity, and Language (REAL) module debuted on the website in October. The Institute is in discussions with The Joint Commission to disseminate the module nationwide. • The Institute will be working with the Office of Disease Prevention and Health Promotion to reduce disparities in adverse drug events, hospital-acquired conditions, and hospital readmissions. The results of the pilot work will inform the HHS National Action Plan for Adverse Drug Event Prevention. • The Institute is submitting as a subcontractor with UHC on the TCPI opportunity, and is also working on its own submission.

	<ul style="list-style-type: none"> The Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) collaborative will continue in 2015. The Institute expects to work again with the Massachusetts Learning Collaborative as a SAN for rural providers. Roth said that the EHEN results speak volumes and suggested that staff create a slide deck with the data for members to show their boards. Roth also suggested presenting the information at the spring Policy Assembly.
Other Business (Jacobs/Engler)	<ul style="list-style-type: none"> There was no other business.
Adjourn	The conference call was adjourned at 11:45 am. The next Institute board meeting will take place Tuesday, March 17 at the Westin Georgetown in Washington, DC.

Submitted by:

ATZ 12-22-14

Anna M. Roth, RN, MS, MPH
Secretary

**DATE**

March 10, 2015

TO

Board of Directors

FROM

Anna Roth, RN, MS, MPH, Nominating
Committee Chair

RE

Board Vacancies

MEMORANDUM

The Institute nominating committee met January 20 to consider nominees for vacancies in the treasurer and at-large member positions, both created by the end of Clifford Wang's term. The nominating committee's recommendations will be presented to the association board of directors March 16.

Candidate for Treasurer: Susan Moffatt-Bruce, MD, PhD

The nominating committee recommends Susan Moffatt-Bruce, MD, PhD, for treasurer. The term will begin July 1, 2015 and run through June 30, 2016. Moffatt-Bruce has served on the board of directors since 2012 and also serves on the finance committee.



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

Moffatt-Bruce is a cardiothoracic surgeon and chief quality and patient safety officer at The Ohio State University Wexner Medical Center (OSUWMC). As chief quality and patient safety officer, she is responsible for data collection, analysis, and process improvement for the 7-hospital, 1400-bed, 1200-physician academic medical center.

Moffat-Bruce completed her undergraduate degree at McGill University and her medical school and general surgery residency at Dalhousie University. She completed her doctor of philosophy in transplant immunology at the University of Cambridge and her cardiothoracic surgery fellowship at Stanford University with additional training in thoracic transplantation. Moffat-Bruce was on staff at the University of British Columbia for two years before she was recruited to OSUWMC.

Over the past eight years at OSUWMC, Moffat-Bruce has developed a passion for quality and patient safety initiatives. She was trained at Intermountain Healthcare and the Institute for Healthcare Improvement and is a Black Belt in Six Sigma. She recently completed her master of business operational excellence at the Fisher School of Business.

Moffatt-Bruce is currently associate professor of surgery, Division of Thoracic Surgery, in the Department of Surgery and associate professor in the Department of Molecular Biology, Immunology, and Medical Genetics. She was appointed associate dean of clinical affairs for quality and patient safety in 2012.

Since becoming chief quality and patient safety officer in 2010, Moffat-Bruce has been responsible for the implementation of the safe surgical checklist and crew resource management across the medical center. She has also standardized processes that have reduced central line infections, pressure ulcers, and ventilator-associated pneumonia. With the recent introduction of an integrated electronic medical record, she has worked to reduce medication safety events and has led the organization to be very successful in the Centers for Medicare & Medicaid Services' Hospital Value-Based Purchasing Program. In 2013 and 2014, Moffatt-Bruce helped lead OSUWMC to third place in the UHC Leadership and Quality rankings. She designed a curriculum for medical students around quality, patient safety, and high reliability and recently organized a multi-professional resident quality forum that allows residents to identify and solve patient safety issues.

Candidate for At-Large Member Director: Susan Currin, RN, MS

The nominating committee recommends Susan Currin for at-large member director. The initial term for this position will begin July 1, 2015 and run through June 30, 2017. She will be eligible for re-election for up to two additional two-year terms. Currin is completing her third year of service on the education committee.



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

San Francisco General Hospital and Trauma Center (SFGH) is the sole provider of trauma and emergency psychiatric services for the City and County of San Francisco. As leader of the medical center that serves approximately 100,000 patients annually and provides 20 percent of the city's inpatient care, Currin oversees a dynamic organization that offers a wide spectrum of inpatient and outpatient services to a diverse patient population.

As San Francisco's public hospital, SFGH's mission is to provide quality health care and trauma services with compassion and respect to patients, including the city's most vulnerable. SFGH is also one of the nation's top academic medical centers and partners

with the University of California, San Francisco on clinical training and research. SFGH is the lynchpin of the Healthy San Francisco Program, which provides primary and specialty care access to the uninsured.

SFGH is designated by the American College of Surgeons for trauma services and The Joint Commission on the Accreditation of Healthcare Organizations for stroke and traumatic brain injury care. It is also the only hospital in San Francisco to earn the World Health Organization's Baby Friendly certification. Currin is currently leading SFGH's pursuit of magnet nursing status. She is also presiding over the construction of a new acute care building, a project that a record number of San Francisco voters support.

Currin has more than 25 years of experience as a hospital leader. Before becoming CEO, she served as chief operating officer and chief nursing officer at SFGH. Before joining SFGH, she was quality and service leader at Kaiser Permanente.

Currin is chair of the San Francisco health plan board. She gained special recognition for hospital fiscal management from the mayor's municipal fiscal advisory committee in 2007 and was named one of the "Most Influential Women in Bay Area Business" by the *San Francisco Business Times* in 2011. She has successfully secured millions in grant funding for a nursing internship program, medication error reduction project, and patient safety initiatives. Currin also helped develop SFGH's world-class Acute Care for Elders (ACE) Unit, which focuses on improving patient outcomes and satisfaction while shortening lengths of stay and reducing nursing home admissions.

Currin attended the American River and Tacoma Community Colleges and holds a bachelor's degree in nursing from San Francisco State University. She also holds a master's degree in nursing from the University of California, San Francisco. She began her career as a student nurse at SFGH in 1975. Three years later, she returned to SFGH as a staff nurse on the medical surgical and critical care units. Currin has participated in America's Essential Hospitals' patient safety and health care policy fellowship programs and the California HealthCare Foundation Health Care Leadership Fellowship Program.



DATE March 10, 2015
TO Board of Directors
FROM David Engler, PhD
RE Institute director's report

MEMORANDUM

Since the October 2014 board meeting, the Essential Hospitals Institute has accomplished these things:

- Completed a large scale evaluation of the population health landscape in essential hospitals and academic medical centers. A manuscript has been prepared for March submission to the Journal for Healthcare Quality. The work is a collaborative effort between the Institute, UHC, and George Mason University.
- Finished the third year of the Centers for Medicare & Medicaid Services (CMS) Partnership for Patients (PfP) contract. The Essential Hospitals Engagement Network achieved a reduction of 4,000 harm events and savings of \$41 million, placing it fifth out of 26 other hospital engagement networks, according to CMS evaluators. CMS has announced a new, one-year cycle of funding for PfP. We will submit our proposal by March 30, 2015.
- Published a research brief on the impact of Medicare's Hospital Acquired Conditions (HAC) Reduction Program on members of America's Essential Hospitals.
- Convened the newly appointed research committee. The research committee recommends three focus areas for research in the coming years: population health, health equity, and payment and delivery system transformation.
- Graduated 31 fellows from 15 member organizations. We have received 39 applications for next year's Fellows Program class, including fellows from several new member hospitals.
- Convened the Essential Women's Leadership Academy advisory committee, which has developed preliminary findings on the mentorship and curriculum components of the program.
- Published the sixth and final installment of the social determinants of health website series.
- Held a cross-community webinar of The National Partnership for the Healthcare Safety Net, sponsored by the Kaiser Permanente Community Benefit Arm.

- An in-person, cross-community summit with representatives from all four communities is scheduled for April 13, in Washington DC.
- Launched Ask Every Patient: REAL, an online learning module for members of America's Essential Hospital's to support collection of race, ethnicity, and language data.
- Issued a call for abstracts to all members for a new, four-part Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) webinar series to be launched in May. Open to all members, this new series will be a member-to-member learning network to share successful strategies to improve patient experiences.
- Submitted two new grant applications to CMS as part of the Transforming Clinical Practice Initiative (TCPI). The Institute submitted one application as the prime contractor for the strategic alignment network (SAN) to support physicians treating vulnerable populations in rural communities. The Institute submitted a second application as a subcontractor to UHC to deploy the REAL module in physician practices in UHC's networks.
- Submitted a three-year grant proposal to Kaiser Permanente Community Benefit arm to support funding for Institute work in population health and equity.

Research Activities

Population Health Landscape Review

The Institute partnered with UHC and George Mason University to conduct a large-scale evaluation of population health initiatives around the country. This evaluation was based on an analysis of 121 hospital-led population health programs, sampled from submissions to America's Essential Hospitals Gage Awards and UHC poster presentations from 2012 to 2014.

The project team collected and analyzed this information as it developed a conceptual framework for population health, particularly as it applies to essential hospitals and academic medical centers. The findings are being summarized in a peer-reviewed article focusing on the unique role essential hospitals and academic medical centers play in enhancing population health.

The Institute also has hosted two webinars on population health to simultaneously disseminate and collect information. The first webinar served to present the conceptual framework, review preliminary results from the landscape review, and showcase three exemplar programs from member hospitals. The second webinar explored the future of population health and incorporated findings from group interviews of various experts in the field.

Social Determinants of Health

In January, the Institute concluded a website series on the social determinants of health. The series of 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 also 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

Other Online Resources

The recent website article, *Emergency Preparedness: When Winter Weather Strikes*, discusses considerations for maintaining hospital operations under extreme winter conditions. Specifically, the piece highlights key preparedness and response strategies by two essential hospitals: Henry Ford Health System, in Detroit, and The MetroHealth System, in Cleveland.

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

In 2013, Essential Hospitals Institute, National Association for Community Health Centers, and George Washington University formed the National Partnership for the Health Care Safety Net. Funded by the Kaiser Permanente Community Benefit program, this three-year initiative focuses on improving access to high-quality health care among underserved populations by promoting collaboration and partnerships between essential hospitals and community health centers.

At its inception, the National Partnership choose four communities – Atlanta, Cleveland, Denver, and Richmond – to serve as case studies for this effort. The key priorities for these communities include coverage expansion (Atlanta), Medicaid sustainability (Cleveland), specialty care access (Denver), and premium and copayment assistance (Richmond).

Into its third year, the National Partnership has worked with each community to build and inform collaboration with key stakeholders, develop a strategic plan, and provide technical assistance. In addition, each community partner was required to develop a comprehensive work plan to maintain momentum and accomplish goals. Some of the key milestones for this project include these:

- educational webinars on targeted topics of interest for each community
- technical assistance in the form of brief reports, charts, research briefs, and policy insights
- in-person stakeholder meetings within each community
- a website to highlight the National Partnership and community activities

The National Partnership also held a cross-community webinar on December 16, 2014, and has scheduled an in-person, cross-community summit April 13, 2015, with members from all four community partners. These are the goals of the conference:

- to provide a networking opportunity for members of the National Partnership communities
- to discuss best practices and identify opportunities for further collaboration between federally qualified health centers (FQHC) and hospitals
- to examine current and future policy and health care issues that impact safety net providers (e.g., Section 1115 waivers, Medicaid expansion, payment reform)

The current grant for the National Partnership ends in April 2016 and efforts are underway to address future funding and sustainability.

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 project funded by the Patient-Centered Outcomes Research Institute (PCORI), is focused on the following objectives:

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

Year One, which began on January 1, 2015, will employ focus group interviews and surveys with patients, providers, and caregivers from selected hospitals to identify the most important transitional care components and outcomes identified by patients and caregivers. Year Two will focus on implementation efforts to further evaluate the effectiveness of care transition programs. This will include retrospective and longitudinal comparative analyses of patient and caregiver experiences with specific transitional care components. In Year Three, the ACHIEVE team will complete all analyses, prepare materials for dissemination, and develop a large-scale implementation plan.

