

ESSENTIAL DATA

Our Hospitals, Our Patients

Results of America's Essential Hospitals
2018 Annual Member Characteristics Survey

PUBLISHED MAY 2020



AMERICA'S
ESSENTIAL
HOSPITALS



ABOUT AMERICA'S ESSENTIAL HOSPITALS

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 more than 300 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.



ABOUT ESSENTIAL HOSPITALS INSTITUTE

Essential Hospitals Institute is the research and education 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 this with an eye toward improving individual and population health, especially for vulnerable people.

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Brian Roberson, MPA
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Foreword

The nation's essential hospitals—our more than 300 members—share a mission to ensure equitable access to high-quality health care. This annual profile of their work and of the people and communities they serve documents the vital role they play caring for vulnerable people and communities at large.

Essential Data also illustrates the social and economic challenges that influence health and weigh heaviest on the disadvantaged people and communities our members serve. While the details in this report vary year to year, the story remains the same: Millions of people rely on essential hospitals for exceptional care, jobs and economic activity, and front-line leadership in times of greatest need.

Our member hospitals' primary commitment is to serving all people, regardless of financial or social status. But their work extends outside the hospital walls, helping to meet social needs throughout their community. Essential hospitals fill four other key roles:

- 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 improving population health and preparing for and responding to natural disasters and other crises.

Essential hospitals operate with margins about a third that of other hospitals; yet even with their limited means, essential hospitals shoulder a disproportionate share of the nation's uncompensated care costs. These financial challenges drive our hospitals to develop and implement innovative programs that elevate quality, add value, reduce disparities, and improve population health.

Each year, this report reminds us how essential our hospitals are to their communities. Thank you for letting us share the story of the people and communities they serve and services they provide.

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



Methodology

This report offers a snapshot of America's Essential Hospitals members. The report primarily features data collected through the association's 2018 Annual Member Characteristics Survey, which was sent to 96 health systems representing 196 member hospitals, with responses from 69 systems representing 142 hospitals. The survey excluded hospitals that joined the membership after the survey's launch. Essential Hospitals Institute, the research and education arm of the association, provided technical support and analysis of survey results. Additional data from the American Hospital Association's 2018 Annual Survey of Hospitals, the Centers for Medicare & Medicaid Services' fiscal year 2018 Hospital Cost Report, the Centers for Disease Control and Prevention WONDER database, as well as data from the American Community Survey, U. S. Department of Housing and Urban Development, U. S. Department of Agriculture, and U.S. Bureau of Economic Analysis were used to support this report's findings.

Providers examine samples in a phlebotomy lab at Oregon Health & Science University, in Portland, Oregon.



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These key data points show the vital role our hospitals play in communities nationwide and the social and economic challenges those communities face.

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Opposite page photo: Children play basketball during an adaptive sports camp run by St. Luke’s Health System, in Boise, Idaho.

ESSENTIAL HOSPITALS



The nation relies on essential hospitals as a source of care for all people, including the vulnerable, making them providers of choice for patients of virtually every ethnicity and language. Racial and ethnic minorities made up 54 percent of member discharges in 2018.

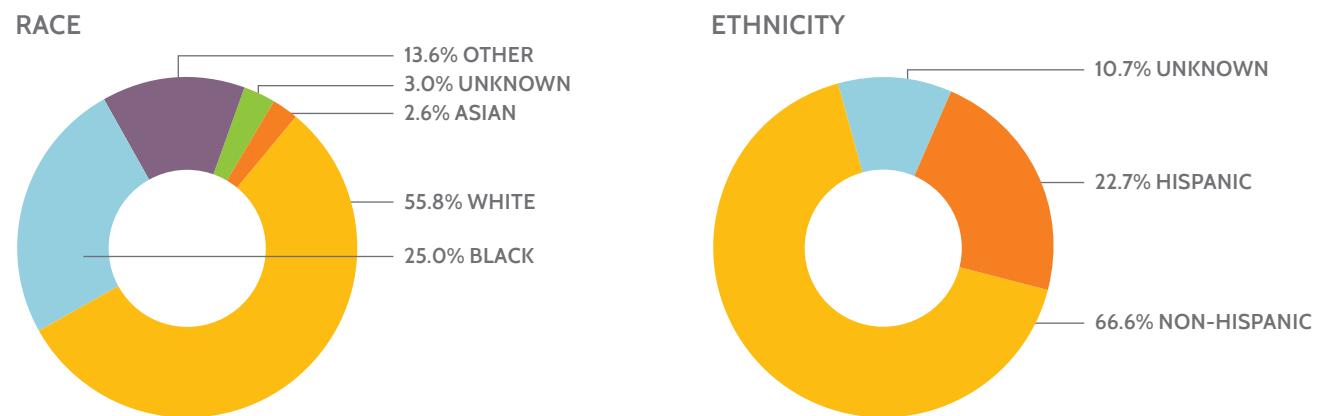
In 2018, three-quarters of essential hospitals' patients were uninsured or covered by Medicaid or Medicare. Only about one in four inpatient discharges and outpatient visits at essential hospitals were covered by commercial insurance. Our member hospitals face severe financial challenges due to the disparity between commercially insured patients and those covered by public programs—or not covered at all. These hospitals are given the impossible task of offsetting losses from public program underpayments and charity care with commercial payments, which track closer to costs.

In 2018, the American Hospital Association (AHA) estimates U.S. hospitals received nearly \$76.6 billion less than the cost of the care they provided to Medicare and Medicaid beneficiaries.¹ This problem is compounded by proposals to reduce Medicaid funding and policy changes in the private insurance market, threatening to expand the ranks of the uninsured and erode support for essential hospitals. A swelling uninsured population coupled with less support puts health care access at risk for patients across the country.



