

2014 ESSENTIAL DATA

Our Hospitals, Our Patients

*Results of America's Essential Hospitals 2014 Annual
Member Characteristics Survey*

Published: June 2016



AMERICA'S
ESSENTIAL
HOSPITALS

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 the most vulnerable. Since 1981, America's Essential Hospitals has initiated, advanced, and preserved programs and policies that help these hospitals ensure access to care. We support members with advocacy, policy development, research, and education.

Our nearly 275 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.

METHODOLOGY

This report updates the status of short-term, acute-care hospitals, psychiatric hospitals, and women's and children's hospitals within America's Essential Hospitals' membership. The report is based on data collected through America's Essential Hospitals' 2014 Annual Member Characteristics Survey and presents a snapshot of that data at time of publication. The annual survey was sent to 116 members of America's Essential Hospitals, and 97 responses were submitted, for a response rate of 84 percent. These 97 responses represent 108 hospitals within the membership. The survey excluded hospitals that joined the membership after the survey's launch, and hospitals with missing or incomplete data. The analytics team of Essential Hospitals Institute provides technical support and analysis of survey results.

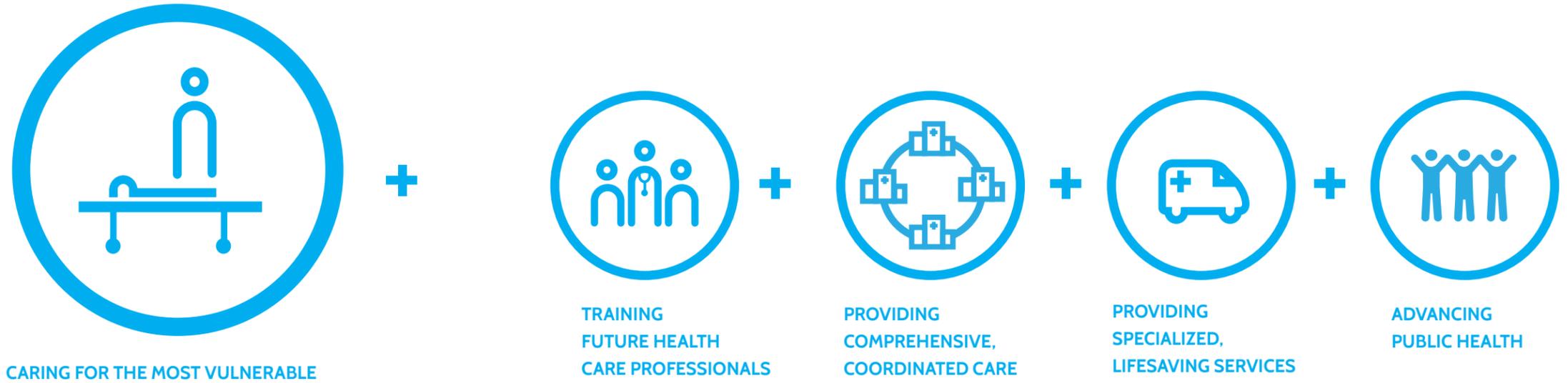
To compare our members with other acute-care hospitals nationally, America's Essential Hospitals relies on data from the American Hospital Association's (AHA's) Annual Survey of Hospitals. AHA has conducted this survey since 1946, collecting data on organizational structure, facilities, services, community orientation, utilization, finances, and staffing. National comparison statistics for this report were calculated using data from the 2014 AHA Annual Survey of Hospitals. For 2014, members were able to submit data for multiple hospitals in one survey, and as a result of aggregation, the final survey sample reflected in this report is 97 member organizations representing 108 hospitals.

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WE ARE ESSENTIAL

Essential Hospitals—our members—share five fundamental characteristics.



The 2014 data below demonstrates these characteristics.

Complex Patients

- Essential hospitals' patients generally are sicker and more complex than those served at other hospitals nationwide.

Uncompensated Care

- Essential hospitals provided more than \$7.8 billion in **uncompensated care**, more than 18 percent of all uncompensated care nationally, up from 16.8 percent in 2013.¹
- Roughly half of all inpatient discharges and outpatient visits were for **uninsured or Medicaid** patients. Medicare patients accounted for 29 percent of inpatient and 22 percent of outpatient visits.
- **Commercially insured** patients accounted for only 19.2 percent of inpatient and 26.5 percent of outpatient visits.
- Member hospitals delivered more than 233,000 **newborns** in 2014, 67 percent of which were paid for by Medicaid.

