

Executive Summary

Whether the nation is ready for real health care transformation remains to be seen, but many observers are wondering aloud if the U.S. has finally reached a tipping point. Costs are escalating in a manner that health care economists and policymakers (and, indeed, many hospital leaders) view as unsustainable, and, at the same time, an expanding body of evidence is revealing that quality is not what it should be. The focus on access to care and the rising numbers of uninsured has rallied cries for an answer to this seemingly unending crisis. Transparency and accountability are huge market forces that are picking up considerable steam and dramatically affecting the health care landscape. In Greater Cincinnati, each of these forces is having a profound effect on hospital decision-making. All of these factors will also be in play during the upcoming Presidential election.

In addition, the debate over the role of “consumerism” continues. With more cost-sharing strategies for employees likely in years ahead, the issue of whether this extra burden will spur truly activated consumers remains unresolved. Still, initiatives such as the launch of Google Health (in partnership with the Cleveland Clinic), which will give patients access to and control of their own medical records, are among many different efforts beginning to revolutionize thinking about a more patient-centric health care model.

Area hospital investment in health information technology is an important – and growing -- piece of facility budgets. The federal government is pushing the adoption of electronic health records as a means to improve efficiency, quality and safety and to decrease costs.

Along with worries over growing numbers of uninsured is more in-depth scrutiny of hospitals’ commitment to serving this group. Legislators and policy leaders in the Tristate and across the nation have begun to look carefully at hospital practices relating to indigent care and at times, to their tax-exempt status in general. Local hospitals have supported efforts to get more people covered and have jointly and voluntarily developed billing and collection guidelines and a common financial aid form.

The Centers for Medicare and Medicaid Services, in an attempt to reduce costs and improve quality, is advancing the concept of “value-based purchasing.” This approach rewards hospitals for efficient, high quality care (or at least provides hospitals full “marketbasket” reimbursement rates for reporting out certain quality measures). CMS also increasingly posts hospital performance information online. Most local hospitals participate in Medicare’s efforts to improve performance and value. In fact, Greater Cincinnati hospitals remain at the forefront of the “value” movement in general as they agreed in 2007 to launch a voluntary to make hospital-specific performance data available to the public.

The manner in which some health care will be delivered in the future is also undergoing significant change. “Convenience clinics” are in place in a number of retail outlets in the Tristate, and physician-based surgery centers and the like are proliferating. Much attention is also being focused on the care of those with chronic disease, as this care comprises an inordinate amount of health care spending. Hospitals are active participants in local efforts to improve such care.

Enormous changes have been taking place in the physical environment of the local health care marketplace, and increasing competition is evident, particularly in areas of high population growth. Competition is also increasing between Tristate hospitals and those in the Dayton area, as is clearly evident along the I-75 corridor in Butler and Warren counties. A local construction boom has been evident as hospital financial pictures improved somewhat over the past several years. But for a number of hospital providers, budgets are tightening up, as was evidenced in recent announcements by several hospitals of the elimination of some positions. Some observers are beginning to predict tougher financial times for hospitals may lie ahead.

Utilization of hospital services is up slightly, with discharges, inpatient days and total surgical cases (including inpatient, outpatient and freestanding) rising over the past five-year period. The increases moderated somewhat, however, over the 2006-2007 period.

Hospital/physician relations are becoming more complicated, with some hospitals bringing physician groups into their systems or collaborating on joint ventures. This is in response, at least in part, to direct competition from physician-owned facilities not aligned with a hospital. Signs that some surgery patients are choosing physician-owned “niche” facilities for their care are evident in local hospital utilization statistics. Debate has heated up over the past few years as to the long-term effect physician-owned facilities might have on the ability of community hospitals to deliver a full range of care as well as continue to serve as a health care safety net.

What one health care forecaster calls a “human resource crisis of unprecedented magnitude” is awaiting the health care system when baby boomer caregivers leave the workforce in full force. Short-term solutions used in the past to address cyclical shortages won’t work, and astute hospital leaders will be looking at technology-based transformations that focus on how care is delivered, along with work redesign and a strong focus on retaining existing workers as long as possible. Health Council vacancy studies have recorded some short-term gains in certain positions over the last few years.