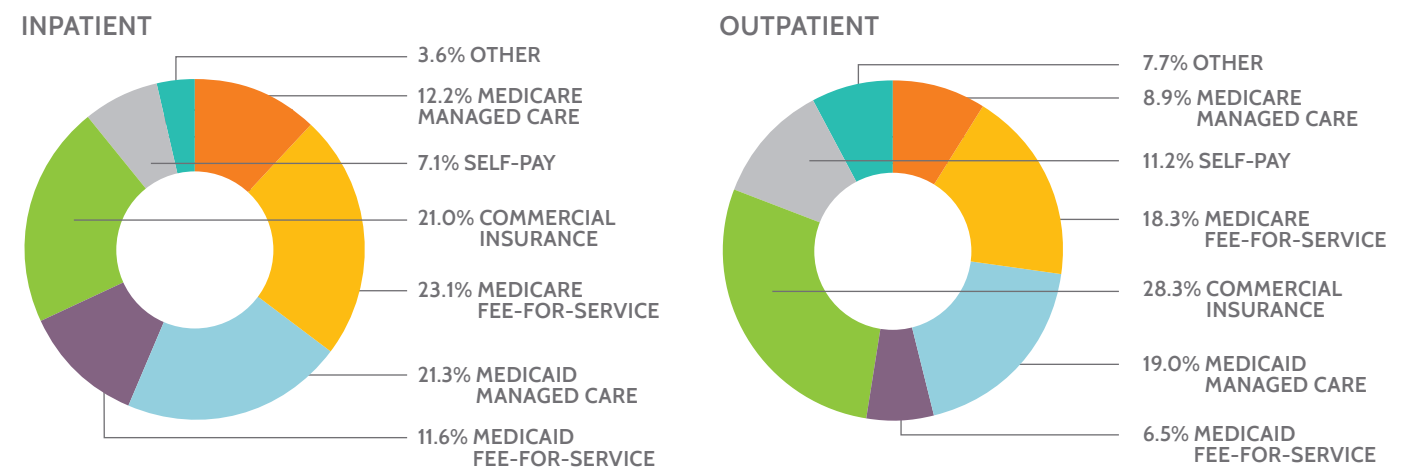
A patient consults with his doctor at the Henry Ford Health System Heart and Vascular Institute; (pages 2–3) An infant receives care in the neonatal intensive care unit at the University of Florida Shands Children's Hospital, in Gainesville, Florida.

FIGURE 1
Inpatient Discharges by Race and Ethnicity
Members of America's Essential Hospitals, 2018



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

FIGURE 2
Inpatient and Outpatient Utilization by Payer Mix
Members of America's Essential Hospitals, 2018



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

Committing to Underserved Communities

Without essential 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. Because of this unique relationship with vulnerable people and populations, our member hospitals help to make up the foundation of these communities. Serving their mission to ensure access for people who face severe financial challenges, essential hospitals provide high levels of uncompensated and unreimbursed care. Nearly 50 percent of essential hospitals support a charitable foundation.

In 2018, our members provided nearly \$6.6 billion in uncompensated care—or nearly 15.9 percent of all uncompensated care provided at hospitals nationwide.² Of this total, \$6.2 billion represents care provided under formal charity care policies—just one part of the larger uncompensated care picture.³ Many face financial challenges because they provide a disproportionate share of uncompensated care.

FIGURE 3

Average Uncompensated Care

Members of America's Essential Hospitals versus All Hospitals Nationwide, 2018



Share of National Uncompensated Care

Members of America's Essential Hospitals, 2018



In 2018, 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 2.5 percent—a third of the 7.6 percent margin for all hospitals nationwide. Without Medicaid disproportionate share hospital (DSH) payments, overall member margins would have sunk to a 1.6 percent loss.²



Our mission is, and our vision is, to create health equity by giving folks the capacity to be healthy, and our way to do that is through education, research, and community engagement.”

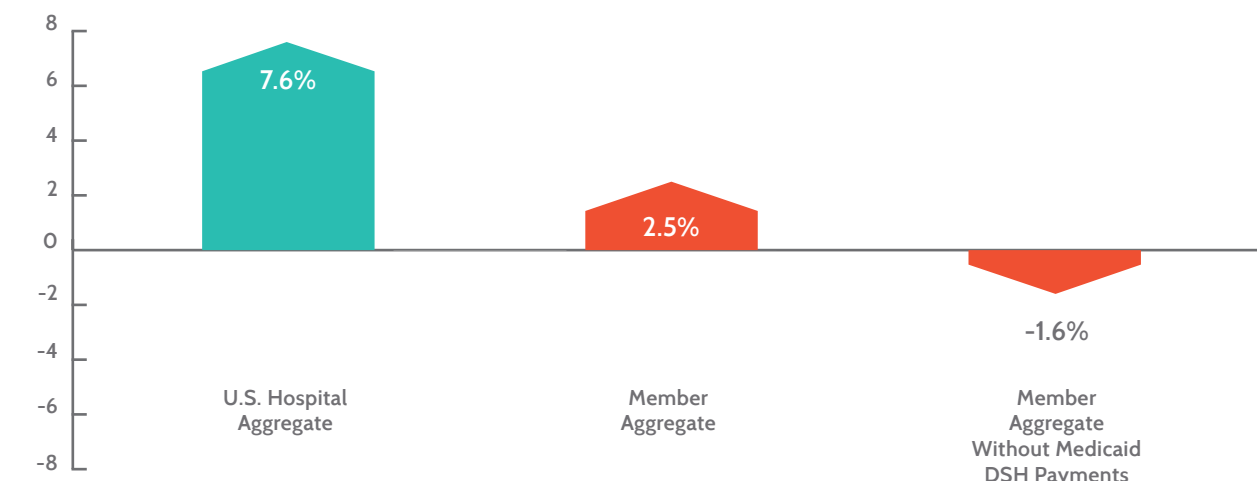
KATHY REEVES, MD

SENIOR ASSOCIATE DEAN FOR HEALTH EQUITY, DIVERSITY, AND INCLUSION;
DIRECTOR, CENTER FOR BIOETHICS, URBAN HEALTH, AND POLICY
TEMPLE UNIVERSITY HEALTH SYSTEM
PHILADELPHIA

