FALL 2001

ARIZONA HEALTH FUTURES

IN THIS ISSUE:

SLHI
A Catalyst for Community Health
St. Luke's Health Initiatives

TRAUMA: *The Canary in the Mine*

"The emergency room is the canary in the health care mine. Trauma is the first canary to fall, due to its cost structure."

JOHN DUVAL, CHIEF OPERATING OFFICER, UNIVERSITY MEDICAL CENTER, TUCSON

Imagine this scenario:

You're a business executive and have health insurance. You're used to easy access to top quality care. You're on a weekend trip in Southern Arizona, when suddenly a semi-trailer rig swerves on the highway and broadsides your car.

You feel searing pain, you lose consciousness. You awake to find yourself being transported to the nearest trauma center. But to your surprise, it's not close by in Tucson. It's in Phoenix. Your own "Golden Hour" of critical emergency care is fading fast.

Unlikely? Not with the scheduled closing of trauma centers in Tucson, and not to the degree you might assume if you knew nothing about Arizona's system of trauma care – or more to the point, Arizona's lack of a system of trauma care.

Most people assume that trauma care, like fire and police safety, is readily available – part of the public safety net in any civilized, ordered society. That may not be true in Arizona. Unlike the air of publicly funded fire and police services, the air in the public and private health care mine is heavy with low reimbursement rates, high levels of uninsured patients, and soaring costs for critical services.

If the trauma canary is going to continue to sing in Arizona, it's going to need some help.

The Shredding of the Safety Net

In this issue of *Arizona Health Futures*, we look at the present and future of Level I trauma care in Arizona: what it is, what the issues are, why they're important, and what we might do to insure the future of this critical component of public safety in a difficult health care environment.

Unfortunately, the timing is good – the tragic events in America on September 11 underscored the possibility of trauma and disaster on a level previously thought remote. Closer to home, Arizona's Level I trauma centers recently completed a study on financial,

(Continued on page 18.)

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What's *Not* in this Issue

The scope of study here is Level I trauma centers, and not trauma centers and emergency services generally. We don't discuss the issue of diversion, the relation of trauma centers to other services of hospitals, or provide any detailed financial information on specific trauma centers, number of uninsured, national figures on types of trauma, etc. These are available at some of the information sources cited.

Our focus is on dissecting the underlying economic, ethical and political issues surrounding Level I trauma centers in Arizona, and what they imply for the future of delivering these critical public services.

WHAT IS A Trauma Center?

The difference between an emergency room and a trauma center is both a matter of law and a matter of degree.

As a matter of law, general hospitals are *required* to have emergency rooms. They are not required to have a trauma center, which is *voluntary*.

As a matter of degree, all emergency rooms are capable of treating ill and injured people: stitching cuts, setting broken bones, removing obstructions, relieving pain and discomfort.

Trauma centers, on the other hand, are capable of dealing with the most severe, life threatening situations: the patient with multiple internal injuries, multiple broken bones – people in severe shock and *trauma* (the medical term for injury), where only the most skilled, quick and intensive intervention within the early period of trauma often spells the difference between life and death.

In the mid-1960s, several states developed a system of specialized centers of care for the seriously injured. The idea was not necessarily to direct injured persons to the *nearest* hospital, but to the hospital *best prepared* to care for the types of injuries sustained. Over time, these facilities became known as trauma centers.

WHAT IS A Trauma System?

Like most things in America, trauma systems come in a variety of flavors. Some states, like Washington and Pennsylvania, have a formal, statewide network of trauma centers. Others, like Arizona, are more informally and loosely organized to the point where it's a stretch to call them a "system."

The degree of regulation and public oversight of the trauma function is equally variable across the nation, as is public funding. In a recent survey of state EMS (Emergency Medical Services) directors, 31 out of 38 states reporting (81%) had trauma legislation on the books; and 21 states (56%) had limited public funding available, although mostly for victims of crime.

Arizona, on the other hand, has neither comprehensive trauma legislation nor even limited public funding for trauma centers.

LEVELS OF Trauma Care

The American College of Surgeons has developed detailed criteria hospitals can use to evaluate the level of care provided to injured patients. These are broken down into four levels, with Level I centers able to handle *any* type of injury that occurs, and Level IV centers able to handle some, but not all, serious injuries.

LEVEL I

Provides total care for all injuries, as well as providing education, research and preventive services. These usually serve a large city or densely populated area. A senior trauma surgeon must be available *in* the hospital at all times.

LEVEL II

Provides total care for all but the most complicated cases, which are sent to a Level I center. In urban areas, Level IIs supplement the resources of Level I care, but in less densely populated areas they often serve as the lead trauma facility. (In Arizona, Flagstaff Medical Center is an example.) A senior surgeon must be rapidly available on short notice.

LEVEL III

Provides initial care and stabilization while arranging transfer to a Level I or II center. These are generally found in rural areas and are required to have continuous general surgical coverage.

LEVEL IV

Provides initial evaluation and stabilization; found primarily in rural areas. They are required to have 24-hour emergency coverage by a physician.

The Golden Hour

The "Golden Hour" is trauma center lingo for the first hour immediately after injury. If the patient receives proper medical care in that first hour, their chances of survival *triple,* and the side effects of injury are significantly decreased. This is one of the reasons why the *distance* between the scene of an accident and a trauma center is so critically important. If it takes a long time to get someone to a trauma center following a severe injury, the chances for recovery diminish.

