

## Executive Summary

Important changes are occurring in the Greater Cincinnati health care delivery system, and evidence of these shifts abounded over the past twelve months. One highly visible sign of change is the host of major hospital construction projects underway or anticipated in the Tristate, including plans for several new full-service, acute care hospitals. (All but one of these will replace existing facilities.) Perhaps more significant is the location of these projects. While some are occurring in the city core, many others are following the population to counties beyond the I-275 beltway.

Area hospitals, whose average age of plant still lags national benchmarks, are playing catch-up, pumping dollars into infrastructure improvements as the intense financial pressures of recent years have lessened to some extent. Access to capital is an ongoing concern as utilization of services in Greater Cincinnati rises, the population ages, and hospitals face **increasing demands for care** along with high patient expectations for access to new technologies. A burgeoning need for more health care workers to serve these patients has not abated, and in fact is expected to worsen over the next decade, a top worry of local hospital leaders.

But the past year has seen several other **critical issues** come to the forefront. Debates over **quality and patient safety** are intensifying, driven by government reports citing medical errors and the like, and by demands of payors and patients for more readily accessible and understandable information on outcomes of care. Area hospitals are engaged in a number of new patient safety initiatives, some of which are collaborative and voluntary in nature. At the same time, reporting mandates are becoming more frequent, and data that measure (or claim to measure) quality are becoming more accessible.

A big worry nationally (and locally) is the growing number of uninsured, an issue that is precipitating new scrutiny of hospitals' commitment to serving this group. Legislators and policy leaders 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 to serve as a resource in policy development.

Competition from **specialty facilities**, most often owned by physician groups, is another major concern for local hospitals, and signs that some surgery patients are choosing these "niche" facilities for their care are evident in local hospital utilization statistics. Debate continues as to the long-term effect such 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.

At the same time, local hospital leaders are anticipating a tougher financial road ahead as both state and local lawmakers attempt to stem unprecedented (and worrisome) growth in **Medicare and Medicaid** spending, and cuts to hospital reimbursement are contemplated as a means to cost-savings.

Costs for liability insurance remain a concern for both hospitals and physicians, and state lawmakers in Ohio have been piecing together a series of medical malpractice reforms. Retaining and recruiting **adequate numbers of physician specialists** in the area remains a top issue in the Tristate, and some solutions are beginning to be put into place. Hospitals are also working on a number of fronts to address serious shortages of nurses and other health care workers.

Consumers are becoming increasingly alarmed as they are asked to pick up a greater share of health premium increases, driven by employers coping with higher benefit costs. While the annual percent increase in health premiums seems to be moderating slightly, few expect the trend to reverse itself anytime soon. Still, studies have documented that local hospital costs are below those of benchmark cities in the region and across the nation. The new **Medicare** drug benefit is intended to provide seniors some relief with rising pharmaceutical costs, though its effects remain to be seen.

To what extent modification of **lifestyles** can be a factor in reducing health costs is becoming a more frequent topic of discussion as evidence proliferates regarding the detrimental effects of such health issues as obesity and smoking. Tristate hospitals and the Health Improvement Collaborative of Greater Cincinnati are working on many fronts to promote healthier behaviors. Some businesses are also implementing programs to improve the health of their employees.

The issue of **health disparities** is gaining renewed attention, as is the increasing diversity of the patient population. Hospitals are not only addressing this issue for their 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:

- The city of Cincinnati lost five percent of its population between 2000 and July 2004, second only to Detroit. Over the same period, Hamilton County's population decreased by 3.6%, and many of its older municipalities are suffering. (Western Hamilton County is the exception, and new health services are flowing to that region.) At the same time, some of the fastest growing areas in Ohio and Kentucky can be found in the Tristate's suburbs. The population of Warren County OH is up 66% since 1990, for example, and now surpasses that of Clermont County for the first time. Greater Cincinnati's population is not only growing more slowly than the U.S. population as a whole; it is getting older. The Tristate is also becoming more diverse as Hispanics and others move into the area. The number of live births remained steady from 2003 to 2004. These population trends have profound implications for health care planners as they design the care system of the years ahead.
- Southwest Ohio is poised to lead the state in job creation, and many of those jobs will be in health care. Whether there will be enough people to fill these open positions remains to be seen. While the local economy shows some positive signs, the region is predicted to lag behind the rest of the nation in economic growth in 2005. Concern is mounting that jobs are following population, relocating out of the city core and into the suburbs. Hospitals provide an annual economic boost of \$7.5 billion to the region, employ more than 46,000 people and are responsible (directly and indirectly) for 94,000 Tristate jobs.
- Hospitals are seeing more patients, and they are staying longer. The number of discharges is on the rise, as is the number of inpatient days. Still, the number of discharges and inpatient days increased at a somewhat lower rate between 2003 and 2004 than it had over the three to four previous years. The number of emergency room visits declined slightly in 2004, after years of steady increase. The number of hospital-based outpatient surgeries is declining, most likely due to increased competition from freestanding facilities. The number of inpatient beds remains nearly 40% lower than twenty years ago but is beginning to increase again as hospitals add needed capacity to keep up with demand.

- Hospitals have generally recovered from the intense financial pressures of a few years ago, and more local hospitals are reporting positive operating margins. But new cost challenges may be on the horizon. The biggest concerns come from state and federal payors, who are working hard to rein in Medicare and Medicaid costs. Hospital leaders remain concerned about their financial viability over the long-term, especially as the population ages, demands for care increase, technology proliferates, labor costs intensify, infrastructure demands continue, and new costs (such as bioterrorism preparedness and patient privacy) take their toll on hospital bottom lines.
- Three newly built full-service hospital structures will soon serve the Tristate. Two (a replacement facility for Middletown Regional Hospital and a new facility for the Health Alliance) will be in Warren County, an area of intense population growth as well as marketplace competition. Adams County Hospital also has plans for a replacement facility underway, and Summit Behavioral Health is readying the new site that will replace its older facility. Patients also have a new option in the Tristate that competes directly with full-service acute care providers: specialty or limited-service hospitals owned by physicians. Some of these facilities have short-stay overnight beds. Lawmakers at both national and state levels are grappling with whether it is in the public interest to limit future proliferation of physician-owned or “specialty” hospitals; a permanent moratorium on physician self-referral to such facilities is under consideration at the federal level.
- Growing attention to the soaring numbers of uninsured are precipitating new challenges for hospitals, such as increased scrutiny of how uninsured patients get billed and how those bills get collected. (Area hospitals recently worked together to re-examine their billing and collections policies for low-income patients.) The amount of uncompensated care hospitals provide locally reached \$140 million (in cost) in 2004. Fewer individuals are covered by employer-based plans, and some, hit with high premiums or co-pays, choose to go without insurance coverage. As more turn to government programs, state budgets are taking a hit. Prescription drug cost relief is now a reality for Medicare patients, though the actual extent of the relief remains to be seen.
- New physician/hospital arrangements are continuing to be announced regularly, such as TriHealth’s recent news that it was acquiring Group Health Associates. At the same time, physicians are aggressively competing with hospitals, and at least two short-stay hospitals owned by physicians are now operating in the Tristate. Medical malpractice remains a critical issue for area physicians, and legislative proposals to attempt to address this crisis abound. Reforms in Ohio are beginning to have some positive effects on the high rates that many physicians claimed were driving them to stop performing high risk procedures, retire early or move their practices out of the Tristate. A new effort, Cincinnati MD Resource Center, a project of the Health Improvement Collaborative of Greater Cincinnati, is working to keep physicians, particularly those specialties in short supply, in the area, and to recruit needed ones. Access to information on physician practices and outcomes is increasing (at least to an extent), driven by consumer need to become more knowledgeable health care decision-makers and by businesses looking for value.
- Consolidation among insurers continues; the Tristate has seen substantial reduction in the number of plans operating here, as well as a change from local to regional or national ownership. Insurer profitability is soaring -- and getting the attention of industry observers. At the same

time, premiums for businesses (and consumers, through co-pays and shared costs) are rising. Enrollment in HMOs is dropping across the U.S. and locally in favor of less restrictive options. At the same time, interest in consumer-driven health plans is rising.

