



Illinois Hospital Association

## **A HEALTHY FUTURE FOR ILLINOIS**

THE ILLINOIS HOSPITAL ASSOCIATION'S GUIDING PRINCIPLES  
FOR HEALTH CARE DELIVERY IN ILLINOIS, 2005 – 2010

**Approved by the IHA Board of Trustees, November 17, 2004**

# INTRODUCTION

With the health care infrastructure in Illinois continuing to face major challenges, the health status of our population is increasingly threatened. The Illinois Hospital Association (IHA), which represents those institutions that are the foundation of our state's health care system, believes in an optimally healthy delivery system through which every Illinois citizen receives access to high-quality, medically necessary health care.

In *A Healthy Future for Illinois*, IHA renews its vision for the future of the health care delivery system of the 21<sup>st</sup> Century in Illinois, providing principles to guide health care stakeholders faced with the challenges of continual change.

The report was developed by a task force of hospital leaders from throughout Illinois who believe that it is all our responsibility to help improve the system of the future, as opposed to simply react to it. To do so, we carefully considered current and emerging issues in health care. For example, profound demographic shifts over the next 25 years will result in significant increases in demand for inpatient acute-care services. These shifts include an aging baby boomer generation, increasing life expectancy, and rising fertility rates. It is expected that these changes will increase the volume of inpatient hospitalizations and significantly alter the mix of services required by patients.

It is also likely that 70 to 80% of all medical dollars will go to the treatment of chronic diseases. By 2020, the health care delivery system may not be able to accommodate the volume, much less payment cutbacks, the rising number of uninsured, government mandates, disaster readiness, technology and workforce requirements. To address these issues, the principles embodied in this report give renewed commitment to meeting the needs and expectations of tomorrow. We will use these principles to move IHA's affirmative agenda on policy issues from the present to a future vision. We will also use them as a measure for other health care reform proposals from different organizations.

This report:

- Summarizes IHA's core guiding principles for the health care delivery system;
- Assesses the State's current public policy environment;
- Outlines IHA's ideal vision for seven specific issue areas of the future;
- Forecasts trends for each of the issues for the period 2005-2010; and
- Sets forth guiding principles that respond to ideal vision and forecasts.

## CORE PRINCIPLES

IHA believes that an optimal health care delivery system has at its core three basic principles:

- Protecting and expanding access to health care/health coverage;
- Improving quality;
- Efficient stewardship of resources

Collaboratively, the core principles are to protect and expand access to health care/coverage and improve quality through the efficient stewardship of resources. Efficient stewardship of resources includes reducing unnecessary and avoidable consumption of healthcare resources that are a drain on the delivery system and implementing improved efficiencies. This includes managing chronic care and disease, lifestyle choices, over and under utilization of health care, reducing defensive medicine costs. To achieve these core principles, it is necessary to examine both Illinois' current public policy environment and emerging trends that will determine the actions we take to meet the challenges that lie ahead.

## PUBLIC POLICY ENVIRONMENT

The most substantial turnover in the state legislature in a quarter-century put Democrats in control of the Governor's office and both chambers of the General Assembly in 2002. Despite control by the Democratic Party, significant tension and tenuous alliances exist between the Governor, Speaker of the House and President of the Senate. These relationships, along with strategic partnerships with the minority leaders of the House and Senate, will continue to converge to shape the political and public policy environment.

With Democratic control of the chambers and the executive branch, it is reasonable for the hospital community to anticipate legislation further regulating health care. Government may be more inclined to cover additional services with the expectation that hospitals increase benefits and charity care. However, what is less clear is how to pay for those increased services.

Certain constituencies will continue to engage community and consumer organizations as they press their agenda, as evidenced by legislation such as the Hospital Report Card Act and attempted overhauls of charity care policies and Health Facilities Planning Board responsibilities. Labor unions continue to push for highly regulatory and burdensome legislation on hospitals, presenting themselves as "pro-consumer" in an attempt to out-do their counterparts as they seek to build their memberships. The hospital community recognizes the need to address patient safety and medical error reporting in a non-punitive environment. However, the atmosphere created by the influence of labor unions, the controversy generated by the medical liability crisis, and continued investigations into medical errors could turn the discussion away from sound public policy and a vehicle to improve health care delivery into an attack on hospitals and the health care system.

