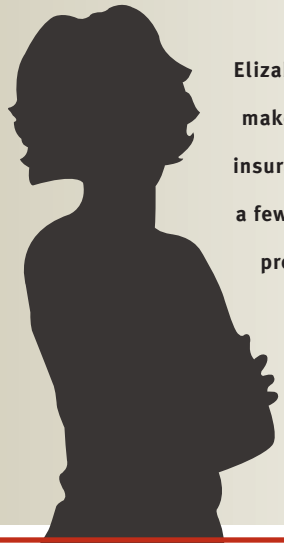
Squeezing the Rock II:

Maricopa County's Health Safety Net

"Getting some people the care they need is like squeezing a rock."

Janice Ertl, RN, Director, St. Vincent de Paul Virginia G. Piper Medical and Dental Clinic



Meet Elizabeth

Elizabeth* is a 24-year-old uninsured woman. Her income of $1,315 per month makes her ineligible for AHCCCS, and her employer doesn't offer health insurance. She develops stomach pains, and when they don't go away after a few days, she goes to an Emergency Room. There she has blood, urine and pregnancy tests, as well as an ultrasound. She's diagnosed with gallstones, which do not require immediate surgery. She's treated for pain and sent home with instructions to follow-up at Mountain Park Health Center in the next few days.**

* This scenario is based on the experiences of a real patient.
** AHCCCS income limit for one adult living alone is $798 per month.

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A Report from St. Luke's Health Initiatives

MAY 2006

Background

In 2002, St. Luke's Health Initiatives (SLHI) published *Squeezing the Rock: Maricopa County's Health Safety Net*, which described "a crazy quilt of emergency rooms, hospital clinics, free and reduced fee clinics, community health centers, school-based clinics, county public health services, and any number of volunteer-driven and often makeshift arrangements to deliver health care to the indigent, the uninsured, the underinsured and – increasingly – the insured."[1]

In 2004, SLHI zeroed in on one important aspect of the health safety net in the report, *Fact and Fiction: Emergency Department Use and the Health Safety Net in Maricopa County*.[2] This study was designed to complement *Urgent Matters*, a national program undertaken by the School of Public Health and Health Services at the George Washington University Medical Center and the Robert Wood Johnson Foundation, that continues to focus on an assessment of health safety net infrastructure generally, and emergency department specifically, in ten communities across the country. Researchers from George Washington University published *An Assessment of the Safety Net in Phoenix, Arizona* in 2004 as part of that work.[3]

An Update

With a number of studies of Maricopa County's health safety net completed within the past four years, why do another one?

- Maintaining the vitality of the health safety net is critical for the greater public good. Ongoing monitoring of health access, quality and cost in systems of care for our most vulnerable citizens helps to inform public policy regarding the distribution of public and private resources to build on the strength of communities and address local needs.
- Margin and mission in health care are at a tipping point. With the passage of Proposition 414 in 2003, the transition of the Maricopa Integrated Health System (MIHS) from a county-run system to a Special Health Care District is now complete. The timing is right to set the stage for the strategic planning and public policy discussion surrounding this vital community asset.
- Our tools for monitoring health system and community health performance continue to improve. Arizona HealthQuery (AzHQ),[4] an integrated health data warehouse, can be used to routinely track safety net conditions and other aspects of health care in Maricopa County.

Given baseline information in past studies and policy discussions of various aspects of health system and community health infrastructure in Maricopa County, this report is intended to be an *update* – and not a comprehensive overview – of the health safety net in the greater Phoenix metro area. We take a look at its principal providers and clients, track what's changed, and what hasn't, in the past four years; review progress in addressing policy issues raised in our 2002 *Squeezing the Rock* report, and make suggestions for future policy consideration and action.

Method

For consistency, we track changes in safety net providers and clients in the 2001-2004 period. AzHQ allows us to track 2005 numbers, but since they are not yet available from all providers, we focus on general trends, make projections and utilize 2005 data when appropriate.

As in past studies, we conducted approximately 50 interviews with health care providers, advocates, public officials, patients, analysts and others with a stake and interest in the Maricopa health safety net. The data alone do not begin to tell the rich stories of "squeezing the rock" to provide care to people in need, often in the face of daunting obstacles and limited resources.

Finally, any study of the health safety net has to be set within the context of the dislocation, fragmentation and perverse incentives that characterize much of the American health care system today. In addition to drawing on national safety net reports, we build on a number of past SLHI studies and policy primers on health system issues of access, quality and cost. These are available at SLHI's web site, www.slhi.org, and referenced as necessary.