The issue of health disparities is gaining renewed attention by hospitals, as is the increasing diversity of the patient population. These issues not only affect hospital patients and their families; this diversity is also being reflected in the makeup of the health care workforce itself.

A look at the local health care environment reveals the following:

- Population continues to grow in suburban counties, and the Greater Cincinnati metropolitan area (as based on a 15-County region) is now the largest in Ohio, surpassing metro Cleveland. The region added more than 12,500 people between 2006 and 2007 and now ranks as the 24th largest metro area in the nation. Boone County KY and the Warren/Butler County OH areas are Tristate population hotspots. Nearly 563,000 people now call the Warren/Butler county area home. This compares to Hamilton County’s population, now estimated at 842,369 persons. The city of Cincinnati gained a small number of residents, according to the latest census updates. Still, its population has declined since 1990, along with most other large cities in Ohio. The population in the GCHC membership area grew 6.1% from 2000 to 2007 to 2,214,239 residents. GCHC member hospitals recorded 31,716 live births in 2007.
- Health care planners are responding in force to these population shifts. Many new construction projects have been completed or announced over the last few years along the I-75 corridor between Cincinnati and Dayton. Cincinnati Children’s Hospital Medical Center has opened a major outpatient and diagnostic facility in Liberty Township, and Linder Center of HOPE, a new mental health facility, has begun operations in Mason. Atrium Medical Center opened its new hospital campus in Franklin in 2007. The West Chester Medical Center, a full hospital facility, is due to open in early 2009 along I-75 in West Chester. TriHealth owns land for a potential ambulatory development along I-75 in the future.
- The building boom continues into Northern Kentucky and other areas of the metro region. St. Elizabeth Medical Center will soon have a new outpatient center along I-75 in Kentucky. In 2006 TriHealth opened Bethesda Medical Center Arrow Springs in Warren County. Both Bethesda North and Good Samaritan hospitals have completed major expansions. Summit Behavioral Care opened a new replacement patient recovery center in 2006. Cincinnati’s west side will also have a new hospital facility soon. Mercy Health Partners announced in June it intends to build a new facility and will close its Western Hills and Mt. Airy hospitals. In outlying areas, Dearborn County Hospital in Indiana unveiled a new patient tower in early May, and Adams County Regional Medical Center recently

opened its new (replacement) facility in Seaman, Ohio. Mercy Hospital Clermont has also completed an extensive expansion.