Although the legislature annually supports the expansion of state funding for scholarships for nursing and other health professionals, these efforts alone will not satisfy current and projected health care workforce needs. Even though IHA has participated successfully in regional workforce summits, more broad-based resources and initiatives are needed to draw more youth to the health care profession.

Hospitals and emergency rooms are being put in the position of filling the health care void by serving as the first and last resort for vulnerable populations, including the uninsured, the elderly and the mentally ill. The drain and overload placed on the system by this patchwork approach could weaken the health care delivery fabric. At the same time hospitals are struggling to upgrade technology and provide an attractive work environment to attract quality health care professionals. Meanwhile, they are challenged by such trends as the rising numbers of the uninsured, the slow/low payment by government and private payers, the need to update their

facilities, growing pressures to increase charity care, and ever-increasing medical liability premiums. The trial bar in Illinois significantly hampered the many efforts that were made to arrive at a solution to the medical liability crisis. An optimum package could delay the flight of many physicians from Illinois.

With the passage of the Health Care Justice Act, a task force has been formed to create a health care access plan and issue a report by March 2006. The plan may address ways to better provide preventive, acute and long-term health care needs.

Going forward, there are a number of variables that can affect future trends. Those variables include the balance of power in the state legislature, as well as continued protection of funding for the Medicaid program. Specifically, the consolidation of power with the Democratic Party brings with it a tendency to support social programs. However, if the chasm between the leaders continues, and a funding solution-be it a significant turn-around in the economy or increases in sales or income tax-does not occur, funding for Medicaid, KidCare, FamilyCare, along with programs for the elderly and mentally ill may be in jeopardy.

## IDEAL VISION

The following represents IHA's "ideal vision" on those issues that are key in developing the future health care delivery system:

- **PATIENT AND COMMUNITY NEEDS:** Patient focus, with balance between a community's expectations of the hospital as a provider of services to a diverse and complex community, and a financially viable business enterprise.
- **ACCESS AND COVERAGE:** Guaranteed access to and coverage for health care benefits, without eroding coverage for those currently insured.
- **CAPITAL:** Access to capital to build a strong health care delivery infrastructure, emphasizing technological changes.
- **INFORMATION TECHNOLOGY:** Advanced information technology rapidly implemented throughout hospitals in support of improved patient care processes, outcomes, and satisfaction.
- **QUALITY:** Provision of the highest quality care for every patient every time, which includes systemic approaches to facilitate a safety culture in order to prevent and reduce avoidable patient injury.
- **MEDICAL LIABILITY:** Access to care and fair compensation for patients injured as a result of medical negligence.
- **WORKFORCE:** Adequate supply of well prepared workers who are not unnecessarily limited in their scopes of practice by regulatory constraints. Careers in health care considered careers of choice.

# THE FORECAST

The trends summarized below are predictions of what is likely to happen in the next five years, not recommendations for what should happen. Their sequencing does not imply prioritization.

## PATIENT AND COMMUNITY NEEDS

**IDEAL VISION: Patient focus, with balance between a community's expectations of the hospital as a provider of services to a diverse and complex community, and a financially viable business enterprise.**

### FORECAST:

- **Patients.** Over the next five years the patient base will continue to diversify. Meaning, the patient of the 21st century will defy categorization into one homogeneous group. Some patients are sophisticated consumers of health care, who consult the World Internet Wide Web for information about their own care or that of other family members, and may consider alternative therapies. Because employer-based coverage may mean frequent changes in providers, these patients are less connected and loyal to a single provider. Other patients, often Medicare beneficiaries or those from other countries that provide health care through the government, are more comfortable with the traditional model of receiving care. Such patients do not challenge their physician's decisions, and prefer not to change providers. Other patients are poor, or disenfranchised, speaking languages other than English. Some are disabled and in need of specialized care and services and some are uninsured or Medicaid recipients. The bottom line is that disparity among patient groups will increase.
- **Communities.** Communities will also continue to diversify in terms of patients and families served, for which an increasingly diverse delivery system must provide. Rural communities will become older and poorer, while suburban communities will become increasingly mobile. Rural hospitals will continue their key function of providing access to essential health care. Hospitals in urban areas will perpetuate their roles as research centers and educators of future providers. Both rural and urban hospitals will continue their status as anchors of economic stability for their communities.
- **Demographics.** Demographic shifts over the next 10 to 25 years will result in significant increases in demand for inpatient acute-care services. These shifts include an aging baby boomer generation, a rise in the country's population, and increasing life expectancy. It is expected that these demographic changes will add to the volume of inpatient hospitalizations and significantly alter the mix of services required by patients. Hospitals must be prepared to respond to these changes and epidemiologic trends. Both inpatient and outpatient hospital capacity planning will be important over the next 10 years.
- **Public Mission.** Based on their inception as almshouses for the poor, hospitals are viewed as being responsible for providing care to all, regardless of ability to pay, as well as education and prevention activities for the benefit of the community, and more recently activities related to bioterrorism preparedness. This expectation that the hospital provide public good services is the basis for the tax-exempt status of not-for-profit hospitals, which has already