- Employers are increasingly interested in – and involved in – efforts to measure quality of care as they look for ways to reduce rising health care costs. While premiums are not rising as sharply as in recent years, the trend is still upward. Some efforts, such as Bridges to Excellence, involve rewarding providers for optimal care. Fewer employers overall are offering health insurance coverage to employees; providing such benefits is particularly challenging for smaller businesses. Employee cost-sharing is on the rise; few expect this trend to change anytime soon.
- Hospitals and health care providers are adapting to meet expanding demand for electronic exchange of health care data. Locally, HealthBridge, a not-for-profit community group, is facilitating the electronic exchange of patient information among physicians and hospitals. Patient privacy remains a significant concern (and expense) as hospitals struggle with the costs of further safeguarding the protected health information of their patients.
- Tort reform continues to surface on legislative agendas in Ohio and Kentucky. Some feel that the Ohio medical malpractice law signed into law in 2003 is beginning to have some effect on rates, but most agree challenges remain. At the federal level, a new patient safety bill shields hospitals as they work to improve medical errors and the like, and debate continues on whether physicians should be able to self-refer to facilities they own. (Hospitals claim such specialty facilities drain away paying patients and leave them less able to serve the community, especially the medical indigent.)
- New patient safety and quality improvement efforts in the Tristate abound, such as the Hospital Quality Improvement Project, a group of 17 facilities that are sharing data, best practices, and opportunities for improvement. One patient safety effort locally that focused on reducing infection rates in the ICU has attracted national attention. The government has begun to tie reimbursement to outcomes data reporting, and business interest in quality improvement efforts is on the rise.
- Some analyses project a need for up to one million RN FTEs by 2020. Locally, despite the launch of new nursing programs, shortages remain. Efforts are underway to reduce an accompanying shortage of nursing faculty. Locally, creating a more favorable work environment, improving communication skills for workers, and promoting health careers to schools and in the community are high priorities for collaborative work by area hospitals and schools of nursing. Shortages push up labor costs and contribute to such challenges as hospital “diversions.” Other areas of the country are experiencing similar trends, and concern is growing that problems will worsen as baby boomers age. The area’s Nursing Workforce Initiative and Health Care Workforce Center have a number of efforts underway to help hospitals address these issues for both the short- and the long-term.
- State governments are tackling Medicaid budgets that have been expanding at an unsustainable pace. The number of enrollees is increasing, costs are rising and state budgets are feeling intense pressures. At the federal level, Congress acted in April to cut the Medicaid budget by \$10 billion

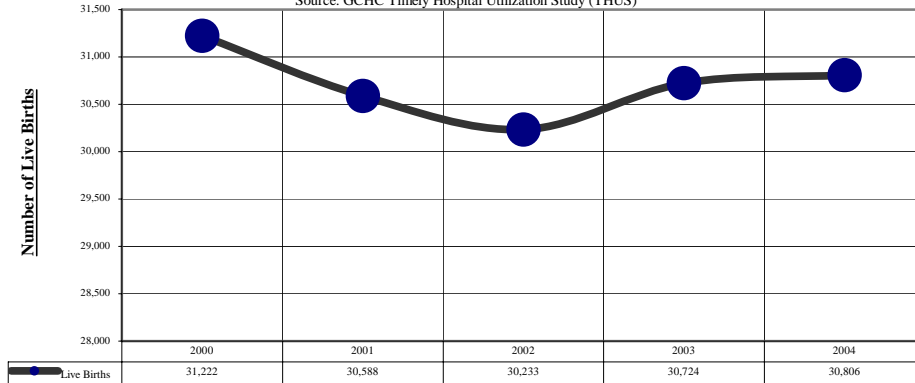
over the next five years. Cuts can mean reduced eligibility, curtailed services and freezes or reductions to provider payments. In Ohio, the Governor is attempting to shift public dollars from costly nursing home care to services provided in the home and community. Programs in recent years to get more children covered have generally achieved some success, but continued funding in this area is uncertain. Managed care options, disease management programs, technology efficiencies and more attention to preventive health are other ways being investigated as potential means to help bring costs under control.