A Safety Net Refresher

In our 2002 *Squeezing the Rock* study, we used the Institute of Medicine's (IOM) comprehensive definition of the health safety net: "*Those providers that organize and deliver a significant level of health care and other related services to uninsured, Medicaid and other vulnerable populations.*"

The IOM further defines two distinguishing characteristics of a "core" safety net provider:

- *Either by legal mandate or explicitly adopted mission they maintain an "open door," offering access to services for patients regardless of their ability to pay.*
- *A substantial share of their patient mix is uninsured, Medicaid and other vulnerable populations.*

Given this definition, some argue that the ultimate safety net is the hospital emergency department (ED). Federal law requires that all patients who come to the ED must have an exam to ensure that their condition is stable and does not require immediate attention. Because these terms are difficult to define, and because a patient's condition may be difficult to determine by a cursory triage exam, the overwhelming majority of clients that come to the ED are seen – although not necessarily in a quick and efficient manner.

We continue to follow the IOM's comprehensive definition of the safety net in this update, with a focus primarily on the outpatient side of the equation. We also discuss safety net issues and ED use, but not in any detail. We refer readers to the previously cited *Fact and Fiction* report on ED use in Maricopa County for additional information.

Bottom line, we're less concerned with tidying up the loose ends of definition, structure, licensing, funding and relationships that characterize the Phoenix metro region's health safety net than we are with describing the changing environment in which these organizations operate, the growing clientele base of people who use their services, and prospects for a future in which the health needs of uninsured and underserved populations are projected to outstrip the resources available to meet them.

WHAT'S NOT INCLUDED

It is impractical, if not impossible, to define and document all instances of organizations and individuals providing safety net services in Maricopa County.

We focus on principal ambulatory care safety net providers as identified, knowing full well that many other organizations provide such services to some degree. The fact that we don't reference them does not mean they aren't important. Further, we do not discuss dental and behavioral health services in any detail, but acknowledge that they are critical pieces of core safety net health services. SLHI reports that focus on these issues are available on our website.[5]

The Federal and State Context

All safety net systems in the U.S. are different, but they operate in a common context:

- **Employer-based insurance is decreasing.**

  In the 2001-2004 period, employer-based coverage in the U.S. for those under 65 went from 66.4% to 63.2% – a 3.2% decrease. In the same period, employer-based coverage in Arizona went from 61.6% to 55.7% – a 5.9% decrease. See Table 1.

- **The number of uninsured is increasing.**

  About 4.6 million people were added to the U.S. uninsured roles in the 2001-2004 period. Approximately 35,000 persons were added to the ranks of the uninsured in Arizona in the same period – a slight decline in percentage of uninsured (17.9 to 17.1) due to the effects of increased AHCCCS enrollment. See Table 2.

TABLE 1*: Health Insurance Coverage 2001-2004, People Under 65 Years Old

	Persons <65 US			Persons <65 AZ		
Health Insurance Coverage	2001	2004	Change	2001	2004	Change
Population (millions)	248,312	255,942	3.1%	4,709	4,995	6.1%
% Uninsured	16.5%	17.8%	1.3%	20.0%	19.7%	-0.3%
% Employment-based Insurance	66.4%	63.2%	-3.2%	61.6%	55.7%	-5.9

TABLE 2*: Health Insurance Coverage 2001-2004, All Ages

	All Persons US			All Persons AZ		
Health Insurance Coverage	2001	2004	Change	2001	2004	Change
Population (millions)	282,082	291,155	3.2%	5,316	5,767	8.5%
% Uninsured	14.6%	15.7%	1.1%	17.9%	17.1%	-0.8%
% Employment-based Insurance	62.6%	59.8%	-2.8%	58.1%	52.7%	-5.4%

* U.S. Census, Current Population Survey

- **Enrollment in Medicaid is increasing.**

  Nationwide, Medicaid enrollment increased approximately 20% in the 2001-2004 period. Following the passage of Proposition 204 in 2000 (increasing Medicaid eligibility from 40% of the federal poverty level (FPL) to 100% FPL), enrollment in Arizona's Medicaid program (AHCCCS) increased 49% from 2001-2004 (over 61% in Maricopa County). Today, AHCCCS enrollment is over one million persons. Over the past year, the growth rate has flattened out and is more consistent with national rates. See Table 3.

- **Medicaid spending is increasing.**

  Consistent with enrollment growth, total expenditures for AHCCCS programs nearly doubled between 2001 and 2005. In the same period, however, the proportion of state general fund expenditures earmarked for AHCCCS actually decreased by 1.4%. See Figure 1.

TABLE 3: Growth in AHCCCS Enrollment, 2001-2005[10]

	AHCCCS Covered Lives*		Population	
	AZ	Maricopa County	AZ	Maricopa County
2001	700,980	348,732	5,197,474	3,192,000
2004	1,044,959	562,837	5,633,997	3,524,000
2005	1,052,270	572,027		
Growth 2001-2004	49.1%	61.4%	8.4%	10.4%
Growth 2004-2005	0.7%	1.6%		

* Acute Care and Long Term Care

- **Federal safety net spending per uninsured person is decreasing.**

  The federal per uninsured person rate fell from $546 to $498 in the 2001-2004 period. Adjusted for inflation, total federal spending for care for the uninsured increased by 1.3% from 2001 to 2004, while the number of uninsured increased by 11.2%. These trends resulted in an 8.9% decline in spending by the federal government per uninsured person.[6]

- **Public insurance and safety net programs are increasingly fragmented and under budgetary pressure.**

  AHCCCS administers 13 separate programs, many of which face continuing pressure to enact cost containment strategies, such as controlling drug costs, reducing provider payments, restricting eligibility, increasing co-payments, etc. See Figure 2.