The "Golden Hour" is just one of the reasons there is a drop in preventable death rates from 17-35% *before* trauma centers are implemented in a community to 2-7% *after* implementation.

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THE Arizona Picture

In Arizona, hospitals *self-designate* the level of trauma care they are able to provide. Seven hospitals – five in Maricopa County and two in Tucson – designate themselves as Level I trauma centers. By so designating, they declare that there will be, immediately available at all times, a trauma surgeon, anesthesia and emergency physicians. In addition, a full range of surgical specialties must be "on-call and promptly available": cardiac surgery, hand surgery, neurosurgery, obstetrics and gynecology, ophthalmologic surgery, surgeons qualified to operate on facial injuries, orthopedic surgery, plastic surgery, critical care medicine physicians, radiologists and thoracic surgery.

LEVEL I TRAUMA CENTERS IN ARIZONA

Maricopa County

Maricopa Medical Center
St. Joseph's Hospital and Medical Center
Good Samaritan Regional Medical Center
John C. Lincoln Hospital-North Mountain
Scottsdale Healthcare-Osborn

Tucson

Tucson Medical Center*
University Medical Center*

Flagstaff

Flagstaff Medical Center**

* TMC and UMC have announced they will drop their Level I status at the end of 2001, due to financial losses.

** Flagstaff Medical Center self-designates as a Level II trauma center, but cares for the majority of trauma patients in Northern Arizona.

PRACTICE makes PERFECT

As with any person or system required to complete a complicated task, trauma surgeons and centers improve with practice. People treated in low volume trauma centers have a 30% greater chance of death than similar patients treated at high volume centers.

ARIZONA LEVEL I
Trauma Centers

BY THE NUMBERS

VOLUME

Number of admitted patients	9,093
Total patients admitted / non-admitted	14,036

ADMITTED PATIENTS BY MECHANISM OF INJURY

Motor Vehicle Accidents	69%
Falls	9%
Other Accidents	5%
Assault	5%
Gun Shot Wounds	5%
Stab	5%
Suicide	2%
Unknown	1%

Interestingly, auto insurance makes up less than 10% of total revenues for trauma patients, yet auto accidents account for almost 70% of total patients. This conceivably represents a "revenue enhancement" opportunity in the future, perhaps pursued through tort reform.

PAYER MIX

Commercial	48%
Uninsured	11%
AHCCCS (Medicaid)	35%
Medicare	6%

AVERAGE LENGTH OF STAY (ALOS)

4.8 days

AVERAGE PATIENT COST PER STAY

$8,930

Data, financial information and charts are extracted from Bishop and Associates Arizona Trauma System Finance Survey, September 2001 (2000 data)

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ARIZONA LEVEL I Trauma Centers

BY THE NUMBERS

ADMITTED TRAUMA PATIENTS*

INJURY SEVERITY	PATIENTS	%	AVG. PATIENT COST	ALOS	ICU** ALOS
ISS 1-8	4,429	49%	$ 4,816	2.8	0.6
ISS 9-14	2,781	31%	7,927	4.7	1.2
ISS 15-24	1,190	13%	14,822	7.9	3.1
ISS>25	693	8%	29,266	12.7	7.3
TOTALS	9,093	100%	$ 8,930	4.8	1.6

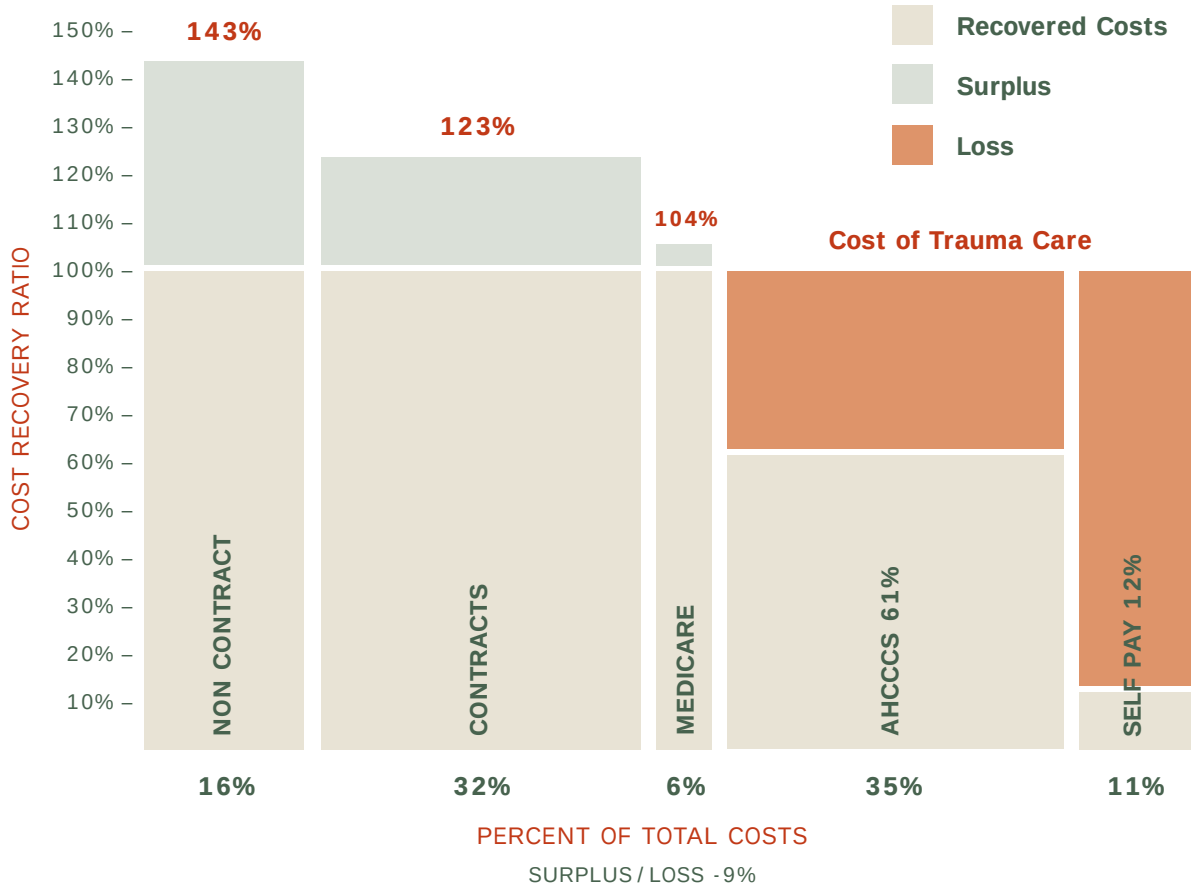
* Admitted patients are assessed by an Injury Severity Score (ISS): the higher the score, the more serious (and more expensive to treat) the injury. *Non-admitted patients,* which totaled 4,943 in 2000, are comprised of both trauma patients who die in the ER, and those who are transported to a trauma center by paramedics due to their high potential for serious injury. Such patients, upon evaluation by a trauma physician in the ER, are determined to not be seriously injured. The average patient cost for all non-admitted patients was $1,497.