Conducted with Medicare fee-for-service beneficiaries within high-risk populations, the project will primarily focus on hospital-to-home transitions. The effort is headed by Mark Williams, from the University of Kentucky, and includes a consortium of research affiliates:

- America's Essential Hospitals
- Boston Medical Center
- Caregiver Action Network
- Health Research & Educational Trust of the American Hospital Association
- Joint Commission Resources
- Kaiser Permanente Southern California
- Louisiana State University Sciences Center
- National Association of Area Agencies on Aging
- Tellingen/Colorado Foundation for Medical Care
- United Hospital Fund

- University of Illinois Chicago
- University of Pennsylvania
- Westat

Leadership Programs

Fellows Program

During session II of the 2014 Fellows Program, the class learned key performance management skills, including coaching, feedback, recognition, and courageous conversations. They used Myers-Briggs Type Indicator assessments to better understand and manage their own preferences and how to practice versatility with others.

After the first session, fellows began planning and implementing their projects, and have been engaged in monthly, hour-long, peer-to-peer coaching webinars. These webinars support fellows' project work and help prepare them for their project report presentations during the third session.

During session III, fellows shared leadership challenges and successes experienced during their project implementation. Fellows also attended the association's semiannual Policy Assembly, where they learned about current legislative activities on Capitol Hill and attended a tutorial on effective communication and lobbying techniques in preparation for their Hill visits. Fellows met with their congressional delegations to advocate on behalf of essential hospitals.

Essential Hospitals Women's Leadership Academy

The Essential Hospitals Women's Leadership Academy is a new program designed to increase the aspirations, promotions, and executive competencies of female leaders at essential hospitals. Program planning and development has begun. An advisory committee of board members has met by telephone to discuss and give feedback on the mentorship component and curriculum.

Performance Improvement

Essential Hospitals Engagement Network (EHEN)

The initial hospital engagement network (HEN) contract with the Partnership for Patients and Centers for Medicare & Medicaid Services (CMS) ended December 8, 2014. The announcement for an additional year of funding was released February 12. The Institute will submit a proposal (due March 30, 2015) for funding from June 1, 2015, through May 31, 2016. We are optimistic for the proposal's success, given EHEN's leading role on health equity and the high evaluation marks EHEN received in August 2014.

Since the contract's conclusion, staff has spent time collecting feedback on the hospitals' experiences and how to improve similar efforts in the future. Staff developed a template for the EHEN hospitals' use to present outcomes from the project at the national and EHEN levels, as well as individual hospital results and achievements. Staff continue to respond to ad hoc requests from the evaluation contractor at the Partnership for Patients, helping to solicit feedback from our network as that evaluation progresses. The final report to CMS is due in September 2015.

Health Equity

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

The Office of the Assistant Secretary (OASH) Office of Disease Prevention and Health Promotion (ODPHP) is currently focused 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. The Institute and EHEN have been approached to join this project. There is no additional federal funding; however, the results of the project will be shared with all participating hospitals and health systems. The Institute is working with our EHEN hospitals to explore participating in this partnership, as ADEs and disparities will remain focuses for EHEN under any future PfP funding.

Work on the Ask Every Patient: REAL project continues. This work kicked off in March 2014 as one of the special focuses of the EHEN. The project aims to improve quality of care for all patients by promoting standardized collection of race, ethnicity, and language (REAL) information so hospitals can build a robust and accurate picture of the people they serve. That information will also help hospitals identify disparities in care and outcomes.

The online module went live on the association's website in October and we hosted an orientation webinar in January 2015 to introduce the learning module widely to the membership. The Institute continues to work with its consultant to make the module available to all members and explore ways to market it widely to all hospitals in partnership with The Joint Commission.

HCAHPS

A four-part webinar series, Patient Experience Forum, has been scheduled from May to 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.

The Institute conducted a call for abstracts February 9 to 27, and will review proposals throughout mid-March. We have also started researching potential funding sources for 2016 programming. A preliminary description of the series has been posted to the association's website and an initial marketing email will go out before the end of March. We are considering different focus areas, including the pediatric survey, emergency department survey, and other specialty topics, as well as a holistic CAHPS approach (rather than focusing on the hospital version only).

Transforming Clinical Practices Initiatives

The Transforming Clinical Practice Initiative (TCPI) is a new project supported by CMS. The initiative is designed to support 150,000 clinician practices over 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 as a prime contractor for SAN and as a subcontractor as part of UHC's submission for a PTN. The awards will be made in early May, with an expected start date of June 1, 2015. If the Institute wins a TCPI-SAN award, it likely will add two new staff members. If UHC secures an award, the Institute's work as a subcontractor would be handled by existing staff.

Data Collection and UHC Subcontract

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

Analytics Update

Each year, the association's *Essential Hospitals Vital Data* report makes use of several national comparison data points published by the American Hospital Association (AHA). This year, the AHA delayed publication of key data points, which, in turn, delayed the next update to *Essential Hospitals Vital Data*. As of late February, staff was working toward a March or early April publication of the updated document.

The Institute also has started planning the fiscal year (FY) 2014 Annual Hospital Characteristics Survey, a key data source for *Essential Hospitals Vital Data*. There will be several exciting changes for 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 survey responses expected, we will launch a more robust orientation, training, and communications strategy, which will include these elements:

- a 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 also will adjust the survey timeline and format in response to feedback from our survey coordinator satisfaction and feedback survey conducted in November. Responses indicated the desire for a later launch and deadline date. As such, the survey will now launch June 1 and the deadline will be October 31. Additionally, there was an almost 50-50 split among survey coordinators asking for the format of the survey to 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 and the *Essential Hospitals Vital Data* report, the analytics team recently published a research brief, *HAC Reduction Program Penalties: An Undue Burden on Essential Hospitals?*, which details the impact of Medicare's Hospital Acquired Conditions (HAC) Reduction Program on member hospitals compared with other hospitals nationally. The department also is working on a research project on trauma response at essential hospitals.



DATE March 10, 2015
TO Board of Directors
FROM Ann Scott Blouin, MD, Women's Leadership Academy
 Advisory Committee Liaison to the Board
RE Advisory Committee Report

MEMORANDUM

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

The advisory committee has held two of three planning calls focusing on mentorship and curriculum. The last call will be in March and will focus on in-person activities and program evaluation.

Mentorship Component

The committee recommends a formal process to solicit mentors and mentees. The process of matching mentors with mentees includes assessing expectations from both parties and mentee interviews. We will use the interviews to determine mentee expectations for the mentorship and their development needs.

From there, staff will identify gaps and match mentees with mentors based on experience and expertise. Staff will discuss possible pairings with mentors and present mentors with final selections for approval. Both parties will be asked to sign a formal contract outlining roles, responsibilities, and expectations for the mentorship. Before meeting in person, mentors and mentees will have the opportunity to meet over the phone to determine if the match is compatible.

Formal mentor and mentee training will take place to explain roles and expectations. Training components and content will relate to the core curriculum. The mentorship component will be evaluated on an ongoing basis throughout the mentorship.

Curriculum

The program curriculum will focus on three themes:

- **Human resources and essential hospital financing** – Participants will explore coaching, performance management, selection, and recognition techniques. There may also be an opportunity to attend a hospital finance breakout session at the annual conference.

- **Leaders as agents of change** – Participants will have the opportunity to gain the tools and skills needed to lead change at their organizations. Armed with these tools, female leaders will build confidence to take on more challenging roles.
- **Work-life balance** – Participants will learn strategies to better manage time and priorities.



DATE March 10, 2015
TO Board of Directors
FROM Delvecchio Finley, MPP, Education Committee
 Member
RE Education Committee Report

MEMORANDUM

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

Annual Conference: VITAL2015

We shared with the board in October 2014 our plans to conduct a call for proposals to assist in identifying sessions for the annual conference program. This process is now complete. Key highlights are below:

- 79 total submissions
- 39 hospitals represented in the submissions
- 44 proposals selected for oral or poster presentation

A draft agenda is included in appendix B of this report.

Additionally, staff are working to identify alternate vehicles for using the proposals not selected for the annual conference. These include webinars, interest group meetings, blog posts, and more. Our goal is to highlight nearly every submission in some way throughout the year.

Fellows Program

We have accepted 39 applicants from 21 different organizations to the new 2015 Fellows Program class; a list of participants is attached in Appendix C of this report. This year, we targeted recruitment at new members, new CEOs, and fellows alumni. We held informational conference calls and sent personalized letters to stakeholders. We received applications from two new members, Care New England and Jersey City Medical Center. We also received six applications

from organizations with new CEOs, including Hennepin County Medical Center, Cook County Health & Hospitals, Harborview Medical Center, Tampa General Hospital, West Virginia University Hospitals, and Howard University.

In the next few months, staff will hold calls with the fellows' CEOs to discuss their role as a sponsor and to go over our commitment to them and their organizations.

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	Delvecchio S. Finley, MPP (2014-2016) CEO Harbor-UCLA Medical Center Torrance, California
Sherrie D. Williams, MD, MHS Vice Chair (2014-2016) Medical Director of Pulmonary Rehabilitation and Smoking Cessation The MetroHealth System Cleveland	James R. Gonzalez, MPH (2014-2016) President and CEO University Hospital Newark, New Jersey
D. Craig Cathcart, RN (2013-2015) Director of Legislative Affairs and Advocacy Swedish Covenant Hospital Chicago	Thomas J. Quattroche, PhD (2013-2015) Senior Vice President of Marketing, Planning and Business Development Erie County Medical Center Buffalo, NY
Theodore Chan, MD (2013-2015) Chair of Emergency Medicine UC San Diego Health System San Diego	Arnold Tabuenca, MD (2013-2015) Chief Medical Officer Riverside County Regional Medical Center Hospital Administration Moreno Valley, California
Susan R. Cooper, MSN, RN (2014-2016) Chief Integration Officer, Senior Vice President of Ambulatory Care Regional One Health Memphis	Joseph Woelkers, MA (2013-2015) Executive Vice President and Chief of Staff UT Health Northeast Tyler, Texas
Susan A. Currin, RN, MS (2014-2016) CEO San Francisco General Hospital and Trauma Center San Francisco	



VITAL2015

Connect. Inspire. Lead.

June 24-26
The Westin Gaslamp Quarter
 San Diego

Tracks: CL = Clinical Leadership; EL = Executive Leadership; I&A = Innovation and Adaption; FIN = Finance; Q&PS = Quality and Patient Safety

MONDAY, JUNE 22		
8 am – 5 pm	Fellows Program	Harbor, 3 rd Floor
TUESDAY, JUNE 23		
8 am – 5 pm	Fellows Program	Harbor, 3 rd Floor
11 am – 5 pm	Association Board of Directors Meeting (closed)	Coronado, 3 rd Floor
noon – 5 pm	Government Relations Academy	Sierra, 2 nd Floor
5:30 – 7 pm	Reception (invitation-only)	California Foyer, 2 nd Floor
WEDNESDAY, JUNE 24		
7 am – 7 pm	Conference Registration Open	California Foyer, 2 nd Floor
7 – 8 am	Continental Breakfast	California Foyer, 2 nd Floor
7:30 am – 1:30 pm Tracks: CL, EL, I&A, Q&PS	Site Visit to UC San Diego (space is limited and preregistration is required) Tour Option #1: Sulpizio Cardiovascular Center Tour Option #2: Moores Cancer Center Tour Option #3: Jacobs Medical Center Building Site (hard hat tour)	Offsite, Buses will depart the hotel lobby at 7:30 am
8 am – noon	Institute Board of Directors Meeting (closed)	Coronado, 3 rd Floor
8 am – 2 pm	Fellows Program	Harbor, 3 rd Floor
8 am – 2 pm	Government Relations Academy	Sierra, 2 nd Floor
2 – 3 pm		
INTEREST GROUP MEETINGS		
Tracks: EL, FIN	340B Interest Group Meeting	Santa Fe, 2 nd Floor
Tracks: CL, EL	Medical Leaders Interest Group Meeting	Plaza, 2 nd Floor
3:30 – 5 pm	Opening General Session Welcome & Conference Overview	California Ballroom, 2 nd Floor

