

Essential Hospitals

VITAL DATA

*Results of America's Essential Hospitals Annual Hospital
Characteristics Report, FY 2013*

Published: March 2015



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 more than 250 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, first established in 1988 as the National Public Health and Hospital Institute, is the private, nonprofit research arm of America's Essential Hospitals. The Institute researches and promotes best practices in health care, especially for vulnerable populations and underserved communities. We use data analysis and lessons learned to help members of America's Essential Hospitals and the larger industry improve quality and efficiency.

The Institute, which also educates and trains senior administrators and clinical leaders, comprises a Research Center and the Transformation Center, a catalyst for innovative change to improve quality and safety.

METHODOLOGY

This report updates the status of short-term, acute care hospitals within America's Essential Hospitals' membership. The report is based on data collected for fiscal year (FY) 2013 through America's Essential Hospitals' Annual Hospital Characteristics Survey. The annual survey was sent to 102 members of America's Essential Hospitals, and 83 responses were submitted, for a response rate of 81 percent. These 83 responses represent 99 acute care hospitals within the membership. The survey excluded non-acute care member hospitals, 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 2013 AHA Annual Survey of Hospitals. Several members submitted survey data to America's Essential Hospitals for individual hospitals within their health system, while reporting to AHA's Annual Survey of Hospitals as a single, system-level entity. In those instances, survey data for the individual hospitals were aggregated to create a single, system-level entity to ensure data comparability with the AHA Annual Survey of Hospitals. As a result of aggregation, the final survey sample reflected in this report is 81 member organizations representing 99 acute care hospitals.

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WE ARE ESSENTIAL

Members of America's Essential Hospitals share five fundamental characteristics.



CARING FOR THE MOST VULNERABLE

The FY 2013 data below demonstrates these characteristics.

Complex Patients

- Essential hospitals' patients are generally sicker and more **complex** than those served at other hospitals nationwide.
- Nearly half of patients discharged by members of America's Essential Hospitals were **minorities**.

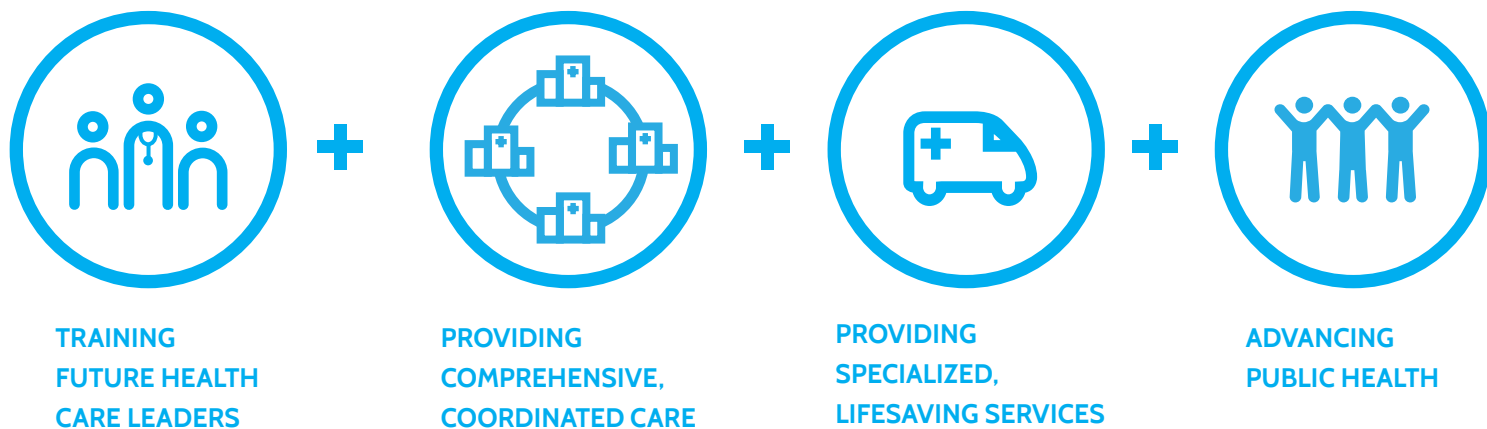
Uncompensated Care

- Essential hospitals provided more than \$7.8 billion in **uncompensated care**, nearly 17 percent of all uncompensated care provided nationwide.¹
- Roughly half of all inpatient discharges and outpatient visits were for **uninsured or Medicaid** patients. Medicare patients accounted for 23 percent of inpatient and 21 percent of outpatient visits.