** ICU = Intensive Care Unit

"Emergency rooms are viewed as the place where poor people go to get their health care. But trauma centers are viewed differently. Everyone, including wealthy people, may have the need to use them. We all sleep better because we have the fire and police departments, and because we have a trauma system – just in case."

DAN COLEMAN, CEO, JOHN C. LINCOLN HEALTH NETWORK

ARIZONA TRAUMA SYSTEM*
(INCLUDING PHYSICIAN SUPPORT COSTS)



* This chart indicates that Arizona trauma centers make a modest surplus on privately insured (non-contract and contract) patients. They lose money on self-pay (non-insured) and AHCCCS patients. AHCCCS accounts for fully 35% of the total volume, yet reimburses only 61% of trauma center costs.

THE BOTTOM LINE: ARIZONA TRAUMA SYSTEM

	Amount	% of Costs	Per Stay
Revenue	**$ 95,587,328**	**91%**	**$6,810**
Direct Cost	54,045,970	51%	3,851
Net Physician Support Cost	16,367,192	16%	1,166
Indirect Cost	34,553,981	33%	2,462
Total Costs	**$104,967,143**	**100%**	**$7,478**
Loss / Profit	**($9,379,815)**	**-9%**	**($668)**

With revenue of $95.5 million, low payments from AHCCCS and high physician support costs, the Arizona Trauma System is experiencing substantial loss. The $9.3 million loss in 2000 breaks down to a $5.9 million loss for Phoenix trauma centers and $3.4 million for Tucson. Trauma center officials report that losses in 2001 will be significantly higher than 2000.

CULTURE AND COSTS:

Do Level Distinctions Matter?

Does it make a difference whether a hospital has a Level I or Level II trauma center?

Looking at costs alone, the answer is yes. Level I centers incur increased costs in the form of 24-hour availability of operating room (OR) personnel, a trauma surgeon, radiology, etc. These "readiness" costs are not as high for a Level II center, where a trauma surgeon and OR personnel must not always be on site at the hospital.

Because of this – and because of the precarious state of health care financing generally – some hospital administrators say they would be better off to get out of the trauma center business to reduce expensive in-house readiness costs.

So why don't they? According to Tom Sadvary, chief operating officer at Scottsdale Healthcare, the answer has to do with culture.

"Our trauma center is resource intensive from a financial and talent perspective," he says. "But the trauma program is integral to our culture – and we are meeting a vitally important community need. Clinical support services are more responsive to all patients because the trauma program exists."

The distinction is that between an integrated, coordinated and planned system of trauma care – a public approach – and a more informal, voluntary and market-sensitive system of trauma care – the private approach.

Culture and Competition

Based on interviews with a number of persons close to the Arizona health care scene, the development of Level I trauma centers has proceeded along a path not unlike that of PETT scanners and other expensive medical technology: the competition gets one, so you have to get one, too, or risk losing business and the ability to attract top medical talent to your facility.

This is one conceivable reason why there are five Level I trauma centers in Maricopa County alone – three of them clustered together in Central Phoenix. One hospital upgrades its trauma center to care for the most severe injuries, and others follow suit.

Hospitals can gain a competitive advantage from trauma – the "halo effect," or credibility an institution can gain with the general public from promoting the fact that the hospital can and will care for the most severely injured and sickest patients. In turn, this attracts and becomes a training ground for young surgeons and emergency personnel who want to be where the action is and sharpen their skills.

As one hospital executive describes it, it's a "rush" for a young neurosurgeon to deal with a complicated case where the outcome is uncertain and hardly routine. The more such cases they handle, the better their surgical skills become.

