ESSENTIAL DATA

Our Hospitals, Our Patients

Results of America's Essential Hospitals 2015 Annual Member Characteristics Survey

AMERICA'S ESSENTIAL HOSPITALS

Published June 2017

ABOUT AMERICA'S ESSENTIAL HOSPITALS

America's Essential Hospitals is the leading association and champion for hospitals and health systems dedicated to high-quality care for all, including vulnerable people. Since 1981, America's Essential Hospitals has initiated, advanced, and preserved programs and policies that help these hospitals ensure access to care. We support members with advocacy, policy development, research, and education.

Our more than 300 members are vital to their communities, providing primary care through trauma care, disaster response, health professional training, research, public health programs, and other services. They innovate and adapt to lead the broader health care community toward more effective and efficient care.

ABOUT ESSENTIAL HOSPITALS INSTITUTE

Essential Hospitals Institute is the research and quality arm of America's Essential Hospitals. The Institute, established in 1988, supports the nation's essential hospitals as they provide high-quality, equitable, and affordable care to their communities. Working with members of America's Essential Hospitals, we identify promising practices from the field, conduct research, disseminate innovative strategies, and help our members improve their organizational performance. We do this with an eye toward improving individual and population health, especially for vulnerable people.

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FOREWORD

Welcome to *Essential Data*, an annual snapshot of the hospitals and health systems of America's Essential Hospitals. More than just a collection of data points, this document tells a story about the essential people and communities our members serve. It also tells a story about the vital role our hospitals play in communities nationwide.

Our hospitals share a common set of attributes that define what it means to be essential. **First and most important, they commit to caring for low-income and other vulnerable people.** But the benefits they provide a community extend far beyond that core role and touch every life, regardless of social or economic status.

Our hospitals also:

- provide specialized, lifesaving services, such as level I trauma and neonatal intensive care, emergency psychiatric services, and burn treatment;
- train the next generation of health care professionals to ensure the community's supply of doctors, nurses, and other caregivers meets demand;
- offer comprehensive, coordinated care across large ambulatory networks to bring services to where patients live and work; and
- fill a central public health role by going outside their walls to improve population health and to prepare for and respond to natural disasters and other crises.

Essential hospitals do all this with severe funding constraints that force them to operate with a margin less than half that of other hospitals. But these financial challenges also drive our hospitals to accomplish more with less and develop innovative programs that improve health care quality and value and reduce disparities.

This report tells a unique story of our essential people, essential communities, and essential hospitals. We're pleased to share it with you.