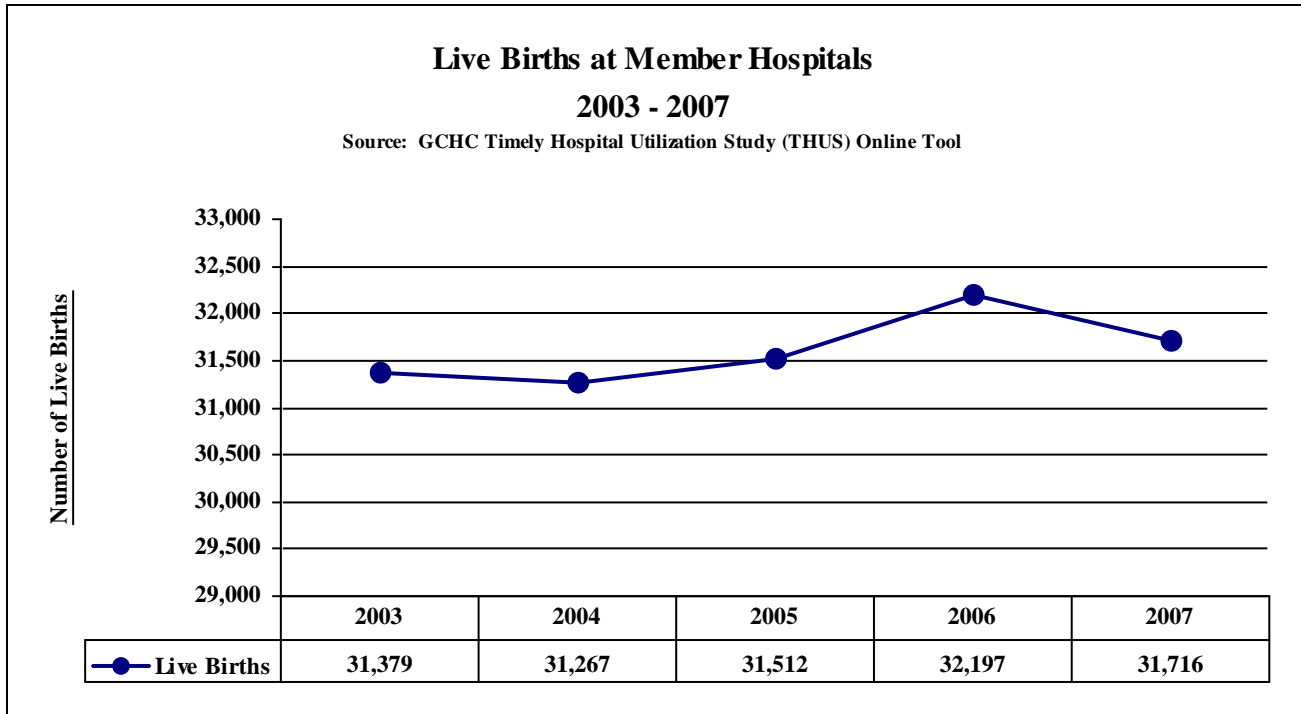
- Locally, the jobless rate in June 2008 rose to 6%, according to the federal Bureau of Labor Statistics, a 0.7% increase over June 2007. The picture was a bit bleaker in other metro regions of Ohio, including Dayton and Cleveland, and Ohio's June jobless rate at 6.6% was the highest since June 1993. (The area unemployment rate rose in July to 6.4% and in August to 6.3%, remaining near a 15-year high.) Still, the Cincinnati USA Partnership Economic Outlook 2008 notes total employment growth locally continues to lag behind the nation as a whole, a trend that is counter to that of previous years, when local job growth typically kept pace with national numbers. Employment in educational and health services increased the fastest of any sectors over the past 5 years, up 13% over the period. At the same time, while manufacturing as a whole in the region has declined, new opportunities in aerospace, biotechnology, and advanced manufacturing are potential positive spots in years ahead.
- The number of patients coming to area hospitals for treatment has shown a slight overall increase over the past five years. However, virtually every indicator -- emergency department use, patient discharges, average length of stay, inpatient days and the number of surgeries -- has flattened out more recently. The number of staffed beds has risen in recent years. New hospital construction underway throughout the Tristate will provide additional needed capacity in the future. An aging baby boom population, longer life spans, increases in the number of individuals with chronic disease and consumer demand are among the factors driving up the use of hospital inpatient services.
- While area hospitals haven't felt the same degree of financial pressures recently that plagued them just a few years ago, most continue to face significant financial challenges. In fact, about half of GCHC acute-care member hospitals reported an operating loss for calendar or fiscal 2007. In addition, the federal government's desire to reign in Medicare and Medicaid costs may portend tougher hospital financial times ahead, and hospitals are seeing dramatic increases in uncompensated care and bad debt. At the same time, hospitals are working hard to cut costs, increase efficiencies and maintain or improve quality of patient care.
- Government reports show the number of uninsured has reached 48 million. Public attention is growing as the insurance crisis explodes into moderate and middle income groups, and this issue has been a focus of this year's Presidential election. Area hospitals participate in a number of initiatives to help get more people covered. The number of hospital emergency department visits has been on the upswing in recent years, and rising numbers of uninsured or underinsured in the community could be a factor in this increase. Greater Cincinnati hospitals provided more than \$239 million to those unable to pay in 2007, a 19% increase over the previous year.
- The hospital/physician landscape continues to change in the Tristate. Hospital leaders have been putting renewed emphasis on their relations with physicians both as a means to improve quality and efficiency and to stave off more aggressive physician competition. In one move, Deaconess Associations, the parent of Deaconess Hospital, is offering an ownership stake in its hospital facility for up to 100 physician partners. At the same time, at least 43% of Greater Cincinnati internists and family practitioners, about 1,000 doctors, now work for hospitals and health systems, a number that has been rising. Another big change is the growing use of "hospitalists" to manage the care of a patient during his or her hospital stay. To address chronic illness issues, many areas of the country, including Greater Cincinnati, are experimenting with the concept of a "medical home" that pays primary care physicians more money to better oversee and coordinate patients' care.