CULTURE AND COSTS:

The challenge is how to maintain the extensive staff necessary to keep the program on the cutting edge. In addition to the primary trauma team on call, the trauma center needs "bench strength," second call and back-up physicians and nurses in case the first team is already occupied with a patient.

According to one administrator, "the bottleneck right now is the talent issue." It's finding and attracting skilled professionals who are willing to do trauma at odd hours of the night and weekends, and sometimes for little or no pay, depending on insurance status and payer contracts.

Prestige, Perception and Price

Jack Jewett, senior vice president for public policy at Tucson Medical Center (TMC), sums up the dilemma succinctly: "While some hospitals consider community goodwill and prestige as key factors supporting their trauma business, TMC is focused on the hospital's financial survival as the controlling factor."

It's a dilemma more and more trauma centers face: pay the price of being Level I and face financial hardship, or downgrade services or even withdraw from trauma care.

But how much of being a Level I facility is a function of perception of quality compared to reality?

Flagstaff Medical Center, for example, self-designates as a Level II trauma facility but operates as a de facto Level I facility in Northern Arizona and handles most of the major trauma cases – with lower overhead. Some observers on the national scene point out that Level II centers, which don't have to maintain education, prevention and outreach functions, can often provide better quality than a Level I center that might use a large number of residency physicians in training.

This is only one *perception*, however – there is little hard data and research on which to make such comparisons.

Regional Trauma Centers

People close to the trauma center scene at the national level say too much has been made of whether a facility ought to be Level I or Level II. The real issue is whether a facility is a good candidate to be a *regional trauma center:* having the capability to handle the most severe cases within a specified geographical region with an extensive and defined mix of support around it.

For example, in Seattle there is one regional Level I adult and pediatric trauma center for the four state area of Washington, Alaska, Montana and Idaho; but there is an extensive network of Level II-V trauma facilities around it that handle all but the most severe cases. Together, they comprise a planned and coordinated *trauma system.*

The distinction is that between an integrated, coordinated and planned system of trauma care – a *public* approach – and a more informal, voluntary and market-sensitive system of trauma care – the *private* approach.

Culturally and politically, Arizona has always been in the private sector camp. The issue on the table, driven by hard financial realities and a difficult health care market, is whether this is the best model for the future.

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Trouble in Tucson

The health care marketplace isn't in good shape anywhere in Arizona, but in Tucson and Southern Arizona, it's particularly acute.

In 1999 alone, Tucson Medical Center's (TMC) costs of operating its Level I trauma center exceeded revenues by $3.3 million; in 2001 the loss for both TMC and University Medical Center (UMC), Tucson's other Level I trauma center, is projected to be close to $6 million.

The net effect? TMC and UMC have announced they will close their top-level trauma centers at the end of the year.

Multiple Problems

For the past 16 years, TMC and UMC have jointly administered a trauma program. It's highly coordinated, with one medical director and administrative support located at UMC. University Physicians Inc., the faculty organization at UMC, staffs both facilities during the day, but just UMC at night. TMC depends on community-based physicians to provide nighttime coverage.

Tucson has a number of problems:

- Difficulty recruiting, retaining and paying physicians – especially surgeons and specialists – who are willing to cover nighttime call. The market for physicians in Arizona is less attractive than other states. In Tucson, specialists are stretched especially thin. Physicians can receive high stipends to take call, and that's a major factor in trauma center financial losses.
- Low reimbursement rates. Arizona is a state with a high proportion of managed care contracts, and Tucson hospitals have unfavorable rates of reimbursement even compared with Phoenix hospitals. This financial squeeze has been compounded by the Balanced Budget Act of 1997, which resulted in a significant cut in Medicare reimbursement to hospitals. AHCCCS (Medicaid) reimbursement rates are also low.
- High rate of uninsured patients. Arizona has one of the highest uninsured rates in the nation. Tucson, which is close to the border, receives a large number of foreign nationals who legally cross the border under the Federal Humanitarian Medical Parole Program but often have no source of payment for mandated care in emergency departments. The Federal Emergency Medical Treatment and Active Labor Act of 1987 (EMTALA) mandates treatment for *all* people entering emergency departments with a medical condition – whether they are here legally or not, and regardless of ability to pay.

There are major public safety issues at stake with TMC and UMC out of the Level I trauma business at the end of the year. In addition to a potential increase in preventable deaths, there will likely be spillover to Phoenix hospitals as patients are routed to the nearest available Level I trauma center. Tucson officials realize they have a serious problem and are considering a number of responses, including seeking public funds.

The rationale for public support – which might include structural integration and combined services as well as funding – is the same as that for critical police and fire services: A trauma system is a necessary public service, and it ought to be publicly supported.

STAB STAB STAB

A weakened Level I trauma system decreases Arizona's state of readiness to respond not only to a normal flow of critically injured patients, but also to unforeseen disasters and emergencies.

To that end, the Arizona Department of Health Services retained a consulting group to assist in developing a trauma system plan for the state. Together with the State Trauma Advisory Board – or STAB – they undertook a planning process involving over 200 participants from a broad-based panel of stakeholders and put together a plan intended to "provide a framework for the establishment of a comprehensive trauma system in Arizona."