and will likely continue to be challenged by those who criticize hospitals' use of a business model that includes comprehensive billing and collection policies.

- **Uncompensated Care.** Illinois hospitals provide hundreds of millions in uncompensated care. Hospitals will continue to struggle with maintaining the proper balance between their role as providers of safety net services and their need to run successful business organizations. Hospital policies for free or discounted care to the uninsured, and their billing and collection practices, will come under increasing scrutiny by government authorities, members of the media and the general public.
- **Community Benefits.** Individual communities will expect their hospitals to provide free or discounted services, while at the same time maintaining the financial ability to offer benefits ranging from trauma care to immunization programs to all members of the community. Hospitals will face increasing pressures to improve the way they relate to their communities, to consult with various community groups in assessing needed services, and to receive their feedback on the hospital's performance. In 2005, hospitals began reporting their community benefits to the State.
- **Diversity.** Board governance will diversify to adequately reflect the community's ethnic composition, and hospitals will be required to provide language assistance services to an increasingly diverse population.
- **Limited Service Providers.** For-profit specialty ("niche") providers that skim the most profitable services from the community hospital will continue to threaten the hospital's ability to subsidize unprofitable services such as emergency rooms, trauma units and community services with revenue from profitable services. Current Certificate-of-Need requirements prevent the proliferation of specialty hospitals, but limited service facilities such as ambulatory surgical centers, imaging centers, and others threaten the ability of hospitals to fulfill the social contract with their communities. Diminished CON requirements will open the door to further proliferation of specialty facilities.
- **Economic Contribution.** Hospitals are one of the top 3 employers in 48 of Illinois' 102 counties, and may also be the single largest source of federal dollars flowing into a community. Hospitals will continue to increasingly contribute to the community's economic health.

## ACCESS AND COVERAGE

**IDEAL VISION: Guaranteed access to and coverage for health care benefits, without eroding coverage for those currently insured.**

### FORECAST:

- **General.** Having health insurance is associated with better health outcomes and receiving appropriate care across a range of preventive, chronic and acute care services. In Illinois, about 63% of health insurance coverage is employer based; 4% individual coverage; 8% Medicaid; 11% Medicare and 14% uninsured. Coverage varies significantly by employer size, with 55% of smallest employers and 92% of the largest employers offering coverage. Barring a major change in the economy, employer based coverage will continue to decline over the next five years as part-time and temporary workers increase; public program coverage will remain stable even under substantial state budget pressures; and the number of uninsured will rise in Illinois.
- **Uninsured.** The combined effects of the continued erosion of employer-sponsored coverage and the increase in population will be the main reason for growth in the uninsured population. A comprehensive analysis of government data shows that 8 out of 10 of the uninsured are in working families. While the population believes by a 2-1 margin that they prefer a universal health insurance program to the current employer-based system, that support becomes conditional if it means limited choice of physicians or waiting lists for non-emergency treatment.

As part of their mission, in 2003, Illinois hospitals served as the safety net for 1.7 million residents who were uninsured. The expected increase in the number and percentage of uninsured persons in the next 10 years will increase and strain the resources of safety net hospitals/providers and emergency rooms.

- **Employer-Based Insurance.** Health and retirement benefits for Illinois workers will decrease over the next 10 years as more companies seek to reduce costs and premiums continue to rise. Because the wage base is not keeping up with health spending, employers and patients alike will feel the pressure. This is especially true for smaller employers who will elect to continue dropping health benefits altogether or discontinue subsidized dependent coverage.

The fundamental shift of cost bearing from the employer to the consumer and provider of services will increase. PPOs and Health Savings Accounts (HSAs) will gain substantial market share as the product(s) of choice for consumer-driven models as the insurance industry is betting that these models will be as popular as 401K's in the next 5-10 years.