- Member hospitals delivered nearly 207,000 babies in 2013, 70 percent of which were paid for by Medicaid.

Community Cornerstone

- Essential hospitals provided **non-emergency outpatient care** to 38 million patients, averaging 471,097 non-emergency outpatient visits per hospital.
- Essential hospitals treated more than 7.2 million patients in their **emergency departments**, averaging 89,380 visits per hospital.
- **Inpatient admissions** averaged nearly 23,000 per hospital, more than three times the inpatient volume of other acute-care hospitals nationwide.
- Essential hospitals **trained** an average of 254 physicians (defined as U.S. medical and dental residents) per hospital, 14 times as many as those trained at other U.S. teaching hospitals.



- Essential hospitals operated nearly one-third of all **level I trauma** centers and **psychiatric care** beds and more than two-thirds of the **burn care** beds available to treat the critically injured in the nation's 10 largest cities.²

High Quality, High Value

- Patients at essential hospitals have consistently **increased their satisfaction** ratings of their care experience. Member scores on all 10 of the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) measures of patient experience and satisfaction have increased steadily since 2010.
- 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 -3.2 percent, compared with 5.7 percent for all hospitals nationwide.³ Without Medicaid **disproportionate share hospital (DSH) payments**, aggregate member operating margins would drop to -12.5 percent.

OUR VALUE IN DATA

FIGURE 1

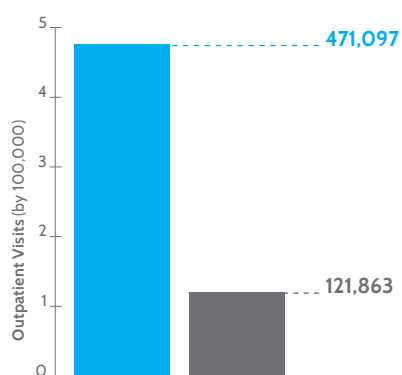
Average Inpatient and Outpatient Utilization

*Members of America's Essential Hospitals
Versus Other Acute Care Hospitals Nationwide, FY 2013*

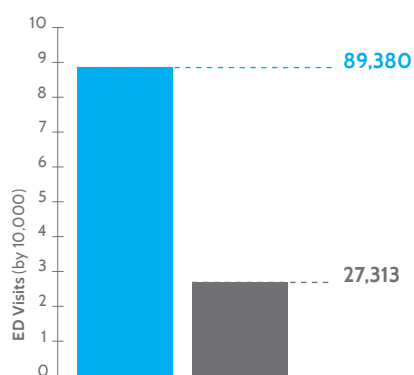
In 2013, members of America's Essential Hospitals provided non-emergency **outpatient care to 38 million patients** and treated more than **7.2 million patients in their emergency departments**.

Our members averaged nearly 23,000 inpatient discharges per hospital, more than **three times the inpatient volume** of other acute care hospitals nationwide.

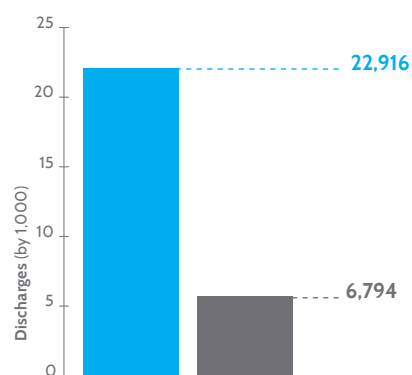
Average Number of
**NON-EMERGENCY OUTPATIENT
VISITS PER HOSPITAL**