- The government is actively recruiting eligible Medicare recipients to sign up for the new prescription drug plan. At the same time, the solvency of the Medicare program over time continues to be debated, particularly as baby boomers begin to age. Medicare reimbursement rates to hospitals have been more favorable in recent years. New attention is being paid to the quality of care received by Medicare beneficiaries, another attempt to improve care yet also contain costs.
- In recent years, government and community leaders have been paying more attention to the “community benefit” that hospitals provide in return for their tax-exempt status. Local hospitals are active participants in improving community health. Most offer a wide range of community education, health screenings, support groups and similar activities. Hospitals actively participate in the work of the Health Improvement Collaborative of Greater Cincinnati, a broad-based coalition of physicians, hospitals, insurers, business leaders, and community representatives. The Collaborative is a partner in a number of challenging projects underway in the Tristate, including efforts to retain and recruit minority physicians and health professionals, to ensure an adequate supply of physician specialists, to promote active living and healthy eating by encouraging Ohioans to get “On the Move,” and to reduce the incidence of low birth weight.
- The Tristate’s population is becoming more culturally diverse. The influx of Hispanics, Asians and other cultural groups into the area is precipitating a number of programs hospitals are putting into place to make it easier for these patients to make health care decisions. A Limited English Proficiency Task Force (LEP) has led a collaborative hospital effort to improve standards of care for this audience. Hospitals are also working to address the issue of health disparities and to assist in providing business opportunities for minority suppliers.
- As state and federal budgets tighten and policymakers explore cost-savings they may gain from shifting patients out of nursing homes and into home-based and community care, long-term care facilities are expressing growing concern. In Ohio’s state biennial budget, significant changes are underway to attempt to shift public dollars away from institutional care and into home and community-based care. Such moves are controversial. Workforce worries join cost and regulatory woes as top challenges for Tristate long-term care providers. The number of nursing home beds that fall under large group ownership is increasing in the local area, as it is nationally. Efforts are underway at state and national levels to provide consumers more information about long-term care options to aid them in making informed decisions about where to go for care.
- Area hospitals are receiving and using federal grants to enhance their abilities to respond in the event of a mass-casualty incident, whether natural or manmade. Hospitals are working closely with other emergency response organizations on planning, training exercises, early surveillance

systems, alternative care centers and the like. These efforts put an added burden on already constrained hospital resources.

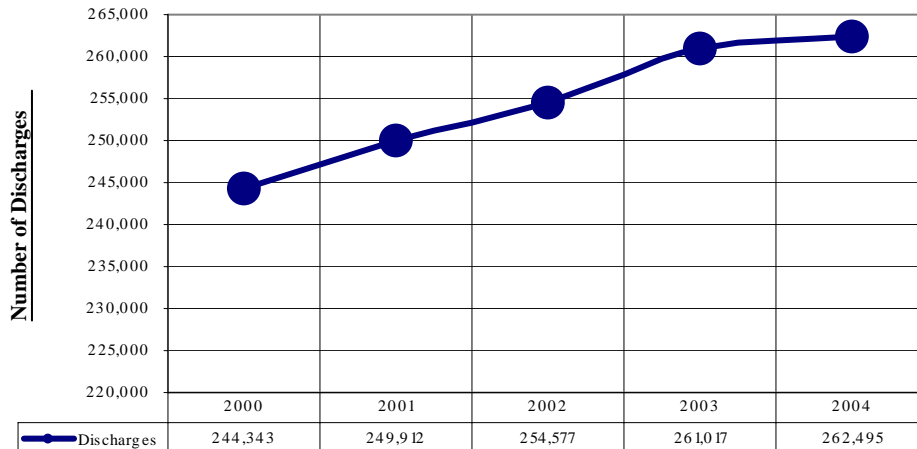
**Live Births at Member Hospitals  
2000-2004**