Among other things, the plan recommends an oversight body – a private foundation – to oversee the management of the trauma system. However, the plan will require funding and legislative approval. Given Arizona's current budget shortfall predictions, the timeframe for implementation is unknown.

Regardless, more people in the field are coming to the conclusion that Arizona needs some type of statewide infrastructure to insure a high level of trauma care and disaster readiness, and the proposed Arizona Trauma Foundation could fill that role.

As it stands now, however, there is no real political support for trauma care, like there is for fire and police services. The recent tragic events of September 11 might well provide an occasion to illustrate for politicians and the general public that trauma is every bit as much an issue of public safety as police and fire services, and the state needs to plan and provide for it accordingly.

SOURCES

In addition to interviews with key individuals and stakeholder groups, we have utilized some of the following sources of information and data:

- **Arizona Trauma System Finance Survey, Bishop and Associates, October 2001.**
- **Committee on Trauma, American College of Surgeons. *Resources for Optimal Care of the Injured Patient: 1999.***
- **National Trauma Data Bank Report, 2001 (www.facs.org / ntdbproject / forward.html).**
- **Washington State Department of Health. *Annual Report: Emergency Medical and Trauma Prevention – FY2000* (www.doh.wa.gov / hsqa / emtp / download / AnnualRept00.pdf).**
- **Trauma Resource Network (www.traumacare.com).**
- **American Association for the Surgery of Trauma (www.aast.org).**

TRAUMA Physicians

On CALL

The burden of on-call responsibilities – being available to work 24 hours a day, regular business hours or not – is best framed against the background of the economic realities facing a private-practice physician.

In the not-so-distant past, a physician could extend health care to uninsured patients with no expectation of payment that covered costs, because profits earned by treating insured or full-pay patients would be shifted to cover the losses. This scenario is far less common since the advent of managed care and patient panels. Specialty physicians called in to treat uninsured patients through the emergency department are often faced with a double-edged sword: federal regulations require the physician to provide treatment, which is interpreted to include follow-up care in the office until the problem is resolved, yet payment is rarely forthcoming. As physicians receive lower reimbursement for care, there is less profit available to cover the cost of delivering care.

That's hardly the half of it. According to the recent Bishop study of Level I trauma care in Arizona, uninsured patients account for only 11 percent of trauma patients in Arizona. A bigger problem is AHCCCS, which covers 35 percent of trauma patients seen in Arizona but reimburses only 61 percent of AHCCCS patients' trauma costs.

Add these economic realities to the trend of more specialists performing procedures in outpatient surgical suites rather than hospital operating rooms, and it's not surprising that fewer physicians are willing to take emergency call.

Pay to Play: Physician Stipends

What would you expect to pay to get a plumber out to your house at 3 a.m. on a Saturday night to fix a broken water pipe?

Not the normal hourly rate, that's for sure.

Increasingly, the same thing is true for trauma centers and emergency rooms. Physicians are demanding – and getting – stipends to be on call.

As Dr. Peter Aiello, a Phoenix ophthalmologist, explains, "This system [stipends] rewards the physician for his or her labor and provides a mechanism to pay for the overhead [supplies, personnel, etc.]. It manages what would otherwise eventually be an overwhelming and unwelcome responsibility for providing indigent care."

Hospital administrators report that the stipends can be significant: $2,000 a day for an anesthesiologist, $500,000 a year for orthopedic coverage. It's basic supply and demand. If there aren't enough doctors who are willing to be on call, then hospitals have to pay high fees to attract them.

Stipends solve the problem of securing coverage by specialist groups that tend to be problematic: neurosurgery, orthopedics, plastic surgery, anesthesia, ophthalmology. But according to the Trauma Resource Network (**www.traumacare.com**), "an interesting byproduct of high levels of compensation is diminishing levels of support, so that even high stipends do not guarantee that the most qualified surgeons will remain on trauma call or be responsive."

The other "byproduct," of course, is a financial straightjacket for hospitals, which have no place to pass along these high stipends. Stipends for specialists are a major factor in the dismal financial picture for Arizona trauma centers.

Trauma

No Mas: The Physicians' Perspective

One of the great ironies of modern health care in America is that we admonish providers to adopt the philosophy and practices of modern business, and then get upset when they do.

This is no more apparent than in the trauma business, and emergency departments generally, where it's getting difficult to get physicians to take call.

On the one hand, some hospital administrators privately complain about being "held up" by physicians, especially the surgical specialists, who use "extortion" techniques to obtain big bucks to take call (see "Pay to Play" sidebar). The plans won't pay, individuals don't have that kind of money, and the hospital has to come up with the cash itself or risk opening its emergency doors with no one there to do the work.

But that's not how physicians see it. Here's another side of the story, in their own words.

It's a Business – Unfortunately

Richard Perry, M.D., is a general surgeon in private practice. He used to have privileges at five major hospitals in the Phoenix area, but he's dropped them all except for one.

"In the 80s I could pay my overhead, work a decent number of hours and make a decent living. With the advent of managed care, which is really managed profits for shareholders, you have lower reimbursement rates and increasing numbers of uninsured people. This is a huge problem in Arizona.

"Do the numbers. In the late 80s a general surgeon got about $1,000-$1,200 per case. Today, it's about half – $550 per case.

"My overhead for everything [office, staff, insurance, etc.] is probably $125 an hour, or $1,000 per day. So, I have to do two cases a day just to break even, or 10 cases per week, 400 cases per year.