- **Safety net programs across the country face a declining number of providers to see an increasing number of clients.**

  The shortage of physicians, nurses and other health care professionals in Arizona and elsewhere is well documented.[7] Shortages are especially acute in specialty care.

FIGURE 1: AHCCCS Funding Sources FY 2001-FY 2006[8]

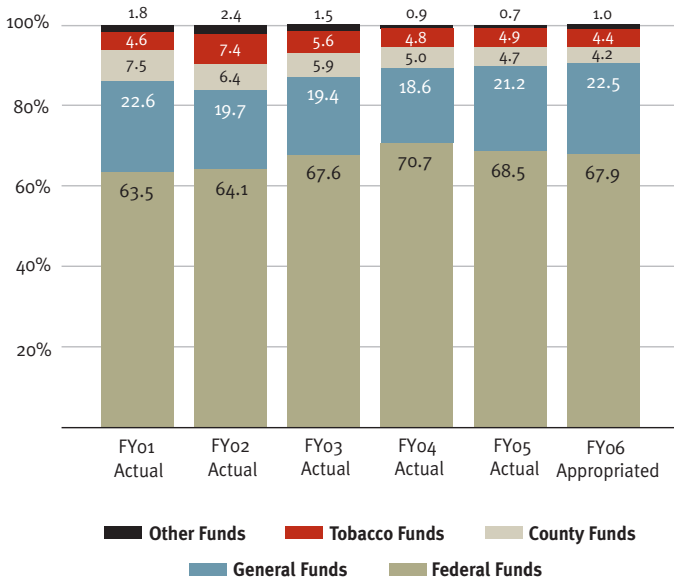


FIGURE 2: AHCCCS-Administered Programs and Enrollments, 2005[9]

- **Arizona Health Care Cost Containment System (AHCCCS) – 527,472**
- **AHCCCS for Families with Children (AFC) – 113,332**
- **Health Insurance for Parents – 13,456**
- **KidsCare – 50,927**
- **Arizona Long-Term Care System (ALTCS) – 41,656**
- **Breast and Cervical Cancer Treatment Program (BCCTP) – 90**
- **Freedom to Work (FTW) – 777**
- **Medical Assistance Only (SSI-MAO) – 122,880**
- **Medical Expense Deduction (MED) – 4,665**
- **Federal Emergency Services (FES) – 73,820**
- **Medicare Cost Sharing (MCS) – 9,766**
  - Qualified Medicare Beneficiary (QMB)
  - Specified Low-Income Medicare Beneficiary (SLMB)
  - Qualified Individual (QI-1)
- **SOBRA for Children – 87,112**
- **SOBRA for Pregnant Women – 9,276**

Elizabeth's ED Visit #1

- **Pain is treated**
- **Surgeon declines to consult on non-acute situation**
- **Discharged, told to follow-up at local community health center**
- **Acute problem – as defined in the ED – is addressed**

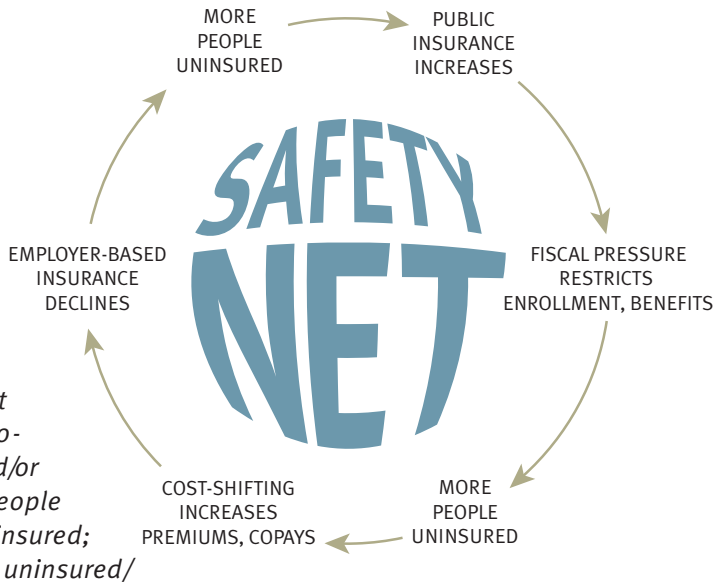
CHARGES

ER visit	$250
CBC	$65
Chem Panel	$145
Urinalysis	$60
Urine Pregnancy Test	$60
Abdominal Ultrasound	$190
Reading of Ultrasound	$95
TOTAL	**$865**

The logic of the American health care system – or rather the *illogic* of it – is relentless:

In the face of rising health care costs and global competition, employers reduce health benefits or increase employee contributions; more workers become uninsured or enroll in the public system; increased enrollment in the public system puts fiscal pressure on federal and state budgets; policy makers, in turn, restrict enrollment in public programs, restrict benefits and/or increase co-pays; more people drop out and become uninsured; providers treat ever more uninsured/underinsured patients and pass on the costs throughout the system in the form of higher charges and insurance premiums; employers react to the rising costs and premiums by reducing/eliminating benefits or passing them on to employees in an ever escalating cycle. This is illustrated in Figure 3.