FIGURE 4

National Operating Margins

Members of America's Essential Hospitals versus All Hospitals Nationwide, 2018



Meeting Patients Where They Are

In 2018, members of America’s Essential Hospitals provided non-emergency outpatient care to 80 million patients and treated 14 million patients in their emergency departments.² Our members have a median of 12 ambulatory care locations, half 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 areas would otherwise lack. On the inpatient side, our members averaged more than 18,000 discharges per hospital—nearly three times more

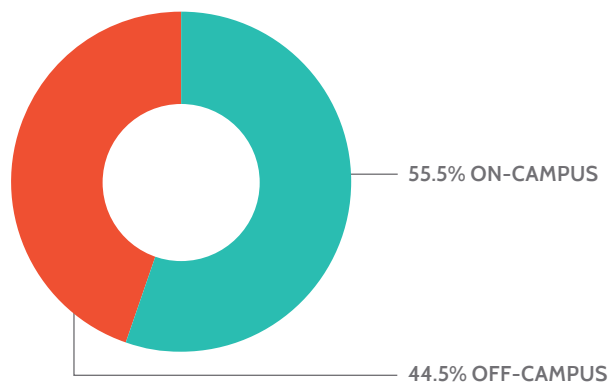
than the inpatient volume of other acute-care hospitals nationwide.² About half our members participate in accountable care organizations (ACOs). ACO participants agree to be accountable for the quality, cost, and overall care of beneficiaries assigned to them. The high rate of essential hospital participation in this model shows a strong commitment to coordinating care among providers to improve quality and lower costs.

FIGURE 5
Beyond Their Walls
Members of America’s Essential Hospitals, 2018

ESSENTIAL HOSPITALS OPERATE A MEDIAN OF 12 AMBULATORY CARE LOCATIONS PER HOSPITAL



OUTPATIENT VISITS
On-Campus versus Off-Campus visits



AMBULATORY CARE LOCATIONS
On-Campus versus Off-Campus visits

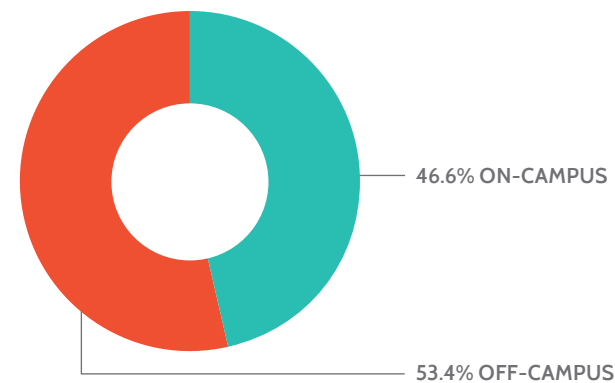
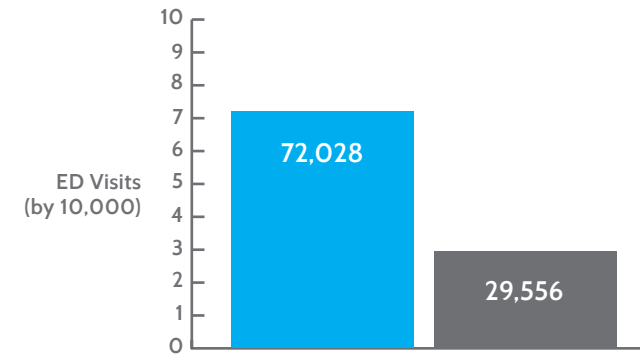
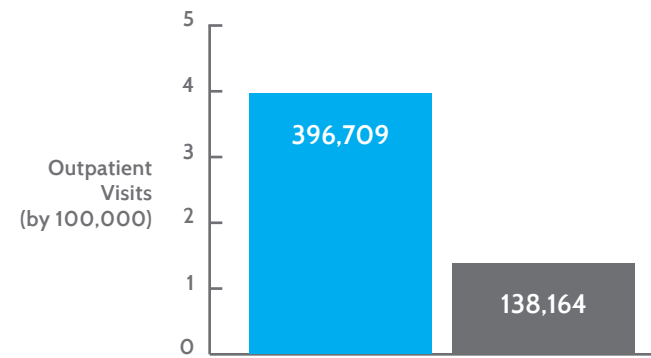


FIGURE 6
Average Inpatient and Outpatient Utilization
Members of America’s Essential Hospitals versus Acute-Care Hospitals Nationwide, 2018

EMERGENCY DEPARTMENT VISITS PER HOSPITAL



NON-EMERGENCY OUTPATIENT VISITS PER HOSPITAL



■ AMERICA'S ESSENTIAL HOSPITALS
 ■ OTHER ACUTE-CARE HOSPITALS NATIONWIDE

“We try to bring dignity, regardless of where you are in your socioeconomic status or where you are in the severity of injury—to everyone involved.”

SARAH HENDRICKSON, MD
 COMMUNITY TRAUMA INSTITUTE DIRECTOR
 THE METROHEALTH SYSTEM
 CLEVELAND

Telehealth services can improve care and expand access for communities essential hospitals serve. Our member hospitals have made significant investments to offer routine and specialized care via telehealth, offering remote patient monitoring for post-discharge and chronic care management at rates double that of other acute-care hospitals.