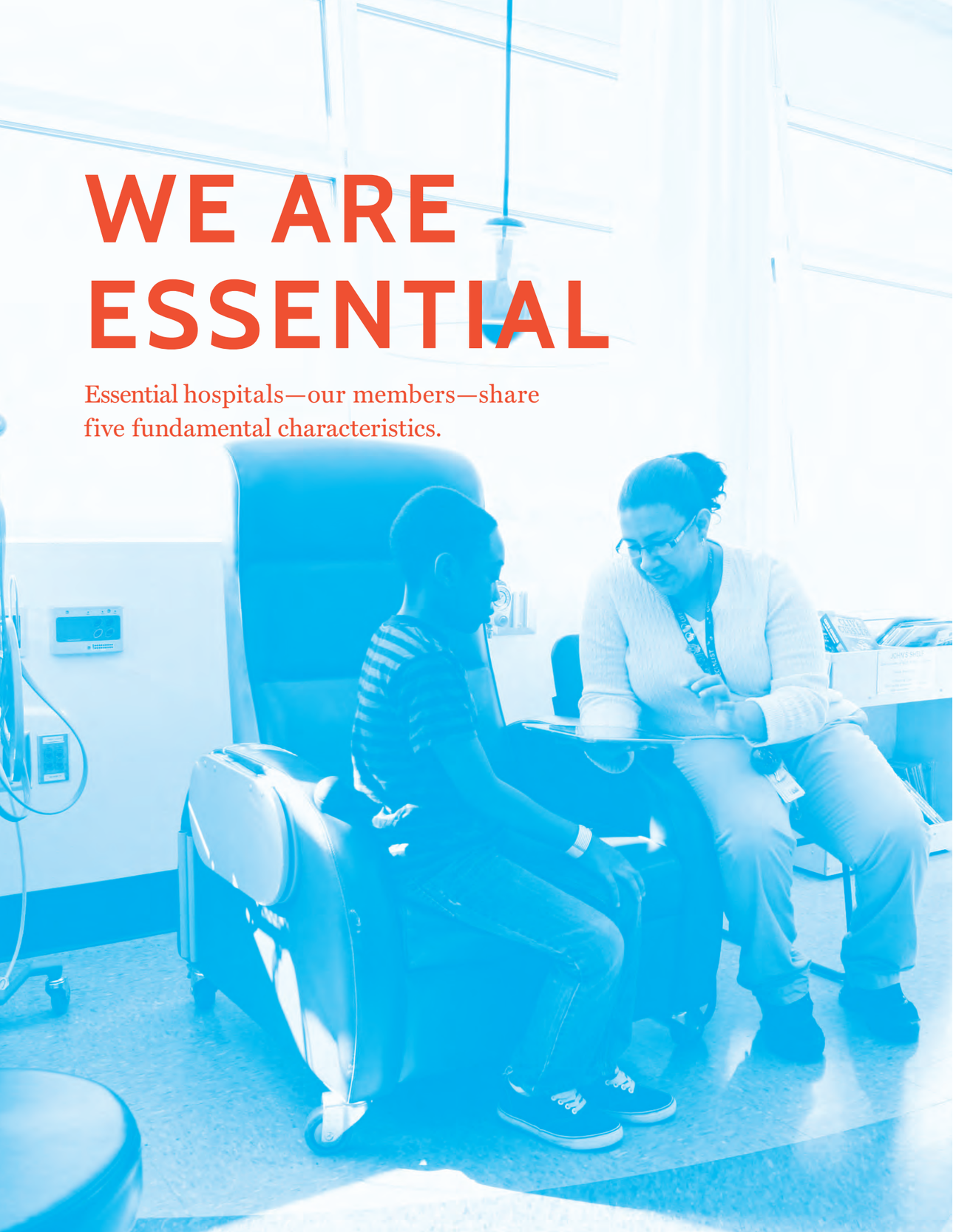
BRUCE SIEGEL, MD, MPH
President and CEO
America's Essential Hospitals

METHODOLOGY

This report updates the status of America's Essential Hospitals members, including short-term, acute-care hospitals; psychiatric hospitals; and women's and children's hospitals. The report features data collected through America's Essential Hospitals' 2015 Annual Member Characteristics Survey and presents a snapshot of that data at time of publication. America's Essential Hospitals sent the annual survey to 130 members and collected 92 responses, for a response rate of 71 percent. These 92 responses represent 131 hospitals within the membership. The survey excluded hospitals that joined the membership after the survey's launch. Essential Hospitals Institute, the association's quality and research entity, provided technical support and analysis of survey results. Additional data from the American Hospital Association's 2015 Annual Survey of Hospitals, the Centers for Medicare & Medicaid Services' fiscal year 2015 Hospital Cost Report, and the American Community Survey were used to support this report's findings.

WE ARE ESSENTIAL

Essential hospitals—our members—share five fundamental characteristics.



01.
Caring for
THE VULNERABLE

02.
Providing
COMPREHENSIVE, COORDINATED CARE

03.
Training
FUTURE HEALTH CARE PROFESSIONALS

04.
Providing
SPECIALIZED, LIFESAVING SERVICES

05.
Advancing
PUBLIC HEALTH

Caring for

THE VULNERABLE

Essential People

Like our hospitals, **our patients are essential**—to their families, to their friends, and to their community. All people, regardless of their social or economic circumstances, can **count on essential hospitals for the best possible care**.