	<p>Chairman's Remarks William B. Walker, MD – <i>Director and Health Officer, Contra Costa Health Services; Board Chair, America's Essential Hospitals</i></p> <p>Opening Keynote Speaker Eric Topol, MD – <i>Director, Scripps Translational Science Institute and Author, The Patient Will See You Now and The Creative Destruction of Medicine</i></p>	
5:30 – 7 pm	Opening Reception	Garden Terrace, 4 th Floor
THURSDAY, JUNE 25		
7 am – 4:30 pm	Conference Registration Open	California Foyer, 2 nd Floor
7 – 8 am	Continental Breakfast and Targeted Networking	California Foyer, 2 nd Floor
8 – 9 am	CRITICAL CONVERSATIONS (choose one of five)	
Track: CL	<p>Understanding and Using REAL Data to Target Culturally Competent Care</p> <p>Moderator: Matilde Roman, JD – <i>Senior Director, Office of Culturally and Linguistically Appropriate Services, New York City Health and Hospitals Corporation</i></p> <p>Julia Joseph-Di Caprio, MD, MPH – <i>Chief of Pediatrics and Assistant Chief of Provider Services, Hennepin County Medical Center</i></p> <p>Victor Sosa – <i>Co-Founder and Director, Natividad Medical Foundation's Indigenous Interpreting+</i></p>	Plaza, 2 nd Floor
Track: EL	<p>Integrating Rural Providers in a Revitalized Strategic Plan</p> <p>Mark Birdwhistell, MPA – <i>Vice President, Administration and External Affairs, UK HealthCare</i></p> <p>Rob Edwards, MBA – <i>Director of Strategic Initiatives and Regulatory Affairs, UK HealthCare</i></p>	Santa Fe, 2 nd Floor
Track: I&A	<p>Street Medicine, Respite Care: Meeting the Needs of Homeless Populations</p> <p>Dan Castillo, MHA – <i>CEO, LAC+USC Medical Center</i></p> <p>Mercy Egbujor, DNP, APRN – <i>Family Nurse Practitioner, Santa Clara Valley Medical Center, Valley Homeless Healthcare Program</i></p> <p>Leslie Enzian, MD – <i>Director, Medical Respite Program, Harborview Medical Center</i></p>	Del Mar, Lobby Level
Track: FIN	Foundations of Essential Hospitals Financing	Sierra, 2 nd Floor
	<p>Sarah Mutinsky, JD, MPH – <i>Deputy General Counsel, America's Essential Hospitals; Associate, Eyman Associates, PC</i></p>	
Track: Q&PS	<p>How Safe is Your Hospital? Really?</p> <p>James L. Reinertsen, MD – <i>President, The Reinertsen Group; former Chief Executive Officer (CEO), Park Nicollet Health Services and Caregroup</i></p>	La Jolla, Lobby Level

9 – 10:15 am	General Session President's Remarks and Town Hall Meeting	California Ballroom, 2 nd Floor
10:15 – 10:45 am	Networking Break	California Foyer, 2 nd Floor
10:45 am – noon	EDUCATION BREAKOUT SESSIONS (choose one of five)	
Track: EL	Sustaining Philanthropic Support While Under the Media Microscope Frederick Cerise, MD, MPH – <i>Chief Executive Officer, Parkland Health & Hospital System</i> George Engdahl, MA – <i>Vice President of Development and Capital Campaign Director, Parkland Foundation</i> David Krause, D.Min. – <i>President & CEO, Parkland Foundation</i> Cynthia A. Scott, MSW, MBA – <i>Senior Development Officer, Parkland Foundation</i>	Santa Fe, 2 nd Floor
Track: FIN	New Models of State Medicaid Financing Speakers TBD	Sierra, 2 nd Floor
Track: I&A	Integrating Behavioral Health and Primary Care via Texas' 1115 Waiver Brittney Nichols – <i>Program Manager, Regional Learning Collaborative, UT Health Northeast</i> Alan Podawiltz, DO, MS – <i>Chair of Psychiatry, JPS Health Network</i> Wayne Young, MBA – <i>Senior Vice President, Behavioral Health, JPS Health Network</i>	Plaza, 2 nd Floor
Track: I&A	The Intersection of Hunger and Health Kathy Chan – <i>Director of Policy, Cook County Health & Hospitals System</i> Diana B. Cutts, MD – <i>Director, Office of Pediatric Research and Advocacy, Hennepin County Medical Center</i> Steven McCullough, MBA – <i>Vice President of Community Partnerships, Greater Chicago Food Depository</i>	Del Mar, Lobby Level
Track: Q&PS	LEAN and other Tools for Operational, Clinical, and Service Excellence Cathy Duquette, PhD, RN – <i>Executive Vice President, Nursing Affairs, Lifespan/Rhode Island Hospital</i> Susan Ehrlich, MD, MPP – <i>Chief Executive Officer, San Mateo Medical Center</i> Iman Nazeeri-Simmons, MPH – <i>Chief Operating Officer, San Francisco General Hospital</i> Nidia Williams, MA – <i>Administrative Director, Operational Excellence (OpX), Lifespan/Rhode Island Hospital</i>	La Jolla, Lobby Level

noon - 2 pm	Gage Awards Luncheon	California Ballroom, 2 nd Floor
2:15 – 2:45 pm	MINI-SESSIONS (choose one of five)	
Track: CL	Care Transitions Taskforce: Bridging Silos from Hospital to Home Karishma Oza, MPH – <i>Care Transitions Analyst, San Francisco General Hospital</i> Michelle Schneidermann, MD – <i>Associate Clinical Professor of Medicine, San Francisco General Hospital</i>	Plaza, 2 nd Floor
Track: EL	Leading a Hospital Turnaround in a Non-Expansion State Robert Brooks, MBA – <i>Executive Vice President & COO, Erlanger Health System</i>	Santa Fe, 2 nd Floor
Track: FIN	Current Finance Issues Speaker TBD	Sierra, 2 nd Floor
Track: I&A	Innovations in Health Care Julie Cerese, RN, MSN – <i>Senior Vice President, Performance Improvement, UHC</i>	Del Mar, Lobby Level
Track: Q&PS	The Daily Safety Brief: A Real-Time Review Anne Aulizio, MSN, RN – <i>Patient Safety Officer, The MetroHealth System</i>	La Jolla, Lobby Level
3 – 3:30 pm	MINI-SESSIONS (choose one of five)	
Track: CL	Clinical Workforce Practices to Maximize Clinical Effectiveness Speaker TBD	Plaza, 2 nd Floor
Track: EL	Care Coordination among DSRIP Partners Maureen E. Fahey, RN, MBA – <i>President, PMA, Inc.</i> John “Skip” F. Williams Jr., MD, EdD, MPH – <i>President, Downstate Medical Center, State University of New York</i>	Santa Fe, 2 nd Floor
Track: FIN	Better Care and Lower Costs with Proactive Palliative Care Heather Harris, MD – <i>Associate Medical Director, Supportive & Palliative Care Service, San Francisco General Hospital</i> Anne Kinderman, MD – <i>Director, Supportive & Palliative Care, San Francisco General Hospital</i>	Sierra, 2 nd Floor
Track: I&A	Culture of Health – 100 Million Lives Campaign Speaker TBD	Del Mar, Lobby Level
3 – 3:30 pm	MINI-SESSIONS (continued, choose one of five)	
Track: Q&PS	Self-Administered Home Antimicrobial Infusion for the Uninsured	La Jolla, Lobby Level

	Kavita P. Bhavan, MD, MHS – <i>Medical Director, Infectious Diseases/OPAT Clinic and Medical Director, Antimicrobial Stewardship, Parkland Health and Hospital System</i>	
3:30 – 4:15 pm Tracks: CL, EL, FIN, I&A, Q&PS	Poster Session (see attached for listing of poster presentations)	California Ballroom, 2 nd Floor
4:15 – 4:45 pm Tracks: CL, EL, I&A, Q&PS	<p>Rapid-Fire Presentations</p> <p>Quick, Effective, Preventive: Routine, Opt-Out HIV Testing Nancy Miertschin, MPH – <i>Manager, HIV Projects, Harris Health System</i></p> <p>Better Maternal Experience, Better Patient Retention Sue Kehl, RN, MSN – <i>Director, Women's & Children's Health, Santa Clara Valley Medical Center</i></p> <p>Empowering At-Risk Communities HERE and Now Aaron Byzak, MBA – <i>Director of Government and Community Affairs, UC San Diego</i></p> <p>Safer Care from Tragedy of Patient Stairwell Death Jeff Critchfield, MD – <i>Medical Director, Risk Management, San Francisco General Hospital and Trauma Center</i></p>	California Ballroom, 2 nd Floor
6:30 – 10 pm	VITAL2015 Celebration Sponsored by Supplemental Health Care	Offsite, USS Midway
FRIDAY, JUNE 26		
7 am – noon	Conference Registration Open	California Foyer, 2 nd Floor
7 – 8 am	Breakfast	California Foyer, 2 nd Floor
8 – 9 am	CRITICAL CONVERSATIONS (choose one of five)	
Track: CL	<p>Breaking Barriers to Improve Gender Disparities</p> <p>Kathy Donofrio, DNP, MBA, RN – <i>Associate Vice President, Nursing and Women's Health Director, Swedish Covenant Hospital</i></p> <p>Jennifer Tscherney, MPS – <i>Executive Director, Swedish Covenant Hospital Foundation</i></p>	Plaza, 2 nd Floor
Track: EL	<p>The Neuroscience of Leadership</p> <p>Lynn Elliott – <i>Managing Director, Fahy Consulting</i></p> <p>Patty Fahy, MD – <i>Principal, Fahy Consulting</i></p>	Santa Fe, 2 nd Floor
Track: FIN	<p>Medicaid and Medicare DSH: Current Rules & Future Challenges</p> <p>Sarah Mutinsky, JD, MPH – <i>Deputy General Counsel, America's Essential Hospitals; Associate, Eyman Associates, PC</i></p>	Sierra, 2 nd Floor
8–9 am	CRITICAL CONVERSATIONS (continued, choose one of five)	
Track: I&A	How to Create a Positive LGBTIQ Atmosphere in Your Hospital	Del Mar, Lobby Level

	Julie Weckstein, MSW – <i>Licensed Clinical Social Worker, UC Davis Health System</i>	
Track: Q&PS	Reducing Violence and Building Skills for Psych Patients: The Role of a Behavior Support Team Renuka Ananthamoorthy, MD – <i>Chief of Service, Kings County Hospital Center</i> Jennifer Morrison-Diallo – <i>Coordinating Manager, Kings County Hospital Center</i> Liliane Rocha – <i>Assistant Director of Hospitals, Kings County Hospital Center</i>	La Jolla, Lobby Level
9am – noon	Closing General Session Federal Legislative and Regulatory Update Beth Feldpush, DrPH – <i>Senior Vice President for Policy and Advocacy, America's Essential Hospitals</i> Shawn Gremminger, MPP – <i>Director of Legislative Affairs, America's Essential Hospitals</i> National Health Policy: Views from Policymakers National and state policy leaders will speak on issues affecting hospital funding and member hospitals. Closing Keynote Speaker Zubin Damania, MD – <i>Director of Healthcare Development, Downtown Project Las Vegas</i>	California Ballroom, 2 nd Floor
1 – 4 pm	POSTCONFERENCE WORKSHOP (registration is required and additional fee applies)	
Track: EL	Providers of Choice: Essential Hospitals in a New Era of Competition Rich Neimand – <i>President and Creative Director, Neimand Collaborative</i> David Clayton – <i>Consultant, Neimand Collaborative</i>	Santa Fe, 2 nd Floor

PRELIMINARY LISTING OF POSTER PRESENTATIONS

Evaluation of a Falls Pilot on a Medical-Surgical Unit
Eskenazi Health

Patient Flow Intervention
Harbor-UCLA Medical Center

Documentation of Hierarchical Condition Categories Using Scribes
Hennepin County Medical Center

Disease and Access to Nutritious Food among Highland Hospital Patients
Highland Hospital, Alameda Health System

Arizona Partners with California to Improve Perinatal Outcomes
Maricopa Integrated Health System

School Health: Linking Medical Homes to Student Success in Cleveland
The MetroHealth System

Transitions Before Noon
Norwegian American Hospital

ProACTive Care Transition Communication Reduces Repeat ED Visits
Olive View-UCLA Medical Center, Olive View-UCLA Education and Research Institute

Optimizing Specialty Care within the Safety Net Hospital System
San Francisco General Hospital and Trauma Center

Sounding the Alarm on Inpatient Falls: Icons and Education
San Francisco General Hospital and Trauma Center

Reentry Medicine: A Medical Home for the Recently Incarcerated
Santa Clara Valley Medical Center

Outpatient Care Coordination for Complex Patients
Santa Clara Valley Medical Center

Ambulatory and Inpatient Teamwork Improves Patient Safety
UAB Hospital, University of Alabama Health Services Foundation, PC

Supply Optimization – An Ongoing Cycle of Improvement
UC Davis Health System

Creating and Sustaining One-piece Flow in the Primary Care Setting
The University of Texas Medical Branch

Preparing for Population Health: Information Competency
The University of Texas Medical Branch

Reducing Acute Care Utilization of Frequently Admitted Patients
The University of Texas Medical Branch