“We need place-based solutions—solutions that really come to understand the people and the neighborhoods, the actors in those communities, the difficulties that they’re facing, and how to begin to build effective intervention strategies and opportunities for efficacy and youth activism.”

SHARON HOMAN, PhD
 PAST PRESIDENT, SINAI URBAN HEALTH INSTITUTE
 SINAI HEALTH SYSTEM
 CHICAGO

UC Davis Health, in Sacramento, runs a clinical telehealth program to increase health care access by connecting patients and their physicians with specialists.

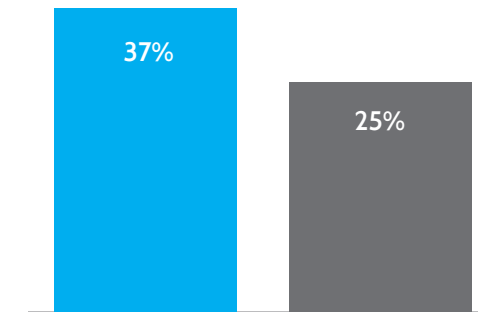


FIGURE 7

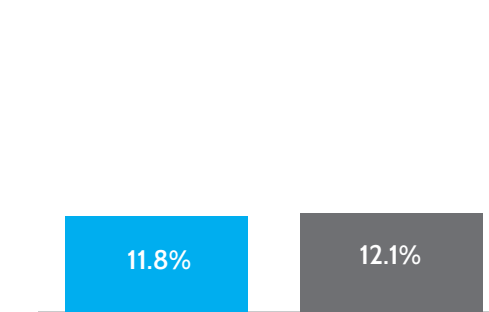
Access to Telehealth Services

Members of America’s Essential Hospitals versus Acute-Care Hospitals Nationwide, 2018