Community Cornerstone

- Essential hospitals provided **non-emergency outpatient care** to 46.7 million patients, averaging nearly 445,000 non-emergency outpatient visits per hospital.
- Essential hospitals treated more than 8.2 million patients in their **emergency departments**, averaging 78,403 visits per hospital.
- **Inpatient admissions** for member acute-care hospitals averaged more than 20,000 per hospital, nearly three times the inpatient volume of other acute-care hospitals nationwide.
- Essential hospitals **trained** an average of 270 physicians (defined as U.S. medical and dental residents) per hospital, nearly seven times as many as those trained at other U.S. teaching hospitals.
- Essential hospitals also trained an average of 50 more residents than supported by federal graduate medical education (GME) funding, meaning they absorbed significant costs to meet their training mission. Other U.S. teaching hospitals trained

less than half that number—an average of only 21 residents above their **GME funding cap**.

- Essential hospitals operated 45 percent of all **level I trauma** centers, 80 percent of **burn care** beds, and more than a third of **psychiatric care** beds in the nation's 10 largest cities.²

High Quality, High Value

- Since 2010, **patient satisfaction** ratings of their care experience at essential hospitals have risen. In general, member scores on all 10 Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) measures of patient experience and satisfaction have increased steadily during this period.
- Member hospitals recognize the importance of delivering recommended care to all patients, matching or **outperforming** other hospitals nationally for treating heart failure and heart attacks.

- Members deliver care at **better cost efficiency** than other hospitals nationwide, scoring slightly below the national median (0.97 versus 0.98 nationally) on the Medicare spending per beneficiary measure of efficiency.*
- Essential hospitals continue to have **lower operating margins** than the rest of the hospital industry. The aggregate operating margin for members was zero percent, compared with 8.3 percent for all hospitals nationwide.³ Without Medicaid **disproportionate share hospital (DSH) payments**, aggregate member operating margins would drop to negative 6.2 percent.

* Hospital Compare. Q1-Q4 2014 Data. Centers for Medicare & Medicaid Services. <https://data.medicare.gov/data/hospital-compare>. Accessed March 2016.