Appendix C: 2015 Fellows Roster

Fellow's Name	System Name
Mary Marran	Care New England
Matthew Quin	Care New England
Jordana Bailey	Coney Island Hospital/NYCHHC
Matthew Luu	Contra Costa Regional Medical Center
Gabriela Sullivan	Contra Costa Regional Medical Center
Timothy Thompson Cook	Contra Costa Regional Medical Center
Irene Marks	Cook County Health & Hospitals System
Krishna Das	Cook County Health & Hospitals System
David Payne	Grady Health System
Ben McKeeby	Grady Health System
Hany Atallah	Grady Health System
Kristina Lundberg	Grady Health System
Johanna Wood	Harborview Medical Center
Drew Lo	Harborview Medical Center
Belma Andric	Health Care District Palm Beach County
Christopher George	Hennepin County Medical Center
Jeffrey Morken	Hennepin County Medical Center
Jeanette Gibbs	Howard University
Kenneth Garay	Jersey City Medical Center
Rita Smith	Jersey City Medical Center
Renuka Ananthamoorthy	Kings County Hospital/NYCHHC
Christine Clare	LA County Harbor- UCLA Medical Center
John Jurenko	New York City Health and Hospitals Corporation
Kristen Baumann	New York City Health and Hospitals Corporation
Ivelesse Mendez-Justiniano	New York City Health and Hospitals Corporation
Dov Marocco	Santa Clara Valley Health and Hospitals System
Laura Haubner	Tampa General Hospital
Jordan Demoss	UAB Hospital
Terri Poe	UAB Hospital
Leah Meraz	University Health System
Virginia Mika	University Health System
Camerino Salazar	University Health System
Carmen Sanchez	University Health System
Doris Tinagero	University of New Mexico Hospital
Toni Davis	University of New Mexico Hospital

Thomas Long	University of New Mexico Hospital
Cody Boyd	University of Texas Health Science
Michele Bosworth	University of Texas Health Science
Manuel Vallejo	West Virginia University Hospital



DATE March 10, 2015
TO Board of Directors
FROM Jasel Fritz, MPH, Fellows Program Manager
RE Fellows Program Participation

MEMORANDUM

During its October 2014 meeting, the board expressed interest in learning more about member participation trends in the Fellows Program.

A list of participating members is included in appendix A of this report. The attached document shows the member hospitals that have participated in the program in the past nine years. It shows the year(s) each organization participated, as well as the number of years since each organization sent a fellow.

Staff have identified five organizations that used to consistently send participants to the program, but that haven't done so in the past three years:

- Regional One Health
- UK HealthCare
- Laguna Honda Hospital and Rehabilitation Center
- LAC+USC Medical Center
- The MetroHealth System

Staff also identified four organizations that used to send fellows, but due to leadership changes, have not recently sent participants.

Based on our findings, we focused this year's marketing strategy on new members, organizations with new CEOs, and Fellows Program alumni. Next year, we will target the five organizations above that were once frequent participants. We plan to assess these organizations to determine why they have not sent fellows and what we can do to remove obstacles to participation.

Appendix A

Hospital	City	State	Participation year(s)	Years since hospital last participated
Boston Medical Center	Boston	MA	07, 10, 13, 14	0
Contra Costa Health Services	Martinez	CA	09, 10, 11, 13, 14	0
Grady Memorial Hospital	Atlanta	GA	05, 06, 11, 13, 14	0
Harbor-UCLA Medical Center	Torrance	CA	08, 10, 12, 13, 14	0
Harborview Medical Center	Seattle	WA	05, 06, 10, 12, 13, 14	0
New York City Health and Hospitals Corporation	New York	NY	05, 06, 07, 08, 10, 11, 12, 13, 14	0
Riverside County Regional Medical Center	Moreno Valley	CA	12, 14	0
Santa Clara Valley Health & Hospital System	San Jose	CA	06, 12, 13, 14	0
Stony Brook University Hospital	East Setauket	NY	08, 10, 13, 14	0
Swedish Covenant Hospital (new member)	Chicago	IL	14	0
University Health System	San Antonio	TX	06, 09, 10, 12, 14	0
University of Illinois Hospital & Health Sciences System	Chicago	IL	14	0
UNM Health Sciences Center	Albuquerque	NM	07, 11, 10, 12, 13, 14	0
UT Health Northeast	Tyler	TX	13, 14	0
UW Medical Center	Seattle	WA	08, 14	0
West Virginia University Hospitals, Inc.	Morgantown	WV	13, 14	0
Arrowhead Regional Medical Center	Colton	CA	07, 08, 13	1
Cambridge Health Alliance	Somerville	MA	05, 06, 10, 12, 13,	1
City and County of San Francisco Department of Public Health	San Francisco	CA	05, 06, 07, 10, 11, 13	1
Denver Health	Denver	CO	05, 06, 07, 08, 12, 13	1
Harris Health System	Houston	TX	05, 06, 07, 08, 12, 13	1
Kern Medical Center	Bakersfield	CA	13	1
Lakeside Medical Center	Belle Glade	FL	13	1
NuHealth (new CEO)	East Meadow	NY	11, 12, 13	1
San Francisco General Hospital and Trauma Center	San Francisco	CA	05, 06, 07, 10, 11, 13	1
TMC Hospital Hill	Kansas City	MO	07, 13	1
Alameda Health System	Oakland	CA	12	2
Leonard J. Chabert Medical Center	Houma	LA	12	2
Regional One Health	Memphis	TN	07, 12	2
UK Albert B. Chandler Hospital	Lexington	KY	10, 12	2
Hennepin County Medical Center	Minneapolis	MN	06, 09, 10, 11	3
Laguna Honda Hospital and Rehabilitation Center	San Francisco	CA	10, 11	3
Lee Memorial Health System	Fort Myers	FL	11	3
Lyndon Baines Johnson General Hospital	Houston	TX	11	3
Sinai Health System	Chicago	IL	07, 11	3
Virginia Commonwealth University Health System	Richmond	VA	11	3
Broward Health	Fort Lauderdale	FL	08	4
John H. Stroger Jr. Hospital of Cook County	Chicago	IL	05, 08, 10	4
LAC+USC Medical Center	Los Angeles	CA	06, 10	4
Los Angeles County Department of Health Services	Los Angeles	CA	07, 08, 10	4
Howard University Hospital	Washington	DC	09	5
Hurley Medical Center	Flint	MI	09	5
The MetroHealth System	Cleveland	OH	06, 08, 09	5

University of Texas Health Sciences Center at Houston	Houston	TX	11	5
LSU Health Care Services Division	Baton Rouge	LA	08	6
Parkland Health & Hospital System (New CEO)	Dallas	TX	06, 08	6
Portland VA Medical Center	Portland	OR	08	6
University Medical Center of El Paso	El Paso	TX	08	6
University of New Mexico Sandoval Regional Medical Center	Rio Rancho	NM	08	6
Memorial Healthcare System	Hollywood	FL	07	7
St. Luke's Health System	Boise	UT	07	7
Marlborough Hospital (UMASS)	Marlborough	MA	06	8
University Medical Center of Southern Nevada	Las Vegas	NV	06	8
Broadlawns Medical Center	Des Moines	IA	05	9
Metroplus Health Plan	New York	NY	05	9



DATE March 10, 2015
TO Board of Directors
FROM Stan Hammack, Membership Committee Chair
RE Member Satisfaction Survey

MEMORANDUM

Background

The membership committee recently reviewed the results of an America's Essential Hospitals member survey. Given the recent changes at the association (e.g., rebranding and expanded programming), staff believed a survey would be a timely undertaking. America's Essential Hospitals retained the experienced association consulting firm McKinley Advisors (McKinley) to conduct the assessment to better understand members' needs and challenges, as well as their perception of whether the association brings value to membership. McKinley conducted telephone interviews with member hospital and health system CEOs, as well as an online survey.

Survey Overview

The online survey was distributed to all individuals identified in the association's database as being with a member hospital or health system. The survey spanned 33 days, from December 9, 2014, to January 12, 2015. In total, we received 390 completed and partially completed survey questionnaires, an 8.5 percent response rate.

Key Findings and Recommendations

Overall membership health is strong.

Respondents gave high marks to key membership health indicators, including overall satisfaction, likelihood to recommend, and the value of membership relative to the cost of dues. The association fares as well as, if not better than, other trade associations and associations in various health care fields. The next chart displays the association's net promoter score, which measures the willingness of customers to recommend a company's products or services to others. It serves as a proxy for gauging overall customer satisfaction with and brand loyalty to an organization. The score represents the difference between the promoter and detractor percentages, and scores greater than zero are seen as a positive indicator.

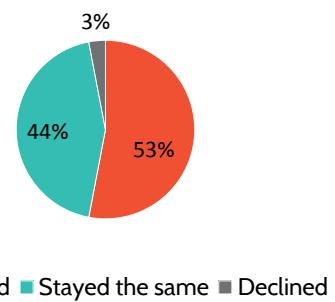
Net Promoter Score = 21
[Promoters - Detractors] (N= 311)



Responses to, and outcomes of, the rebranding effort are positive.

The majority of respondents (right) state that their perception of the association has improved since they first became a member, and one-third of these respondents directly attribute this improvement to the rebranding efforts and fresh leadership at the association. Furthermore, the majority of respondents say their institution is likely to renew its membership, and half of respondents are extremely confident America's Essential Hospitals will be relevant to their institution five years from now.

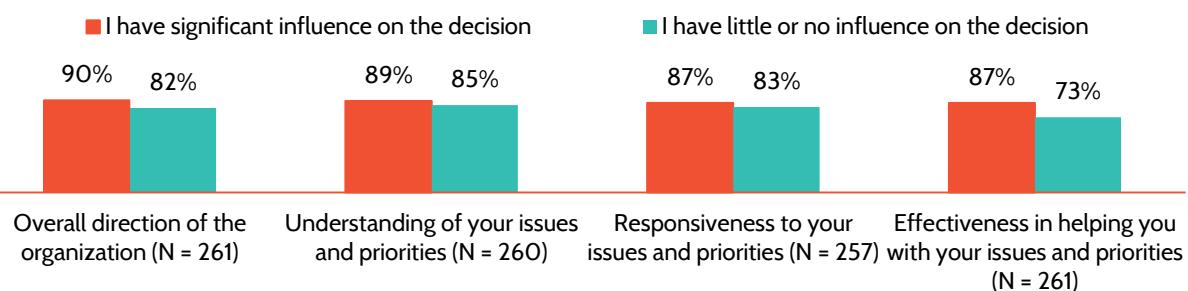
From the time you joined America's Essential Hospitals (formerly NAPH) until now, have your impressions of the organization: (N = 215)



Perceptions are significantly stronger at the decision-maker level.

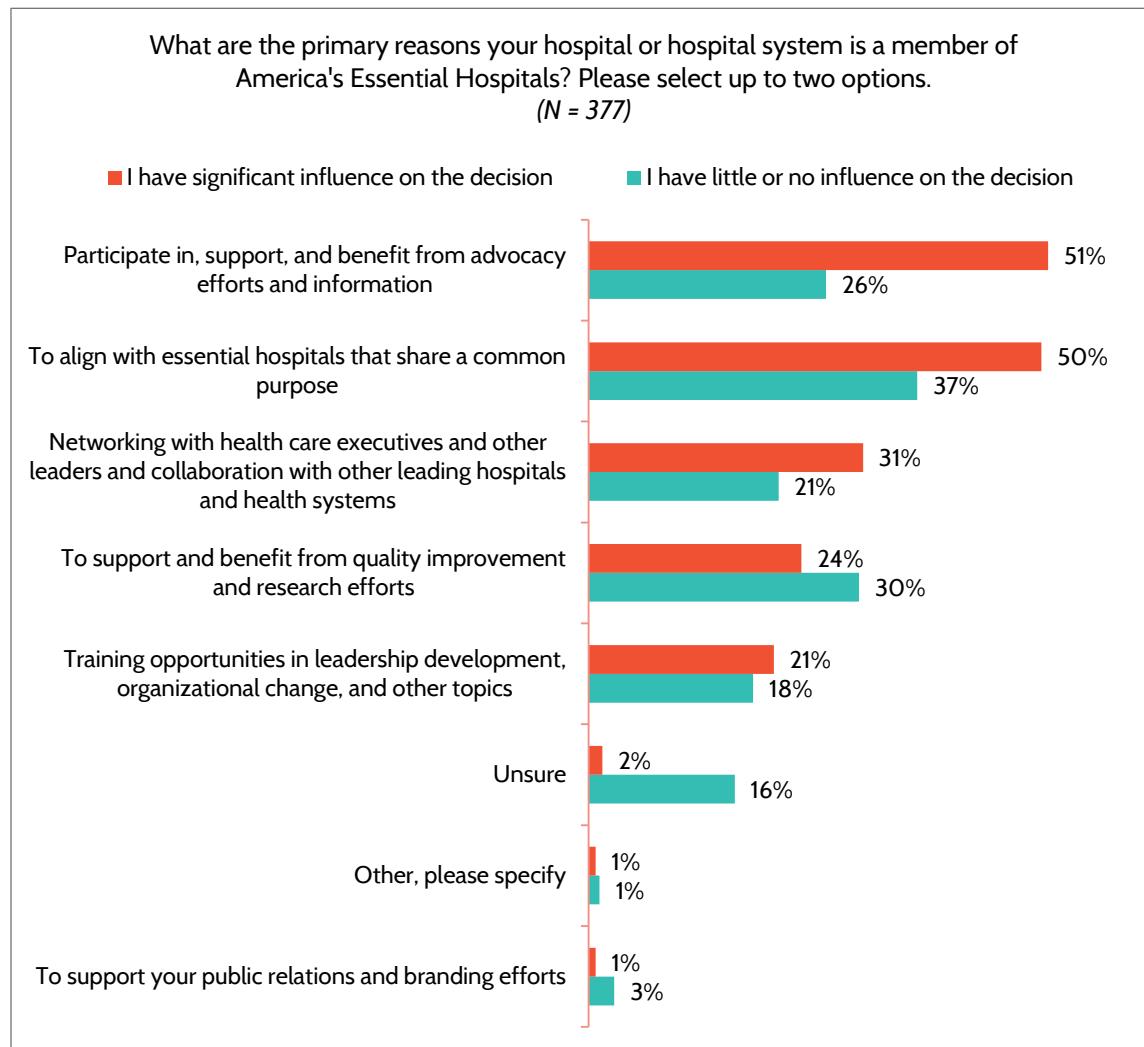
For nearly every data point in the survey, the decision-maker in an organization has a stronger, more positive perception of America's Essential Hospitals than does an individual who does not influence the decision to be an association member.