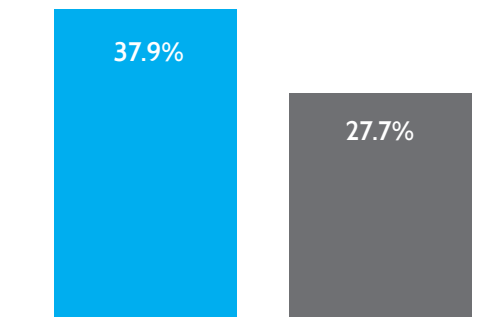
CONSULTATION AND OFFICE VISITS



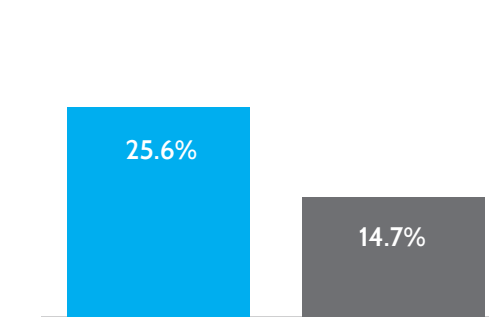
eICU



STROKE CARE



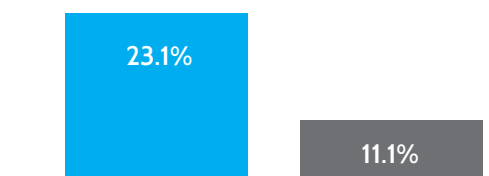
PSYCHIATRIC AND ADDICTION TREATMENT



REMOTE PATIENT MONITORING, POST-DISCHARGE



REMOTE PATIENT MONITORING, CHRONIC CARE MANAGEMENT



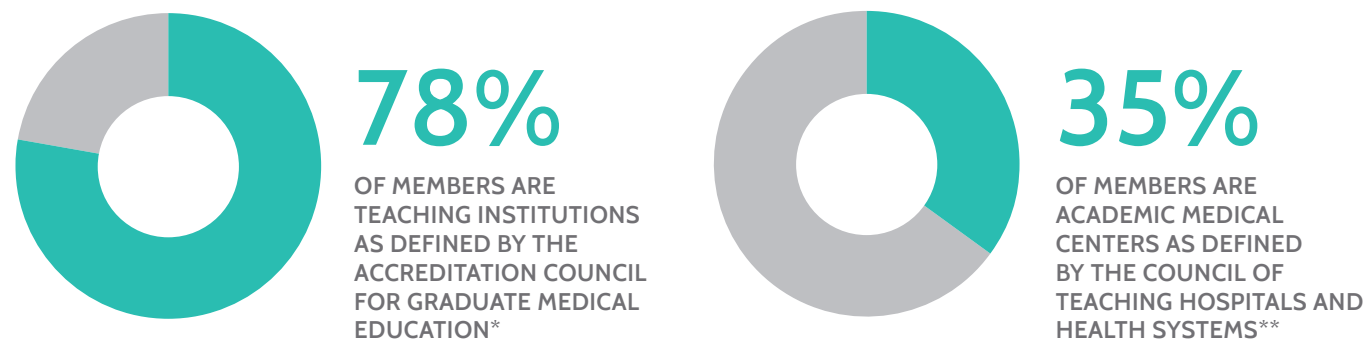
■ AMERICA'S ESSENTIAL HOSPITALS
 ■ OTHER ACUTE-CARE HOSPITALS NATIONWIDE

Next Generation Essential Providers

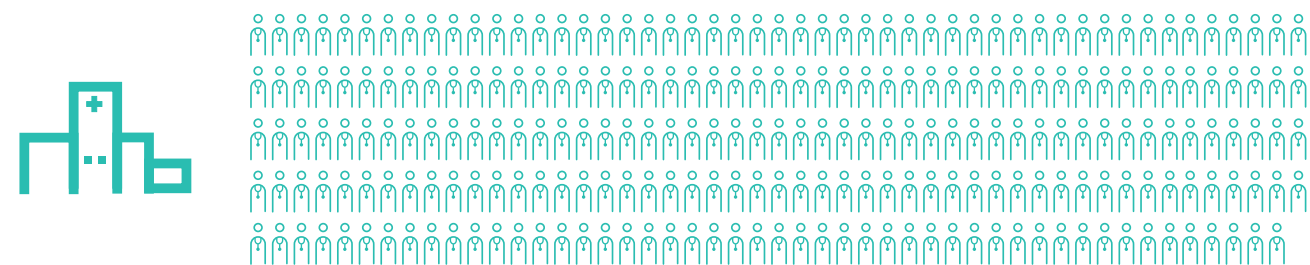
Essential hospitals are dedicated to training the next generation of health care professionals. Three-quarters of America's Essential Hospitals members are teaching institutions.² On average, essential hospitals trained three times as many physicians as other U.S. teaching hospitals. Essential hospitals also trained 25 percent more physicians beyond their federal funding cap than other U.S. teaching hospitals.^{3,4} Nearly one in 10

allied health professionals trained in an acute-care facility received their training at a member hospital.² 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.

FIGURE 8
Number of Physicians Trained
Members of America's Essential Hospitals versus Other Acute-Care Hospitals, 2018



Each member teaching hospital trained an average of **244** physicians in 2018.



Other U.S. teaching hospitals each trained an average of **81** physicians.



* (8.2% of all teaching institutions as defined by ACGME; 30.3% of nonmembers are teaching institutions as defined by ACGME)

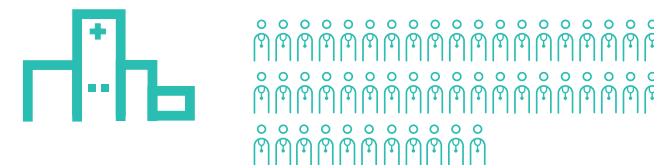
** (26% of all academic medical centers as defined by COTH; 4.5% of nonmembers are academic medical centers as defined by COTH)



Eskenazi Health, in Indianapolis, partners with the Indiana University School of Medicine to train future clinicians.

FIGURE 9
Number of Physicians Trained above Federal Funding Cap
Members of America's Essential Hospitals versus Other Acute-Care Hospitals, 2018

Of the **244** physicians, **49** were trained beyond supported federal graduate medical education (GME) funding.



Other U.S. teaching hospitals trained less than one quarter of that number—**11** were trained beyond supported federal GME funding.

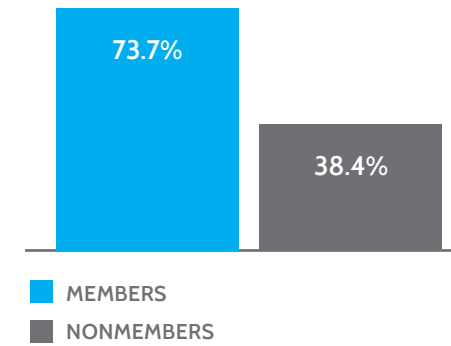


Care on the Front Lines

In the wake of natural disasters, mass violence, pandemics, and other crises, communities rely on the lifesaving services offered by essential hospitals. In 2018, our members responded to disasters across the country, from the Stoneman Douglas and Santa Fe high school shootings to Hurricane Florence and wildfires across California. Essential hospitals lead the field in trauma and intensive care, including burn, psychiatric, emergency psychiatric, pediatric,

and neonatal intensive care. Our members are community resources for highly specialized emergency and intensive care. Essential hospitals house a third of the nation's level I trauma centers, which care for every aspect of severe injury and play a leading role in trauma research and education. In addition, almost three-quarters of our members provide emergency psychiatric services, compared with about a third of nonmembers that provide such care.²

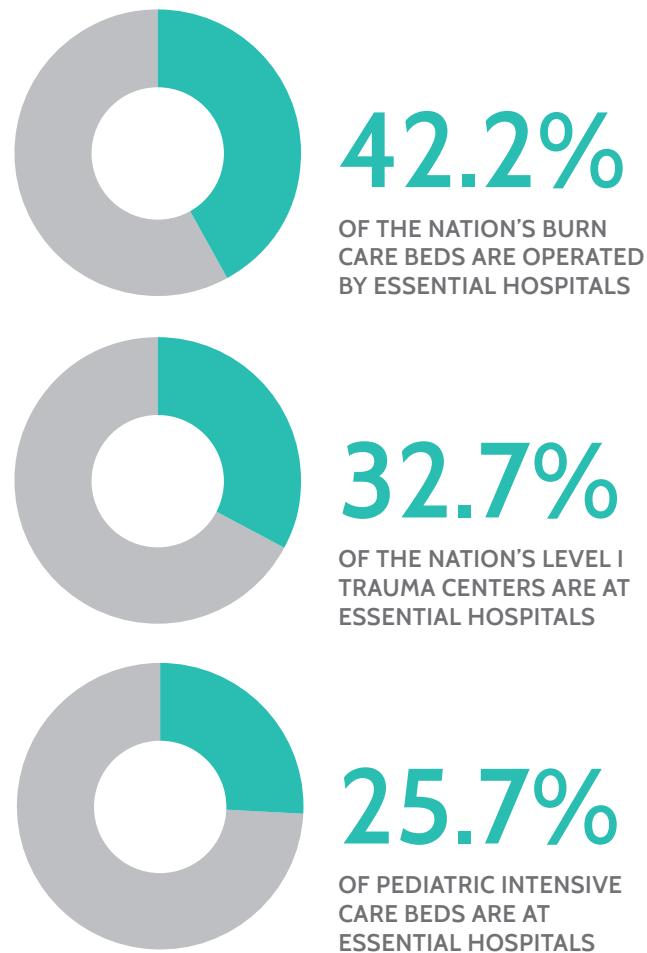
FIGURE 11
Hospitals Providing Emergency Psychiatric Services
Members of America's Essential Hospitals versus Other Acute-Care Hospitals Nationwide, 2018



“Many essential hospitals really carry the burden of trauma and violence in the nation. These are the places that are truly day in and day out seeing this epidemic of violent injury. The role of an essential hospital is to lead and to provide help and care in the community not just when they get to us.”