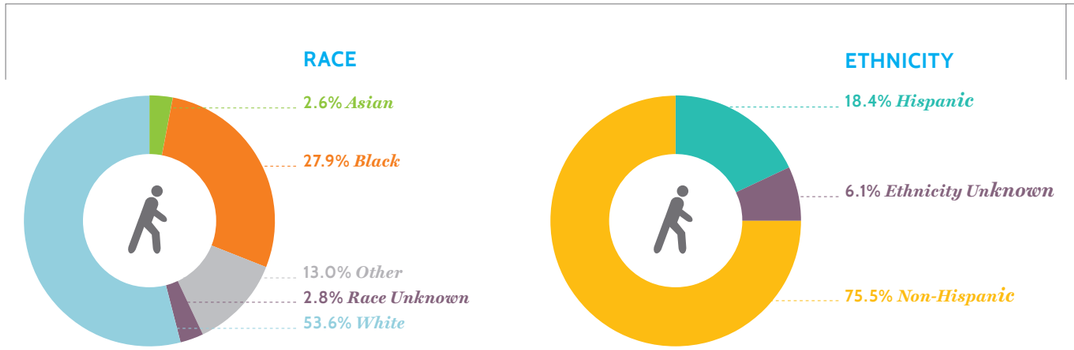
Our members make this commitment as cornerstones of their community and reliable sources of individual care and lifesaving services. In fact, one in 10 U.S. residents are born at an essential hospital.[1] As community anchors and partners, essential hospitals are dedicated to delivering high-quality health care to all, including the vulnerable.

Their commitment to ensuring patient access has made essential hospitals providers of choice for patients of virtually every ethnicity and language. Nearly half of member discharges in 2015 were for racial and ethnic minorities. As an essential part of care delivery, the collection of race, ethnicity, and language data is a priority for essential hospitals. In 2015, members reported fewer patients with unknown ethnicity than ever before.

FIGURE 1

Inpatient Discharges by Race & Ethnicity

Members of America's Essential Hospitals, 2015



Note: Numbers might not add up to 100 percent due to rounding.

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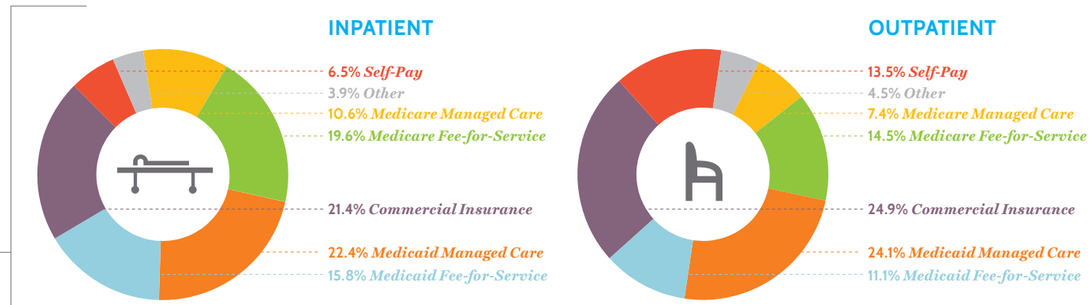
FIGURE 2

Inpatient and Outpatient Utilization by Payer Mix

Members of America's Essential Hospitals, 2015



Note: Numbers might not add up to 100 percent due to rounding.

Nearly half of all inpatient discharges and outpatient visits were for uninsured or Medicaid patients. Medicare patients accounted for 30.2 percent of inpatient and 21.9 percent of outpatient visits. **One in four patients were covered by traditional commercial insurance.**

While the nation has made progress toward expanding insurance coverage and lowering levels of uncompensated care, essential hospitals continue to face the financial challenges of uninsured patients and inadequate government reimbursement. In 2015, the American Hospital Association (AHA) estimates hospitals received nearly $58 billion less than the cost of the care they provided to Medicare and Medicaid beneficiaries.[2] Proposals to further reduce Medicaid funding could threaten services our member hospitals provide to vulnerable people and underserved communities.

The neonatal intensive care unit at Santa Clara Valley Medical Center provides families exceptional resources and care, including important skin-on-skin time.