Source: GCHC Timely Hospital Utilization Study (THUS)



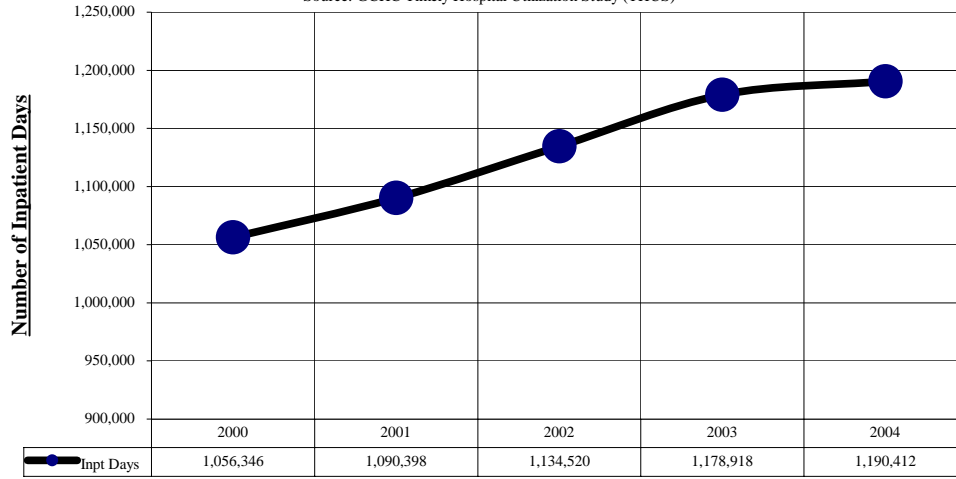
**Discharges at Member Hospitals  
2000-2004**

Source: GCHC Timely Hospital Utilization Study (THUS)



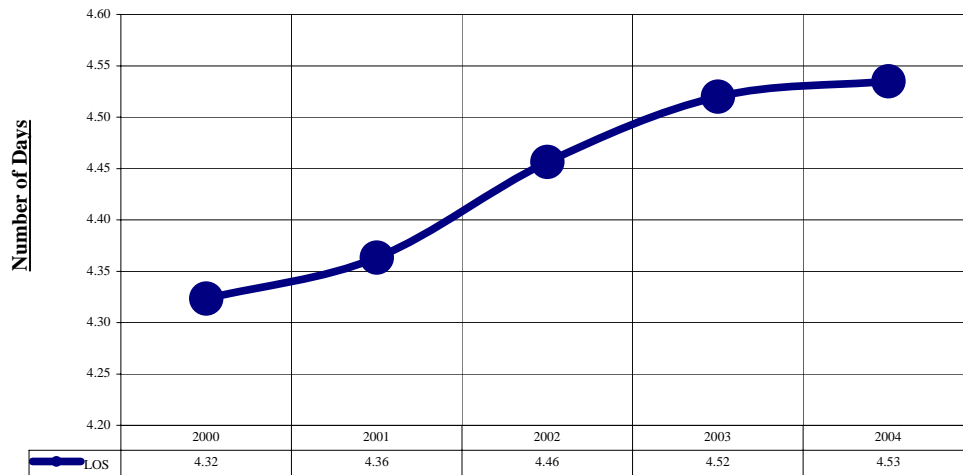
**Inpatient Days at Member Hospitals  
2000 - 2004**

Source: GCHC Timely Hospital Utilization Study (THUS)