JENNIFER AVEGNO
UNIVERSITY MEDICAL CENTER NEW ORLEANS
NEW ORLEANS

FIGURE 10
Specialty Care Services
Members of America's Essential Hospitals, 2018



ESSENTIAL HOSPITALS OPERATE MORE THAN 6,000 PSYCHIATRIC CARE BEDS AND 3,400 NICU BEDS



The MetroHealth System, in Cleveland, is the longest-operating level I trauma center in one of the top 10 cities for severe traumas. MetroHealth is part of the Trauma Survivors Network, an American Trauma Society program built to connect and support trauma survivors and caregivers through the continuum of care.

ESSENTIAL COMMUNITIES



Essential hospitals' work extends widely outside their walls, helping to meet social needs throughout their community and improve population health.

Our hospitals are committed to serving the vulnerable—this motivates them to operate where need is greatest, in communities that might otherwise lack access to care. They provide services in a wide variety of communities, from 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 and makeup, these communities each make essential contributions to the social fabric and economic prosperity of their states and the nation.

“If we don't all work together to confront the realities that complicate the health of our communities, we're simply applying tourniquets and ignoring the actual cause of the bleeding.”

TRACEY DECHERT, MD
 BOSTON MEDICAL CENTER
 BOSTON



Central Health, in Austin, Texas, hosts an annual fall event providing the community no-cost sports physicals, immunizations, back packs, and Zumba classes; (pages 16–17) A traditional dancer performs during a Community Conversation and Resource Fair hosted by Central Health to educate the Pflugerville, Texas, community about ways the health system and its community partners work to improve access to care.

Meeting Social Needs

U.S. Department of Housing and Urban Development data show that essential hospitals serve communities in which more than 360,000 individuals struggle with homelessness.⁵ Homeless patients might be predisposed to worse health outcomes, as lack of stable housing is a significant social determinant of health. To address this, many essential hospitals offer medical respite or permanent housing assistance programs that are critical to improving the health of these people. In addition, many of our members' communities face inadequate access to nutritious food, which has been

linked to poor physical and mental health outcomes. In 2018, nearly 10 million people in our members' communities had only limited access to healthy food.⁶ 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 23.2 million individuals live below the federal poverty line, and more than 15.3 million are uninsured.^{7,8} Without our hospitals' commitment to these patients, many would have nowhere to turn for critical health care needs.

Our member hospitals are vital components of their communities, ensuring all people have affordable access to high-quality care— from basic services to high-intensity, lifesaving treatment. Their patients are essential—to their family, friends, and community—regardless of their social or financial status. From the very beginning of their lives, many Americans have a relationship 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.² The populations

essential hospitals serve face disproportionate challenges to healthy births. Our member hospitals serve counties in which maternal mortality rates can exceed 52 maternal deaths per 100,000 live births, compared with 19 deaths per 100,000 nationally, and infant mortality rates can exceed 18 infant deaths per 1,000 live births, compared with 5.8 per 1,000 nationwide.⁹ Essential hospitals invest in programs to mitigate social risk factors and help pregnant women, new mothers, and infants beat these staggering odds.

FIGURE 12
Social Needs in Essential Communities
Members of America's Essential Hospitals, 2018



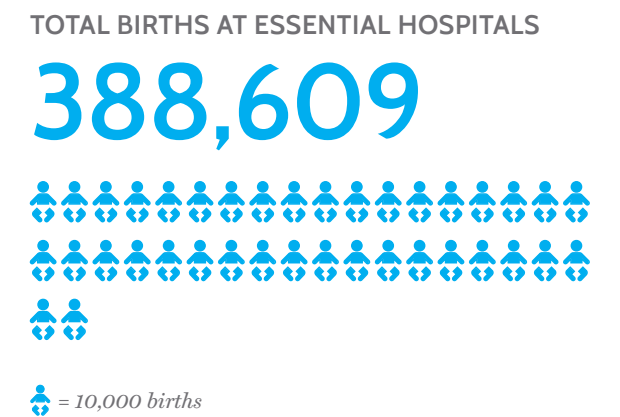
FIGURE 13
Economic Needs in Essential Communities
Members of America's Essential Hospitals, 2018



University Health System, in San Antonio, offers a level IV neonatal intensive care unit that includes a comprehensive team of neonatal specialists and state-of-the-art facilities.



FIGURE 14
Births
Members of America's Essential Hospitals, 2018



Building Healthy Communities

As anchors in their communities—central sources of care, jobs, and services—essential hospitals can influence patients’ social, economic, and environmental circumstances. These factors can account for up to half of what determines their health. Essential hospitals use their innovative population health programs to change the course of upstream factors, improving the overall health of a population. One third of our members have a formal relationship with a local health department—further, some essential hospitals are the health department in their community. A formal relationship also could entail a contractual

agreement and sharing personnel and resources with a local health department. An additional 57.9 percent of our members informally meet or share information with a health department.

Given their diverse patient populations, essential hospitals prioritize the collection of race, ethnicity, and language information during care delivery and use this data to reduce health disparities. Nine of 10 member hospitals offer linguistic services.² Patients at essential hospitals rely on the culturally and linguistically appropriate care that only our members can provide.



