



*In January 2005, a team of researchers visited Cleveland, Ohio, to study that community's health system, how it is changing and the effects of those changes on consumers. The Center for Studying Health System Change (HSC), as part of the Community Tracking Study, interviewed more than 85 leaders in the health care market. Cleveland is one of 12 communities tracked by HSC every two years through site visits. Individual community reports are published for each round of site visits. The first four site visits to Cleveland, in 1996, 1998, 2000, and 2002, provide baseline and trend information against which changes are tracked. The Cleveland market includes Ashtabula, Cuyahoga, Geauga, Lake, Lorain and Medina counties.*

## LEADERSHIP CHANGES REINVIGORATE CLEVELAND'S HEALTH CARE MARKET

While Cleveland continued to struggle from significant job losses and a weak economy, the community's major health systems—the Cleveland Clinic Health System (CCHS) and University Hospitals Health System (UHHS) strengthened their financial positions and maintained dominance in the market. The new CEO of UHHS has played a key role in stabilizing the system's finances. After years of contentious rivalries, new leadership at both institutions has sparked speculation about new market directions, including increased collaboration across Cleveland's health organizations.

Other noteworthy developments include:

- Health plans expanded consumer-oriented product lines and programs but did not aggressively pursue providing patients with cost and quality information about providers.
- New health leadership fostered community-wide collaborations that expanded public health, clinical research and clinical data-sharing efforts.
- Rising numbers of uninsured people and dwindling financial support strained safety net capacity.

### New Leaders Improve Hospital Finances, Spur Collaboration

The two major Cleveland health systems—the Cleveland Clinic Health System and University Hospitals Health System—have remained the dominant players. The two systems account for the majority of the hospital market share and also are among Cleveland's largest employers. Three independent hospitals—MetroHealth System, Parma Community General Hospital and Lake Hospital System—split most of the remaining market share.

Although the hospital market remained stable, significant leadership changes have created uncertainty about where Cleveland's health market is headed. At CCHS, Toby Cosgrove

became CEO, while Tom Zenty, formerly of Cedars-Sinai in Los Angeles, became the CEO at UHHS. New CEOs also were named at MetroHealth System, the area's largest safety net hospital, and Parma Community General Hospital. Market observers viewed the leadership changes positively but were uncertain of the eventual effects. Some were optimistic that new leadership would bring fresh perspectives and a clean slate given prior conflicts and rivalries.

New leadership at UHHS already has led to financial stabilization after 10 years of operating losses, including \$76 million in 2002 and 2003. Zenty has initially focused on internal reorganization, cost control and shedding unprofitable business lines nonessential



## Cleveland Demographics

*Cleveland Metropolitan Areas  
200,000+ Population*

### Population<sup>1</sup>

2,242,632

### Persons Age 65 or Older<sup>2</sup>

13.6% 10.1%

### Median Family Income<sup>2</sup>

\$31,796 \$31,301

### Unemployment Rate<sup>3</sup>

6.7% 6.0%

### Persons Living in Poverty<sup>2</sup>

10% 13%

### Persons Without Health Insurance<sup>2</sup>

8% 14%

#### Sources:

<sup>1</sup> U.S. Census Bureau, *County Population Estimates, 2003*

<sup>2</sup> HSC Community Tracking Study Household Survey, 2003

<sup>3</sup> Bureau of Labor Statistics, *average annual unemployment rate, 2003*

to core operations instead of generating top-line revenue growth. Zenty has acted decisively to cut expenses, including eliminating 320 staff positions over the last 18 months, closing St. Michaels Hospital, selling a psychiatric hospital to Lake Hospital System, and shedding ownership of some medical facilities and health clubs. As a result, Moody's Investors Service revised University Hospitals' financial outlook from negative to stable, citing significant progress in improving operating performance, developing a long-range strategic plan and instilling greater accountability.

UHHS' regained financial health may allay fears voiced two years ago that the system might weaken and dissolve, leaving Cleveland with a single major health system. However, the two systems may now renew efforts to expand facilities and amenities to attract patients that could lead to duplication of services and excess capacity. Some local stakeholders suggested that although CCHS has sewn up cardiac care in the local market, orthopedic services may become the new battleground as hospitals invest in this service line to attract physicians. However, in the short term, UHHS plans to continue focusing on internal strengthening, especially catching up on information technology investments and further raising the visibility of premier programs in pediatric health and cancer care.