Active employees currently pay 23% of the health care burden; we will see employees continue to pay greater percentages in the next 5-10 years given insurance cost increases. The rise in out-of-pocket payments will delay patients seeking health care and many may not buy insurance if their premium share rises significantly. In addition, the increased costs will disproportionately affect sicker patients, patients with chronic conditions, and patients who require expensive medications or are hospitalized. As employers and insurers lobby to have

maximum flexibility in coverage, seek repeal of mandated benefits and change to out-of-pocket and lifetime benefit maximums, strain will be put on patients and providers to pick up those costs. In the end, the underinsured population will increase significantly.

- **Individual-Based Insurance.** Individual-based coverage in Illinois is sparse and expensive. The HIPAA-CHIP pool provides a safety net for those who cannot buy insurance in the individual market; however this coverage is expensive. The size of the HIPAA-CHIP pool will grow with economic downturns. There will be public pressure to make this coverage more affordable and expand this (or other state insurance pools) as employers-especially self-insured employers-move people from the private employer based insurance system to the public pool.
- **Medicare.** On average, the Medicare program covers 58% of beneficiary costs and 94% of hospital costs in Illinois. Further pressure will build as the population grows and spending as a percentage of gross domestic product doubles in 25 years. The population is growing 1% per year, which will account for a large percentage of the increase in health spending. In addition, the baby boomer generation will start impacting Medicare significantly in 2010 and continue throughout the forecast of this report. We will probably face a Balanced Budget Act II in 2005, which will result in provider payment cuts in exchange for expanded pharmacy services.
- **Medicaid.** The Medicaid program covers most beneficiary costs and 80% of hospital costs in Illinois. Initiatives to expand Medicaid eligibility, maintain current payment rates and stabilize payment cycles will be challenged by the State's budget deficit. Illinois will continue to try and maximize federal dollars to increase Medicaid rates and increase coverage of care. Providers will continue to be underpaid by the Illinois Medicaid program and pressure will build to redefine medical benefits or restrict eligibility. Because of this, more physicians will refuse to accept this program. In the future, we expect discussions on the state Medicaid programs utilizing block-grants.
- **Mental Health.** Hospital psychiatric units across Illinois will continue to close, primarily because of inadequate payment, health care worker shortages and competing interests for resources. The current financial model, where the psychiatric unit must cover its fully allocated costs, will continue to be unsupportable given restricted benefits for mental conditions by both public and private payers. In addition, the quality and availability of care (including detox) for patients diagnosed with both mental health and substance abuse will continue to erode, especially in rural areas. Patients with mental illnesses and addictive disorders will continue to be present in hospital emergency departments in ever-growing numbers.
- **Reform.** While barring business leaders drastically changing their benefits, fundamental changes in the economy, or a health care outbreak/bioterrorism attack leading to a drastic increase in the uninsured population, it is unlikely there will be major health care reform in the next 10 years. **IHA believes it is not acceptable to sit idly by as our current health care delivery system becomes less and less able to meet patient needs.**

## CAPITAL

**IDEAL VISION:** Access to capital to build a strong health care delivery infrastructure, emphasizing technological changes (with financial stability to consider accessing it and the ability to repay it).

### FORECAST:

- **Capital Influence.** Capital need is influenced by a condition of infrastructure; future population growth rate; future health status; physician demand growth rate; and historical capital spending. Each of these factors will continue to affect each hospital uniquely based on its specific location in Illinois.
- **Gap.** There is and will continue to be a widening gap between hospitals identified as having broad access to capital and those identified as having limited access to capital. In addition, the gap between hospitals that are staying ahead of depreciation and those that are falling behind will continue to widen. While a majority of hospitals appear to be spending enough capital at least to stay ahead of depreciation, a significant minority, including most rural hospitals, are NOT.
- **Capital Requirements.** While hospitals overall have been dedicating more resources to construction as a percentage of capital spending in recent years, construction spending as a percentage of total health care expenditures decreased substantially over the last 40 years and was at its lowest point in 2002. The average age of the hospital plant in Illinois has increased in the industry, especially in rural communities illustrating the relatively low level of spending on construction. Thus, over the next 5 to 10 years, deteriorating plants will demand significant capital investment.

Technological changes will demand the largest amount of capital investment by hospitals. Technology acquisition, i.e., digital radiology systems; computerized physician order entry systems; and major information technology is hospitals' most frequently cited intended capital purchase. After technology, expanding capacity such as increasing emergency room and operating room capacity is the most frequently planned capital purchase over next five years.