Average Number of
**EMERGENCY DEPARTMENT
VISITS PER HOSPITAL**



Average Number of
**INPATIENT DISCHARGES
PER HOSPITAL**



 America's Essential Hospitals (N=81)  Other Acute Care Hospitals Nationwide (N=4,671)

FIGURE 2

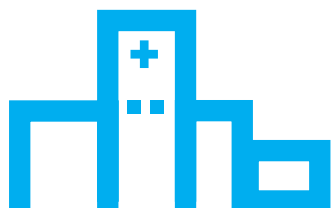
Number of Physicians Trained

*Members of America's Essential Hospitals
Versus Other Acute Care Hospitals Nationwide, FY 2013*

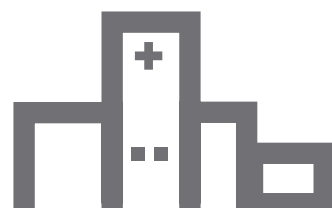
On average, essential hospitals **trained 14 times as many physicians*** as other U.S. teaching hospitals.

* Physicians is defined as U.S. medical and dental residents.

Each member teaching hospital trained an average of 254 physicians in 2013.



Other U.S. teaching hospitals each trained an average of 18 physicians.



Note: Numbers are rounded to the nearest whole number.
Source: American Hospital Association. Annual Survey of Hospitals. 2013.

FIGURE 3

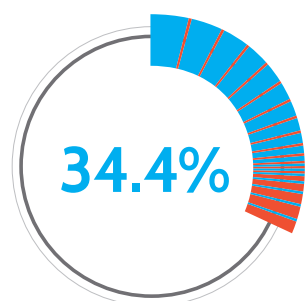
Share of Critical and Specialty Services in the 10 Largest Cities in the United States

Members of America's Essential Hospitals, FY 2013

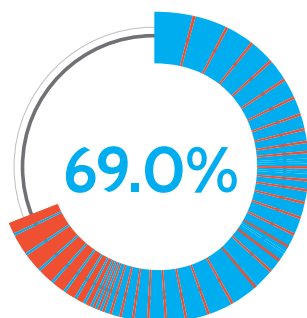
The 10 largest cities in the United States are home to more than 25 million people. Within these cities, our member hospitals provide **roughly one-third of level I trauma and psychiatric services and two-thirds of burn care services.**



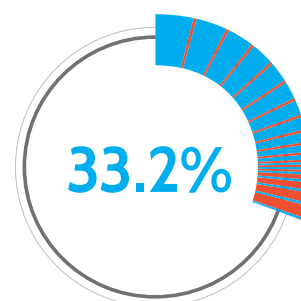
LEVEL I TRAUMA CENTERS



BURN CARE BEDS



PSYCHIATRIC CARE BEDS



10 LARGEST CITIES IN THE UNITED STATES



Member Share of These
Services in 10 Largest Cities
in the United States

Note: Burn care figures are not comparable to 2012 figures due to change in AHA data.

Source: United States Census Bureau. American FactFinder. <http://factfinder2.census.gov/faces/nav/jsf/pages/index.xhtml>.

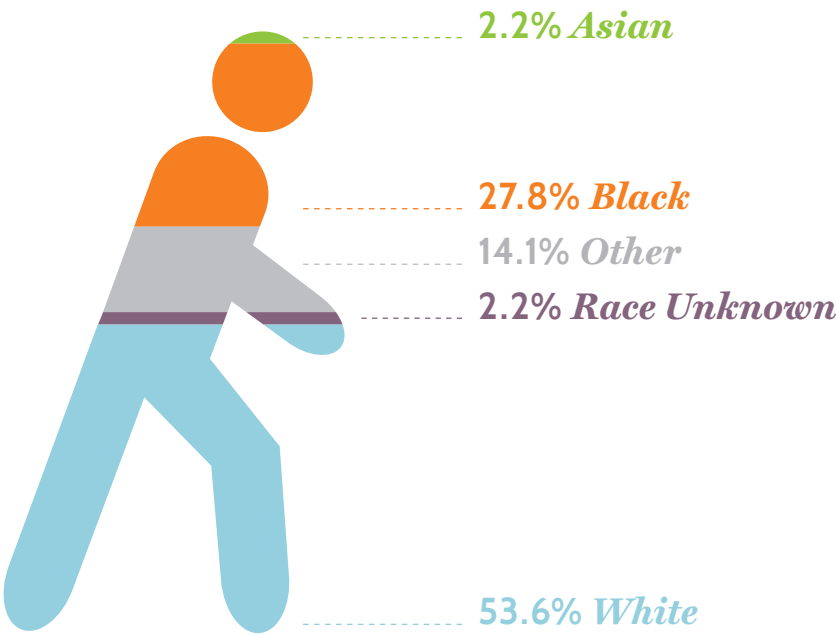
Accessed December 2014. Accessed March 2015; American Hospital Association. Annual Survey of Hospitals. 2013.

