America’s Essential Hospitals is the leading champion for hospitals and health systems dedicated to high-quality care for all, including the vulnerable. We support our 325 members with advocacy, policy development, research, and education. Communities depend on essential hospitals to provide specialized, lifesaving services; train the health care workforce; advance public health and health equity; and coordinate care. Essential hospitals innovate and adapt to lead the way to more effective and efficient care.

Essential Hospitals Institute is the research and quality arm of America’s Essential Hospitals. The Institute 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 all of this with an eye toward improving individual and population health, especially for vulnerable people.

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FOREWORD

America’s Essential Hospitals, which represents hospitals dedicated to caring for the nation’s most vulnerable patients, proudly shares this annual snapshot of our 325 members and the people and communities they serve.

This report, Essential Data, is more than a collection of numbers and charts. It tells a story about the vital role our hospitals play in communities nationwide—and the social and economic challenges those communities face. While the details of this report vary from year to year, the big picture remains the same: Millions of Americans and their families rely on essential hospitals for everything from routine care to complex, lifesaving services.

What is an essential hospital? Our members share a common set of attributes. First and most important, they commit to serving all people, regardless of financial or social status. Everyone can count on care at an essential hospital.

But the benefits essential hospitals provide extend far beyond that core characteristic and touch every life in a community. Essential hospitals fill four other key roles, including:

- providing specialized, lifesaving services, such as level I trauma and neonatal intensive care, emergency psychiatric services, and burn treatment;
- training the next generation of health care professionals to ensure the community’s supply of doctors, nurses, and other caregivers meets demand;
- delivering comprehensive, coordinated care across large ambulatory networks to bring services to where patients live and work; and
- filling a 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 operating margins about half that of other hospitals and a disproportionate share of the nation’s uncompensated care costs. These financial challenges drive our hospitals to accomplish more with less, and they respond with innovative programs that elevate quality, add value, reduce disparities, and improve population health.

Thank you for letting us share with you this story of our essential people, essential communities, and essential hospitals.

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

This report offers a snapshot of America’s Essential Hospitals members, including short-term, acute-care hospitals. The report primarily features data collected through the association’s 2016 Annual Member Characteristics Survey, which was sent to 115 members and garnered 82 responses, for a response rate of 71 percent. The responses represent 116 hospitals within the membership. The survey excluded hospitals that joined the membership after the survey’s launch. Essential Hospitals Institute, the research and quality arm of the association, provided technical support and analysis of survey results. Additional data from the American Hospital Association’s 2016 Annual Survey of Hospitals, the Centers for Medicare & Medicaid Services’ fiscal year 2016 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.

Caring for THE VULNERABLE
page 8

Providing COMPREHENSIVE, COORDINATED CARE
page 18

Training FUTURE HEALTH CARE PROFESSIONALS
page 24

Providing SPECIALIZED, LIFESAVING SERVICES
page 28

Advancing PUBLIC HEALTH AND HEALTH EQUITY
page 32
Caring for THE VULNERABLE
Essential People

Our member hospitals, cornerstones of community health, commit to serving as reliable sources of care—from basic services to high-intensity, lifesaving treatment.

Their patients also are essential—to their family, friends, and community. Regardless of their social or financial status, they can count on essential hospitals for the best possible care. In fact, many Americans begin their lives with our member hospitals—one in 10 U.S. residents are born at an essential hospital, and Medicaid covers more than half of live-birth deliveries at these hospitals.

Essential hospitals’ commitment to caring for all people, including the most vulnerable, has made them providers of choice for patients of virtually every ethnicity and language. Racial and ethnic minorities made up 68 percent of member discharges in 2016.

FIGURE 2

Inpatient Discharges by Race & Ethnicity
Members of America’s Essential Hospitals, 2016

Note: Numbers might not add up to 100 percent due to rounding.
In 2016, three-quarters of essential hospitals’ patients were uninsured or covered by Medicaid or Medicare. Commercial insurance covered only about **one in four inpatient discharges and outpatient visits** at essential hospitals.

This disparity between commercially insured patients and those covered by public programs—or who have no coverage at all—creates severe financial challenges for essential hospitals. In 2016, the American Hospital Association (AHA) estimates hospitals nationally received nearly $69 billion less than the cost of the care they provided to Medicare and Medicaid beneficiaries. Making matters worse, proposals to reduce Medicaid funding and policy changes in the private insurance market threaten to swell the ranks of the uninsured and erode support for essential hospitals, putting access at risk.
Essential Communities

Our hospitals’ commitment to serving the vulnerable means they operate where need is greatest.