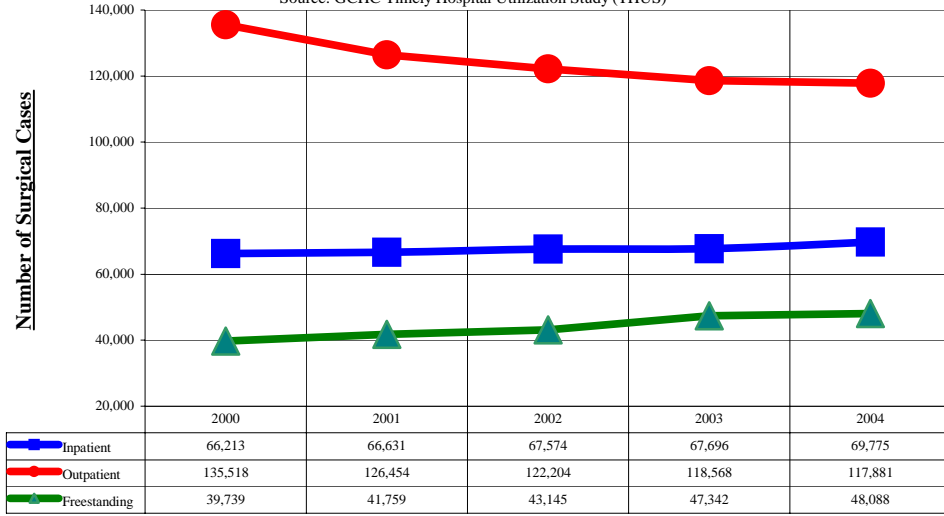
**Average Length of Stay at Member Hospitals  
2000-2004**

Source: GCHC Timely Hospital Utilization Study (THUS)



**Surgical Cases at Member Hospitals  
2000-2004**

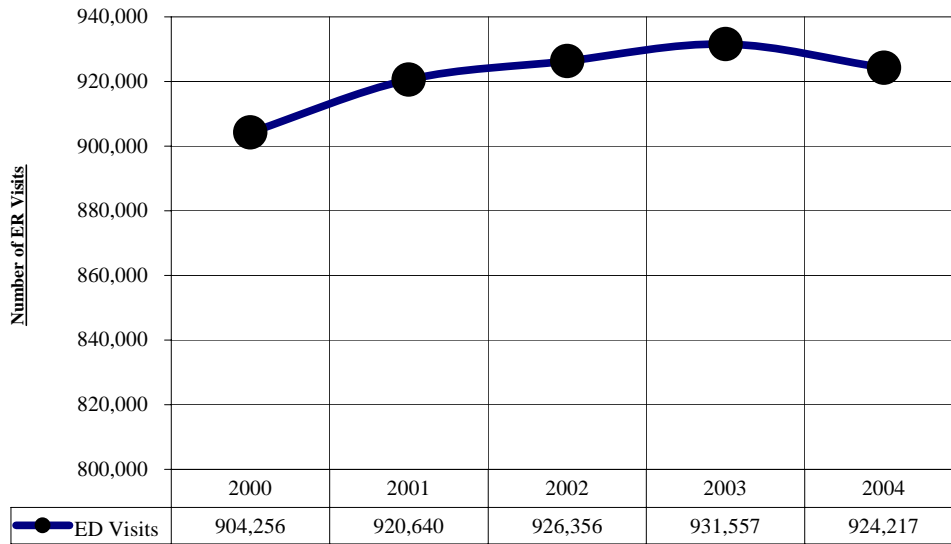
Source: GCHC Timely Hospital Utilization Study (THUS)



**Emergency Department Visits at Member Hospitals  
(Excludes Freestanding ED Facilities)**

2000-2004

Source: GCHC Timely Hospital Utilization Study (THUS)



**Emergency Department Diversions  
Number of Hours on Diversion  
August 2002 – July 2005**

Source: Greater Cincinnati Health Council