"To make a decent living, I have to do at least 800 cases per year, and that's on top of all of the time with patients, follow-up calls, and a huge amount of paperwork. A general surgeon can make about $200,000-$250,000 in Phoenix and $350,000 in most other places outside of Arizona. The difference is less managed care, more fee for service, and lower numbers of uninsured and undocumented persons.

"I have surgeon friends elsewhere who bill what I bill, but collect twice as much. They don't have managed care, and they have fewer uninsured patients.

"I've done what I had to do: drop plans, drop hospitals, and become more selective in the patients I see.

"The retirement age for surgeons in the 70s and 80s was 65-70 years old, but now it's down to 57-60 years old. Why? You have to work twice as hard just to stay even, see more patients you don't get paid for, and are expected to be on call constantly.

"It's harder for young surgeons to get started these days. They have $80,000-$100,000 in debt from medical school and then a long residency program where they don't start earning a good income until their early 30s. So where are they going to go for a caseload of 800 patients? They go to the emergency rooms. But now in emergency departments – which can be interesting and challenging work – you see more and more people who can't pay, and you have to treat them anyway. EMTALA is an unfunded mandate.

"A day doing trauma work can equal two days in private practice – if you can get paid, that is.

"One Thursday night on ER call in a Phoenix hospital where I no longer have privileges, I had 14 patients sent to me, and not one of them had insurance. It's insane.

(Continued on page 14.)

Physicians

Physician Support Costs

Includes total and average (per trauma center) physician support cost by specialty. These costs include physician stipends and related costs for physicians to be on call at trauma centers.

SPECIALTY	AZ TOTAL	AZ AVERAGE
Trauma Surgery	$ 4,699,621	$ 671,374
Neurosurgery	2,620,669	374,381
Orthopedic Surgery	3,371,048	481,578
Plastics	790,076	112,868
Anesthesia	3,586,706	512,387
Oral	159,791	22,827
Hand	68,568	9,795
Urology	12,483	1,783
Ophthalmology	27,145	3,878
Other Specialties	1,031,085	147,298
TOTALS	$16,367,192	$2,338,170

Physician support costs at Arizona Level I trauma centers range from $530,000 – $4.3 million.

"I finished my training in 1998, some 17 years after I graduated from high school without a break. I started my private practice one year ago, doing anything I could to keep the doors open, to pay my employees, the rent. You contract to get what they [insurers] give you. When the office starts to get full, you pick and choose, drop the late payers and the low payers. As a new practitioner, especially in surgery, you work in the ERs. A daytime trauma call can mean leaving my full schedule of patients, and it's hard to reschedule them because my calendar is full for months."

JOZEF ZOLDOS, M.D., A PHOENIX HAND SURGEON ALSO TRAINED IN PLASTIC SURGERY

IT'S A BUSINESS

(Continued from page 13.)

"Bottom line, you can't expect docs to pay for charity care out of their own pockets. Ironically, I can't even help a patient out anymore by lowering his bill or doing something for free because I know he's having a hard time. They can get me for discrimination. Now I do all of my charity work for St. Vincent DePaul's program, where it's all managed for me.

"The relationship between the physician and patient is severed. That's the business model, the result of managed care. Is it progress? I don't think so."

Physicians and Trauma: The Central Issues

Based on SLHI's research and conversations with observers of the trauma care scene in Arizona, several factors combine to exacerbate the problem of physician supply and demand:

- ***Lifestyle.*** For more and more physicians, doing trauma and emergency work during the nights and weekends is not a choice they are willing to make faced with other family and personal choices. For many people – and not just physicians – money is no longer the chief motivating factor. It's lifestyle.
- ***Increasing specialization.*** Physician supply data can be misleading. Many specialty surgeons go on to sub-specialize and may no longer feel qualified to treat trauma patients or even general emergency department patients. Eye surgeons may specialize in RK surgery, cataract surgery, glaucoma treatment; orthopedists may specialize in sports medicine, foot and knee surgery, joint replacements, etc. Trauma care itself is becoming a specialization, even among the specialists.
- ***Outpatient work.*** More physicians are doing work in outpatient surgical centers, and no longer need to have staff privileges at hospitals, which come with ED call requirements attached. It doesn't make sense to ask certain physicians to be on trauma call if they don't use the hospitals for their work.

Put these factors together with low reimbursement rates, one of the highest uninsured rates in the nation (less of a factor in trauma care than in emergency rooms generally) and a lack of any coordinated system of trauma and emergency care in the state, and it's no wonder that Arizona's costs for physicians on call at trauma centers are well above the national average.

What is "extortion" to a hospital administrator is merely the cost of doing business in a vastly contracted and changed health care environment.

An analog model might be what happened to energy prices in California following the wake of deregulation. If health care is *just* a business, then there's little difference between the reaction of physicians and energy companies: Supply goes down, demand goes up, prices rise.

"I'm working well over 100 hours per week almost routinely. Last night I came home early – at 10:30 p.m. My personal life is nil. At a certain point you have to think, if I'm busy in my daytime practice, why would I ruin my family life [take ER call]? I have an eleven-year-old son. I'd like to see him grow up. We have to think of our family, our personal life."

PHOENIX SURGEON, ANONYMOUS

RESPONSES *and*

THE BURDEN OF A GREAT OPPORTUNITY

Arizona is rapidly approaching a crisis point with its major trauma centers. It's already there in Tucson, with the announced closing of TMC's and UMC's Level I trauma centers. The potential ripple effect of this on other trauma centers and hospitals is unknown.