FIGURE 4

Inpatient Discharges by Race and Ethnicity

Members of America's Essential Hospitals, FY 2013

RACE



Nearly half of patients discharged by members of America's Essential Hospitals were **minorities**.

ETHNICITY

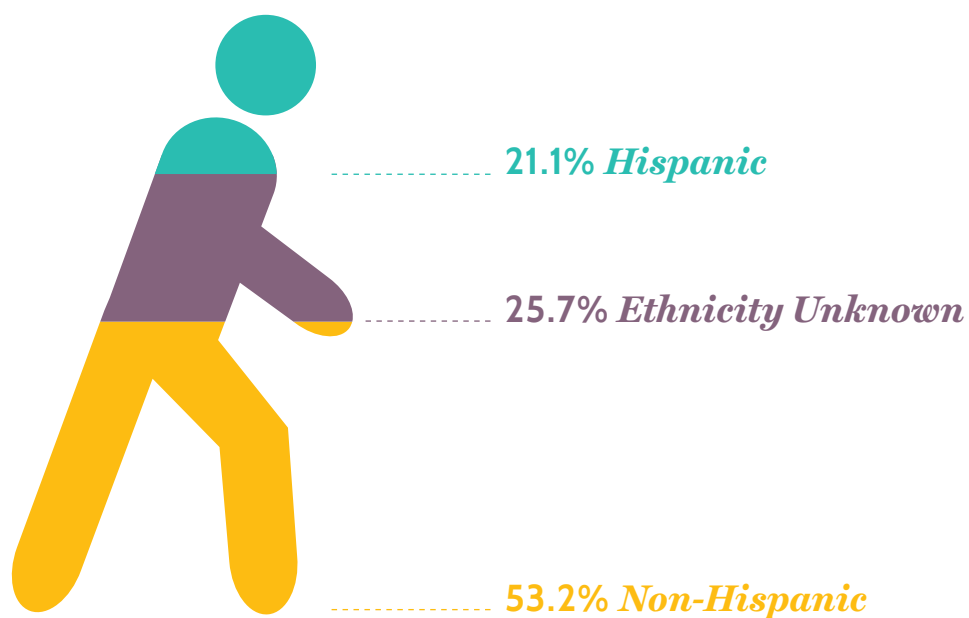
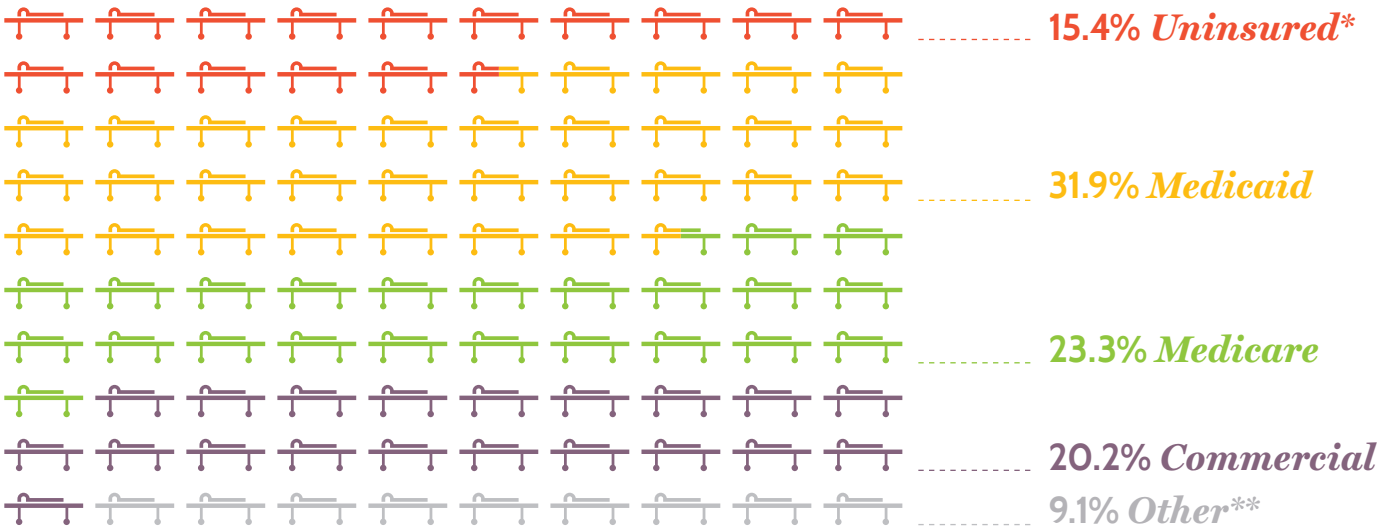