FIGURE 3: An Escalating Cycle



In the middle, under pressure from both increasing numbers of patients and limited human and financial resources to provide necessary care, is the health safety net.

At one time, the safety net was an escape valve for pressure in the system. People without health insurance or a regular source of care, as well as those who, for one reason or another, were unable to navigate the complexities of the health care system, could expect to get care at comprehensive community health clinics, free and reduced fee clinics run by nonprofit and charitable groups, and – as a last resort – hospital emergency rooms. As uncoordinated and underfunded as this care was (and still is), there were sufficient primary care and specialist providers in place to patch together a local community response.

Like a Balloon

Today, the escape valve functions more like a balloon: the overflow of patients and the shortage of financial and human resources both within and without the health safety net combine to expand the membrane to the breaking point. Many public hospitals were the first institutions to break under the pressure;[11] the current federal and state fiscal climate for Medicaid and other public programs is projected to make it even more difficult for community health centers and other safety net providers to provide the same level of services in the future and remain financially viable.[12]

While the safety net in Maricopa County has proven remarkably resilient since our first report in 2002, it is groaning under the sheer weight of a rapidly growing population and rising numbers of uninsured; a critical shortage of primary care physicians, specialists, nurses and other health professionals whose services are in demand throughout the entire health care system; increased operating costs; and a continuing migration away from the "medical home" concept of the primary care center to the just-in-time "Circle K" world of the emergency room.

The dream of an integrated, coordinated health safety net system that provides comprehensive care to low-income and uninsured persons is as elusive as ever. The fact of the matter is that the safety net sits within a larger system that is itself increasingly fragmented, inefficient and inaccessible to persons who need care. As long as pressure continues to build in the balloon without an escape valve of its own, it is destined to burst.

The Safety Net Puzzle: *An Update*

Growth Pressures

TABLE 4: Representative Safety Net Growth Pressure 2001-2004

	Number of Clients (Visits Where Noted) 2001	2004	% Change
Clinica Adelante	17,000	28,000	65%
Las Fuentes Health Clinic	4,000 (visits)	4,932 (visits)	23%
Maricopa Health Care for the Homeless	5,000	6,000	20%
Maricopa Integrated Health System Primary Care	406,000 (visits)	332,607 (visits)	-18%
Mission of Mercy	12,274 (visits)	8,566 (visits)	-30%
Mountain Park Health Center	25,000	46,000	85%
Neighborhood Christian Clinic	2,328 (visits)	3,572 (visits)	53%
School-Based Health Clinics (statewide)	27,000 (visits)	40,000 (visits)	48%
St. Joseph's Primary Care Clinics	11,000	21,000	47%
St. Vincent de Paul Clinic	10,000 (visits)	13,000 (visits)	30%

Many safety net providers in Maricopa County have seen significant increases in patients and clinical visits in the 2001-2004 period.

As Table 4 illustrates, many safety net providers in Maricopa County have seen significant increases in patients and clinical visits in the 2001-2004 period. The patient profile, payer mix and access patterns vary by type of provider, but the following factors are present across the board:

1. **POPULATION GROWTH.** According to U.S. census figures, Maricopa County had a net gain of over 300,000 persons in the 2001-2004 period alone.
2. **PROPOSITION 204.** The dramatic increase in the state's AHCCCS (Medicaid) program (Table 3) since the passage of Proposition 204 has brought more people into the formal health care system. In safety net providers, this shows up in places like community health centers and hospital inpatient/clinic services.
3. **COMMUNITY HEALTH CENTER EXPANSION.** As a result of a federal five-year, $780 million initiative to expand community health centers (CHCs), Mountain Park Health Center added three sites in Maricopa County and is planning a fourth. Clinica Adelante also expanded services. Expanded facilities meet an expanding need in growing Valley communities.
4. **GROWING NUMBERS OF UNINSURED.** While the mix of the uninsured/insured ratio has stabilized since 2001 due to the AHCCCS expansion, the total number of uninsured has increased as the result of decreasing employer-based health insurance, growth in the general population, and the continuing influx of both documented and undocumented immigrants. The dramatic increase in patients seen at the Neighborhood Christian Clinic in Phoenix, for example, consists primarily of undocumented immigrants.
5. **CHRONIC HEALTH PROBLEMS.** It's not only numbers of patients that are up, but visits per patient: All safety net providers report an increase in patients with chronic conditions, especially diabetes, who require more time and follow through.
6. **LACK OF ACCESS TO SPECIALISTS.** All safety net providers report continuing problems with access to specialty care, especially in high demand/professional shortage specialties like orthopedics and general surgery. Even when referrals are found, people without health insurance or who face high co-pays are increasingly unable to pay the bill.
7. **PRESSURE ON CHARITY CARE.** Financial pressures on providers (stagnant or declining reimbursement rates from both private and public payers, increasing overhead costs, labor shortages, malpractice premiums, etc.) make it more difficult to provide charity care and/or to shift free and reduced-fee care to other parts of the system. Nationally, the percentage of physicians who provide charity care is decreasing.[13] Anecdotally, safety net providers report that while physicians, nurses, dentists and other health care professionals continue to provide charity care where possible, it is becoming harder to meet the increased demand.
8. **GEOGRAPHICAL AND ADMINISTRATIVE FRAGMENTATION.** While the expansion of community health centers has helped, safety net providers in Maricopa County that primarily serve low income and uninsured persons are clustered in central Phoenix, leaving large sections of the Valley without easily accessible services. In the absence of any formal administrative structure linking safety net providers, such as a common data system to track encounters and share information, providers develop their own informal, ad hoc networks of people and institutions to call for services or favors – often a hit or miss approach.