- Potential physician supply in certain areas of practice remains a concern for the future; factors such as the movement of physicians into higher paying specialty areas, a wave of “baby boomer” physicians poised to retire over the next several years, and increasing numbers of physicians leaving practice earlier because of dissatisfaction or low morale, could potentially precipitate such shortages in years to come.
- Pressure is building among frustrated employers to fundamentally restructure the U.S. health care system. Fear exists that more companies will forego offering insurance coverage as a cost-savings measure. Businesses are looking at the use of alternative insurance products, such as health savings accounts, as a means to keep insurance costs affordable. Employees are being hit with higher deductibles and co-pays, and some are finding these cost increases unaffordable. Many Tristate companies are trying to better arm their employees with information on cost and quality of health care. Wellness and disease management programs are other ways in which employers are trying to control costs.
- Health insurers are testing new strategies in the health care marketplace. Some are following the lead of the federal government in banning payments to hospitals for care that results from a serious medical error. The focus of health plans (and employers) on provider performance has been increasing for years. Efforts are also increasing to link payment to performance.
- Not-for-profit hospitals (virtually all of those locally) filing tax returns must now adhere to the requirements of the new Form 990, which was adopted last December. The federal tax form is meant to put pressure on hospitals to be both more financially transparent and at the same time more accountable for the benefits they receive as tax-exempt organizations. In recent years, legislators at all levels have begun to demand that hospitals demonstrate compliance with community benefit standards. In the Tristate, hospitals offer a wide range of community education, health screenings, support groups and similar activities.
- A number of area hospitals have made the move to electronic medical record-keeping. Advocates of electronic health records (EHRs) believe such an approach enhances accuracy, safety, and financial and administrative savings as well as case and records management. HealthBridge, a not-for-profit regional health information organization, continues to draw national attention for its accomplishments as an electronic health exchange. HealthBridge connects hospitals, physicians, labs, public health, nursing homes and billing companies in our region through a shared infrastructure.
- In the Tristate, much legislative attention has been given to getting more individuals, particularly children, insured. Ohio also passed a Health Simplification Act this year to reduce administrative burdens for providers as they deal with health plans and also a bill that requires hospitals to procure direct care nurse input in developing a staffing plan. Kentucky passed new trauma legislation and kept CON in place, and also passed a health care “transparency” bill.
- Area hospitals are in the forefront of many quality improvement initiatives. These include a new website that posts outcomes and process measures for twenty local facilities. Many local hospitals are participating in the Physician Impact Project that will standardize and better communicate messages to physicians on certain quality-related regulatory or accreditation requirements. Investment in health information technology is an important component of quality improvement.
- Hospital and health leaders throughout the Tristate are paying more attention to health disparities. Many will be involved in a new effort of the Health Improvement Collaborative to address equity and language issues and their effects on quality of care. Locally, the Limited English Proficiency Task Force is assisting hospitals with contracts that provide telephone-based and on-site translation services. The