FIGURE 5

Inpatient and Outpatient Utilization by Payer Mix

Members of America’s Essential Hospitals, FY 2013

INPATIENT



* 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.

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

OUTPATIENT



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. 2013.

FIGURE 6

Share of National Uncompensated Care

Members of America's Essential Hospitals, FY 2013

Members of America's Essential Hospitals provided more than

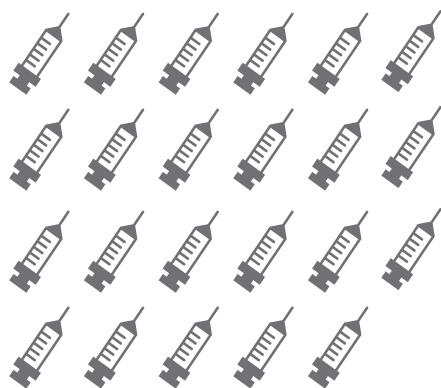
\$7.8 BILLION IN
UNCOMPENSATED
CARE



This is enough money to

develop more than

23 LIFE-SAVING
VACCINES



 = 1 Vaccine

deliver

798,500 BABIES IN THE
UNITED STATES



 = 10,000 babies

Source: PATH. Investing in Vaccines for the Developing World. http://www.ghettoalliance.org/files/VAC_vacc_invst_fs.pdf. Accessed June 2014.

Source: Young J. Six Charts That Illustrate Just How Much Higher Health Care Costs Are for Americans. March 26, 2013. http://www.huffingtonpost.com/2013/03/26/charts-health-care-costs-americans_n_2957266.html. Accessed June 2014.