Health care's dominance in the Cleveland economy has generated substantial civic interest in collaborations among the major health organizations. Furthermore, leadership changes at University Hospitals Health System, the Cleveland Clinic and Case Western Reserve University have helped erase previous ill will and created opportunities for a fresh start.

In December 2002, UHHS and Case Western signed a 50-year partnership to combine research efforts. Previously,

University Hospitals' 100-year-old partnership with the university was jeopardized when Case Western and the Cleveland Clinic discussed the potential for a similar partnership beginning in 1998. UHHS and Case Western attempted to renegotiate their long-term partnership, but they abandoned the effort in early 2002. Instead, a three-year partnership was agreed on, until issues regarding leadership and the allocation of research funding could be resolved.

The new 50-year partnership established a joint research enterprise called the Case Research Institute (CRI), which brings together the strategic planning, operational aspects and financial support for all research initiatives of the clinical departments of UHHS University Hospitals of Cleveland and the Case Western medical school. The dean of the Case Western medical school serves as the CRI director, while the institute's board has equal representation from UHHS University Hospitals of Cleveland and Case Western, along with two outside directors.

UHHS, CCHS, MetroHealth, the Veterans Administration and Case Western also have increased collaboration in biomedical research, including a \$50 million stem cell and colon cancer research effort and integrating cancer research efforts at CCHS and UHHS. In addition, the Case Western medical school, CCHS and UHHS are working to develop joint recruitment and joint appointments of selected research positions.

## Hospitals Expand to Ease Capacity Constraints

Many hospitals in the Cleveland market are expanding or restructuring capacity, including CCHS, Parma Community General Hospital and MetroHealth System. Two years ago, Cleveland hospital emergency depart-

ments struggled with crowding after two hospitals closed in 1999. The closing of two more hospitals in 2003, St. Michaels and Deaconess, further strained capacity. New capacity is expected to ease emergency department congestion and meet future demand, while some expansions are designed to meet patient demand for modern facilities and privacy.

Much of the expanded capacity focuses on profitable service lines, including cardiac and cancer care. CCHS is adding a new 300-bed cardiac care tower to free space in the main hospital facility for surgery, intensive care units, cancer, neurosciences and the emergency department. CCHS also plans to build a new facility to expand genetic and stem cell research on its campus. Expansions at other CCHS hospitals include a new 103-bed tower at Hillcrest Hospital and a women's health center at Fairview Hospital. The Hillcrest addition expands the emergency room and cancer center and will reportedly reduce ambulance diversions.

MetroHealth System also has opened new primary health care centers and expanded its emergency department, which reportedly is not yet operating at full capacity. In addition, it has focused on renovating facilities to attract more commercially insured patients. Before 2003, Parma Community General Hospital focused on cancer care and cardiac surgery. Since 2003, the hospital's expansion efforts have focused on the emergency department, medical-surgical intensive care beds and cardiac care intensive care unit beds. UHHS has not pursued expansions given its focus on restructuring internal operations to achieve financial stability.

Despite the considerable expansion in specialty care, market observers were not overly concerned about the potential for rising health care costs. New specialty facilities were viewed as

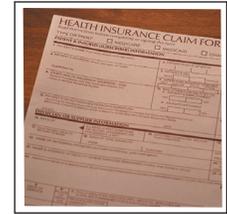
a way to centralize specialty care and free up beds for other services. Also, maintaining state-of-the-art facilities meets expectations of a community with a nationally recognized health system.

### Limited Health Plan Efforts to Lower Costs and Improve Quality

The Cleveland economy continued to lose jobs, especially in manufacturing, as companies relocated because of corporate mergers. As of November 2004, Ohio's unemployment rate was 6.5 percent.

Although not facing the same cost pressures as two years ago, employers continued to pass higher health care costs to workers. Common benefit changes include raising patient cost sharing through higher deductibles, copayments and coinsurance and increasing the share of premiums paid by workers. Market observers were especially concerned about rising health care costs for early retirees who don't become eligible for Medicare until age 65. Employers providing retiree health coverage set limits on their contributions many years ago, and retirees have begun to exceed these limits. As health insurance premiums rise, retirees exceeding these limits bear the full cost of premium increases.