FIGURE 3

Social Needs in Essential Communities

Members of America's Essential Hospitals, 2015

Our communities have more than

275,000

HOMELESS INDIVIDUALS

8.5 MILLION

people served by essential hospitals

HAVE LIMITED ACCESS TO HEALTHY FOOD

FIGURE 4

Economic Needs in Essential Communities

Members of America's Essential Hospitals, 2015

Our communities have more than

4.6 MILLION

FAMILIES BELOW THE POVERTY LINE

21.5 MILLION

INDIVIDUALS WITHOUT HEALTH INSURANCE

Essential Communities

Although our hospitals most often serve large, urban areas, **their reach can extend across broad regions and into communities of all sizes**—and all are essential to the social fabric and economic prosperity of their states and the nation.

Our hospitals' commitment to serving the vulnerable and disadvantaged means they operate where need is greatest—communities that face high levels of poverty, homelessness, and food insecurity.

An analysis of data from the U.S. Department of Housing and Urban Development shows that essential hospitals serve communities in which more than 275,000 individuals struggle with homelessness.[3] Lack of stable housing is a significant social determinant of health, and homeless patients may be predisposed to worse health outcomes. Many essential hospitals offer medical respite programs that are critical to improving the health of these people.

"Essential hospitals serve many of our most disadvantaged communities. This focus on mission means access to care for people who might otherwise have nowhere to turn."

–JOHN HAUPERT
BOARD CHAIR, AMERICA'S ESSENTIAL HOSPITALS
PRESIDENT AND CEO, GRADY MEMORIAL HOSPITAL, ATLANTA

The communities our hospitals serve also struggle with food insecurity. In 2015, 8.5 million people in these communities had only limited access to healthy food.[4] Inadequate access to nutritious foods has been linked to poor physical and mental health outcomes. To combat food insecurity, essential hospitals are partnering with community organizations to create food pantries, community gardens, and meal delivery services.

An estimated 4.6 million families live below the federal poverty line in communities served by essential hospitals, and more than 21.5 million individuals in those communities go without health insurance.[5,6] Without essential hospitals' commitment to these patients, many would have nowhere to turn for critical health care needs.