Based on your experience, how would you describe America's Essential Hospitals?



Advocacy and research/benchmarking/information sharing are the most important benefits of membership, but relative importance depends on an individual's role.

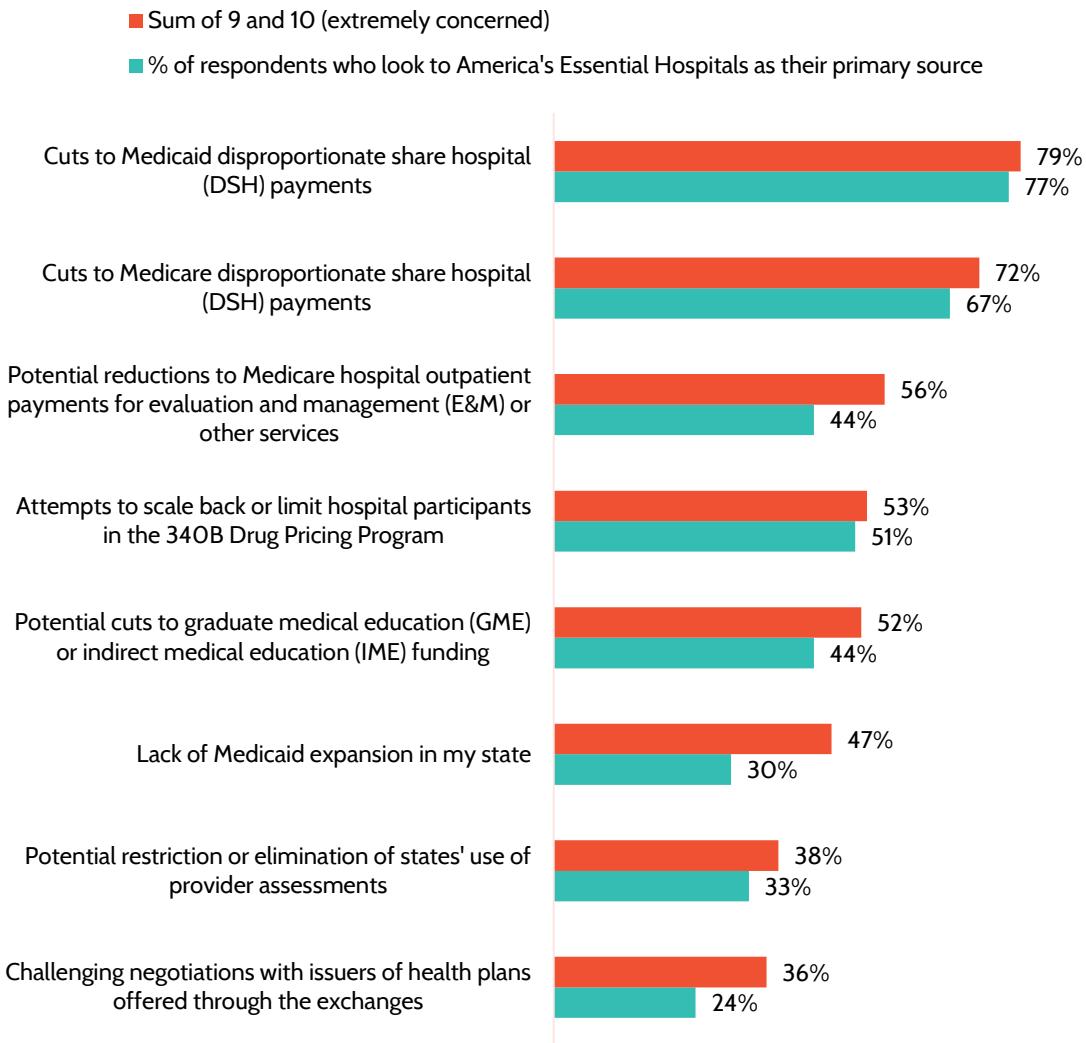
Advocacy support and research/benchmarking/information sharing were viewed universally as the most important benefits America's Essential Hospitals offers. However, individuals in higher positions in their institutions are more likely to gravitate towards the association's advocacy work, while other managers place more importance on benchmarking and best practices resources.



Respondents consider America's Essential Hospitals their primary source of support on many of their most pressing challenges.

There is a strong correlation between the challenges and issues respondents identify as most pressing and the likelihood they will turn to America's Essential Hospitals first on an issue. In other words, the association and the resources it provides are well-aligned with its members' challenges.

Top concerns versus issues where America's Essential Hospitals is a primary source





DATE March 10, 2015
TO Board of Directors
FROM Rhonda Gold, Chief Financial Officer
RE 2015 Revised Budget

MEMORANDUM

This memorandum updates you on the 2014 preaudited financial results compared with the approved budget, and presents proposed revisions to the 2015 approved budget. Our audit fieldwork began March 2; we will forward to you audited financial statements once they are final and reviewed by the audit and compliance committee. For your information, we have included a copy of the auditor's engagement letter with this material.

We ask the board to vote on one action item:

- Approve a 2015 revised budget

Due to delays by the Centers for Medicare & Medicaid Services (CMS) in releasing the request for proposals for renewal of hospital engagement networks, including our Essential Hospitals Engagement Network (EHEN), this contract will not be funded until June 1. This postponement presents significant financial implications for the Institute. Personnel, rent, office equipment and webinars normally budgeted under the contract will not be charged to the program until mid-year, increasing costs to the organization. We are optimistic the contract will be renewed in June; during this transitional period, the Institute's healthy net asset balance from prior years' unspent funds will cover the ongoing costs of our performance improvement work. Accordingly, staff asks the board to vote on revising the 2015 approved budget to reflect CMS' funding delay. This memo outlines proposed budget revisions.

2014 Financial Summary:

Columns 1 through 5 of attachment I present the 2014 approved budget; columns 6 through 10 present our preaudited results; and columns 11 through 13 reflect the budget variances.

Preaudited unrestricted income (column 8) is \$7.53 million (including \$5.49 million from the CMS Partnership for Patients (PfP) contract with EHEN), which is offset by \$6.49 million in expenses, leaving an unrestricted operating surplus (before investment gains of \$14,800) of \$1.03 million. This surplus is \$1.11 million more than budget primarily due to unspent funds from the PfP contract. This fixed-price contract award (December 8, 2013 through December 7, 2014) totaled almost \$5.59 million, of which \$4.36 million in expenses was spent, resulting in a profit of \$1.2 million (representing a 22 percent profit margin). This surplus will be used to support staff's

ongoing performance improvement work until CMS awards a new contract. After funding these ongoing costs, we estimate the net profit margin on the contract to be 3 percent above the budgeted 8 percent profit margin.

The 2014 preaudited net assets are \$6.82 million (column 8), in addition to \$589,000 (column 9) in temporarily restricted assets, for a total of \$7.41 million. This represents an increase of \$1 million from 2013 and a return on net assets of 16 percent. Of this total balance, \$3.3 million is in a board-designated special purpose fund for programs and other activities that further the Institute's mission; and \$900,000 is reflected in a board-designated operating reserve to cover recurring expenses (e.g., salaries and benefits, rent, office, travel, program, and ongoing professional services). The remaining \$2.62 million represents unrestricted net assets. These unrestricted and board-designated reserves are reflected at the bottom of attachment I.

2015 Revised Budget:

The 2015 approved and revised budgets are detailed in attachments II and III, respectively; attachment IV presents the change between the approved and revised budgets. Each attachment presents the funded and unfunded programmatic costs of the Institute: research, analytics, performance improvement, Fellows Program, innovation and partnerships, and general and administrative. For purposes of the budget, "unfunded" refers to revenue and expenses not externally funded.

The revised budget (attachment III) includes a June 1 renewal from CMS for the Essential Hospitals Engagement Network fixed-price contract. It also reflects a \$595,000 contribution (the same level as the approved budget) from the association to support research and analytics work that is not externally funded. Because Kaiser Permanente's three-year grant to support transformation initiatives ended in 2014, core support from membership dues continues to be necessary to support the Institute's important research and analytical work.

While we prepare our proposal to renew the EHEN contract, staff has focused on expanding the Institute's portfolio with CMS and private funders. We are pleased to report that as of February, there is \$5.5 million in pending grant requests; \$1.9 million for a four-year proposal to the Transforming Clinical Practice Initiative (TCPI), Practice Transformation Networks (PTNs); \$679,000 for a two-year subcontract with UHC for its proposal to TCPI; \$860,000 for a three-year renewal of the Massachusetts' Delivery System Transformation Initiatives (DSTI) plan; and a \$2 million, three-year proposal to continue our Kaiser Permanente funding. A summary of changes reflected in the revised budget are described below.

Grant Income: increase of \$506,000 (from \$998,000 in the approved budget to \$1.5 million). Budgeted grant income in the revised budget reflects these projects:

- Kaiser Permanente collaboration with the National Association of Community Health Centers and The George Washington University Milken Institute School of Public Health:

\$438,000 in 2015 (three-year grant ending May 2016), a reduction of \$32,000 from the approved budget

- renewal of the DSTI learning collaborative pursuant to CMS' approval of Massachusetts' DSTI renewal: \$275,000 (three-year grant award of \$860,00), the same level as reflected in the 2015 approved budget
- Improving Care Transitions, a three-year project recently awarded by the Patient-Centered Outcomes Research Institute: \$127,000 (three-year grant award of \$431,000). The approved budget did not reflect this grant award. The project is led by the University of Kentucky, includes a consortium of research affiliates, and is intended to identify which care transition outcomes are most important to patients and to evaluate current efforts for improving transitions and interventions.
- a proposal to Kaiser Permanente to continue core Institute transformation work funding, which expired in December 2014 (three-year proposal totaling \$2 million, of which \$344,000 is budgeted in 2015); an increase of \$94,000 from the approved budget
- a four-year proposal totaling \$1.97 million (of which \$320,000 is budgeted in 2015) to the Transforming Clinical Practice Initiative (TCPI), Practice Transformation Networks (PTNs). The Institute's will provide strategic support to PTNs and their participating clinicians through collaborative learning, evidence-based coaching, and effective use of data to improve practice. The approved budget did not reflect this proposal.
- unrestricted grant from UHC: \$400,000 (same level as in the approved budget)

Contract Income: reduction of \$2 million from the approved budget due to the delay in the EHEN renewal until June 1. The approved budget assumed \$5.15 million in revenue for the full year in 2015; the revised budget reflects funding of \$3.11 million.

The 2015 revised budget (column 8 of attachment III) reflects total, unrestricted budgeted revenue of \$5.87 million and budgeted expenses of \$6.72 million, leaving an unrestricted operating deficit of \$847,000 (compared with an \$80,000 approved, budgeted deficit).