Got Insurance?

If you don't have health insurance, hard cash will do.

In a recent study, researchers posing as patients seen in an emergency department the night before made calls to schedule an appointment for urgent follow-up care. The callers used the same clinical scenarios, but different insurance information. The results:

- **The callers succeeded in scheduling an appointment only about half the time: 47.2% succeeded in getting appointments within one week.**
- **Callers with private insurance succeeded 63.6% of the time.**
- **Callers with Medicaid coverage, 34.2%.**
- **Uninsured callers offering to pay $20 up front and arrange payment of the balance, 25.1%.**

Interestingly, uninsured callers offering to pay in full were as likely to receive a follow-up appointment as privately insured callers. Money talks.[14]

Access to Specialists

The ability to successfully refer low income and uninsured patients to specialty services not available through ambulatory clinics is a perennial problem for safety net providers, and is even more acute in 2006 than it was five years ago. This is true not only for medical specialties, but also for dentists and behavioral health specialists.

Clients requiring surgery pose particular problems. While it may be possible to find a surgeon willing to donate his or her services, the cost of the operating room and anesthesia must also be arranged. Most facilities require a substantial portion of the bill to be paid prior to non-emergent surgery.

To take just one example, consider orthopedics. The MIHS Health Center clinics lost their orthopedic services in 2004, and the negative ripples quickly spread through the community. One safety net physician described an increasingly common event:

> *"I had a patient who had a sewing needle in her knee. She kneeled on it by accident. I couldn't get her in to an orthopedist. Three ERs refused to do anything for her. After almost three weeks, I finally got a private orthopedist to do the surgery for free. She still had to pay the hospital fees."*

The same pressure on finding medical specialists is well documented in Valley emergency rooms, the "big box" of safety net care for ever increasing numbers of residents, many of them with health insurance. We have discussed issues with specialists, hospitals and ERs in previous reports, but underscore their importance in this context to stress the inescapable conclusion that the pressures impacting the safety net reverberate throughout the entire health care system.

Elizabeth's Community Health Center Visit

Elizabeth recounts her ER visit, is subsequently examined and told she needs surgery. The CHC tells her to go to the local public hospital.

- **Sliding Fee Scale – $40**
- **No repeat labs needed**

HealthCare Connect:
A New Safety Net Option

One of the changes in the Maricopa County health safety net since 2001 is the addition of HealthCare Connect, a federally-funded Community Access Project, which provides a network of primary and specialty care sites, lab, radiology, and pharmacy services at discounted prices to low income, uninsured clients who earn too much to qualify for AHCCCS but can't afford their own health insurance and lack access to employer-based insurance. Clients pay an annual enrollment fee of $50 and low co-pays when they access services. They pay no monthly premiums, and no medical conditions are excluded. HealthCare Connect mirrors a successful effort in Pima County that serves about 8,000 persons annually.

Clients in these networks must pay up front at the time of their visit, so the program does not enroll people living in poverty. Experience from Pima County demonstrated that the poor could not pay the required discounted cost for a health care visit. At the end of 2005, HealthCare Connect was serving 2,900 people, who have had over 7000 encounters with the health system.

Community Health Centers refer clients to HealthCare Connect for specialty care access, but with variable success. Mountain Park Health Center has successfully referred a large number of clients, although they express concerns about specific areas of access. Clinica Adelante, which serves a population that is poor and more transient, has had less success with HealthCare Connect for specialty referrals. Many of Clinica's clients earn too little to join the discount program. Further, early experience suggests that the HealthCare Connect provider network is not geographically accessible for this far-west Valley population. As the HealthCare Connect network grows, however, this issue may be ameliorated.

Elizabeth's ED Visit #2

One week after her visit to the CHC, Elizabeth shows up at the Maricopa Medical Center Emergency Room. She does not have any medical records with her – no copy of her ultrasound or the report, no lab results. She has minimal pain, no fever, but is anxious and demands to see a surgeon.