FIGURE 5

Average Uncompensated Care

Members of America's Essential Hospitals
Versus All Hospitals Nationwide, 2015

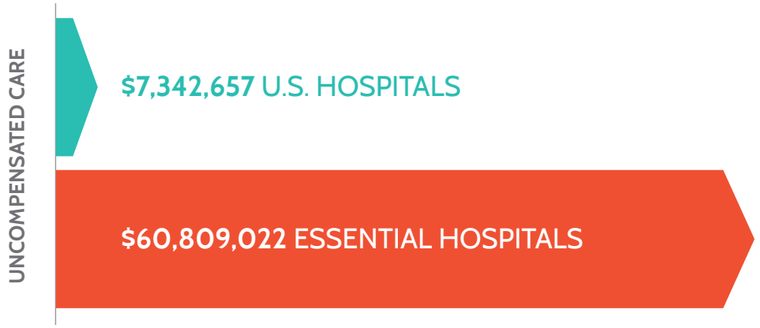


FIGURE 6

Share of National Uncompensated Care

Members of America's Essential Hospitals, 2015

Members of America's Essential Hospitals provided more than

$6B = 16.9%

IN UNCOMPENSATED CARE

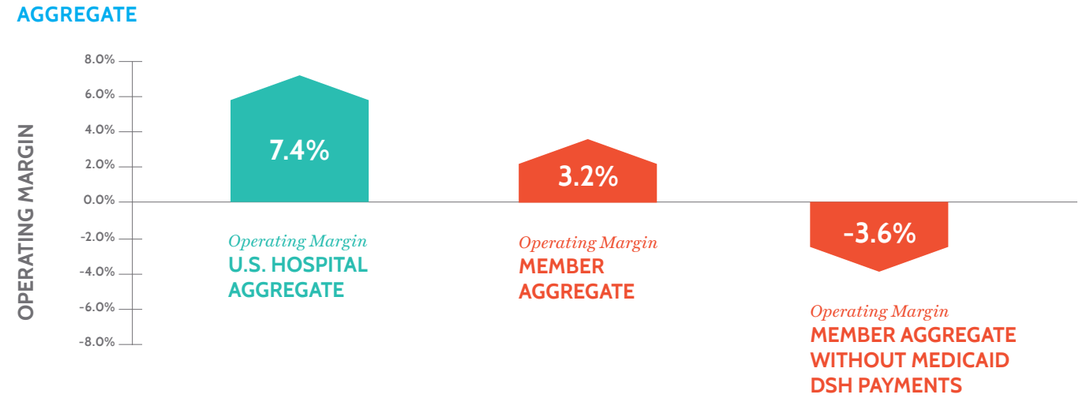
OF ALL UNCOMPENSATED CARE NATIONWIDE

AMERICA'S ESSENTIAL HOSPITALS

FIGURE 7

National Operating Margins

Members of America's Essential Hospitals
Versus All Hospitals Nationwide, 2015



Essential Hospitals

We call our members essential to describe their unique relationship to the vulnerable people and communities they serve. **Without our hospitals, vulnerable patients and underserved communities would face severely limited access** to both routine care and lifesaving services, such as trauma care.

As part of their commitment to caring for the most vulnerable members of their communities, essential hospitals provide high levels of uncompensated and unreimbursed care. In 2015, members provided more than $6 billion in uncompensated care—or nearly 17 percent of all uncompensated care provided at hospitals nationwide.

Due to this level of uncompensated care, members of America's Essential Hospitals continued in 2015 to operate with margins significantly lower than the rest of the hospital industry. The average aggregate margin for member hospitals was 3.2 percent—less than half the 7.4 percent margin for all hospitals nationwide. Without Medicaid disproportionate share hospital payments, overall member margins would have sunk to a 3.6 percent *loss*.

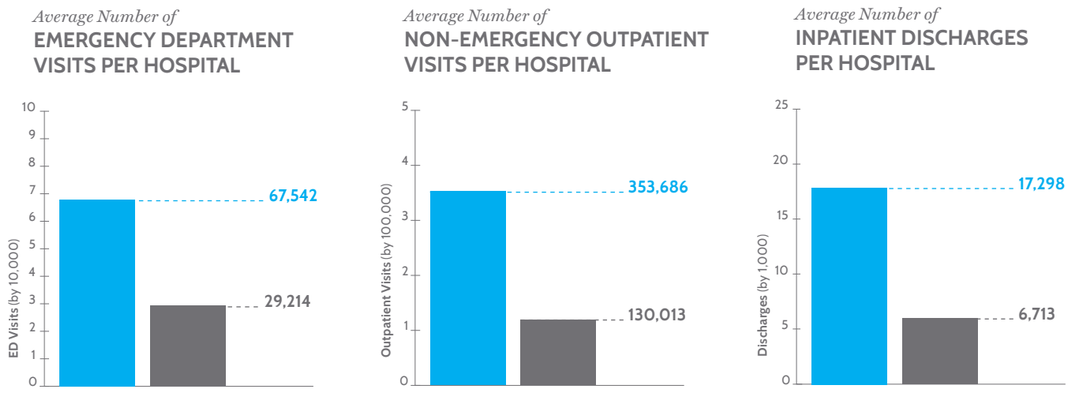
Providing

COMPREHENSIVE COORDINATED CARE

FIGURE 8

Average Inpatient and Outpatient Utilization

Acute-Care Members of America's Essential Hospitals Versus Other Acute-Care Hospitals Nationwide, 2015

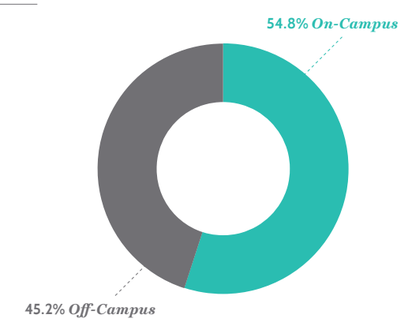


In 2015, members of America's Essential Hospitals provided non-emergency outpatient care to 72.2 million patients and treated more than 13.8 million patients in their emergency departments. **Our members averaged more than 17,000 inpatient discharges per hospital**—2.5 times greater than the inpatient volume of other acute-care hospitals nationwide.

FIGURE 9

Beyond Their Walls

Location of Outpatient Visits, Members of America's Essential Hospitals, 2015



"The Thomas Street center is a blessing. Social work, testing, education, support groups, mental health, referrals—it will be there for you. I've been here for 37 years and now I'm a mentor; we are patients helping other patients."