The significant increase in the budgeted operating deficit is due to the following changes:

- \$321,000 in salaries and fringe costs for five months of unfunded EHEN personnel time spent on performance improvement
- \$25,000 for five months of webinar and copier rental costs not covered by the EHEN contract
- \$101,300 for five months of rent not covered by the EHEN contract
- \$13,500 for information technology not covered by the EHEN contract
- \$306,000 less in overhead coverage and profit due to the contract renewal delay.

As reflected on the bottom of attachment III, 2015 revised budgeted net assets (restricted and unrestricted) are \$10.3 million (column 10, of attachment III), of which \$4.36 million is temporarily restricted by funders for future grant expenditures. Of the total budgeted \$5.97 million in unrestricted reserves, \$3.3 million is set aside in a board-designated reserve for a special purpose fund and \$900,000 is reflected as a board designated operating reserve, leaving an unrestricted net asset balance of \$1.77 million.

These materials will be reviewed with you during the board meeting but please do not hesitate to contact Rhonda Gold at rgold@essentialhospitals.org or 202-585-0109 if you have questions.

ATTACHMENT I
2014 PreAudit vs Budget

	col 1	col 2	col 3	col 4	col 5	col 6	col 7	col 8	col 9	col 10	col 11	col 12	col 13
	Total: 2014 Budget					Total: 2014 PreAudit					Total: Unrestricted	Temp Restricted	Grand Total: PreAudit
	Funded	Unfunded	Total: Unrestricted	Temp Restricted	Total	Funded	Unfunded	Total: Unrestricted	Temp Restricted				
INCOME:													
Unrestricted Grant from UHC	\$ -	\$ 350,000	\$ 350,000		\$ 350,000	\$ -	\$ 350,000	\$ 350,000		\$ 350,000	\$ -	\$ -	\$ -
Grant Income	\$ 1,694,600	\$ -	\$ 1,694,600	\$ 250,000	\$ 1,944,600	\$ 1,411,238	\$ -	\$ 1,411,238	\$ -	\$ 1,411,238	\$ (283,362)	\$ (250,000)	\$ (533,362)
Government Contract	\$ 5,493,800	\$ -	\$ 5,493,800		\$ 5,493,800	\$ 5,493,807	\$ -	\$ 5,493,807		\$ 5,493,807	\$ 7	\$ -	\$ 7
Fellows Program	\$ -	\$ 292,500	\$ 292,500		\$ 292,500	\$ -	\$ 221,000	\$ 221,000		\$ 221,000	\$ (71,500)	\$ -	\$ (71,500)
Miscellaneous	\$ -	\$ -	\$ -		\$ -	\$ -	\$ 55,500	\$ 55,500		\$ 55,500	\$ 55,500	\$ -	\$ 55,500
Net Assets Released from Donor Restrictions	\$ -	\$ -	\$ -	\$ (1,694,061)	\$ (1,694,061)	\$ -	\$ -	\$ -	\$ (1,406,300)	\$ (1,406,300)	\$ -	\$ 287,761	\$ 287,761
TOTAL INCOME	\$ 7,188,400	\$ 642,500	\$ 7,830,900	\$ (1,444,061)	\$ 6,386,839	\$ 6,905,045	\$ 626,500	\$ 7,531,545	\$ (1,406,300)	\$ 6,125,245	\$ (299,355)	\$ 37,761	\$ (261,594)
Personnel	\$ 2,742,400	\$ 1,207,600	\$ 3,950,000		\$ 3,950,000	\$ 2,431,551	\$ 1,191,049	\$ 3,622,600		\$ 3,622,600	\$ 327,400	\$ -	\$ 327,400
Equipment and Furniture	\$ -	\$ 22,800	\$ 22,800		\$ 22,800	\$ -	\$ 18,000	\$ 18,000		\$ 18,000	\$ 4,800	\$ -	\$ 4,800
Office Supplies & Services	\$ 106,000	\$ 185,500	\$ 291,500		\$ 291,500	\$ 34,641	\$ 93,066	\$ 127,707		\$ 127,707	\$ 163,793	\$ -	\$ 163,793
Rent	\$ 220,000	\$ 129,500	\$ 349,500		\$ 349,500	\$ 219,985	\$ 113,329	\$ 333,314		\$ 333,314	\$ 16,186	\$ -	\$ 16,186
Travel, meetings & incentives	\$ 318,200	\$ 320,000	\$ 638,200		\$ 638,200	\$ 776,107	\$ 215,704	\$ 991,811		\$ 991,811	\$ (353,611)	\$ -	\$ (353,611)
Depr. and amort.	\$ -	\$ 41,000	\$ 41,000		\$ 41,000	\$ -	\$ 29,978	\$ 29,978		\$ 29,978	\$ 11,022	\$ -	\$ 11,022
Consultants & sub-contracted svces	\$ 2,103,500	\$ 314,500	\$ 2,418,000		\$ 2,418,000	\$ 988,031	\$ 224,298	\$ 1,212,329		\$ 1,212,329	\$ 1,205,671	\$ -	\$ 1,205,671
Information Technology	\$ -	\$ 70,900	\$ 70,900		\$ 70,900	\$ 111,978	\$ 27,275	\$ 139,253		\$ 139,253	\$ (68,353)	\$ -	\$ (68,353)
Misc., Taxes and Insurance	\$ -	\$ 29,000	\$ 29,000		\$ 29,000	\$ -	\$ 23,678	\$ 23,678		\$ 23,678	\$ 5,322	\$ -	\$ 5,322
Project Development	\$ -	\$ 100,000	\$ 100,000		\$ 100,000	\$ -	\$ -	\$ -		\$ -	\$ 100,000	\$ -	\$ 100,000
Sub-total before grant overhead coverage	\$ 5,490,100	\$ 2,420,800	\$ 7,910,900	\$ -	\$ 7,910,900	\$ 4,562,293	\$ 1,936,378	\$ 6,498,671	\$ -	\$ 6,498,671	\$ 1,412,229	\$ -	\$ 1,412,229
Allocation of Overhead to Grants	\$ 1,291,100	\$ (1,291,100)	\$ -		\$ -	\$ 1,099,817	\$ (1,099,817)	\$ -		\$ -	\$ -	\$ -	\$ -
Total Expenses	\$ 6,781,200	\$ 1,129,700	\$ 7,910,900	\$ -	\$ 7,910,900	\$ 5,662,110	\$ 836,561	\$ 6,498,671	\$ -	\$ 6,498,671	\$ 1,412,229	\$ -	\$ 1,412,229
Operating Net Income (Loss)	\$ 407,200	\$ (487,200)	\$ (80,000)	\$ (1,444,061)	\$ (1,524,061)	\$ 1,242,935	\$ (210,061)	\$ 1,032,874	\$ (1,406,300)	\$ (373,426)	\$ 1,112,874	\$ 37,761	\$ 1,150,635
Non-Operating Income:													
Total Non-Operating Income (investment)	\$ -	\$ -	\$ -		\$ -	\$ -	\$ 14,866	\$ 14,866		\$ 14,866	\$ 14,866	\$ -	\$ 14,866
Total Operating & Non-Operating Income	\$ 407,200	\$ (487,200)	\$ (80,000)	\$ (1,444,061)	\$ (1,524,061)	\$ 1,242,935	\$ (195,195)	\$ 1,047,740	\$ (1,406,300)	\$ (358,560)	\$ 1,127,740	\$ 37,761	\$ 1,165,501
Net Assets:													
Prior Year Net Assets	\$ 4,876,464	\$ 897,577	\$ 5,774,041	\$ 1,996,061	\$ 7,770,102	\$ 4,936,390	\$ 837,651	\$ 5,774,041	\$ 1,996,060	\$ 7,770,101			
Change in Net Assets	\$ 407,200	\$ (487,200)	\$ (80,000)	\$ (1,444,061)	\$ (1,524,061)	\$ 1,242,935	\$ (195,195)	\$ 1,047,740	\$ (1,406,300)	\$ (358,560)			
Net Assets, End of Year	\$ 5,283,664	\$ 410,377	\$ 5,694,041	\$ 552,000	\$ 6,246,041	\$ 6,179,325	\$ 642,456	\$ 6,821,781	\$ 589,760	\$ 7,411,541			
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	\$ 5,283,664	\$ 410,377	\$ 5,694,041	\$ 552,000	\$ 6,246,041	\$ 6,179,325	\$ 642,456	\$ 6,821,781	\$ 589,760	\$ 3,211,541			
Total Net Assets	\$ 5,283,664	\$ 410,377	\$ 5,694,041	\$ 552,000	\$ 6,246,041	\$ 6,179,325	\$ 642,456	\$ 6,821,781	\$ 589,760	\$ 7,411,541	\$ -		

Attachment II
2015 Approved Budget

										col 6	col 7	col 8	col 9	col 10						
	Research	Analytics	Performance Improvement	Fellows	Innovation and Partnerships	G&A	Total: 2015 Budget			Total:										
	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			
Grant Income	\$ 748,600	\$ 748,600			\$ -				\$ 249,400	\$ 249,400		\$ 998,000	\$ -	\$ 998,000	\$ 2,006,000	\$ 3,004,000				
Government Contract	\$ -			\$ 5,150,000	\$ 5,150,000				\$ -			\$ 5,150,000	\$ -	\$ 5,150,000		\$ 5,150,000				
Tuition Income	\$ -				\$ -	\$ 262,500			\$ -			\$ -	\$ 262,500	\$ 262,500			\$ 262,500			
Investment Income	\$ -				\$ -				\$ -			\$ -	\$ -	\$ -		\$ -				
Miscellaneous	\$ -				\$ -				\$ -			\$ -	\$ -	\$ -		\$ -				
Contribution/Support from AEH	\$ 293,400	\$ 293,400	\$ 293,400	\$ 264,800	\$ 36,800	\$ 36,800	\$ 36,800	\$ -	\$ -	\$ -		\$ -	\$ 595,000	\$ 595,000			\$ 595,000			
Net Assets Released from Donor Restrictions	\$ -				\$ -				\$ -			\$ -	\$ -	\$ -		\$ -	\$ (998,000)	\$ (998,000)		
TOTAL INCOME	\$ 748,600	\$ 293,400	\$ 1,042,000	\$ 264,800	\$ 5,150,000	\$ 36,800	\$ 5,186,800	\$ 262,500	\$ 249,400	\$ -	\$ 249,400	\$ 400,000	\$ 6,148,000	\$ 1,257,500	\$ 7,405,500	\$ 1,008,000	\$ 8,413,500			
Personnel	\$ 263,700	\$ 254,900	\$ 518,600	\$ 213,800	\$ 1,804,300	\$ 34,600	\$ 1,838,900	\$ 171,000	\$ 99,700	\$ 305,000	\$ 404,700	\$ 873,000	\$ 2,167,700	\$ 1,852,300	\$ 4,020,000		\$ 4,020,000			
Consultants & sub-contracted svces	\$ 378,400	\$ -	\$ 378,400		\$ 1,349,700	\$ -	\$ 1,349,700	\$ 142,300	\$ 95,000	\$ 15,000	\$ 110,000	\$ 77,500	\$ 1,823,100	\$ 234,800	\$ 2,057,900		\$ 2,057,900			
Equipment	\$ -				\$ -				\$ -			\$ 21,000	\$ -	\$ 21,000	\$ 21,000		\$ 21,000			
Office Supplies & Services	\$ 3,300	\$ 25,900	\$ 29,200	\$ 40,600	\$ 48,400	\$ 1,700	\$ 50,100	\$ 13,300	\$ 1,700	\$ 2,000	\$ 3,700	\$ 82,000	\$ 53,400	\$ 165,500	\$ 218,900		\$ 218,900			
Rent	\$ -				\$ 220,000	\$ 220,000			\$ -			\$ 134,000	\$ 220,000	\$ 134,000	\$ 354,000		\$ 354,000			
Travel & meetings	\$ 25,600	\$ 12,600	\$ 38,200	\$ 10,400	\$ 275,400	\$ 500	\$ 275,900	\$ 116,100	\$ -	\$ 500	\$ 500	\$ 141,000	\$ 301,000	\$ 281,100	\$ 582,100		\$ 582,100			
Depr. and amort.	\$ -				\$ -				\$ -			\$ 21,300	\$ -	\$ 21,300	\$ 21,300		\$ 21,300			
Information Technology	\$ -				\$ -				\$ -			\$ 69,300	\$ -	\$ 69,300	\$ 69,300		\$ 69,300			
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	\$ 671,000	\$ 293,400	\$ 964,400	\$ 264,800	\$ 3,697,800	\$ 36,800	\$ 3,734,600	\$ 442,700	\$ 196,400	\$ 322,500	\$ 518,900	\$ 1,560,100	\$ 4,565,200	\$ 2,920,300	\$ 7,485,500	\$ -	\$ 7,485,500			
Allocation of Overhead to Grants	\$ 77,600	\$ -	\$ 77,600	\$ -	\$ 1,068,500	\$ 1,068,500		\$ -	\$ 53,000	\$ 53,000	\$ 1,199,100	\$ 1,199,100	\$ 1,199,100	\$ (1,199,100)	\$ -					
Total Expenses	\$ 748,600	\$ 293,400	\$ 1,042,000	\$ 264,800	\$ 4,766,300	\$ 36,800	\$ 4,803,100	\$ 442,700	\$ 249,400	\$ 322,500	\$ 571,900	\$ 361,000	\$ 5,764,300	\$ 1,721,200	\$ 7,485,500	\$ -	\$ 7,485,500			
Operating Net Income (Loss)	\$ (0)	\$ 0	\$ 0	\$ -	\$ 383,700	\$ (0)	\$ 383,700	\$ (180,200)	\$ 0	\$ (322,500)	\$ (322,500)	\$ 39,000	\$ 383,700	\$ (463,700)	\$ (80,000)	\$ 1,008,000	\$ 928,000			
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	\$ (0)	\$ 0	\$ 0	\$ -	\$ 383,700	\$ (0)	\$ 383,700	\$ (180,200)	\$ 0	\$ (322,500)	\$ (322,500)	\$ 39,000	\$ 383,700	\$ (463,700)	\$ (80,000)	\$ 1,008,000	\$ 928,000			
Net Assets, End of Year	\$ 108,333	\$ (299,017)	\$ (190,684)	\$ (125,600)	\$ 6,454,692	\$ (235,294)	\$ 6,219,398	\$ (133,316)	\$ 0	\$ (384,326)	\$ (384,326)	\$ 1,356,310	\$ 6,563,025	\$ 178,757	\$ 6,741,781	\$ 1,597,760	\$ 8,339,541			
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)	\$ 6,454,692	\$ (235,294)	\$ 6,219,398	\$ (133,316)	\$ 0	\$ (384,326)	\$ (384,326)	\$ 1,356,310	\$ 6,563,025	\$ 178,757	\$ 2,541,781	\$ 1,597,760	\$ 4,139,541			
Total Net Assets	\$ 108,333	\$ (299,017)	\$ (190,684)	\$ (125,600)	\$ 6,454,692	\$ (235,294)	\$ 6,219,398	\$ (133,316)	\$ 0	\$ (384,326)	\$ (384,326)	\$ 1,356,310	\$ 6,563,025	\$ 178,757	\$ 6,741,781	\$ 1,597,760	\$ 8,339,541			