OUR VALUE IN DATA

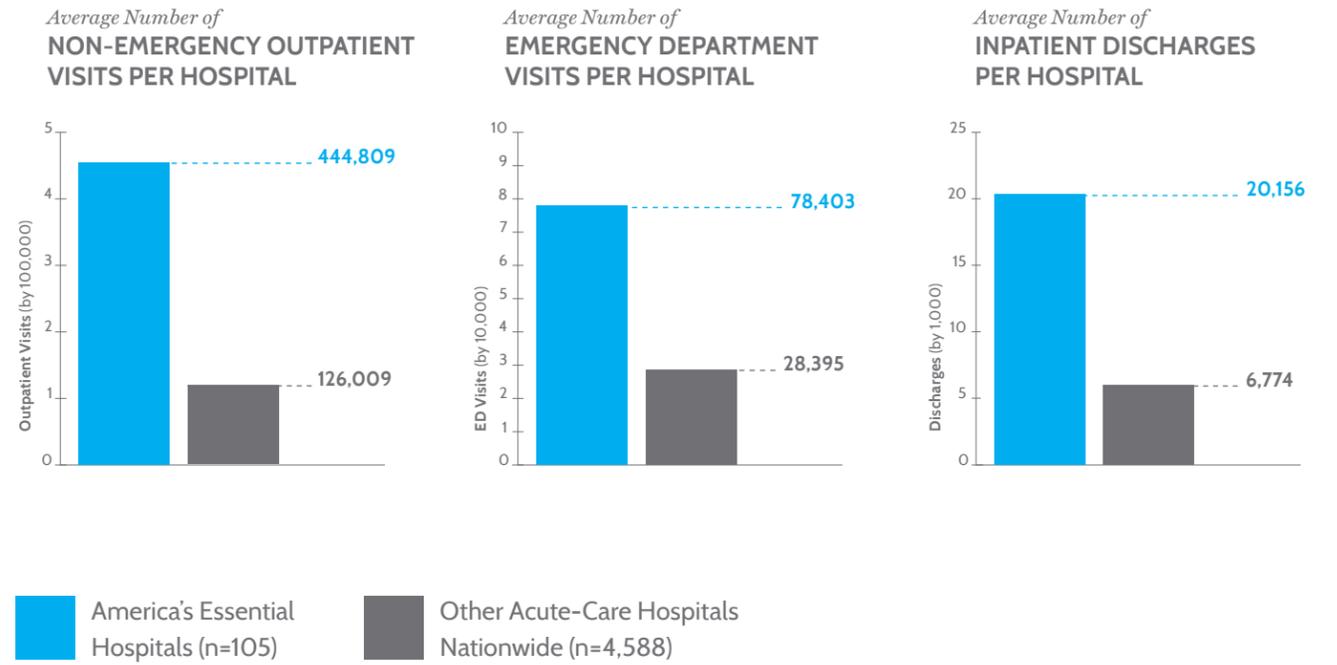
FIGURE 1

Average Inpatient and Outpatient Utilization

Acute-Care Members of America's Essential Hospitals
Versus Other Acute-Care Hospitals Nationwide, 2014

In 2014, members of America's Essential Hospitals provided non-emergency **outpatient care to 46.7 million patients** and treated more than **8.2 million patients in their emergency departments.**

Our members averaged more than 20,000 inpatient discharges per hospital, nearly **three times the inpatient volume** of other acute-care hospitals nationwide.



Source: American Hospital Association. Annual Survey of Hospitals. 2014.

FIGURE 2

Number of Physicians Trained

Members of America's Essential Hospitals
Versus Other Acute-Care Hospitals Nationwide, 2014

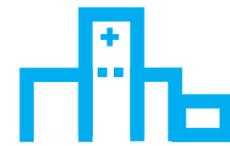