## INFORMATION TECHNOLOGY

**IDEAL VISION:** Advanced information technology rapidly implemented throughout Illinois hospitals in support of improved patient care processes, outcomes, and satisfaction.

### FORECAST:

- **Focus.** Hospitals will focus on expansion and advancement of technology services, including telemedicine, distant technology and wireless services that support quality patient care that is effective and efficient. Hospitals will need visionary leaders that understand IT advancements and integration as they relate to patient care and treatment.
- **Standardization.** Regulations will continue to move us towards standardization of health care information. Consolidation and change will occur in the IT vendor community with those IT vendors advancing that provide standardized, interoperable IT solutions.
- **Electronic Health Care Record.** Pilot programs for the electronic health care record will be initiated by the federal government in 2004 in collaboration with the Department of Defense, Veterans Administration and Centers for Medicare and Medicaid Services.
- **Coding.** Major clinical coding changes will be introduced and expanded throughout the health care community requiring educational training of hospital staff and major changes to update and integrate historical patient information.
- **HIPAA.** HIPAA requirements will be completed, including the implementation of claims attachments, first report of injuries, provider identification numbers, health plan identifiers, and security.
- **Grants.** Information technology incentive and grant programs will be introduced by the federal government in federal fiscal year 2007. The technology gap among providers will be narrowed with increasing innovative grant programs and federally provided software available to small, rural and economically disadvantaged hospitals.
- **Performance Measures.** Consumers will have readily available performance measurements on process, outcome, financial performance, utilization, and staffing on hospitals, physician offices, home health, nursing homes, and other health services. Hospitals will routinely report performance information on infections, patient errors, and near misses to a federal information-reporting center.
- **Medicaid.** The Illinois Department of Public Aid will upgrade their adjudication and reimbursement systems to keep pace with the advancement of federally mandated requirements.
- **Improvements.** While technology promises to facilitate improvements in patient safety, it will create additional financial challenges for hospitals.

## QUALITY

**IDEAL VISION:** Provision of the highest quality care for every patient every time, which include systemic approaches to facilitate a safety culture in order to prevent and reduce avoidable patient injury.

### FORECAST:

- **Mission.** Quality of care will be the mission of Illinois hospitals. Illinois hospitals will integrate quality performance throughout their organization to provide the highest level of patient care and expect quality performance from every employee within their organization. Hospital governance will be re-focused on the performance of hospitals.
- **Federal Government's Role.** The Centers for Medicare and Medicaid Services will propel hospitals through rapid change to embrace the CMS vision of "Providing the right care for every patient every time." The goals highlighted in the Institute of Medicine's "Crossing the Quality Chasm" report will become the goals of the CMS 8<sup>th</sup> Statement of Work for hospitals.
  - The goals will be focused on the right care for every patient that is "effective, efficient, timely, equitable, safe, and patient centered."
  - CMS will expand beyond the current measurements to include performance measurements on all services, patient experience, and nurse and physician staffing.
  - CMS will move to a single national contracting cycle for all states for Quality Improvement Organization.
- **National/State Performance.** Hospitals will report their infections and errors to a national reporting center. Illinois hospitals will outperform the national averages in terms of publicly reported national process and outcome measurements.
- **Accreditation.** Accreditation practices will continue to expand to focus on the quality of process and outcome performance of providers through random, unannounced surveys that heavily focus on tracer methodologies.
- **Performance Measurement.** Payment for performance will be based initially upon process and outcome measurement and expand into non-payment for overuse, underuse, and medical errors. Performance measurement and public reporting demands will continue to increase among all hospital providers and represent process, outcome, and care continuum measurements as well as financial and staffing performance.

Providers will use federal incentive and grant programs to integrate information technology that will readily facilitate performance measurement reporting and provide for real time medical intervention advice in treating patients.

- **Evidence Based Practice.** As evidence based practice and standards of care recommendations increase, hospitals will be expected by CMS to readily integrate practices and rapidly achieve 100% compliance with the standard of care. CMS will

provide the information technology diffusion and resources to rapidly disseminate expected practice standards among hospitals and care providers.