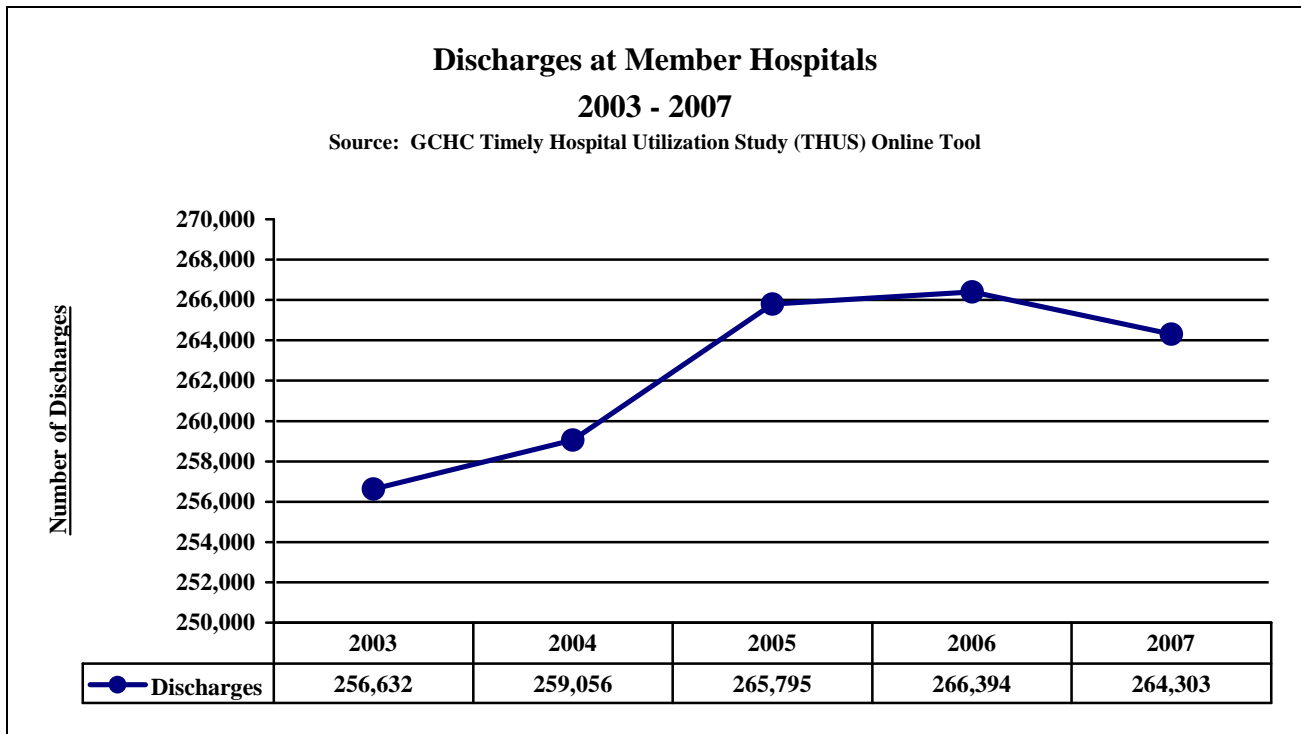
task force is also working to assist hospitals to better serve other special-needs patients, such as deaf or hard-of-hearing individuals and to enhance best practices sharing.

- Nursing homes locally share with hospitals concerns over such critical issues as workforce shortages, medication safety, quality improvement and reimbursement. In particular, the Joint Commission has been urging intensified attention to the accuracy of medications given to patients as they transition from one care setting to another or from one practitioner to another, and area hospitals and long-term care facilities are working together to address such issues. The high cost of nursing home care is forcing state leaders to put additional emphasis on moving individuals into less costly home- or community-based services.
- Hospitals have a critical role in ensuring that the Tristate is prepared for potential emergencies, such as flu epidemics, natural disasters, chemical spills or acts of terrorism. In recent years, the region has directed many resources to the coordination of planning efforts with public health, fire and other response organizations. Such planning has put additional burden on area hospitals, and it remains a top concern of hospital officials locally and nationally.