The major health plans in the Cleveland market—Medical Mutual of Ohio, Anthem Blue Cross Blue Shield and UnitedHealthcare—developed new products and programs, largely in response to employer demand and recent federal legislation. In particular, the health plans have introduced high-deductible insurance products coupled with either health reimbursement arrangements (HRAs) or health savings accounts (HSAs). These consumer-directed products are designed to raise patients' cost awareness through higher deductibles and spending accounts. Given their weak



### Health System Characteristics

Cleveland	Metropolitan Areas 200,000+ Population
<b>Staffed Hospital Beds per 1,000 Population<sup>1</sup></b>	
3.2	3.1
<b>Physicians per 1,000 Population<sup>2</sup></b>	
2.2	1.9
<b>HMO Penetration (including Medicare/Medicaid)<sup>3</sup></b>	
22%	29%
<b>Medicare-Adjusted Average per Capita Cost (AAPCC) Rate, 2005<sup>4</sup></b>	
\$699	\$718

Sources:

<sup>1</sup> American Hospital Association, 2002

<sup>2</sup> Area Resource File, 2003 (includes non-federal, patient care physicians, except radiologists, pathologists, anesthesiologists and residents)

<sup>3</sup> Interstudy Competitive Edge, markets with population greater than 250,000

<sup>4</sup> Centers for Medicare and Medicaid Services. Site-level payment rates refer to Medicare Advantage AAPCC Payment Rates by County (Part A + Part B Aged Rates). National figure is actual payment per capita, based on payments for Medicare Coordinated Care Plans and the number of Coordinated Care Plan enrollees in April 2005.



## Health Care Utilization

Cleveland                      Metropolitan Areas  
200,000+ Population

### Adjusted Inpatient Admissions per 1,000 Population<sup>1</sup>

259                                      197

### Persons with Any Emergency Room Visit in Past Year<sup>2</sup>

19%                                      18%

### Persons with Any Doctor Visit in Past Year<sup>2</sup>

84%                                      78%

### Persons Who Did Not Get Needed Medical Care During the Last 12 Months<sup>2</sup>

5.1%                                      5.7%

### Privately Insured People in Families with Annual Out-of-Pocket Costs of \$500 or More<sup>2</sup>

44%                                      44%

Sources:

<sup>1</sup> American Hospital Association, 2002

<sup>2</sup> HSC Community Tracking Study Household Survey, 2003

leverage with the major health systems, the health plans provide only limited consumer information on cost and quality to support these new product lines. UnitedHealthcare, for example, is focusing instead on physician education and the development of swipe card technology to permit electronic verification and deductions from the patient's spending account by physician offices.

Employers and health plans largely disbanded quality-reporting initiatives after CCHS dropped out of the Cleveland Quality Choice Program in the late 1990s. As a result, most of the current quality initiatives in Cleveland are sponsored by the local health systems or national and governmental entities. For example, although it refused to participate in the Cleveland Quality Choice Program, CCHS quality efforts include its own internal quality initiative, the Cleveland Clinic Quality Institute. CCHS, along with other area hospitals, also participates in the Centers for Medicare and Medicaid Services hospital quality initiative and the Joint Commission on the Accreditation of Healthcare Organization quality reports.

The Cleveland Clinic also has developed the Cleveland Health Network (CHN), a network of northeastern Ohio health providers that includes about 20 hospitals and physician-hospital organizations. CHN contracts with employers and insurers to deliver and manage care on either a shared- or no-risk basis. One of CHN's primary contracts is with Anthem Blue Cross and Blue Shield for a Medicare Advantage plan covering a four-county region. Over time, however, CHN has become increasingly involved in the analysis and benchmarking of health care quality data.

Participation in quality reporting programs reportedly has allowed hospitals to engage physicians in quality improvement activities. For example,

CCHS ties physicians' annual reviews to quality reports. At UHHS, quality indicators are used to identify problems and then a task force is created to resolve the issue. In contrast, market observers were generally pessimistic about the health plans' ability to implement pay-for-performance programs in the Cleveland market. Anthem began a small pilot program with CCHS in 2002 and sets payment-rate increases based on a range of performance indicators. However, payments are made through the participating hospitals rather than to individual physicians, and physician awareness of the pilot program was limited.