- **Patient Safety.** There will continue to be pressure from the public, labor unions, and government to make hospital information about patient safety more transparent; the lack of a uniform approach will divert resources from patient care. Adequate staffing levels will continue to be a public policy focus and will continue to have broad-based appeal. Over time hospitals will disseminate their own data.
- **Unions.** Unions will continue to co-opt the public's desire for increased accountability by pushing a number of reforms, including whistleblower protections that do not increase accountability and compromise a hospital's ability to ensure safety and compliance with the law.
- **Environmental Health and Safety.** There will be more attention given to the role of hospitals in promoting environmental health and safety for both patients and communities. This may manifest itself in a number of areas, including indoor air quality, waste management practices, mercury reduction and "green" construction.

## MEDICAL LIABILITY

**IDEAL VISION:** Access to care and fair compensation for patients injured as a result of medical negligence.

### FORECAST:

- **Premiums.** The annual medical liability premiums paid by the average Illinois hospital increased from \$1.5 million in 2001 to \$2.8 million in 2003 – an increase of 84% in just two years. Rising malpractice insurance premiums will continue to exacerbate financial pressures on physicians and hospitals.
- **Expectations Driven by Technology.** Public perception about the omnipotence of medical technology will spur patient expectations for positive medical outcomes, even where risk is high, leading to increased lawsuits where actual outcomes fail to meet expectations. Severity of awards and settlements will continue their upward spiral, with one excessive damage award serving as the floor for the next.
- **Patient Safety.** Patient safety initiatives will continue to evolve slowly, and it is questionable whether medical errors resulting in lawsuits will be diminished to a degree adequate to effect significantly slower growth in medical liability insurance premiums during the next 10 years.
- **Reduced Access.** Physicians will continue to leave Illinois to practice in more favorable litigation climates, retire early or curtail services to avoid high-risk procedures; this will reduce patient access to essential health care. In addition, it will be increasingly difficult to recruit new physicians to certain areas of the state.
- **Political Environment.** Given the likelihood of a Democratic-controlled legislature until the next election following legislative redistricting in 2012, the possibility for significant liability reform, such as a cap on non-economic damages, remains remote.
- **Insurance Regulation.** As physicians and hospitals continue to seek alternatives to total coverage by commercial insurance, self-insurance will likely remain an attractive option, especially with a dwindling number of insurers writing medical liability in Illinois. The potential for increased risk that is generated by increased risk retention and self-insurance may be of concern. According to a recent Standard & Poor's Ratings Services Report on the emerging credit risk of hospital malpractice liability, the health care manager will have to weigh the need to maintain operating margins against the risks of funding malpractice insurance reserves and cost pressures. Self-insurance is one area where increasing risk may not be visible until a significant problem occurs, leading Standard & Poor's analysts to increase their scrutiny of these arrangements in 2004 and beyond.

Institutions practicing self-insurance often rely on reinsurance. An interesting side note is that Illinois Department of Insurance rules unfavorable to the development of reinsurance companies in this state results in millions of dollars for reinsurance coverage going to overseas companies offering such coverage.

- **Professional Regulation.** An inadequate state budget and overburdened Department of Professional Regulation may not be effective in investigating and removing the licenses of incompetent physicians, who may contribute to continued malpractice.

## WORKFORCE

**IDEAL VISION:** Adequate supply of well prepared workers who are not unnecessarily limited in their scopes of practice by regulatory constraints. Careers in health care considered careers of choice.

### FORECAST:

- **Labor Costs.** Labor costs are projected to grow by 18.3 percent between 2000 and 2005. They may grow even faster after 2005 as workforce shortages continue to rise and hospitals spend more on recruiting and training new staff, hiring temporary or agency staff, and other labor-related expenses. Hospital labor cost increases are over 50% higher than service industries as a whole.
- **Shortages and Access.** As health manpower shortages become more compounded, more Illinoisans will encounter access issues. The workforce shortage will worsen as the baby boom generation begins to reach age 65 in 2010 and more professionals retire.
- **Nurses.** In 1988 only 33.1% of Illinois RNs were over the age of 45; in 2000 49.5% were that old. If this trend continues as expected, our state will have 21,359 fewer registered nurses than are needed by 2020. This trend is mirrored in other health care occupations as baby boomers reach retirement age.
- **Trends.** Vacancy and turnover rates are highest among hospital positions that require the least amount of training (food service workers, nursing assistants, security personnel, housekeepers, etc.). In addition, the workforce is expected to be increasingly mobile. This trend will affect positions at all skill levels. Financial pressures will create challenges to the development of sufficient faculty needed to increase the supply of health care workers.
- **Skills.** Workforce needs by skill level will continue to evolve. On the one hand, the need for technology talent will expand. On the other hand, some technology changes can be expected to reduce the need for certain higher expertise.
- **Growth Areas.** Among health care occupations expecting the most growth from 2000 and 2010 are medical records/health information technicians (increase of 49.0%), physical therapy assistants and aides (45.5%), and occupational therapist aides (45.2%).
- **Urban and Rural.** The workforce supply will become more disparate between urban and rural centers. Much of this is due to the difference in population density and the provider base. Urban academic centers will continue to partner relationships on workforce issues as geographic and transportation issues in rural areas create more pressure on hospital and community needs.
- **Delivery of Care and Evidence Based Practice.** The way care is delivered will change as technology advances and labor becomes scarcer. Workforce must reflect systemic reform where education and training coupled with a vision for a more efficient way of delivering care produces enough health professionals with the appropriate skills to assure