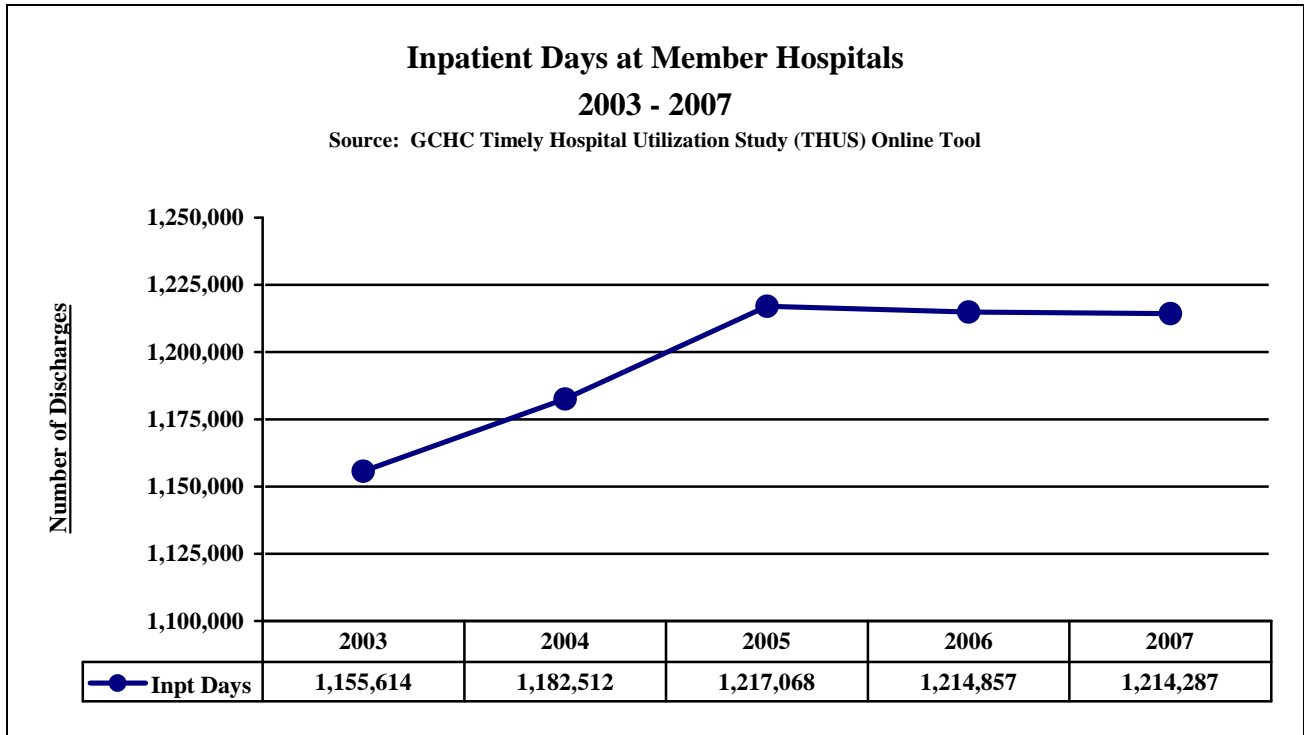
Graph A



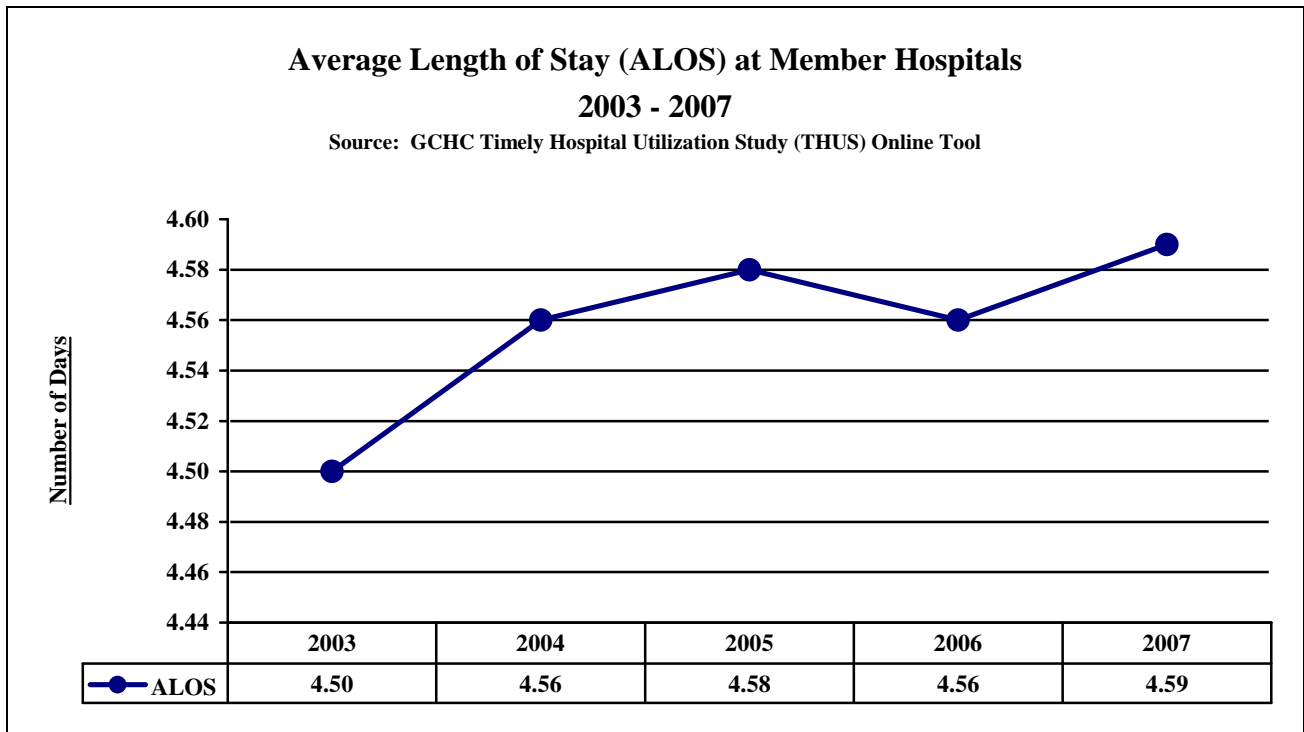