–DAVID DOUHUNT
AIDS PATIENT AND MENTOR ADVOCATE, THOMAS STREET HEALTH CENTER
HARRIS HEALTH SYSTEM, HOUSTON

Training

FUTURE HEALTH CARE PROFESSIONALS

"Without the training essential hospitals provide, we would struggle to meet demand for physicians and nurses—not only in underserved communities, but in every community across the country."

–WRIGHT L. LASSITER III
PRESIDENT AND CEO
HENRY FORD HEALTH SYSTEM, DETROIT

On average, essential hospitals trained **nearly three times as many physicians as other U.S. teaching hospitals.**[7] Essential hospitals also trained **more than four times as many physicians beyond** their federal funding cap as other U.S. teaching hospitals.

Students confer at Kent Hospital, part of the Providence, Rhode Island-based Care New England Health System.

AMERICA'S ESSENTIAL HOSPITALS

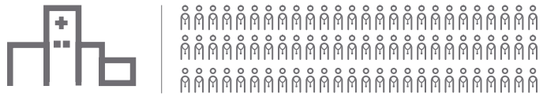
FIGURE 10

Number of Physicians Trained

Acute-Care Members of America's Essential Hospitals Versus Other Acute-Care Hospitals Nationwide, 2015

Each member teaching hospital trained an average of 228 physicians in 2015.

Other U.S. teaching hospitals each trained an average of 78 physicians.



Of the 228 physicians members trained, 36 were trained beyond supported federal graduate medical education (GME) funding.

Other U.S. teaching hospitals trained less than one quarter of that number (eight) beyond supported federal GME funding.

Providing

SPECIALIZED, LIFESAVING SERVICES

FIGURE 11

Specialty Care Services

Members of America's Essential Hospitals, 2015

of the **NATION'S BURN CARE BEDS** *are operated by* **ESSENTIAL HOSPITALS**

of the **NATION'S LEVEL I TRAUMA CENTERS** *are at* **ESSENTIAL HOSPITALS**

of **PEDIATRIC INTENSIVE CARE BEDS** *are at* **ESSENTIAL HOSPITALS**

Essential Hospitals operate more than **6,000 PSYCHIATRIC CARE BEDS** *and* **3,000 NEONATAL INTENSIVE CARE BEDS**

= 100 Psychiatric Care Beds

= 100 NICU Beds

Members of America's Essential Hospitals are leading providers of trauma and intensive care, including burn care, psychiatric care, pediatric care, and neonatal intensive care.

Essential hospitals are community resources for highly specialized emergency and intensive care. More than a third of the nation's level I trauma centers—those able to address every aspect of severe injury—are at essential hospitals. Level I trauma centers also play a leading role in trauma research and education.

AMERICA'S ESSENTIAL HOSPITALS

"In an instant, trauma can touch every life in a community, regardless of who they are or where they come from. Essential hospitals are there to ensure all Americans receive the care they need, when they need it."

–JOE LANDSMAN
PRESIDENT AND CEO
UNIVERSITY OF TENNESSEE MEDICAL CENTER, KNOXVILLE, TENNESSEE

Advancing

PUBLIC HEALTH

The social, economic, and environmental circumstances of a person's life can account for as much as half of what determines their health. **As community anchors—central sources of care, jobs, and services—essential hospitals can influence these circumstances.** Through innovative public health programs, our hospitals change the course of upstream factors to improve population health.

"Care and management should occur outside of the walls of the hospital. And so to solve and to think about these issues of population health, we have got to be able to think differently."

–SUSAN COOPER
CHIEF INTEGRATION OFFICER AND SENIOR VICE PRESIDENT OF AMBULATORY SERVICES
REGIONAL ONE HEALTH, MEMPHIS, TENNESSEE

LINKING PATIENTS TO COMMUNITY SUPPORT
Coastal Connections, Charleston, South Carolina

The Medical University of South Carolina recognizes that nonmedical social and economic challenges—inadequate housing, a lack of transportation, joblessness, and food insecurity, for example—can contribute to poor health. The hospital bridges these gaps with Coastal Connections, a volunteer-run program to help patients and their families find sources of support in the community. The 5-year-old program, staffed largely by college students, has cataloged more than 620 local and statewide resources, which it matches to patients through hospital consultations. Follow-up sessions help patients navigate and manage their choices.