Attachment III
2015 Revised Budget

										col 6	col 7	col 8	col 9	col 10				
	Research	Analytics	Performance Improvement	Fellows	Innovation and Partnerships	G&A	Total: 2015 REVISED Budget											
	Funded	Unfunded	Total	Unfunded	Funded	Unfunded	Total	Unfunded	Funded	Unfunded	Total	G&A	Funded	Unfunded	Total:	Temp Restricted	Total	
INCOME:																		
Unrestricted Grant from UHC	\$ -	\$ -	\$ -			\$ -				\$ -	\$ -	\$ 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	
Investment Income	\$ -	\$ -	\$ -			\$ -				\$ -	\$ -			\$ -	\$ -		\$ -	
Miscellaneous	\$ -	\$ -	\$ -			\$ -				\$ -	\$ -			\$ -	\$ -		\$ -	
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)	
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	
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	\$ 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	

Attachment IV
2015 Revised vs Approved Budget

									col 6	col 7	col 8	col 9	col 10									
	Research			Analytics			Performance Improvement			Fellows			Innovation and Partnerships			G&A	Total: 2015 Revised vs Approved Budget					
	Funded	Unfunded	Total	Unfunded	Funded	Unfunded	Total	Unfunded	Funded	Unfunded	Total	Unfunded	Funded	Unfunded	Total	G&A	Funded	Unfunded	Total:	Temp Restricted	Total	
INCOME:																						
Unrestricted Grant from UHC	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	
Grant Income	\$ 91,400	\$ -	\$ 91,400	\$ -	\$ 320,000	\$ -	\$ 320,000	\$ -	\$ 94,600	\$ -	\$ 94,600	\$ -	\$ 506,000	\$ -	\$ 506,000	\$ -	\$ 3,270,300	\$ -	\$ 3,776,300	\$ -	\$ -	
Government Contract	\$ -	\$ -	\$ -	\$ -	\$ (2,037,000)	\$ -	\$ (2,037,000)	\$ -	\$ -	\$ -	\$ -	\$ -	\$ (2,037,000)	\$ -	\$ (2,037,000)	\$ -	\$ (2,037,000)	\$ -	\$ (2,037,000)	\$ -	\$ -	
Tuition Income	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	
Investment Income	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	
Miscellaneous	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	
Contribution/Support from AEH	\$ -	\$ -	\$ (103,400)	\$ (103,400)	\$ (22,800)	\$ -	\$ (36,800)	\$ (36,800)	\$ -	\$ -	\$ -	\$ -	\$ 163,000	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Net Assets Released from Donor Restrictions	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ (504,000)	\$ (504,000)	
TOTAL INCOME	\$ 91,400	\$ (103,400)	\$ (12,000)	\$ (22,800)	\$ (1,717,000)	\$ (36,800)	\$ (1,753,800)	\$ -	\$ 94,600	\$ -	\$ 94,600	\$ -	\$ 163,000	\$ -	\$ 1,531,000)	\$ -	\$ (1,531,000)	\$ -	\$ 2,766,300	\$ 1,235,300		
Personnel	\$ (60,600)	\$ 103,400	\$ 42,800	\$ 22,800	\$ 386,900	\$ (681,400)	\$ (294,500)	\$ 42,000	\$ (170,300)	\$ 115,000	\$ (55,300)	\$ 77,200	\$ 156,000	\$ (321,000)	\$ (165,000)	\$ -	\$ (165,000)	\$ -	\$ (165,000)	\$ -	\$ (165,000)	
Consultants & sub-contracted svces	\$ (13,000)	\$ -	\$ (13,000)	\$ -	\$ 1,050,200	\$ -	\$ 1,050,200	\$ -	\$ 90,000	\$ -	\$ 90,000	\$ -	\$ 1,127,200	\$ -	\$ 1,127,200	\$ -	\$ 1,127,200	\$ -	\$ 1,127,200	\$ -	\$ 1,127,200	
Equipment	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ (9,000)	\$ -	\$ (9,000)	\$ (9,000)	\$ (9,000)	\$ -	\$ (9,000)	\$ -	\$ (9,000)	
Office Supplies & Services	\$ (500)	\$ -	\$ (500)	\$ -	\$ (6,000)	\$ -	\$ (6,000)	\$ -	\$ (1,200)	\$ -	\$ (1,200)	\$ -	\$ (16,000)	\$ (7,700)	\$ (16,000)	\$ (23,700)	\$ -	\$ (23,700)	\$ -	\$ (23,700)	\$ -	
Rent	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 101,300	\$ -	\$ 101,300	\$ -	\$ -	\$ -	\$ -	\$ (101,300)	\$ 101,300	\$ (101,300)	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	
Travel & meetings	\$ (3,800)	\$ -	\$ (3,800)	\$ -	\$ (143,100)	\$ -	\$ (143,100)	\$ -	\$ (5,100)	\$ -	\$ (5,100)	\$ -	\$ -	\$ (152,000)	\$ -	\$ (152,000)	\$ -	\$ (152,000)	\$ -	\$ (152,000)	\$ -	
Depr and amort.	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ (300)	\$ -	\$ (300)	\$ (300)	\$ -	\$ -	\$ (300)	\$ -	\$ (300)	\$ -
Information Technology	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ (13,200)	\$ -	\$ (13,200)	\$ (13,200)	\$ -	\$ -	\$ (13,200)	\$ -	\$ (13,200)	\$ -
Misc, Taxes and Insurance	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	
Project Development	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	
Sub-total before grant overhead coverage	\$ (77,900)	\$ 103,400	\$ 25,500	\$ 22,800	\$ 1,389,300	\$ (681,400)	\$ 707,900	\$ 42,000	\$ (86,600)	\$ 115,000	\$ 28,400	\$ (62,600)	\$ 1,224,800	\$ (460,800)	\$ 764,000	\$ -	\$ -	\$ 764,000	\$ -	\$ -	\$ 764,000	
Allocation of Overhead to Grants	\$ (13,500)	\$ -	\$ (13,500)	\$ -	\$ 174,000	\$ -	\$ 174,000	\$ -	\$ (8,000)	\$ -	\$ (8,000)	\$ -	\$ (152,500)	\$ 152,500	\$ (152,500)	\$ (152,500)	\$ -	\$ -	\$ -	\$ -	\$ -	
Total Expenses	\$ (91,400)	\$ 103,400	\$ 12,000	\$ 22,800	\$ 1,563,300	\$ (681,400)	\$ 881,900	\$ 42,000	\$ (94,600)	\$ 115,000	\$ 20,400	\$ (215,100)	\$ 1,377,300	\$ (613,300)	\$ 764,000	\$ -	\$ -	\$ 764,000	\$ -	\$ -	\$ 764,000	
Operating Net Income (Loss)	\$ 0	\$ (0)	\$ (0)	\$ -	\$ (153,700)	\$ (718,200)	\$ (871,900)	\$ 42,000	\$ (0)	\$ 115,000	\$ 115,000	\$ (52,100)	\$ (153,700)	\$ (613,300)	\$ (767,000)	\$ 2,766,300	\$ 1,999,300	\$ -	\$ -	\$ 2,766,300	\$ 1,999,300	
Net Assets:																						
Prior Year Net Assets	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	
Change in Net Assets	\$ 0	\$ -	\$ (0)	\$ (0)	\$ -	\$ (153,700)	\$ (718,200)	\$ (871,900)	\$ 42,000	\$ (0)	\$ 115,000	\$ 115,000	\$ (52,100)	\$ (153,700)	\$ (613,300)	\$ (767,000)	\$ 2,766,300	\$ 1,999,300	\$ -	\$ -	\$ -	
Net Assets, End of Year	\$ 0	\$ 0	\$ (0)	\$ (0)	\$ -	\$ (153,700)	\$ (718,200)	\$ (871,900)	\$ 42,000	\$ (0)	\$ 115,000	\$ 115,000	\$ (52,100)	\$ (153,700)	\$ (613,300)	\$ (767,000)	\$ 2,766,300	\$ 1,999,300	\$ -	\$ -	\$ -	
Restricted Net Assets:																						
Special Purpose Fund	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	
Board Designated Operating Reserve	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	
Total Restricted Net Assets	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	
Unrestricted Net Assets	\$ 0	\$ 0	\$ (0)	\$ (0)	\$ -	\$ (153,700)	\$ (718,200)	\$ (871,900)	\$ 42,000	\$ (0)	\$ 115,000	\$ 115,000	\$ (52,100)	\$ (153,700)	\$ (613,300)	\$ (767,000)	\$ 2,766,300	\$ 1,999,300	\$ -	\$ -	\$ -	
Total Net Assets	\$ 0	\$ 0	\$ (0)	\$ (0)	\$ -	\$ (153,700)	\$ (718,200)	\$ (871,900)	\$ 42,000	\$ (0)	\$ 115,000	\$ 115,000	\$ (52,100)	\$ (153,700)	\$ (613,300)	\$ (767,000)	\$ 2,766,300	\$ 1,999,300	\$ -	\$ -	\$ -	



DATE March 10, 2015
TO Board of Directors
FROM Rhonda Gold, Chief Financial Officer
RE Office move update

MEMORANDUM

In our last board update, we informed you that we had executed a nonbinding letter of intent with Boston Properties to lease for new office space the south side of the ninth floor at 401 9th St. NW, Washington, DC. This is a class A LEED Gold building, two blocks from the Archives/Navy Memorial Metrorail subway station and three blocks from the Gallery Place/Chinatown Metrorail stop. Since then, we and our attorney, Thomas R. Petty of Miles & Stockbridge PC, have worked diligently to negotiate final lease terms.

We are pleased to report that after several rounds of negotiations, we have a fully executed lease consistent with the significant terms the association board approved at its October meeting. The association board authorized Bruce Siegel to sign the lease as long as the terms do not differ substantially from the letter of intent.

To foster collaboration and staff input on the office move, we formed a design team and a move committee. The design team comprises association leadership, several additional staff members, architects, real estate brokers, and our project manager. The move committee, led by Human Resources Director Alan Burk, will be responsible for providing staff input on related decisions and projects as they arise (e.g., designing the staff café).