Graph B



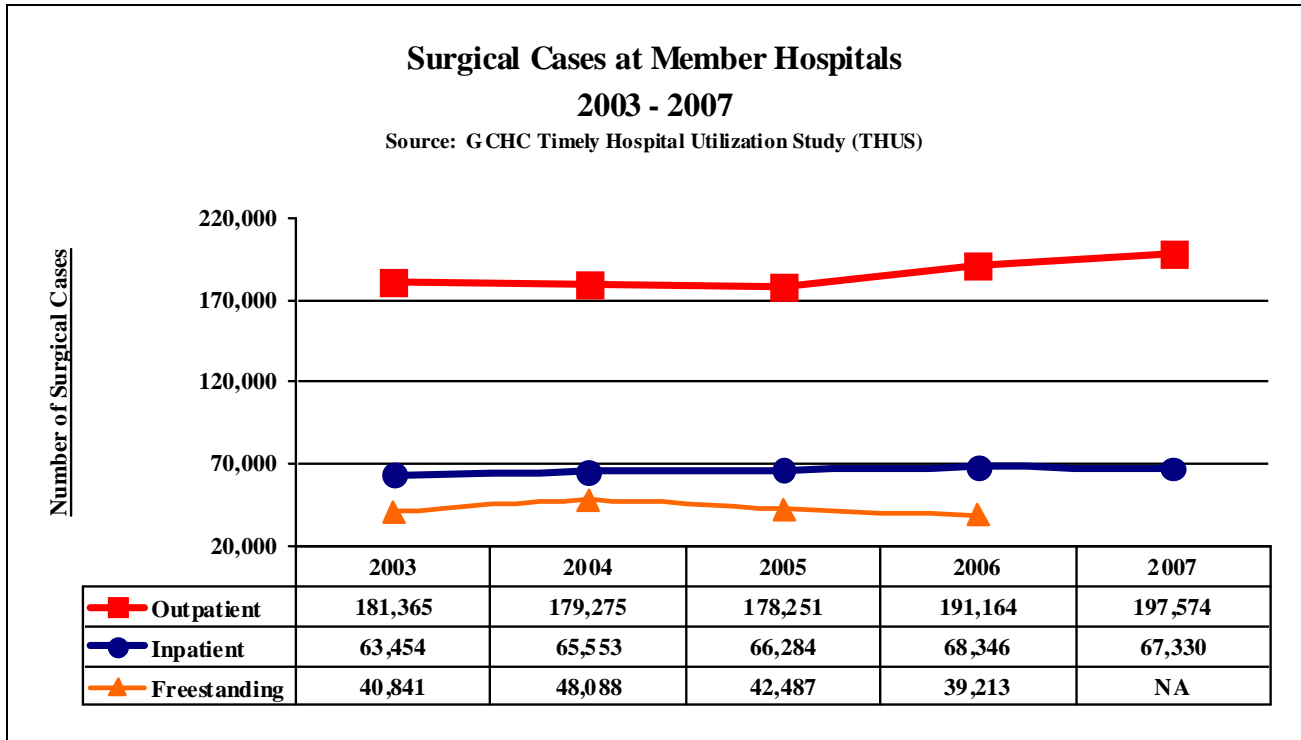
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