On average, essential hospitals **trained nearly seven times as many physicians*** as other U.S. teaching hospitals.**

Essential hospitals also trained more than twice as many physicians beyond their federal funding cap as other U.S. teaching hospitals.

Each member teaching hospital trained an average of 270 physicians in 2014.



Of the 270 physicians, 50 were trained beyond supported federal graduate medical education (GME) funding.



Other U.S. teaching hospitals each trained an average of 41 physicians.



Other U.S. teaching hospitals trained less than half that number – 21 were trained beyond supported federal GME funding.



* 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.

Note: Numbers are rounded to the nearest whole number.

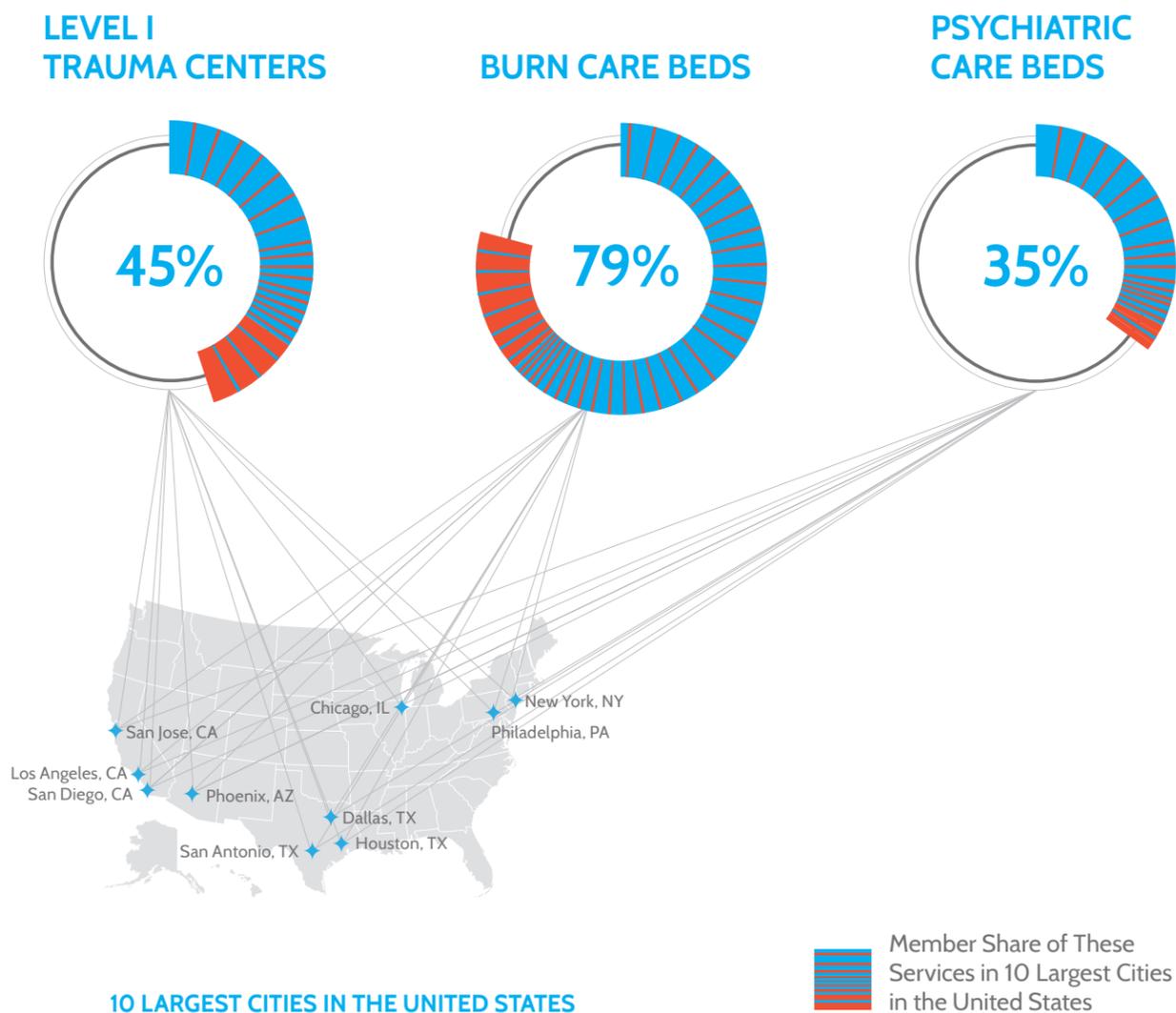
Source: American Hospital Association. Annual Survey of Hospitals. 2014.