Safety Net Provider Update

Clinica Adelante

Clinica offers services at six sites throughout Maricopa County. While they have not added any additional sites since our first safety net report in early 2002, the number of clients they serve has increased markedly: 28,000 in 2004 compared to 17,000 in 2001 – a 65% increase.

Unlike Mountain Park Health Center, Clinica did not benefit substantially from the Prop. 204 AHCCCS expansion. About 60% of their clients were not eligible. Over half of their clients are uninsured, and most (80%) are poor. Clinica officials observed that with Prop. 204, the percentage of uninsured decreased, but the absolute number has remained about the same.

As with all safety net sites in 2005, the prevalence of chronic diseases like asthma, diabetes, and hypertension/cardiovascular disease is extensive and costly. Clinica has programs in place to target these conditions, but it remains a struggle to coordinate care and track data. Clinica staff tried implementing an electronic health record to help in that regard – a critical key to quality disease management programs – but the particular record did not work well.

As reported elsewhere, access to specialty care remains a problem for Clinica clients, whose incomes are too low to access most specialty networks. A decreasing number of specialty physicians offer volunteer coverage to fit the need. For example, if only 10% of Clinica's uninsured clients needed specialty care – a conservative estimate – 1,500 clients would need to be followed for free over time. Clinica continues to refer clients to MIHS for outpatient specialty care. They report that while most can scrape together the $60 or more for the initial visit, they have problems with follow-up in a fragmented, uncoordinated and expensive system.

There is one reported bright spot: Clinica has benefited from a reimbursement structure that provides Medicaid cost-based reimbursement payments for community health centers. Officials state that cost-based reimbursement has helped to achieve more financial stability, although in general, Clinica Adelante operates at a loss. For every $1 in federal and state funds taken in, Clinica gives away $1.20 in sliding fee scale discounts. Ongoing funding constraints contribute to predictable provider turnover, not to mention having to keep pace with the demand for services. Increasing client numbers create pressure to expand, but capital funds are not readily available.

Mountain Park Health Center

Like Clinica Adelante, Mountain Park Health Center (MPHC) has seen a significant enrollment increase in the 2001-2004 period: 25,000 to 46,000 clients, or an 85% increase. Almost 80% identify themselves as Hispanic or Latino.

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Elizabeth's ED Visit #2

(The saga continues...)

Elizabeth has to repeat many of the tests, since her original visit was to a different ER, and records are not available. Elizabeth is seen by a surgeon, who confirms the diagnosis of gallstones. Since her condition is still not an emergency, she is sent home and instructed to return if she has pain or a fever. She is referred to a surgery clinic at MIHS for follow-up and advised to schedule elective surgery "when she has the money." Gallbladder operations cost between $3,000 and $8,000.

CHARGES

ER visit	$ 250
Surgery Consultation	$ 400
CBC	$ 65
Chem Panel	$ 145
Urinalysis	$ 60
Urine Pregnancy Test	$ 60
Abdominal Ultrasound	$ 190
Reading of Ultrasound	$ 95
TOTAL	**$ 1,265**

At the time of our first report, MPHC was working to open their first expansion site in Maryvale. They have since added several sites in addition to their original location in South Phoenix. The Maryvale site, open since 2002, is busy, with over 32,000 visits in 2004. That site, funded through the federal CHC initiative with additional government and philanthropic support, has an on-site pharmacy. Space for more medical capacity and dental services are on the wish list for future expansion.

MPHC also added a site in Tolleson in 2002 that is already bursting at the seams; federal funding has been approved for expansion. A third site in east Phoenix opened in 2004 and serves a diverse patient base that includes Somali and Russian clients. Currently, MPHC is in the process of establishing a fifth site in Tempe.

As with most of the safety net providers, MPHC has experienced a rise in the number of uninsured that is straining their infrastructure. State primary care funds, allocated only to the South Phoenix site, are quickly depleted each year. Despite the rapid expansion to new sites, which has strained cash flow, MPHC has not seen any decrease in clientele at their original South Phoenix site.

At the same time, the AHCCCS expansion through Prop. 204 has been a lifesaver, with as much as a 60% increase in AHCCCS clients in one month in 2002, as low-income clients previously unqualified for AHCCCS began to enroll and receive coverage. There was not an exodus of paying clients to the private sector, a prime concern expressed prior to Prop 204 implementation, and the growth in insured clients, accompanied with the ability to refer for specialty care and cover prescription drugs and other treatments, has been a boon. Like their colleagues at Clinica Adelante, MPHC officials report that cost-based Medicaid payment for services has proven to be a source of stable revenue for CHCs that allows them to continue to offer subsidized care for the uninsured.

MPHC continues to have difficulties with getting their uninsured clients access to specialty services. Officials report that some MPHC patients "don't want to go" to the Maricopa Medical Center for specialty care because they view MedPro (the physician group that staffs the hospital) as only interested in treating insured patients.