## Physician Malpractice Insurance Concerns Continue

The rising cost of malpractice liability insurance in Cleveland has led to intensified political lobbying and the unwillingness of some physicians to provide on-call emergency department coverage. A recent law expanded civil immunity protection to volunteer physicians caring for low-income patients because many physicians believe these patients are more likely to sue—although there is no evidence of this.

Obstetrics and neurosurgery remain the hardest hit specialties. Parma Community General Hospital no longer has neurosurgery coverage, for example. One health plan has raised payment rates for obstetrician/gynecologists to partially offset their rising malpractice insurance costs.

Physicians continue to seek employee status, particularly at the Cleveland Clinic and at UHHS, to gain malpractice coverage through the health systems. Hospitals also are relaxing standards for malpractice insurance coverage and providing admitting privileges to physicians with coverage from lesser-rated insurance companies. Moreover, CCHS and UHHS have each established self-insured malpractice

### Moving to Electronic Medical Records

Despite fears that consolidation can impede market innovation, Cleveland's highly consolidated hospital market has facilitated the adoption of electronic medical records (EMRs) in part because many physicians admit patients to only one hospital system and thus only need to use one system's information system.

The Cleveland Clinic has invested heavily to develop a full service electronic medical record system with pathology, radiology, procedures and patient notes for all outpatient care and expects to include inpatient care by year's end. The EMR allows physician-to-physician communication and is available to physicians who work for CCHS Regional Medical Practices. Patients also have access to an Internet portal that provides information about when tests are needed and when preventive care, such as flu vaccinations, is due.

UHHS implemented a portal where system physicians with Internet access can securely retrieve patient information, including radiology images, reports and transcribed notes. UHHS is in the process of selecting an EMR application to provide a single unified medical record and allow appropriate access for all clinicians and patients. However, not all of the information and systems have been standardized or integrated. Parma Community General Hospital also has an EMR system that allows physicians to obtain diagnostic results electronically at the hospital, their office or home. MetroHealth System has had a fully integrated EMR system since 2001.

In addition, a community-wide collaboration is developing data-sharing capabilities among the major health systems' emergency departments and the federally qualified health centers. The United Way is leading a new initiative to develop a shared electronic medical record between the federally qualified health centers and the emergency departments of the two major health systems and MetroHealth. This initiative is expected to improve access, avoid duplication of services, expedite care, eliminate waste and reduce disparities in care.

arrangements to provide coverage to physicians employed in the health systems. One health plan stopped physicians under contract from billing additional amounts to patients to cover malpractice insurance costs. However, some physicians reportedly are seeking donations from patients to defray malpractice insurance costs.

In an effort to reduce the number of malpractice cases going to court, Ohio passed tort reform legislation limiting noneconomic and punitive damages and increasing the qualifications for expert witnesses in malpractice trials.

In addition, legislation passed creating a state-administered Medical Liability Underwriting Association to serve as back-up coverage for physicians unable to find medical liability coverage. In the past, the Ohio Supreme Court has overturned tort reforms, including caps on damages. However, after a successful campaign by the Ohio Medical Society, four new Supreme Court judges who favor tort reform were elected. Market observers expect this new court to uphold the recently passed legislation.

Although the legislation targets the




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number and size of malpractice claims, observers did not agree on the root causes of escalating liability premiums. Over the last five years, three major malpractice insurers have gone out of business or left the market. While some observers attributed rising costs to consolidation of insurers, others attributed the large premium increases to insurers' need to make up for prior large losses and poor investments.

### **Public Health Organizations Form New Partnerships**

Despite steadily declining state funding, public health has gained a new emphasis in the Cleveland market through collaborations between the Cuyahoga County Board of Health and the Cleveland Department of Public Health. The collaborative environment is reportedly facilitated by a city administration supportive of public health and interested in strengthening the relationship between the city and county health departments. In addition, the city health department director and the county health commissioner reportedly have built a strong working relationship.

The recently forged rapport has allowed the health departments to partner on a number of funding opportunities and has expanded public health activity overall in the Cleveland market. Examples of recent collaborations between the two health departments include: a Steps to a Healthier U.S. grant, four jointly funded local and federal lead poisoning prevention grants, a joint West Nile Virus survey, a joint cardiovascular health grant, and jointly sponsored seminars on obesity, lead poisoning and other health topics.