FIGURE 3

Share of Critical and Specialty Services in the 10 Largest Cities in the United States

Acute-Care Members of America's Essential Hospitals, 2014

The 10 largest cities in the United States are home to more than 25 million people. Within these cities, our member hospitals provide **45 percent of level I trauma** and **nearly 80 percent of burn care services**, and **35 percent of psychiatric care**.



Source: United States Census Bureau. American FactFinder. <http://factfinder2.census.gov/faces/nav/jsf/pages/index.xhtml>. Accessed March 2015; American Hospital Association. Annual Survey of Hospitals. 2014.

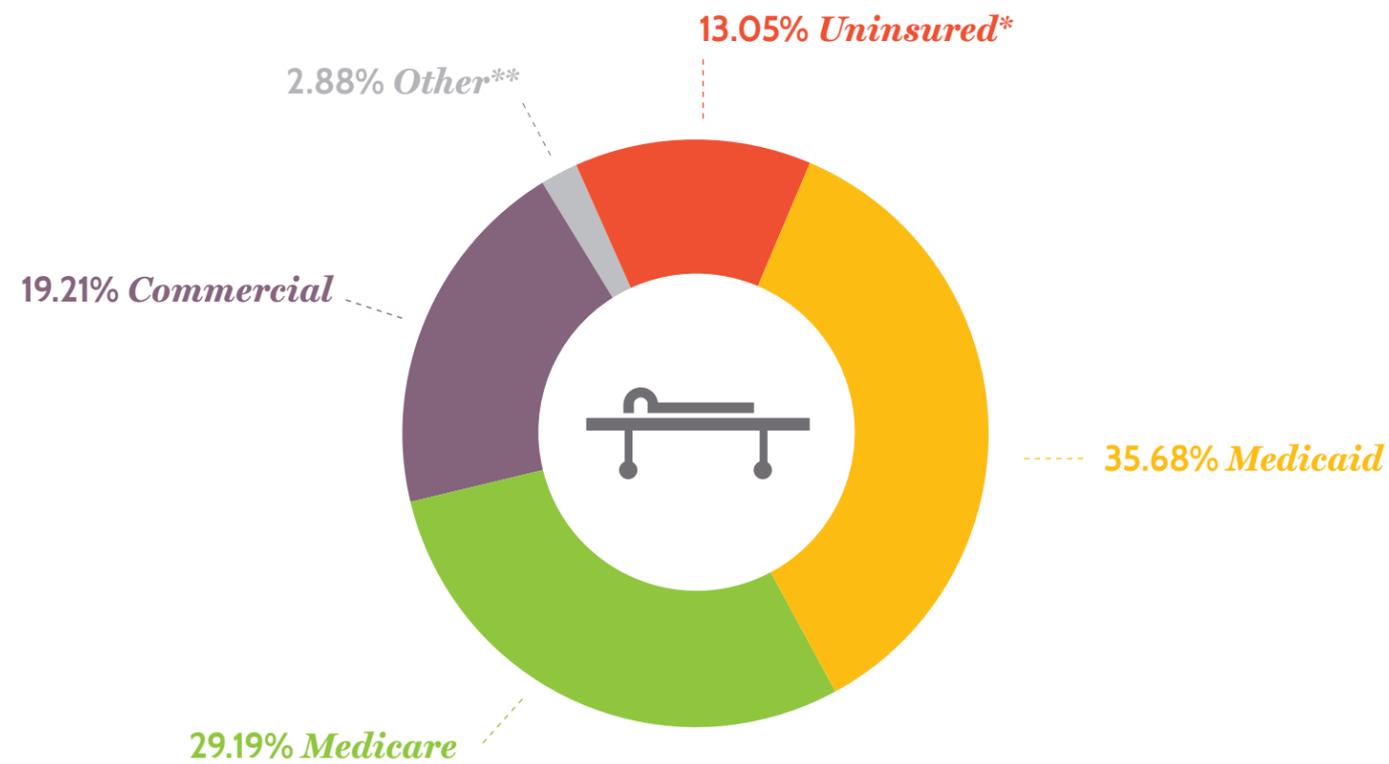
FIGURE 4

Inpatient and Outpatient Utilization by Payer Mix

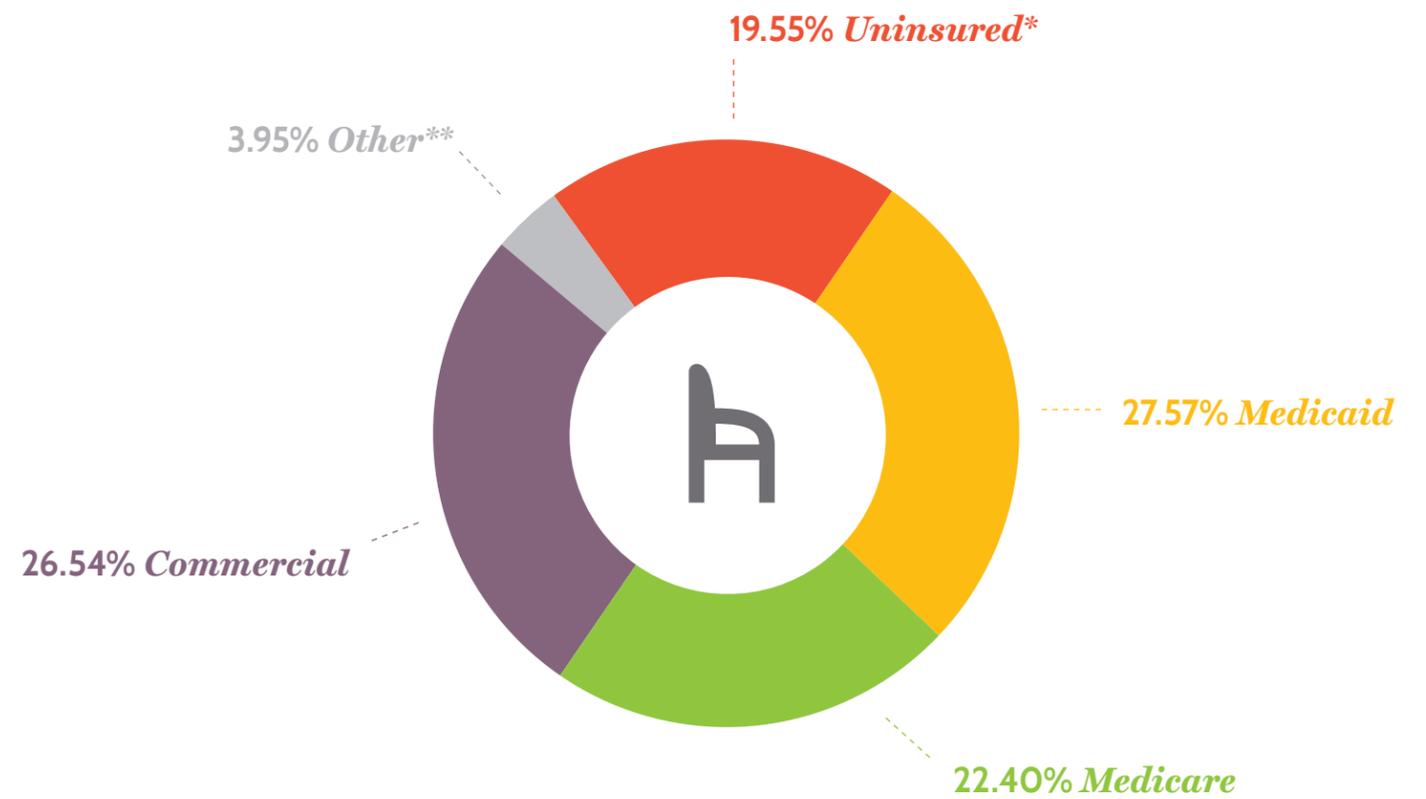
Members of America's Essential Hospitals, 2014