Like all safety net centers, MPHC reports significant increases in the number of patients with chronic diseases such as asthma, diabetes and cardiovascular disease. Also, since implementing an integrated mental health program, encounters in the MPHC Behavioral Health Program tripled between 2003 and 2005.

St. Vincent de Paul

The St. Vincent de Paul (SVDP) Virginia G. Piper Medical and Dental Clinic continues to play a key role in the central Phoenix health safety net. The clinic had 13,000 visits in 2004 compared to 10,000 in 2001 – an increase of 30%. These are provided by a volunteer group of physicians and paid clinical staff. Since the clinic serves only the uninsured, clients who are eligible for AHCCCS or other health coverage are referred to sites such as the Banner Good Samaritan and St. Joseph clinics.

The demographics of the population served by SVDP are changing: Almost 90% is now monolingual Spanish. Officials report that the burden of disease is rising markedly. Chronic disease, always a burden in this population, has risen markedly in recent years. Diabetics are coming in with blood sugars in the 400-500 range (normal 100). If these clients had insurance, they would be hospitalized for stabilization, but without insurance, they are not. The clinic must work with clients for longer periods of time to stabilize them and provide education on how to more effectively manage their conditions prior to transitioning them to a CHC or other provider.

Like all free and reduced fee clinics, SVDP is forced to ration its services. Money is tight, and the needs are great. Janice Ertl, SVDP executive director, struggles with the weight of decisions that she must make. "I have to pick and choose who I can help and who I can't, and to be sure I apply the monies in an ethical way." Is it better to use the limited funds to treat a large number of clients for preventive services or to pay for a surgical treatment for a condition that causes loss of function for a single person?

Like all free and reduced fee clinics, SVDP is forced to ration its services.

Is it better to use the limited funds to treat a large number of clients for preventive services or to pay for a surgical treatment for a condition that causes loss of function for a single person?

SVDP is able to offer many specialty services through their volunteer physicians, but lack neurology and urology services. Funding constraints have pushed clinic staff to focus on prevention – to use fluoride varnish on infants and young children to prevent the pervasive dental caries they see in older children, to identify teens and adults at risk for diabetes and heart disease, and to work with them on better nutrition and exercise. All of this, of course, takes time – and time is at a premium.

SVDP utilizes Maricopa Medical Center's sliding fee scale program heavily for quick entrance to diagnostic services such as MRI, CT scans, and ultrasound. St. Joseph's Hospital covers specialty labs for the clinic. But Ertl expressed reservations about clients' use of the outpatient specialty care at Maricopa Medical Center's outpatient clinics, particularly about their ability to pay the required visit fees.

St. Joseph's Hospital Mercy Clinics

Hospital outpatient clinics face pressures similar to other safety net facilities. St. Joseph's Hospital, for example, serves uninsured clients on a sliding fee schedule based on financial qualifications. They served 21,000 clients in 2004 – an increase of 47% since 2001. Mercy Care Clinics, which include PACC, have a separate program that provides clients primary care services for a small monthly premium.

Primary care services at St. Joseph clinics, including pediatrics, internal medicine, OB-GYN, and dental care, are provided by hospital-employed physicians as well as residents. This is in contrast to some other hospital outpatient clinics that are directly tied to residency programs. While the fees at the St. Joseph clinics cover the visits, lab tests, radiology, and some medications are not covered.

Even in this tertiary care center, specialty access remains an issue. If patients are on a financial assistance program, primary care provider services are covered. Specialists, who are generally not employed by the hospital directly, are not covered under the sliding fee scale. When a patient needs a specialist, the primary care doctor must take the time to make the connection, because it often involves calling in favors. This process, which can't be accomplished by a referral coordinator, creates inefficiencies in overall patient care.

Neighborhood Christian Clinic

The Neighborhood Christian Clinic (NCC) opened its doors in 1999 as a ministry to meet the health care needs of low income, uninsured persons, the great majority of whom are undocumented immigrants. To no great surprise, their "business" has grown steadily over the years – visits in 2005 (4,587) were up almost 30% over 2004 visits alone. NCC moved to a new Central Phoenix facility in 2003 and opened a dental clinic in 2004.

"25 primary care providers come in, but we need 100."

Paul Lorentsen, MD
Director and Founder,
Neighborhood Christian Clinic

NCC currently operates with nine paid staff and is open 28 hours a week. The annual budget is around $900,000, all of which is generated from individual contributions and grants, as well as about 17% from a $20 fee per patient/per visit. The latter is applied to costs for their visit, medications, lab tests and x-rays. Additionally, NCC clocked 7,000 volunteer hours in 2005, up 25% from 2004.

Paul Lorentsen, MD, NCC's director and founder, says that "25 primary care providers come in, but we need 100." Like his colleagues at other safety net facilities, Lorentsen says he is able to cobble together a network of about 40 sub-specialists for referrals, but while they usually contribute their services free of charge, he still has to find money for the OR and other hospital/procedure fees.