In addition, the Case Western medical school is developing the Institute for Population and Patient Health Sciences, a collaboration designed to strengthen the intersection between clinical medicine and public health.

The collaboration will draw on clinical research expertise at CCHS and UHHS. In another sign of the growing collaborative atmosphere, the Cleveland Department of Health is relocating to new facilities at the Case Western Reserve University campus adjacent to the medical school.

### **Budget Woes Pressure Medicaid and the Safety Net**

The state of Ohio faces a \$5 billion deficit stemming primarily from an anticipated \$2 billion increase in Medicaid costs and the loss of \$2.5 billion in revenue if a one-cent sales tax increase isn't extended. The one-cent sales tax increase went into effect in July 2003 and is set to expire in July 2005. Having escaped deep cuts during the last two-year budget cycle, Medicaid now consumes almost 18 percent of Ohio's \$50 billion annual budget, and observers expect significant cuts in Medicaid eligibility as the state balances its budget.

Many expect the governor's proposed budget will include restricting general Medicaid eligibility, eliminating or reducing optional services, lowering reimbursement rates and controlling nursing home costs. Instead of recommendations to restrict eligibility or reduce services, however, the Ohio Commission to Reform Medicaid recently proposed changes designed to hold Medicaid growth to 4 percent annually. The commission's recommendations included changing how the state pays nursing homes, providing financial incentives for less-expensive alternatives to nursing homes—such as assisted living or home-care programs—adding prescription drug copayments, consolidating all state drug purchasing, and imposing a one-time short-term provider rate reduction or freeze.

At the same time, tight state and local budgets are putting pressures on safety net providers. In recent years,

Cleveland safety net providers' finances had become more stable because of Medicaid and State Children's Health Insurance Program expansions that increased eligibility levels for children and parents. However, safety net providers now face increasing demand for care by uninsured people because of the ailing local economy. Among community health centers, for example, Care Alliance experienced an almost 100 percent increase in patient visits in the past two years and Neighborhood Family Practice reported a 65 percent increase in the number of uninsured people treated during the same period.

Nonetheless, community health centers have managed to expand capacity. Care Alliance opened a women's clinic one afternoon per week, and Neighborhood Family Practice opened a second site in February 2005.

Recently, both have relied much more on local philanthropic foundations for funding than in the past because of rising numbers of uninsured and freezes and cuts in state Medicaid funding, including Ohio's disability medical assistance program.

Moreover, in 2003, two hospitals closed—St. Michael's Hospital and Deaconess Hospital. For the most part, patients shifted to MetroHealth System, the major safety net hospital, and to a lesser extent, St. Vincent's Charity Hospital and Huron Hospital. MetroHealth System has continued to expand outpatient clinics, opening Broadway Health Center in July 2004 and Buckeye Health Center in March 2005. The Broadway Center was opened in part to fill gaps left by the closing of St. Michael's Hospital.

MetroHealth had requested a \$15 million increase to raise its annual county subsidy to \$42 million in 2005. Initially, the county was willing to provide \$27.8 million but recently agreed to provide \$35 million for 2005, which will reportedly cause the county to dip into reserves. To cut costs, the county

commission voted to develop a health plan for 8,500 county employees with MetroHealth as the primary provider. The shift to MetroHealth is expected to produce savings for the county that will be passed on to MetroHealth.

### Issues to Track

After significant changes in leadership at the major health systems, Case Western Reserve University and in local government, the Cleveland market may move in new directions. Any changes, however, will occur as Cleveland continues to grapple with a lagging labor market, state and local budget woes, rising numbers of uninsured, and physicians' distress with rising malpractice insurance premiums.

The following issues are important to track:

- How will competition among the major health systems and the system-wide collaborations progress under the area's new health leadership?
- Will consumer-oriented health products stall without health plans' provision of relevant cost and quality information to patients?
- How will the medical malpractice environment in Cleveland evolve? What effect will recently passed tort reform legislation have on malpractice liability insurance premiums?
- Will state and local budget woes lead to Medicaid and safety net cuts that reduce access to care?




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**Cleveland is one of 12 metropolitan communities tracked through site visits by the Center for Studying Health System Change.**



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