Roughly **half of inpatient discharges and outpatient visits** at essential hospitals were for **uninsured or Medicaid** patients.

INPATIENT



OUTPATIENT



* Uninsured patients are those considered self-pay or those covered by a hospital's charity care program or a state/local indigent care program.
 ** Other payers include veterans care, worker's compensation, and prison care.

Note: Percentages do not add up to 100 due to rounding. Outpatient includes emergency department visits.
 Source: America's Essential Hospitals. Annual Hospital Characteristics Survey. 2014.

FIGURE 5

Share of National Uncompensated Care

Members of America's Essential Hospitals, 2014

Members of America's Essential Hospitals provided more than

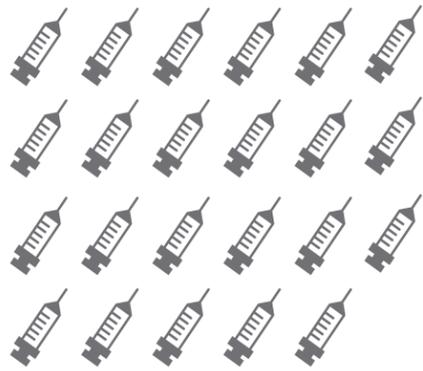


This is enough money to

Source: America's Essential Hospitals. Annual Hospital Characteristics Survey, 2014; American Hospital Association. Uncompensated Hospital Care Cost Fact Sheet, 2016 Update. <http://www.aha.org/content/16/uncompensatedcarefactsheet.pdf>. Accessed March 30, 2016.

develop more than

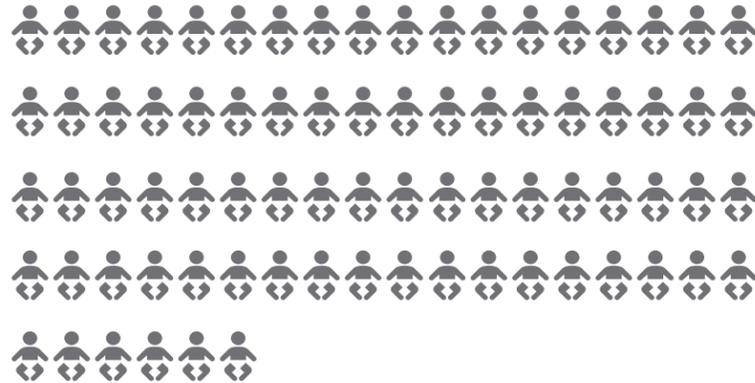
23 LIFE-SAVING VACCINES



= 1 Vaccine

deliver

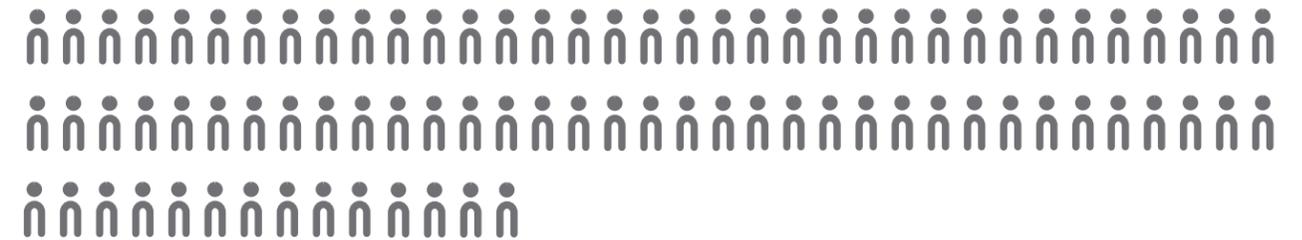
782,200 BABIES IN THE UNITED STATES



= 10,000 babies

provide health care to

821,566 MEN, WOMEN, AND CHILDREN IN THE UNITED STATES



= 10,000 people

OR THE ENTIRE STATE OF NORTH DAKOTA



Source: PATH. Investing in Vaccines for the Developing World. http://www.path.org/publications/files/VAC_investing_fs_2015.pdf. Accessed March 2016.