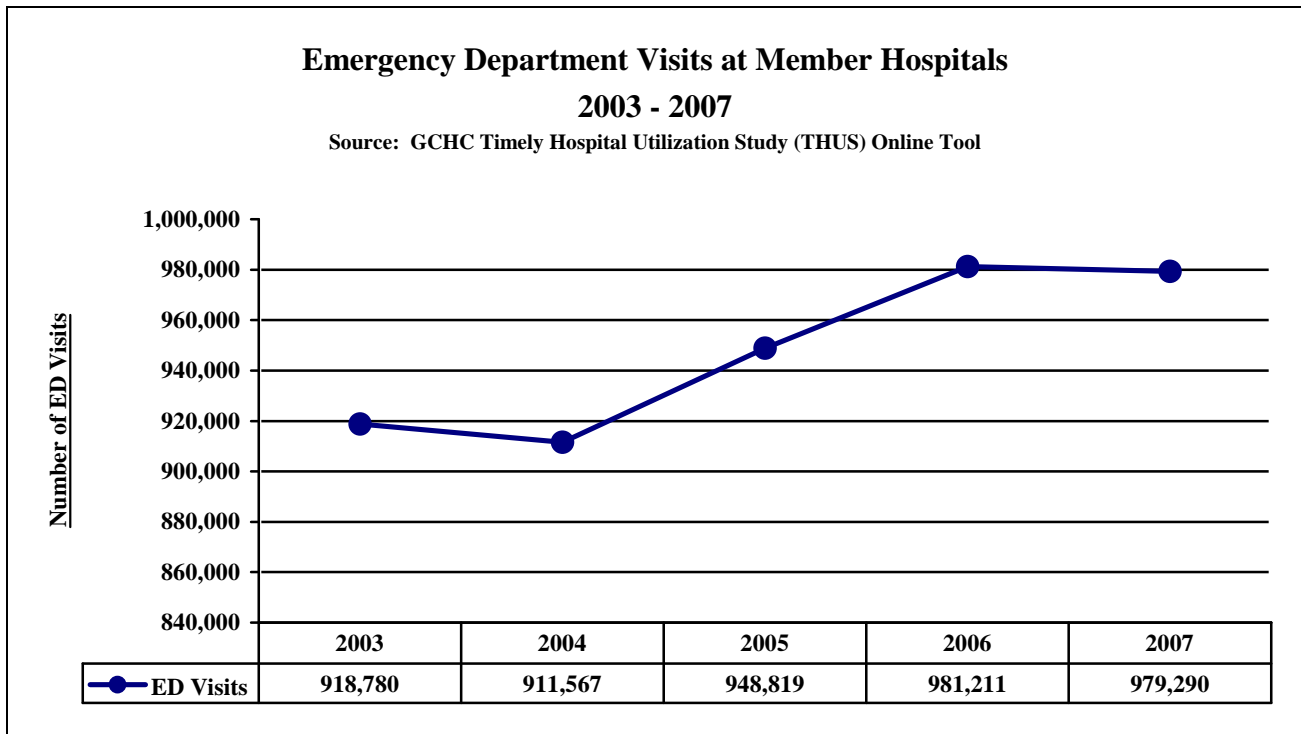
Graph D



Graph E



Graph F



Graph G