Until now, private organizations, with assistance from the Health Department's Bureau of Emergency Medical Services, have created a collaborative working environment. Level I centers have absorbed the cost of trauma care through the traditional mechanism of cost shifting: charging the insured a premium that also covers the uninsured.

Because of changes in health care financing and other reasons discussed in these pages, hospitals and providers have less options for cost shifting and face serious losses on the basis of providing uncompensated or undercompensated care. There's a growing awareness among all of the players that something has to be done in Arizona to address these issues.

Based on SLHI's assessment and discussions with key stakeholders, several themes emerge:

Let the market decide.

Some believe the best approach is to let market forces dictate who survives, who doesn't, and how resources get allocated across the state for trauma care. As messy as it sometimes is, free market proponents believe that "natural attrition" – the so-called "survival of the fittest" – is a better long term solution than some type of planned public response.

Create a statewide trauma system with some teeth in it.

Build on the Arizona Trauma Foundation concept, but actually give it some regulatory authority, oversight and sustained public funding for major trauma centers. For example, it could provide a structure and separate billing system to attract physicians to trauma work, license and regulate trauma centers, require plans to pay additional costs to personnel providing critical trauma services, allow for physicians to work across multiple facilities, pursue tort reform to get auto insurance companies to pick up a greater share of the trauma tab, etc.

Improve state data collection and analysis capabilities.

Resume the compilation and begin the analysis of Trauma Registry data. Once current software problems are resolved, the state can analyze current needs of the trauma system as well as identify targets for prevention in the future. Trauma Registry data can be used in the same way that the Child Fatality Review Board reviews preventable deaths of children and looks for possible interventions.

DILEMMAS

Clearly, this issue is on the front burner of public health policy in Arizona. The timing is right for all of us to come together now for the greater public good.

Review the need for five Level I trauma centers in the Phoenix area.

Some believe there are too many Level I trauma centers in the Valley, especially considered from a geographical perspective, with three of them clustered in central Phoenix and none in the far West or East Valley. On one side, some believe that consolidation would result in cost savings and begin to address the issue of physician coverage. On another side, observers point out that the Valley has the same number of trauma centers as it did 20 years ago – a period in which the population has more than doubled. They argue that consolidation down to a model of a single "super" Level I trauma center wouldn't be the best solution in a spread out area like Maricopa County, where ground transportation from the fringes could seriously cut into the "Golden Hour." There's general agreement that if there is to be one major trauma center, it has be to "omnipotent, geographically available, and have an elegant depth of talent pool."

Dilemmas

The Issue of Trust.

One of the themes SLHI encountered in its investigation of Arizona's Level I trauma centers was a high level of suspicion with which requests for public funding of hospitals are regarded by some in the legislative community. One legislator echoed the sentiment of others by saying, "Sometimes it feels like the hospitals ask for money, and it all goes into a giant black hole. There never seems to be enough."

In our view, part of the difficulty here stems from a lack of understanding of the *true cost of providing health care.*

It remains difficult – and can even be counterproductive – for hospitals to identify, much less publicize, their true cost of providing care because of the labyrinth of cost shifting that takes place. Charitable care, including mandatory treatment of emergency room and trauma patients, is subsidized through profits gained from paying customers. Economic pressures for insurers continue to squeeze available profits, and a public discussion of the true cost of providing care could well hamper the ability of hospitals to continue such cost-shifting.

But without such cost data, some legislators wonder if the hospitals are "crying wolf," even though the large number of hospital conversions from non-profit to for-profit status over the past six years were all driven by harsh financial realities. The other factor to keep in mind is that hospitals have to operate under mandates and regulations that legislators themselves have passed in response to pressures from other constituencies.

Privately, all sides of this story express frustration with perceptions of others that they consider less than accurate. Publicly, they continue to stick to their rhetorical guns.

(Continued on next page.)

RESPONSES AND DILEMMAS

(Continued from previous page.)

The Issue of Competition.

A competitive marketplace makes sense in most aspects of American society. But the reason we don't have competing police or fire services in communities is the same reason we might not want competing trauma care services: they are part of the common, or *public* good, and we spread the cost of providing them equitably among the community members using them – which could be all of us at one time or another.

But given the historical development of multiple Level I trauma centers in a community, each with its own constituencies, financial and staffing needs, who decides what goes, and what stays? On what basis should such allocation decisions be made? Critical mass, geographical location, quality of staff and other resources? If we ask people to cooperate for the greater public good, we ought not to put them at a competitive disadvantage later on as the result of a reallocation of community services.

The Issue of Public Support.

It's easy to talk about public support in theory, but it's much harder to parcel it out among the governmental divisions: federal, state, county and local. The tragic events of September 11 have underscored the importance of disaster/public health/trauma services at all levels of society, and may well spur a frank discussion in Arizona not only of the critical importance of maintaining and enhancing an integrated trauma care system in the state, but also of coming up with a fair and efficient public regulatory, administrative and funding structure.

The intent of this *Arizona Health Futures* Issue Brief has been to provide an independent overview of the financial, policy and organizational issues embedded in Level I trauma centers in Arizona; a sampling of the perceptions of the key stakeholder groups in assessing those issues, and some of the possible responses – and the very real political and ethical dilemmas they imply – in addressing them.