Source: International Federation of Health Plans. 2013 Comparative Price Report. <http://static1.squarespace.com/static/518a3cfee4b0a77d03a62c98/t/534fc9ebe4b05a88e5fbab70/1397737963288/2013+iFHP+FINAL+4+14+14.pdf>. Accessed March 2016.

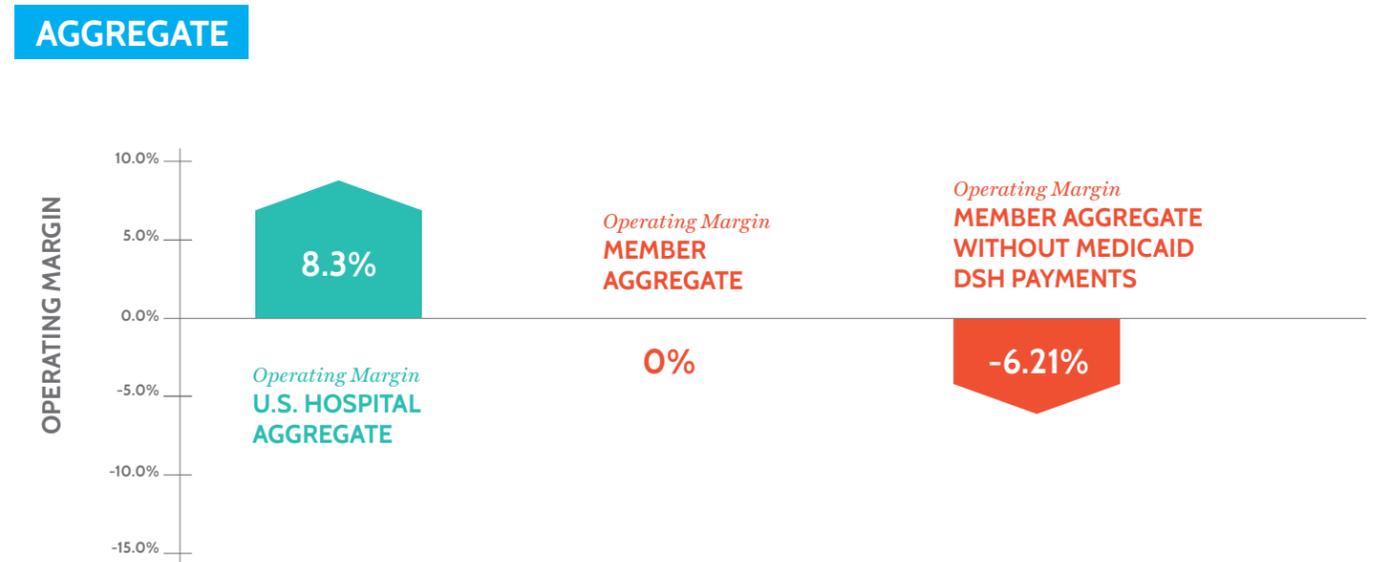
Source: The Centers for Medicare & Medicaid Services. National Health Expenditures 2014 Highlights. <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/highlights.pdf>. Accessed March 2016.

FIGURE 6

National Operating Margins

Members of America's Essential Hospitals Versus All Hospitals Nationwide, 2014

With many essential hospitals operating at a near loss, innovation and efficiency are crucial. In fact, essential hospitals deliver **more cost-efficient care than other hospitals nationwide**, scoring slightly better than the national median on the Medicare spending per beneficiary measure.⁴



Note: DSH stands for disproportionate share hospital.