They provide access in communities that span broad rural regions to the nation’s largest cities—areas with high rates of poverty, homelessness, food insecurity, and other socioeconomic barriers to good health. Regardless of size, these communities each make essential contributions to the social fabric and economic prosperity of their states and the nation.

U.S. Department of Housing and Urban Development data show that essential hospitals serve communities in which more than 350,000 individuals struggle with homelessness. Many essential hospitals offer medical respite programs that are critical to improving the health of these people.

Many of the communities our hospitals serve also face inadequate access to nutritious food, which has been linked to poor physical and mental health outcomes. In 2016, 10.1 million people in our members’ communities had only limited access to healthy food. To combat food insecurity, essential hospitals often partner with community organizations to create food pantries, community gardens, and meal delivery services.

In communities served by essential hospitals, an estimated 25.3 million individuals live below the federal poverty line and more than 19.4 million individuals are uninsured. Without our hospitals’ commitment to these patients, many would have nowhere to turn for critical health care needs.

FIGURE 4

Social Needs in Essential Communities

Members of America’s Essential Hospitals, 2016

Our communities have more than 350,000 homeless individuals.

10.1 million people served by essential hospitals have limited access to healthy food.
FIGURE 5
Economic Needs in Essential Communities
Members of America’s Essential Hospitals, 2016

More than
25.3 MILLION
INDIVIDUALS BELOW THE POVERTY LINE

19.4 MILLION
INDIVIDUALS WITHOUT HEALTH INSURANCE

At the University of California-Davis, essential hospital providers use telehealth to ensure patients of all ages have access to the care they need.
Essential Hospitals

Our members are essential because of their unique relationship to the vulnerable people and communities they serve. Without our hospitals, vulnerable patients and underserved communities across the country would have limited access to both routine care and lifesaving services, such as level I trauma care, burn units, and neonatal intensive care services.

Essential hospitals provide high levels of uncompensated and unreimbursed care as part of their mission to provide access for people who face severe financial challenges. In 2016, our members provided more than $5.5 billion in uncompensated care—or nearly 14.4 percent of all uncompensated care provided at hospitals nationwide. Of this total, $3.5 billion represents care provided under formal charity care policies—just one part of the larger uncompensated care picture.1

With this high level of uncompensated care comes financial challenges. In 2016, members of America’s Essential Hospitals continued to operate with margins significantly lower than the rest of the hospital industry. Member hospitals had an average aggregate margin of 4 percent, which was close to half the 7.8 percent margin for all hospitals nationwide. Without Medicaid disproportionate share hospital (DSH) payments, overall member margins would have sunk to a 1.4 percent loss.1

FIGURE 6

Average Uncompensated Care
Members of America’s Essential Hospitals Versus All Hospitals Nationwide, 2016

$70,776,414 ESSENTIAL HOSPITALS

$7,913,223 U.S. HOSPITALS
Members of America’s Essential Hospitals provided more than

$5.5B = 14.4\%$  $3.5B = 20\%$

OF ALL UNCOMPENSATED CARE

OF ALL CHARITY CARE NATIONWIDE

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FIGURE 7
Share of National Uncompensated and Charity Care
Members of America’s Essential Hospitals, 2016

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FIGURE 8
National Operating Margins
Members of America’s Essential Hospitals Versus All Hospitals Nationwide, 2016

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AGGREGATE

Operating Margin
U.S. HOSPITAL AGGREGATE

7.8\%

Operating Margin
MEMBER AGGREGATE

4.0\%

Operating Margin
MEMBER AGGREGATE

-1.4\%

Operating Margin
MEMBER AGGREGATE

WITHOUT MEDICAID DSH PAYMENTS
Even as they deal with these financial struggles, our hospitals continue to build up their local economies. The average essential hospital employed 2,944 people in 2016. Together, our hospitals accounted for 656,474 jobs nationwide and contributed to $114.8 billion in economic activity. On average, member hospitals report $519.3 million in yearly expenditures, stimulating $1.1 billion in economic activity in their respective states.⁷

**FIGURE 9**

**Economic Impact**  
*Members of America’s Essential Hospitals, 2016*

1,459,689  
Contribution to total jobs in state economies

6,546  
Average contribution to total jobs in state economies per hospital

$114.8 BILLION  
Total expenditures in state economies

$519.3 MILLION  
Average expenditures in state economies per hospital
“The services and things that Parkland and other essential hospitals do go beyond just physical health care. We’re taking care of people’s mental health, we’re taking care of people’s social health, we have specialty programs for the elderly, for the homeless population, and for victims of domestic violence and sexual assault and human trafficking. So we have all of these programs that take care of the whole person.”