access to care. Successful implementation of new technologies will require changes in workflow and clinical processes. The most successful and cost-effective technologies will become an integral part of hospital recruitment and retention strategies. Implementing technology changes and evidence-based practices will lead to a more efficient delivery system, as well as produce increased training demands on providers.

- **Outsourcing.** Workforce shortages and budget pressures will lead to more outsourcing. This will create new management challenges relating to compliance and quality.
- **Diversity.** An increasingly diverse workforce and changing patient demographics will dictate that hospitals become more culturally competent employers. While this places increased demands on hospitals, it also represents an opportunity to better serve diverse patient populations.
- **Physician Shortages.** Physician shortages, particularly in high-risk specialties, can be expected to increase if meaningful changes are not made in the arena of medical malpractice.
- **Mid-Level Practitioners.** As rural communities focus on recruitment and retention of primary care providers and high-risk specialists, some will continue to look to mid-level practitioners to fill the void. However, immediate access to supervising primary care providers will continue to be essential in Illinois under current law.
- **Solutions.** While hospitals increasingly deploy recruitment and retention strategies, system-specific strategies will not provide long-term solutions and will exacerbate shortages for less competitive health care employers.

# GUIDING PRINCIPLES

The following are IHA public policy positions on the issue areas that respond to the preceding forecasts. *The guiding principles are in the order each issue area was addressed and not in any particular order of importance.* **With respect to the health care delivery system, IHA advocates/stands for:**

## COMMUNITY

- **Improved health and functional status -- increasing access to prevention education, early detection, treatment and rehabilitation with other community partners by expanding the continuum of care.**

A resilient and flexible health care system based on patient needs. Individuals must change life styles and behaviors to better their health. Health care providers in the community must share the responsibility for delivery of clinical, educational, and community health care services.

- **High quality medical education and healthcare research for the community.**
- **Educating the public regarding the importance of healthcare and the hospitals' financial security to the community.**

Hospitals' use of a business model must be deemed appropriate for the not-for-profit community hospital as it seeks to sustain its financial viability. Hospitals' ability to cross-subsidize unprofitable services with revenue from profitable services must be protected. Hospitals' tax-exempt benefits are more than offset by their contributions to the communities.

- **Complementing the services of providers, rather than duplicating those services.**

## ACCESS AND COVERAGE

- **Universal and continuous access to health insurance coverage that incorporates the strengths of a pluralistic private and public system for all individuals.**

All individuals should have access to affordable health insurance benefits, whether employed or not. IHA supports expansion of health insurance coverage through (1) government reforms including employers either covering their employees or paying into a system where employees can obtain coverage, e.g., creation of purchasing pools or alliances; (2) tax credits for select populations such as self-employed individuals; (3) development of programs for the millions of Illinoisans who lose coverage during some part of the year. IHA also supports intensified efforts to cover adults and children who are eligible for but not enrolled in Medicaid and SCHIP. Any insurance product must include basic major medical coverage and have reasonable out-of-pocket expenses so as not to exacerbate the underinsured population. Basic medical coverage means emergency care, inpatient hospital and physician care, outpatient services, mental health and substance abuse services.

- **Maximized federal funding for state health care programs to improve access for uninsured populations and payments to providers that are sufficient to cover rising costs and support the infrastructure.**

In the short term, IHA supports a budget priority for adequate reimbursement under Medicaid by continuing to aggressively pursue opportunities to maximize available federal funding for state health care programs.