FREE PRODUCE TO FIGHT FOOD INSECURITY
Food as Medicine, Cook County, Illinois

Feeding America estimates that food insecurity affects more than 729,000 people in Cook County, or about 14 percent of the population. Cook County Health & Hospitals System responds by screening pediatric patients for food insecurity and offering help. Providers at the hospital's Logan Square Health Center ask children whether they have eaten fewer or smaller meals over the previous 12 months. Patients and families who screen positive receive vouchers for free produce from a Greater Chicago Food Depository FRESH truck and referrals to area food pantries and the federal Supplemental Nutrition Assistance Program.

OUTDOOR ACTIVITY AS THE RX FOR GOOD HEALTH
SHINE, Oakland, California

In 2014, East Bay Regional Park District teamed up with University of California-San Francisco Benioff Children's Hospital Oakland to launch the Stay Healthy in Nature Everyday program, or SHINE. Trained clinic volunteers identify chronically ill children who could benefit from outdoor activity and work with their parents and doctor to schedule monthly park visits. SHINE provides free transportation, healthy snacks, and a day of activities led by park staff, including walking, games, and nature lessons. More than 150 children and family members have participated. The hospital has decorated its clinic with posters to inspire and educate families to use parks.

Figure Sources

Figure 1: America's Essential Hospitals. 2015 America's Essential Hospitals Characteristics Survey. October 28, 2016.

Figure 2: American Hospital Association. 2015 AHA Annual Survey. Health Forum LLC. 2016.

Figure 3: U.S. Department of Housing and Urban Development (2016). 2016 AHAR: Part 1 - PIT Estimates of Homelessness in the U.S. https://www.hudexchange.info/resource/5178/2016-ahar-part-1-pit-estimates-of-homelessness. Accessed March 17, 2017.

U.S. Department of Agriculture (2015). Food Access Research Atlas Data Download 2015. https://www.ers.usda.gov/data-products/food-access-research-atlas/download-the-data. Accessed March 17, 2017.

Limited access to healthy food was defined as low-income individuals who live more than one mile from a supermarket in urban areas and more than 10 miles in rural areas.

Figure 4: Centers for Medicare & Medicaid Services. Hospital Service Area File. January 9, 2017.

U.S. Census Bureau. Poverty Status in the Past 12 Months. 2011–2015 American Community Survey 5-year Estimates. 2015.

U.S. Census Bureau. Selected Characteristics of the Uninsured in the United States. 2011–2015 American Community Survey 5-year Estimates. 2015.

A community is defined using data from the 2015 CMS Hospital Service Area File as ZIP codes in which approximately 80 percent of a hospital's Medicare cases reside.

Figure 5: American Hospital Association. 2015 AHA Annual Survey. Health Forum LLC. 2016.

Figure 6:
Member data from: America's Essential Hospitals. 2015 America's Essential Hospitals Characteristics Survey. October 28, 2016.

National data from: American Hospital Association. 2015 AHA Annual Survey. Health Forum LLC. 2016.

Figure 7: America's Essential Hospitals. 2015 America's Essential Hospitals Characteristics Survey. October 28, 2016.

American Hospital Association. 2015 AHA Annual Survey. Health Forum LLC. 2016.

Figure 8: America's Essential Hospitals. 2015 America's Essential Hospitals Characteristics Survey. October 28, 2016.

Figure 9: America's Essential Hospitals. 2015 America's Essential Hospitals Characteristics Survey. October 28, 2016.

Figure 10: Centers for Medicare & Medicaid Services. Healthcare Cost Report Information System, Hospital 2552-10 Cost Report Data Files FY2015. Accessed March 17, 2017.

Figure 11: American Hospital Association. 2015 AHA Annual Survey. Health Forum LLC. 2016.