16.8%

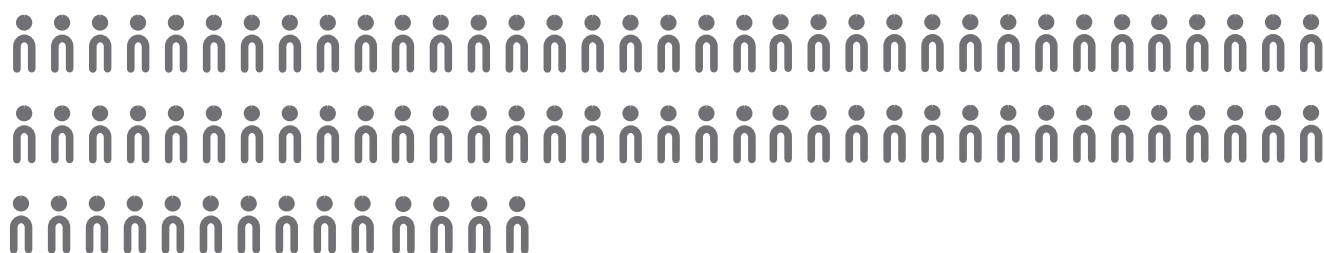
OF ALL
UNCOMPENSATED
CARE NATIONWIDE

Source: America's Essential Hospitals. Annual Hospital Characteristics Survey. 2013; American Hospital Association. Uncompensated Hospital Care Cost Fact Sheet, 2015 Update. <http://www.aha.org/content/15/uncompensatedcarefactsheet.pdf>. Accessed January 22, 2015.

provide health care to

843,000

MEN, WOMEN, AND CHILDREN
IN THE UNITED STATES



OR THE ENTIRE STATE OF SOUTH DAKOTA



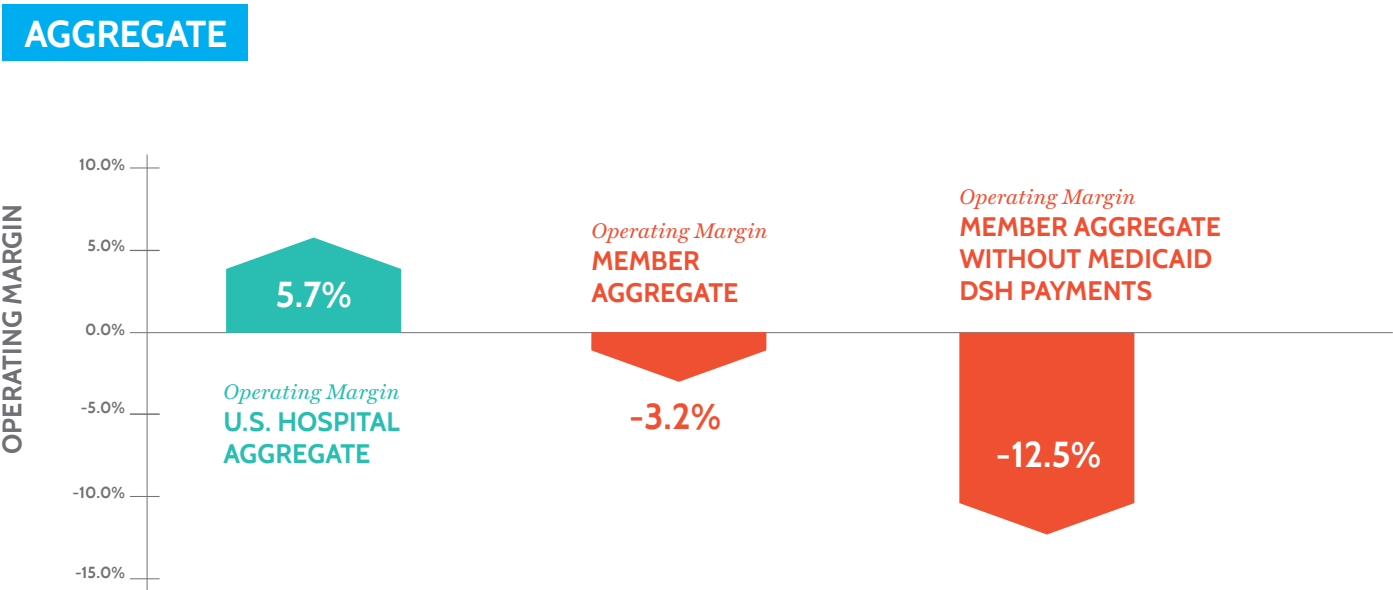
 = 10,000 people

Source: The Centers for Medicare & Medicaid Services. National Health Expenditures 2013 Highlights. <http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/highlights.pdf>. Accessed January 22, 2015.

FIGURE 7

National Operating Margins

Members of America’s Essential Hospitals Versus All Hospitals Nationwide, FY 2013



Note: DSH stands for disproportionate share hospital.