- **Access to care in rural and underserved areas so that it is available in every community without extensive travel.**
- **Reform of insurance company practices regarding continuity of health care services, unfair payment and marketing practices.**

## **CAPITAL**

- **Access to capital to help providers build and maintain facilities that address patient and community needs and keep pace with technological change.**

The health care system must develop new ways to access capital. We encourage new ways to access capital other than bond markets, including government programs such as Hill-Burton; innovative capital loans such as government loans to large uncompensated care providers; not-for-profit insurance company reserve loans to providers to keep adequate networks.

## **INFORMATION TECHNOLOGY**

- **Assistance in standardizing and implementing health care information technology efforts -- especially in rural communities.**

As information technology changes providers will be challenged both on infrastructure and on expertise to meet future IT needs. Providers, especially those in rural, and economically disadvantaged areas, will need support in responding to federal incentive and grant programs. IT changes will correlate directly to quality

## **QUALITY**

- **Organizational and governance approaches that have quality performance as a provider's vision and mission.**

There will be a period of challenges during an interim period when the demand for public reporting escalates and the supporting IT structures are being planned and implemented. Hospitals will be focused on the data collection and reporting requirements and ensuing burdens and at the same time expected to devote staff resources to targeted performance initiatives.

- **Collaboration on quality projects with organizations such as the Leapfrog Group.**

- **A safety environment for patients that improves the process of assessing the safety and effectiveness of prescription drugs, medical devices, procedures and other technologies and advances community health and safety interests. All programs must be based on good science, recognize implications for hospital resources and make sure they are applied broadly to both providers and the community.**

When new requirements for public disclosure of hospital information (including information about staffing levels) are proposed, the information must be directly related to its value to the consumer and financial demands on hospitals are minimized. New requirements that do not recognize the need for legitimate supervision and discipline and open the door to false, malicious, or frivolous reports against hospitals must be resisted.

## **MEDICAL LIABILITY**

- **Meaningful state and federal medical liability reform, including the use of creative models to compensate injured victims.**

Addressing the growing crisis in the medical liability insurance market will ensure that physicians remain in our communities and hospitals can continue to provide quality care. All those affected – government, legislators, physicians, hospitals, insurance providers, business community, attorneys, and patients – should work together to achieve a solution.

## **WORKFORCE**

- **Intensified long-range planning for building and retaining a workforce that can meet the rising demands of the growing and aging population.**

Illinois must develop new programs and policies to increase the supply of health care workers, faculty and programs. In addition, we must collaboratively improve health care career awareness and the image of health care professions while promoting hospitals as employers of choice. Although a state is not exclusively responsible for assuring an adequate health workforce, the public looks to it for leadership because it has responsibilities related to health professionals, i.e., providing support for higher education and the regulation/licensing of health care workers and facilities. Regulatory provisions must reflect current practice needs and workforce supply.

- **A collaborative hospital-physician working relationship.**

Physicians are the most vital and essential component of the health care delivery system. Hospitals are committed to our physicians' success, clinical efficiency and productivity and recognize that we must provide the right environment where this commitment to collaboration can thrive to advance clinical excellence and balance community needs. Solid relationships with the medical staff are imperative and characterized by effective joint efforts, successful recruitment and understanding physician needs despite today's environment of mounting costs, persistent labor shortages, and new sources of competition. We will work together to improve care delivery models, as our ultimate objectives are the same -- to treat and improve the health status of patients.

## **PUBLIC POLICY ENVIRONMENT**

- **A sensible regulatory and legislative environment.**

The financial burden of government regulation should be reduced by eliminating duplicative processes such as those required by hospital accreditors and regulatory agencies. Government mandates must better serve the market without unnecessarily increasing health care costs. Illinois providers spend million of dollars complying with health care related laws dealing with privacy, quality, safety and almost every aspect of health care delivery. We need to manage those changes to avoid confusion, eliminate unnecessary administrative burden and focus valuable resources on improving care.

## **CONCLUSION**

The forecast and guiding principles put forward in this report embrace the three core principles for an optimal health care delivery system:

- Protecting and expanding access to health care/health coverage;
- Improving quality;
- Efficient stewardship of resources

Collaboratively, the core principles are to protect and expand access to health care/coverage and improve quality through the efficient stewardship of resources.

IHA will continue working with other stakeholders to improve the health care system in Illinois. As our population continues to age and the demand for health care resources continues to grow, this work becomes increasingly important. Please join IHA in meeting the challenges described.

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