Clearly, this issue is on the front burner of public health policy in Arizona. The timing is right for all of us to come together now for the greater public good.

TRAUMA: THE CANARY IN THE MINE

(Continued from front page.)

cost and staffing issues; and the State Trauma Advisory Board (STAB) is developing a framework for "a comprehensive trauma system in Arizona."

In preparation for this issue brief, we've utilized state resources, talked to people who know about these issues and have a stake in them, looked at trauma care in other states, and painted what we believe is a fair, independent and balanced picture of a number of complicated and contentious issues.

But trauma care is only one part of a larger crisis facing emergency rooms across the country that quickly spills out into the community through a system of ambulatory and primary care services for low income and uninsured persons that itself is on shaky financial ground. Our Winter 2002 issue of *Arizona Health Futures* will continue with this theme of the shredding of the safety net, with a particular focus on ambulatory care.

the Drift

OBSERVATIONS ON ARIZONA HEALTH ISSUES

by Roger A. Hughes
Executive Director, SLHI

"The Rules of Caring"

At a recent meeting on trauma centers, a former Arizona Congressman, upon hearing of high rates charged by some doctors to be on emergency call, asked, "Whatever happened to altruism?"

To which a hospital administrator replied, "You can't beat the crap out of doctors, then expect them to be compassionate."

Indeed. It's one thing to be charitable and compassionate on a voluntary basis, giving freely of your time and skill to help others who desperately need it. It's quite another thing to be mandated to be compassionate by the new rules of caring: Get down to the hospital at 3 a.m. and patch up somebody who's drunk and blew off his hand with a shotgun. He's uninsured, you might not get paid, but you have to provide compassionate care because it's the law.

And by the way, Doctor: For every patient you treat who's on a managed care contract, we're going to reimburse you Medicare rates, if that. But not to worry. The president of the managed care plan is making $4 million a year, and you can still make $300,000 if you work 80 hours per week. Don't expect the average Joe on the street to cut you any sympathy. His health care premium is approaching 20 percent of his take home pay.

Beyond Caring

This isn't an apologia for physicians. It affects all of us. By mandating compassion, we run the risk of losing our capacity to care.

What started centuries ago as a tradition of voluntary charity care through almshouses, private homes, settlement houses and hospitals – much of it faith-based – has gradually morphed into a tangle of public laws, rules and regulations that mandates care on the principles of compassion and fairness, but then places the burden of that care unfairly on the shoulders of the "caregivers" and not on the rest of us.

So it is that the physician is required to be compassionate in the emergency room at 2 a.m., while the insurance executive who's home in bed isn't.

It's not surprising that some physicians and other health professionals choose to opt out of the system. It's not because they don't care. It's because they see others don't care, including spoiled citizens and lawmakers with a penchant for passing unfunded mandates. They become cynical and disillusioned. They think, why should we be required to care, and not others?

A Blip on the Screen

America is blessed with free clinics, community hospitals and volunteers – including many nurses, physicians and other health professionals – who give generously of their time and talents to help those in need. But as marvelous as this web of caring is, it's a blip on the health care screen of almost 40 million uninsured, skyrocketing costs and cutthroat competition driven by the rules of the marketplace and shareholder expectations.

Consider our own behavior. We buy health care stocks for our retirement portfolios. We expect them to do well and look forward to a cozy future with quality health care on demand and low co-pays, then wonder why doctors aren't feeling so charitable anymore, or why hospitals are thinking of getting out of the trauma care business.

We are seduced by the siren song of free choice and the market economy, yet the last thing we want is physicians who act like businessmen when our own health is at stake, and health organizations that allocate resources solely on the unforgiving scale of profit and loss.

Mandating Compassion

Ironically, the best solution for the trauma and emergency room mess might well be even more mandates for compassion: a mandate for insurance plans to pay surgeons 200 percent of Medicare while on call, a mandate for the federal government to pay for EMTALA, a mandate for the state and hospitals to work together to integrate trauma care services, a mandate for auto insurance companies to pick up more of the tab for car accidents, a mandate for public funding for trauma centers, even a mandate for a base level of health insurance for all citizens.

Some of these mandates are about as likely as snow in July in Arizona. Short term, there are things we can do together voluntarily to integrate the system and make it more efficient. Long term, we need new rules that place the imperatives of compassion and caring on everyone, and not just the few.

Get The Drift, *a bi-weekly column, at* ***www.slhi.org.*** *The opinions expressed here are those of the author, and should not be attributed to SLHI trustees or staff.*

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The purpose of ***Arizona Health Futures*** is to unravel an important health policy topic of relevance to Arizonans, provide a general summary of the critical issues, background information and different perspectives on approaches to the topic; tap into the expertise of informed citizens, and suggest strategies for action.

Arizona Health Futures is available through our mailing list and also on our web site at **www.slhi.org.** If you would like to receive extra copies or be added to the list, please call (602) 385-6500 or e-mail us at **info@slhi.org.**

Comments and suggestions for future issues, as always, are welcome.

St. Luke's Health Initiatives is a public foundation formed through the sale of the St. Luke's Health System in 1995. Our resources are directed toward service, public education and advocacy that improve access to health care and improve health outcomes for all Arizonans, especially our state's most vulnerable citizens.

SLHI
A Catalyst for Community Health

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