Young students from the community learn about CPR at Arrowhead Regional Medical Center, in Colton, California.

“If we’re going to be a part of the community, we’re going to be involved. It’s just kind of part of our DNA.”

JOHN ATKINSON
 DIRECTOR OF PUBLIC RELATIONS AND
 MARKETING
 EAST ALABAMA MEDICAL CENTER
 OPELIKA, ALABAMA

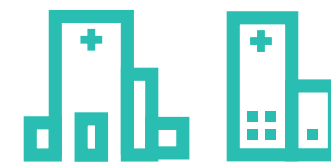
FIGURE 15
Relationships with Local Health Departments
Members of America’s Essential Hospitals, 2018



91.6%

OF MEMBERS HAVE A RELATIONSHIP WITH THEIR LOCAL HEALTH DEPARTMENT

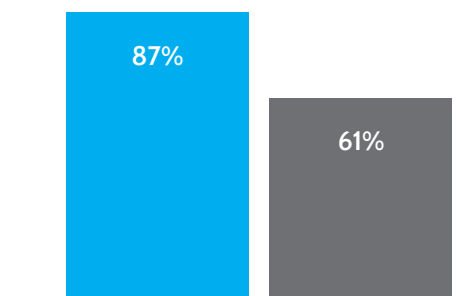
FIGURE 16
Data Sharing to Improve Population Health
Members of America’s Essential Hospitals, 2018



82.5%

OF MEMBER HOSPITALS SHARE DATA WITH PUBLIC HEALTH DEPARTMENTS FOR THE PURPOSE OF POPULATION HEALTH IMPROVEMENT

FIGURE 17
Linguistic Services
Members of America’s Essential Hospitals versus Other Acute-Care Hospitals Nationwide, 2018



■ MEMBER HOSPITALS
 ■ NONMEMBER HOSPITALS

Our member hospitals serve communities with higher rates of unemployment—6.5 percent on average—than nonmember hospitals.¹⁰ Even as they struggle with financial challenges, essential hospitals continue to build up their local economies. The average essential hospital employed 3,101 people in 2018. Together, our hospitals accounted for 679,027 jobs nationwide and contributed to \$124.4 billion in economic activity. On average, member hospitals report \$612.7 million in yearly expenditures, stimulating nearly \$1.3 billion in economic activity in their respective states.¹¹

Further, almost all of our members—97.6 percent—partner with other hospitals or health systems, or with an external federally qualified health center, community health center, or free clinic. In addition, nearly 86 percent partner with external behavioral health clinics, 70 percent have relationships with an external respite care facility, and more than half partner with retail clinics, such as CVS, Walgreens, and Rite Aid.¹²

FIGURE 18
Employment and Economic Impact
Members of America's Essential Hospitals, 2018

1,534,937

CONTRIBUTION TO TOTAL JOBS IN STATE ECONOMIES

7,009

AVERAGE CONTRIBUTION TO TOTAL JOBS IN STATE ECONOMIES PER HOSPITAL

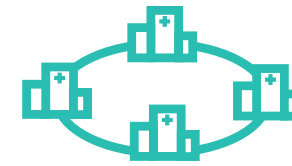
\$124.4 BILLION

TOTAL EXPENDITURES IN STATE ECONOMIES

\$612.7

AVERAGE EXPENDITURES IN STATE ECONOMIES PER ESSENTIAL HOSPITAL

FIGURE 19
Investment in Local Community
Members of America's Essential Hospitals, 2018



61.1%

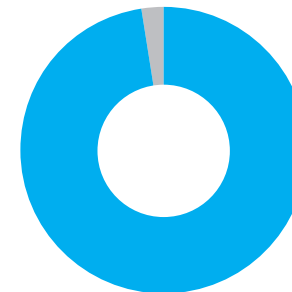
OF MEMBERS HAVE POLICIES TO INVEST IN LOCAL SUPPLY CHAIN PROCUREMENT



75.0%

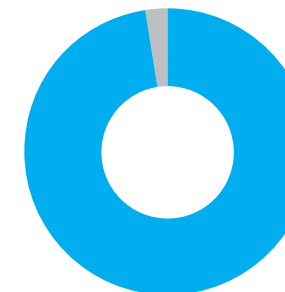
HAVE POLICIES TO INVEST IN LOCAL HIRING AND WORKFORCE DEVELOPMENT

FIGURE 20
Relationships with External Partners to Improve Social Determinants of Health
Members of America's Essential Hospitals, 2018