Recently, we approved a floor plan that includes larger conference facilities to accommodate the full staff, host board meetings, and conduct educational activities. The floor plan also includes a member lounge, staff café, webinar room, several team rooms, and collaborative work areas for informal staff interactions. We recently met with our architects to begin work on the schematic design, which should start to give us a better idea of the “look and feel” of the office.

We will be particularly active in the design phase over the next several weeks. Work will begin on the audio-visual plan, furniture selection, office theme, and phone/data systems. In addition, our project manager will begin seeking requests for proposal from general contractors.

We will update you on the office move process as our planning progresses. Our expected move-in date will be in late December 2015. If you have questions, please contact me at 202-585-0109 or rgold@essentialhospitals.org.

Adapting Chronic Disease Care for the Underserved: Innovations in the Safety Net

Bianca Perez, PhD
Janelle Schrag, MPH

Summary: Safety-net hospitals are resource-constrained and serve complex patients yet are innovators in chronic disease care. Their strategies include personalized care, multidisciplinary teams, and information systems yielding real-time data. Safety-net providers are prime examples from which the health care community can learn to improve the delivery of chronic disease care.

Key words: Chronic disease care, vulnerable populations, safety-net providers, patient-centered care.

Safety-net hospitals care for the underserved in their communities who are at a disproportionate risk of chronic disease because of social disadvantages such as low socioeconomic status, poor living conditions or homelessness, and low levels of education and health literacy.^{1,2} For example, between 2009 and 2010, the prevalence of multiple chronic conditions was twice as high in impoverished populations and consistently higher among minority groups than in their counterparts.³ However, resource limitations at safety-net institutions present number of barriers to providing the level of care these complex patients require. The Affordable Care Act (ACA) has mandated that our health care system adopt new delivery models that can improve quality, equity, and patient-centered care. These models are especially important for people with chronic disease and present safety-net hospitals with new opportunities to provide better care to populations who have the most health risk.

In 2013, the Essential Hospitals Institute investigated chronic disease care for vulnerable patients delivered through several of these models including integrated delivery systems, patient centered medical homes, and community-based programs targeting specific populations and diseases. We selected six health systems (see Box 1) that serve diverse patient populations (e.g., minority groups, disease-specific populations, homeless patients, refugees) and implement different approaches to chronic disease care. This diversity gave us a breadth of understanding of providing chronic disease care to vulnerable patients. We subsequently interviewed 60 individuals including providers, and administrators to identify the facilitators and barriers to caring for chronically

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Box 1.**SUMMARY OF HOSPITAL AND HEALTH SYSTEM SITES**

Name of Site	State	Care Model
University of Chicago Medical Center	IL	Community-based intervention
Denver Health	CO	Patient-centered medical home
Hennepin County Medical Center	MN	Accountable care organization
Memorial Healthcare System	FL	Integrated delivery system
San Francisco General Hospital	CA	Integrated delivery system; patient-centered medical home
Santa Clara Valley Medical Center	CA	Patient-centered medical home

ill patients in the safety net. The discussion below highlights the findings from these interviews, including critical features of chronic disease care and implications for health care leadership.

Critical Features of Chronic Disease Care

The interviews brought to light three critical features of high quality patient-centered chronic disease care models for vulnerable patients. These features were identified by providers and patients across all systems, regardless of their approach to chronic disease management or structure of their delivery system.

Personalized care and outreach. Taking the time to customize care to patients' unique needs is a challenge in settings that face perpetual financial and resource constraints. Safety-net hospitals generally operate on margins considerably lower than the rest of the hospital industry, with an average operating margin of -8.0%, not accounting for disproportionate share payments.^{4,5} Nonetheless, providers in these settings are accustomed to addressing all of their patients' needs, including certain socioeconomic needs that may take precedence over medical needs. For instance, when caring for homeless patients with diabetes, providers understand that finding housing for their patients can take precedence over regulating their blood sugar because patients cannot store insulin without a refrigerator. In fact, our interviews revealed that safety-net hospital providers frequently step out of their assigned roles to meet patients' needs. We saw several cases in which clinicians personally handled insurance claims or acted as a supportive figure in legal situations to ensure their patients received care.

One of the most prominent themes in discussions with providers and patients was the importance of communication and building rapport with disadvantaged patient populations. Patient-provider relationship issues such as building trust, listening to patients' needs and preferences, and considering the burden of treatments on patients

are exceptionally important in these hospital settings given the complex socioeconomic needs of the populations served. Providers stressed the importance of meeting patients where they are and refraining from imposing treatment plans that patients are not ready to adhere to. Safety-net providers are focused on developing care plans that evolve over time, tailoring them to patients' unique circumstances.

Some safety-net hospitals create risk-stratified care clinics to address the needs of complex patients and super-utilizers, i.e., patients with high emergency department or admission rates.⁶ Depending on the severity of their chronic condition and presence of complicating factors, patients are assigned to different tiers, with those in the highest tiers receiving longer and more frequent appointments with a comprehensive care team. While the literature and in-hospital data for risk-stratified care is still limited, providers have heard many accounts from their patients that the experience of care is improving drastically. At the same time, providing this type of care also presents challenges in terms of capacity and scalability. With limited financial and staffing resources, safety-net hospital providers find it difficult to expand these clinics to care for larger populations without compromising on individualized attention.

It is also important to customize outreach strategies when trying to engage and enroll the underserved in chronic disease care programs. Providers identified many challenges in engaging patients without a primary care physician, those with comorbidities and mental health conditions, and the homeless. Limited transportation and mental health disorders such as anxiety often inhibit underserved patients from regularly attending physician appointments. Nonetheless, safety-net providers have found innovative ways to overcome some of these barriers. For example, providers at one hospital deliver care to homeless patients by traveling to remote areas in a mobile clinic or travelling on foot wearing backpacks filled with clinical supplies.

Cross-community, multidisciplinary teams. Team-based care is a staple component of chronic disease care. It is even more important in safety-net settings because it not only provides vulnerable patients with a more comprehensive and effective delivery system, but it also allows providers to delegate and share workloads which can alleviate burnout, a common phenomenon among safety-net hospital staff.⁷ Given their resource constraints and complex patient populations, providers sometimes feel that there is little they can do to help their patients. Working in multidisciplinary teams, however, allows providers to feel more effective in their delivery of care. We heard from several providers that they strongly prefer this model given all of the benefits of multidisciplinary teams.

Care teams should include a wide range of clinical and nonclinical providers who can address patients' complex and multifaceted needs. Team members can include physicians, nurses, pharmacists, social workers, patient navigators, community health workers, financial assistance specialists, and officials from local social service agencies. This breadth often requires safety-net providers to work outside the confines of the hospital system and become more integrated with the local community. Providers believe that establishing ties with community-based organizations (CBO) is crucial to providing high quality, patient-centered care. However, providers would like to see more integration with a wider array of CBOs. Many providers pointed out that hospital

leadership plays a critical role in forming hospital-CBO connections and incorporating CBOs into the overall infrastructure of care delivery.

Robust data and comprehensive performance measures. With the enactment of the ACA and other health policy initiatives,^{8,9} health information technology (HIT) has proven to be an essential component of health reform and innovative delivery systems.^{10,11} This has primarily revolved around new reporting regulations which have acted as catalysts for the improvement and expansion of HIT systems.^{8–11} In addition, pay-for-performance programs, such as those embedded within the patient-centered medical home and accountable care organization, are requiring providers to submit data routinely as evidence of their care model's results in quality and efficiency. However, there is still a great need for the integration of HIT systems and health registries across both clinical and non-clinical organizations. Community-based organizations are much needed resources when treating vulnerable patients with chronic disease, yet breaking down barriers between these services and health systems can be very challenging. Making progress in integrating electronic records between these systems is an important step in managing patients with chronic disease.

In addition to fully integrated HIT systems, providers find that real-time data in particular can be very effective in informing their progress on implementing new care delivery models. Thankfully, real-time data need not be costly or complex to generate. For example, one hospital developed a creative yet simple method for collecting real-time patient experience data. Patients were given a poker chip and asked whether they were satisfied with the care they just received. They answered the question by dropping the chip into a “yes” or “no” box. At the end of the day, providers counted the number of chips in each box. This practice turned out to be highly motivating and encouraging for staff, as they were able to see a clear connection between their interactions with patients and how those interactions affected experience of care—on a daily basis. With very little standing in the way of their development and implementation, these types of innovations in data collection can be valuable within and across safety-net hospital systems, and can greatly inform progress on the implementation of chronic disease models at very little cost.

In terms of specific performance measures, providers pointed out that there are few tools for assessing progress with certain key components of effective chronic disease care models—namely care coordination and collaborative care. Coordination and collaboration are fluid concepts, and providers feel that it is hard to determine when they are achieved. Furthermore, there is a need to develop these tools from the patient perspective. The literature on patient-centered medical homes, for example, reveals no overwhelming evidence that patients experience better care in these settings,^{12–15} despite the fact that the medical home was conceptualized specifically to center care around patient priorities.^{15–17} This may suggest that medical homes and other coordinated care models are not being implemented in ways that are truly patient-centered, in part because patients are not part of the design and implementation process,¹⁸ and in part because the evaluation tools are not developed from their perspectives. The patients' perspectives, priorities, and desires are sorely needed in the principles and frameworks that are defining and guiding the implementation of chronic disease models for vulnerable patients.

Implications for Leadership

Chronic disease management for vulnerable patients is a highly complex process requiring deliberate, targeted strategies. Leadership plays a major role when implementing the critical factors discussed previously. Specifically, there are several strategies that leaders should adopt as they design and implement chronic disease care models.

First, leaders should promote a culture that is focused on caring for one patient at a time. Providers should be encouraged to adopt a holistic approach to care by paying attention to each patient's specific medical, behavioral, social, and economic circumstances. Underserved patients are more likely to experience homelessness, behavioral health difficulties, and other factors that contribute to social isolation,²⁶ which heightens their need to interact with caring and compassionate individuals. Therefore, delivering intensive, individualized care can help fulfill patients' unmet social needs and improve health outcomes as well as experience of care.

Second, it is critical for leadership to adopt the mindset that it takes teams to care for chronically ill, underserved patients. At the center of effective chronic disease care are multidisciplinary teams focused on addressing the social determinants of health. Teams should include a range of clinical and non-clinical providers from within and outside the hospital system, and leverage CBOs that have a bearing on the population's health.

Finally, it is important for leaders to emphasize people ahead of infrastructure when implementing chronic disease care models. Leaders should be more focused on hiring the right providers before focusing on issues such as health information technology and credentialing standards. While infrastructure matters, it is a secondary step to engaging providers who are committed to making a difference in patients' lives. Effective chronic disease care delivery is primarily driven by the unwaveringly compassionate and determined staff members who are prepared to embrace all of the challenges of caring for our nation's most complex patients.

Acknowledgments

The Patient-Centered Outcomes Research Institute (PCORI) supported this work and will use these findings to appropriately target funding that aims to improve patient-centered care for underserved patients with chronic disease. All statements in this report, including its findings and conclusions, are solely those of the authors and do not necessarily represent the views of PCORI, its board of governors, or methodology committee.

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November 21, 2014

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

Dear Ms. Gold:

We are pleased to confirm our understanding of the services we are to provide for Essential Hospitals Institute for the year ended December 31, 2014.

We will audit the statement of financial position of Essential Hospitals Institute as of December 31, 2014, and the related statements of activities and change in net assets, functional expenses and cash flows for the year then ended.

We will also prepare Essential Hospitals Institute's Federal Form 990, Return of Organization Exempt from Income Tax, for the year ended December 31, 2014.

Audit Objective

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

Audit Procedures

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

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

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

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

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

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

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

Management Responsibilities

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

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

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

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

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

Engagement Administration, Fees and Other

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

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

We estimate that our fee for these services will be \$26,750. We will bill you only for the time expended, plus out-of-pocket costs such as travel, report production, typing, postage, etc. Additional expenses are estimated to be \$500. The fee estimate is based on anticipated cooperation from your personnel and the assumption that unexpected circumstances will not be encountered during the audit. Our invoices will be rendered each month as work progresses and are payable on presentation. If we elect to terminate our services for nonpayment, our engagement will be deemed to have been completed upon written notification of termination, even if we have not completed our report. You will be obligated to compensate us for all time expended and to reimburse us for all out-of-pocket expenditures through the date of termination.

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

Sincerely,

GELMAN, ROSENBERG & FREEDMAN

Amy Boland

Amy Boland
Certified Public Accountant

RESPONSE:

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

Officer Signature

Title

Date