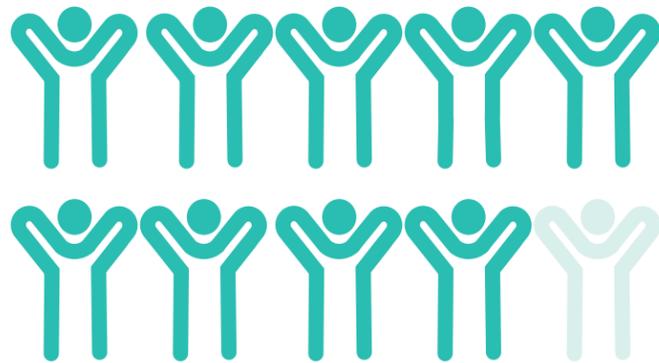
FIGURE 7

Performance on HCAHPS Patient Experience and Satisfaction Measures

Members of America's Essential Hospitals, 2014

In general, member scores on all 10 of the HCAHPS measures of patient experience and satisfaction have increased steadily since 2010.⁵

SATISFACTION



9 out of 10 patients were “satisfied” or “highly satisfied” with the care they received at their hospital.

RECOMMENDATION



9.3 out of 10 patients would “probably” or “definitely” recommend their hospital to family and friends.

Note: HCAHPS stands for Hospital Consumer Assessment of Healthcare Providers and Systems.

Source: Hospital Compare. Q1-Q4 2014 Data. Centers for Medicare & Medicaid Services. <https://data.medicare.gov/data/hospital-compare>. Accessed March 2016.



FIGURE 8

Performance on Selected Process of Care Measures

Members of America's Essential Hospitals, 2014

Member hospitals recognize the importance of **delivering recommended care to all patients, matching or outperforming other hospitals** nationally for treating heart attacks and heart failures.⁶

Members delivered

all of the recommended care for heart failure patients



of the time

all of the recommended care for heart attack patients



of the time

Source: Hospital Compare. Q1-Q4 2014 Data. Centers for Medicare & Medicaid Services. <https://data.medicare.gov/data/hospital-compare>. Accessed March 2016.

GLOSSARY OF TERMS

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.

Charity Care: Care provided to individuals who are determined to be unable to pay. Charity care comes from providers who offer services at a discount or at no cost to individuals who meet certain financial criteria.

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.

ENDNOTES

1. Uncompensated care costs are equal to the uncompensated care charges multiplied by the cost-to-charge ratio. See the Glossary of Terms for additional information and formulas.

Source: American Hospital Association. Uncompensated Hospital Care Cost Fact Sheet, 2015 Update. <http://www.aha.org/content/14/14uncompensatedcare.pdf>. Accessed March 2016.

2. The cities are New York City, Los Angeles, Chicago, Houston, Philadelphia, Phoenix, San Antonio, San Diego, Dallas, and San Jose, California.

Source: The United States Census Bureau. Annual Estimates of the Resident Population for Incorporated Places of 50,000 or More, Ranked by July 1, 2015 Population: April 1, 2010 to July 1, 2015 - United States. <http://factfinder.census.gov/bkmk/table/1.0/en/PEP/2015/PEPANRRSIP.US12A>. Accessed March 2016.

3. The aggregate operating margin for members of America's Essential Hospitals is calculated using the following formula:

$$\text{Aggregate Operating Margin} = \frac{\sum \text{Total Member Operating Revenues} - \sum \text{Total Member Expenses}}{\sum \text{Total Member Operating Revenues}} \times 100$$

This is the same method used by AHA when calculating the aggregate national operating margin.

Source: American Hospital Association. Trendwatch Chartbook 2015: Trends Affecting Hospitals and Health Systems. <http://www.aha.org/research/reports/tw/chartbook/ch4.shtml>. Accessed January 24, 2015.

4. The Medicare spending per beneficiary measure uses the cost of services performed by hospitals and other health care providers during the period immediately prior to, during, and following a beneficiary's hospital stay. The measure is an indicator of a hospital's efficiency relative to the efficiency of the national median hospital.

5. The HCAHPS survey measures patients' perspectives on hospital care. The survey collects information on communication with physicians and nurses, hospital staff responsiveness, pain management, explanation of medications, discharge information, cleanliness and quietness of the hospital environment, overall satisfaction, and whether the patient would recommend the hospital to others.

6. Recommended care is a term used to describe scientifically based, appropriate, and timely treatment for specific medical conditions including heart failure, heart attack (or acute myocardial infarction), and pneumonia. Core quality measures are used to evaluate the percentage of patients who are receiving the recommended courses of treatment for the particular condition. The core measures do not include clinical outcomes but are used to improve treatment processes for patients. The measures do not include treatment for cases in which the recommended care is contraindicated.



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