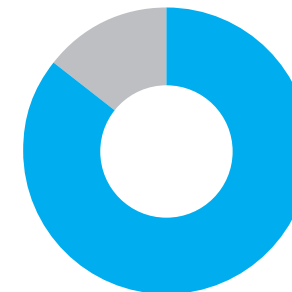
97.6%

PARTNER WITH OTHER HOSPITALS OR HEALTH SYSTEMS



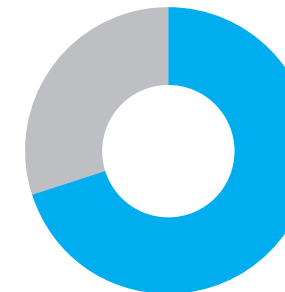
97.6%

HAVE A RELATIONSHIP WITH AN EXTERNAL FEDERALLY QUALIFIED HEALTH CENTER, COMMUNITY HEALTH CENTER, OR FREE CLINIC



85.8%

PARTNER WITH EXTERNAL BEHAVIORAL HEALTH CLINICS



70.0%

HAVE A RELATIONSHIP WITH AN EXTERNAL RESPITE CARE FACILITY



58.6%

58.6% PARTNER WITH RETAIL CLINICS

ENDNOTES

1. American Hospital Association. *Underpayment by Medicare and Medicaid Fact Sheet*. 2020. <https://www.aha.org/system/files/media/file/2020/01/2020-Medicare-Medicaid-Underpayment-Fact-Sheet.pdf>. Accessed March 5, 2020.
2. American Hospital Association. *2018 AHA Annual Survey*. Health Forum LLC. 2019.
3. Centers for Medicare & Medicaid Services. *Healthcare Cost Report Information System, Hospital 2552-10 Cost Report Data Files FY2018*. 2019.
4. Physician is defined as U.S. medical and dental residents; Teaching hospitals are defined as having at least one resident in training
5. U.S. Department of Housing and Urban Development. *2018 AHAR: Part 1 - PIT Estimates of Homelessness in the U.S.*. 2018. <https://www.hudexchange.info/resource/5783/2018-ahar-part-1-pit-estimates-of-homelessness-in-the-us/>. Accessed March 5, 2020.
6. U.S. Department of Agriculture. *Food Access Research Atlas Data Download 2015*. 2017. <https://www.ers.usda.gov/data-products/food-access-research-atlas/download-the-data/>. Accessed March 5, 2020.
7. U.S. Census Bureau. *Poverty Status in the Past 12 Months. 2014-2018 American Community Survey 5-year Estimates*. 2019.
8. U.S. Census Bureau. *Selected Characteristics of the Uninsured in the United States. 2014-2018 American Community Survey 5-year Estimates*. 2019.
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10. U.S. Census Bureau. *Employment Status in the Past 12 Months. 2014-2018 American Community Survey 5-year Estimates*. 2019.
11. 2017 BEA RIMS-II multipliers for hospitals, applied to 2018 American Hospital Association Annual Survey Data and 2018 Medicare Cost Report Data.
12. America's Essential Hospitals. *2019 Essential Hospitals Population Health Survey*. 2019.

FIGURE SOURCES

Figure 1: America's Essential Hospitals. *2018 America's Essential Hospitals Characteristics Survey*. 2020.

Figure 2: America's Essential Hospitals. *2018 America's Essential Hospitals Characteristics Survey*. 2020.

Figure 3: American Hospital Association. *2018 AHA Annual Survey*. Health Forum LLC. 2019.

Centers for Medicare & Medicaid Services. *Healthcare Cost Report Information System, Hospital 2552-10 Cost Report Data Files FY2018*. 2019.

Figure 4: American Hospital Association. *2018 AHA Annual Survey*. Health Forum LLC. 2019.

America's Essential Hospitals. *2018 America's Essential Hospitals Characteristics Survey*. 2020.

Figure 5: America's Essential Hospitals. *2018 America's Essential Hospitals Characteristics Survey*. 2020.

Figure 6: American Hospital Association. *2018 AHA Annual Survey*. Health Forum LLC. 2019.

Figure 7: American Hospital Association. *2018 AHA Annual Survey*. Health Forum LLC. 2019.

Figure 8: American Hospital Association. *2018 AHA Annual Survey*. Health Forum LLC. 2019.

Centers for Medicare & Medicaid Services. *Healthcare Cost Report Information System, Hospital 2552-10 Cost Report Data Files FY2018*. 2019.

Figure 9: Centers for Medicare & Medicaid Services. *Healthcare Cost Report Information System, Hospital 2552-10 Cost Report Data Files FY2018*. 2019.

Figure 10: American Hospital Association. *2018 AHA Annual Survey*. Health Forum LLC. 2019.

Figure 11: American Hospital Association. *2018 AHA Annual Survey*. Health Forum LLC. 2019.

Figure 12: U.S. Department of Housing and Urban Development. *2018 AHAR: Part 1 - PIT Estimates of Homelessness in the U.S.*. 2018. <https://www.hudexchange.info/resource/5639/2018-ahar-part-1-pit-estimates-of-homelessness-in-the-us/>. Accessed March 5, 2020.

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Limited access to healthy food was defined as low-income individuals who live more than 1 mile from a supermarket in urban areas and more than 10 miles in rural areas.

Figure 13: U.S. Census Bureau. *Poverty Status in the Past 12 Months. 2013-2018 American Community Survey 5-year Estimates*. 2019.

U.S. Census Bureau. *Selected Characteristics of the Uninsured in the United States. 2013-2018 American Community Survey 5-year Estimates*. 2019.

A community is defined using data from the 2018 CMS Hospital Service Area File as ZIP codes in which approximately 80 percent of a hospital's Medicare cases reside.

Figure 14: American Hospital Association. *2018 AHA Annual Survey*. Health Forum LLC. 2019.

Figure 15: America's Essential Hospitals. *2018 America's Essential Hospitals Characteristics Survey*. 2020.

Figure 16: America's Essential Hospitals. *2019 Essential Hospitals Population Health Survey*. 2019.

Figure 17: American Hospital Association. *2018 AHA Annual Survey*. Health Forum LLC. 2019.

Figure 18: 2017 BEA RIMS-II multipliers for hospitals, applied to 2018 American Hospital Association Annual Survey Data and 2018 Medicare Cost Report Data.

Figure 19: America's Essential Hospitals. *2019 Essential Hospitals Population Health Survey*. 2019.

Figure 20: America's Essential Hospitals. *2019 Essential Hospitals Population Health Survey*. 2019.

* Data from the 2018 AHA Annual Survey represents America's Essential Hospitals acute-care member respondents (n=198) compared with other acute-care hospitals (n=4,414)

* Data from the 2018 CMS Hospital Cost Reports represents America's Essential Hospitals acute-care members (n=178) compared with other acute-care hospitals (n=2,897)

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 Bureau of Economic Analysis 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 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.



*Hennepin County Medical Center
hosts a nutrition education class
for youth in the community.*



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