With many essential hospitals operating at a 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.

PROPORTION

Percentage of Hospitals with
NEGATIVE MARGINS

Percentage of Hospitals with
POSITIVE MARGINS

**MEMBERS OF
AMERICA'S ESSENTIAL
HOSPITALS**

50.6%

49.4%

**ALL HOSPITALS
NATIONWIDE**

30.5%

69.5%

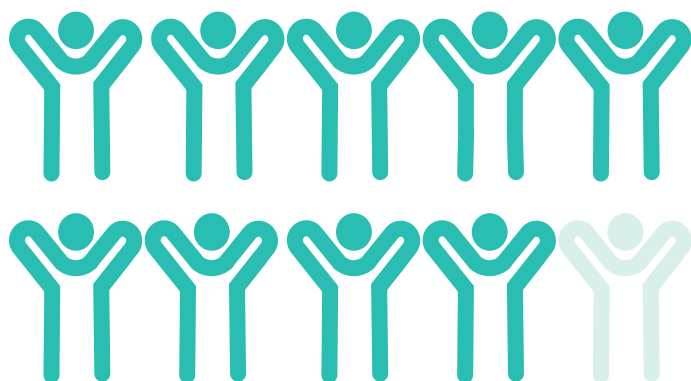
Source: America's Essential Hospitals. Annual Hospital Characteristics Survey. 2013; American Hospital Association. Annual Survey of Hospitals, 2013; Centers for Medicare & Medicaid Services. Hospital Cost Report. 2013; American Hospital Association. Trendwatch Chartbook 2015: Trends Affecting Hospitals and Health Systems. <http://www.aha.org/research/reports/tw/chartbook/ch4.shtml>. Accessed January 24, 2015.

FIGURE 8

Performance on HCAHPS Patient Experience and Satisfaction Measures

Members of America's Essential Hospitals, FY 2013

SATISFACTION



9 out of 10

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

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

Member scores on all 10 of the **HCAHPS** measures of patient experience and satisfaction have **increased steadily** since 2010.

RECOMMENDATION



9.5 *out of* **10**

patients would “probably” or “definitely” recommend their hospital to family and friends.

FIGURE 9

Performance on Selected Process of Care Measures

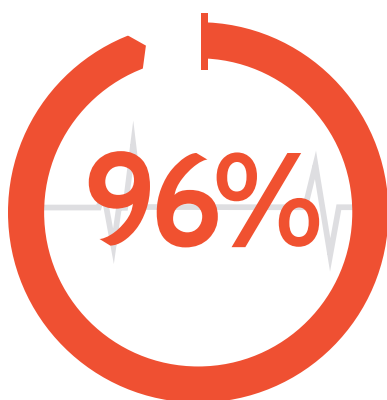
Members of America's Essential Hospitals, FY 2013

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.



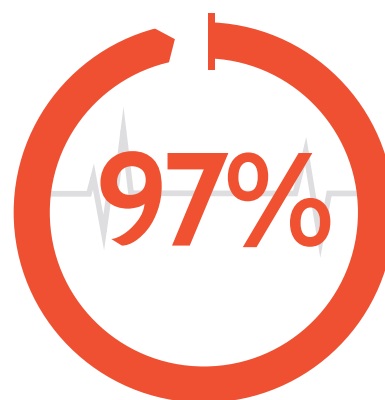
Members delivered

*all of the
recommended care for*
heart failure patients



of the time

*all of the
recommended care for*
heart attack patients



of the time

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 free of charge 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 everyone at or below 138 percent of the federal poverty level.

Medicare: A federal program that provides health coverage for individuals 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/15/uncompensatedcarefactsheet.pdf>. Accessed January 22, 2015.

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, 2013 Population: April 1, 2010 to July 1, 2013. <https://www.census.gov/popest/data/cities/totals/2013/>. Accessed December 14, 2014.

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 Hospital Consumer Assessment of Healthcare Providers and Systems (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.

5. 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.

6. 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.



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