-KYRA BRADLEY
FORMER BURN PATIENT
COMMUNITY DEVELOPMENT SPECIALIST, VICTIM INTERVENTION PROGRAM AND RAPE CRISIS CENTER
PARKLAND HEALTH AND HOSPITAL SYSTEM
Providing

COMPREHENSIVE, COORDINATED CARE
In 2016, members of America’s Essential Hospitals provided non-emergency outpatient care to 79.6 million patients and treated more than 14.7 million patients in their emergency departments.\(^1\)

The typical essential hospital has 35 outpatient departments, a third of which are off campus. This underscores the extent to which essential hospitals reach outside their walls and into the community, expanding access to care where none would exist otherwise.

On the inpatient side, our members averaged more than 18,000 discharges per hospital—2.7 times more than the inpatient volume of other acute-care hospitals nationwide.\(^1\)
FIGURE 11
Average Inpatient and Outpatient Utilization
Members of America’s Essential Hospitals Versus Other Acute-Care Hospitals Nationwide, 2016
Essential hospitals like Benefis Health System, the second-largest health system in Montana, provide state-of-the-art care in both the inpatient and outpatient settings.

About half of our members participate in accountable care organizations (ACOs) or alternative payment models (APMs). ACO participants agree to be accountable for the quality, cost, and overall care of beneficiaries assigned to them, while an APM is a payment approach that provides incentives for high-quality, cost-efficient care. The high rate of essential hospital participation in these models shows a strong commitment to coordinating care among providers to improve quality and lower costs.
“We spent a lot of time focusing on patients’ empowerment and getting patients to understand even for themselves what resources there are, what kind of questions they can ask of their providers, and how to really be an active participant in their health care... We believe that they’re identifying symptoms earlier and helping patients manage better so that they don’t let things go to the point that they end up in an emergency room.”

—Gabrielle Rocque
Medical Director, Cancer Community Network
UAB Health System

**FIGURE 12**
ACO and APM Participation
Members of America’s Essential Hospitals, 2016
Training
FUTURE HEALTH CARE PROFESSIONALS
Three-quarters of America’s Essential Hospitals members are teaching institutions. On average, essential hospitals trained nearly three times as many physicians as other U.S. teaching hospitals. Essential hospitals also trained 23 percent more physicians beyond their federal funding gap than other U.S. teaching hospitals.\textsuperscript{8,9} One in 10 allied health professionals trained in an acute-care facility did so at a member hospital.\textsuperscript{1} Allied health professionals—such as medical technologists, occupational and physical therapists, radiographers, and speech language pathologists—use evidence-based practices to diagnose and treat acute and chronic diseases; promote preventive medicine and wellness; and support health care systems in various settings.

“The next generation of health care professionals will need new skills that expand their reach past clinical excellence. Leadership can be taught and the ability to problem solve is a skill all must learn. Physicians will be key to creating care continuums that serve patients and meet the coming economic challenges. I expect my medical students and residents to excel as they learn leadership, innovation, and performance improvement. The future is bright.”

—SUSAN WALSH, MD
RWJBARNABAS JERSEY CITY MEDICAL CENTER

—SUSAN WALSH, MD
RWJBARNABAS JERSEY CITY MEDICAL CENTER
Each member teaching hospital trained an average of 223 physicians in 2016.

Other U.S. teaching hospitals each trained an average of 76 physicians.

Of the 223 physicians members trained, 41 were trained beyond supported federal graduate medical education (GME) funding.

Other U.S. teaching hospitals trained less than one quarter of that number – 8 were trained beyond supported federal GME funding.
Providing
SPECIALIZED, LIFESAVING SERVICES
As the nation deals with devastating storms, violent acts, and other traumatic events, members of America’s Essential Hospitals are there to care for victims and help heal communities.

In 2016, our member hospitals were at the center of the response to disasters across the country, including Tennessee wildfires, Hurricane Matthew, and the Pulse nightclub shooting, in Orlando, Florida.

Essential hospitals are leading providers of trauma and intensive care, including burn, psychiatric, emergency psychiatric, pediatric, and neonatal intensive care. They 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 care for every aspect of severe injury—are at essential hospitals.\(^1\) Level I trauma centers also play a leading role in trauma research and education.
“We’re the only level I trauma center in central Florida, and we regularly drill and prepare for the worst while hoping it never happens. That’s our role and the commitment we make as an essential hospital to keeping our community safe.”