* Data from the 2015 AHA Annual Survey represents America's Essential Hospitals acute-care member respondents (n=204) compared with other acute-care hospitals (n=4,467)

* Data from the 2015 CMS Hospital Cost Reports represents America's Essential Hospitals acute-care members (n=189) compared with other acute-care hospitals (n=3,297)

Endnotes

1. America's Essential Hospitals. 2015 America's Essential Hospitals Characteristics Survey. October 28, 2016.
2. American Hospital Association. Underpayment by Medicare and Medicaid Fact Sheet. 2016. http://www.aha.org/content/16/medicaremedicaidunderpmt.pdf. Accessed March 17, 2017.
3. U.S. Department of Housing and Urban Development (2016). *2016 AHAR: Part 1 - PIT Estimates of Homelessness in the U.S. Accessed 3/17/2017.* Url: https://www.hudexchange.info/resource/5178/2016-ahar-part-1-pit-estimates-of-homelessness/
4. U.S. Department of Agriculture (2015). *Food Access Research Atlas Data Download 2015.* Accessed 3/17/2017. Url: https://www.ers.usda.gov/data-products/food-access-research-atlas/download-the-data/
5. U.S. Census Bureau (2015). *Poverty Status in the Past 12 Months. 2011-2015 American Community Survey 5-year Estimates.*
6. U.S. Census Bureau (2015). *Selected Characteristics of the Uninsured in the United States. 2011-2015 American Community Survey 5-year Estimates.*
7. Physicians is defined as U.S. medical and dental residents; Teaching hospitals are defined as meeting one of the following criteria: participating site recognized for one or more Accreditation Council for Graduate Medical Education accredited programs, medical school affiliation reported to American Medical Association, member of the Council of Teaching Hospitals of the Association of American Medical Colleges (COTH), or residency approved by American Osteopathic Association.

AMERICA'S ESSENTIAL HOSPITALS

Glossary

Bad Debt: The unpaid obligation for care provided to patients who are considered able to pay but who do not pay. Bad debt includes unpaid deductibles, coinsurance, and copayments from insured patients.

Cost-to-Charge Ratio: The ratio of total expenses to gross patient and other operating revenue.

Disproportionate Share Hospital (DSH) Payments: Payments made by Medicare or a state's Medicaid Program to hospitals that serve a disproportionate share of low-income patients. These payments are in addition to the regular payments such hospitals receive for providing care to Medicare and Medicaid beneficiaries. Medicare DSH payments are based on a federal statutory qualifying formula and payment methodology. Medicaid DSH payments are based on certain minimum federal criteria, but qualifying formulas and payment methodologies are largely determined by states.

Hospital Operating Margin: A measure of the financial condition of a hospital. It is calculated as the difference between the total operating revenues and total expenses divided by total operating revenue.

Medicaid: A program jointly funded by the federal and state governments to provide health coverage to those who qualify on the basis of income and eligibility, e.g., low-income families with children, low-income elderly, and people with disabilities. Many states also extend coverage to groups that meet higher income limits or to certain medically needy populations. Through waivers, some states have expanded coverage even further. In 2010, the Affordable Care Act gave states the additional option to expand their Medicaid program to residents at or below 138 percent of the federal poverty level.

Medicare: A federal program that provides health coverage for individuals age 65 and older, for certain disabled individuals younger than 65, and for people with end-stage renal disease. Medicare has four main components. Medicare Part A provides payments for inpatient hospital care, skilled nursing care, some home-health services, and hospice care. Medicare Part B provides payments for physician services, outpatient hospital care, and other medical services not covered by Part A. Medicare Part A and Part B together are known as "original Medicare." Medicare Part C, also known as Medicare Advantage, is offered by private health care organizations. Medicare Advantage plans cover all services under Parts A and B and usually offer additional benefits. Medicare Part D provides payments for prescription drugs and is offered by private health care organizations. Medicare Part C plans often include coverage for Medicare Part D.

Outpatient Visits: Can include emergency department (ED) visits, clinic visits, outpatient surgery, and ancillary visits, such as labs and radiology.

Uncompensated Care Charges: The sum of charity care charges and bad debt.

Uncompensated Care Costs: Losses on patient care. Uncompensated care costs are calculated by multiplying the uncompensated care charges by the cost-to-charge ratio.

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