—MARK JONES
PRESIDENT
ORLANDO REGIONAL MEDICAL CENTER

FIGURE 15
Hospitals Providing Emergency Psychiatric Services
Members of America’s Essential Hospitals Versus Other Acute-Care Hospitals Nationwide, 2016

Emergency department staff at Baystate Health in Springfield, Massachusetts, are always prepared to help patients experiencing trauma.
Advancing

PUBLIC HEALTH AND
HEALTH EQUITY
Public Health

Essential hospitals are anchors in their community—central sources of care, jobs, and services. As such, they can influence the social, economic, and environmental circumstances of a person’s life, which can account for as much as half of what determines their health.

Through innovative public health programs, essential hospitals change the course of upstream factors to improve population health. Thirty-six percent of our members have a formal relationship with their local health department—in fact, some essential hospitals are the health department for the community they serve. A formal relationship also could entail a contractual agreement and/or sharing personnel and resources with a local health department. Meanwhile, an additional 54 percent of our members informally meet or share information with their health department.

“Health is not the absence of infirmity or disease. It’s not just that they’re not sick, it’s the whole person. If you really take that to heart and look at the whole person, part of that is their environment in which their physical health exists, and that has an absolute direct impact on their physical health.”

—JOEL HUNT
DIRECTOR, CARE CONNECTIONS OUTREACH
JPS HEALTH NETWORK

FIGURE 16
Relationships with Local Health Departments
Members of America’s Essential Hospitals, 2016

90% OF MEMBERS HAVE A RELATIONSHIP with their local health department
Given this diverse patient population, **essential hospitals** make it a priority to collect race, ethnicity, and language data as part of care delivery and use this information to reduce health disparities.

More than eight out of 10 member hospitals offer linguistic services. Nearly half of essential hospitals signed the Equity 123 pledge. The pledge calls on health care leaders to collaborate to eliminate health care disparities and improve quality of care for every patient.
**Figure Sources**

**Figure 1:** American Hospital Association. 2016 AHA Annual Survey. Health Forum LLC. 2017.

**Figure 2:** America’s Essential Hospitals. 2016 America’s Essential Hospitals Characteristics Survey. 2017.

**Figure 3:** America’s Essential Hospitals. 2016 America’s Essential Hospitals Characteristics Survey. 2017.

Definition of “outpatient” has changed from 2015 and now includes ancillary visits.


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


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 6:** American Hospital Association. 2016 AHA Annual Survey. Health Forum LLC. 2017.

**Figure 7:** American Hospital Association. 2016 AHA Annual Survey. Health Forum LLC. 2017.

**Figure 8:** American Hospital Association. 2016 AHA Annual Survey. Health Forum LLC. 2017.

**Figure 9:** 2016 BEA RIMS-II multipliers for hospitals, applied to 2016 American Hospital Association Annual Survey Data and 2016 Medicare Cost Report Data.

**Figure 10:** America’s Essential Hospitals. 2016 America’s Essential Hospitals Characteristics Survey. 2017.

**Figure 11:** American Hospital Association. 2016 AHA Annual Survey. Health Forum LLC. 2017.

**Figure 12:** America’s Essential Hospitals. 2016 America’s Essential Hospitals Characteristics Survey. 2017.

**Figure 13:** Centers for Medicare & Medicaid Services. Healthcare Cost Report Information System, Hospital 2552-10 Cost Report Data File-s FY2016. 2017.

**Figure 14:** American Hospital Association. 2016 AHA Annual Survey. Health Forum LLC. 2017.

**Figure 15:** American Hospital Association. 2016 AHA Annual Survey. Health Forum LLC. 2017.
Figure 16: America's Essential Hospitals. 2016 America's Essential Hospitals Characteristics Survey. 2017.


* Data from the 2016 AHA Annual Survey represents America's Essential Hospitals acute-care member respondents (n=206) compared with other acute-care hospitals (n=4,462)

* Data from the 2016 CMS Hospital Cost Reports represents America's Essential Hospitals acute-care members (n=188) compared with other acute-care hospitals (n=2,867)

Endnotes


9. Physicians are defined as U.S. medical and dental residents; teaching hospitals are defined as teaching institutions are defined as having at least one resident in training.

Glossary

Charity Care: The amount of care provided under hospital-defined policies to offer services at no cost to individuals who meet predetermined financial criteria and are unable to pay.

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.

Economic Impact: The economic impact analysis measures the effect of essential hospital spending and employment on their local and state communities. Using BEA economic multipliers, we measure how every dollar spent by an essential hospital and every employee results in additional spending and employment in local and state economies.

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 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.