Lorentsen reports less success in using HealthCare Connect's network of specialists, because "our clinic doesn't have the capacity to do a lot of paperwork and follow through, and most of our clients don't have the knowledge and patience it takes to access other parts of the system."

NCC, too, reports seeing many more patients with major complications from chronic diseases like diabetes and cardiovascular disease. Fully 80 percent of their patients are returnees. "We've become a full service medical home for them," Lorentsen says.

Maricopa Health Care for the Homeless

The Maricopa County Department of Public Health operates Maricopa Health Care for the Homeless (MHCH), a primary care clinic that recently moved to the new Human Services Campus in Central Phoenix in order to achieve a more effective integration of health and human services. MHCH has seen its patient population increase about 20 percent over the past five years, along with annual funding it receives from the federal Health Resources and Service Administration (HRSA) through the Bureau of Primary Health Care. The HRSA grant makes up about $2.1 million of a $2.3 million budget.

Somewhere between 30-40% of MHCH clients are now enrolled in AHCCCS, which has helped considerably, according to officials. Similar to other safety net clinics, MHCH reports trouble recruiting and keeping physicians and nurses; they currently operate with one MD, one NP and are looking for another professional to handle the follow through with a population characterized by chronic diseases and often significant behavioral health and addiction issues.

The move to a centralized Human Service Campus, however, has precipitated a decline in the need to identify and treat clients in surrounding areas as more services are integrated in one setting. This is a significant improvement from the more geographically dispersed and fragmented health and human services for the homeless and transient population five years ago.

Mission of Mercy

Mission of Mercy, like the Christian Neighborhood Clinic, is a ministry to meet the needs of the low-income and immigrant population. They continue to operate a mobile health clinic that visits Mesa, Maryvale, Phoenix and Tempe on a weekly basis to provide primary care services to uninsured clients, many of whom have come to rely on Mission of Mercy as their sole source of medical care.

A 30% decline in the number of visits between 2001-2004 (9,488 visits were documented in 2005 – an increase of 11% over 2004) is reflective of a conscious decision on the part of Mission of Mercy officials and their volunteer medical providers to focus less on episodic acute care and to provide better care to a growing number of patients with chronic diseases, especially diabetes. In the words of one safety net physician, "You can see everybody and do really crappy care or see some and do good care." Mission of Mercy turns away 25-40 visits a day because the volunteer providers are overwhelmed with patients who need extra time, attention and follow through.

The paradigm shift from episodic care to primary and chronic care began during 2002-2003. According to Catherine Amiot, Mission of Mercy's executive director,

> *"During this time we found that we had too many med students in relationship to the number of patients we were serving. Some observed our clinics had the intensity of a hospital emergency room. We have consciously backed away from this more impersonal model of numbers-driven acute care to a more integrative model of holistic patient care where we spend necessary time addressing the impact issues of chronic disease with the patient and with the family it affects the most."*

The number of volunteer physicians, nurses, pharmacists and other health professionals and assistants has remained relatively steady over the past five years. In 2004, a total of 228 active volunteers contributed almost 13,000 hours of service. Recruiting and retaining medical interpreters is an area of particular need. Mission of Mercy has instituted a "Compassionate Partners Initiative" to create a resource network of hospitals, labs and other health care providers that their primary care providers can use for referrals, tests and specialty care. Like most other ministry- and mission-driven programs, Mission of Mercy is financed almost entirely by private contributions, grants and in-kind services.

Las Fuentes Health Clinic

Las Fuentes provides primary care services to a predominantly Hispanic (61%) and Pascua Yaqui Indian (37%) population in Guadalupe. About 31% of their clients are uninsured; the rest are served under an AHCCCS contract, an Indian Health Services subcontract to serve the Pasqua Yaqui, and private plans. Grants and contributions continue to be an important part of the funding puzzle.

Officials confirm the same issues found in other safety net clinics: limited access to specialists (Nephrologists, Rheumatologists, Cardiologists, General Surgeons) limited access to dental and behavioral health services, and limitations on chronic disease management (costs of medications, costs of diabetic supplies, no case management available, such as promotoras).

Elizabeth – ER Visit #3

See ED visit #2 for the details, because that scenario is repeated six weeks later, with the same work-up, the same diagnosis, and the same advice.

BOTTOM LINE

Elizabeth ends up with $3,395 in hospital bills, plus the costs of medications. She is still uninsured, still with recurring abdominal pain, still with gallstones, and still without money for the operation.

School-Based/School-Linked Health Centers

Statewide, school-based health centers (SBHCs) experienced growth similar to other safety net clinics in the 2001-2004 period, going from 27,000 visits in 2001 to 40,000 visits in 2004 – a 48% increase. While visits increased, the number of clients themselves stabilized at roughly 14,000 users, which underscores the trend for more visits per client. This is a direct result of the prevalence of chronic diseases like diabetes showing up in younger and younger populations.

In Maricopa County specifically, there are 38 SBHCs on school grounds, four SBHCs that are school-linked but not on school grounds, and two mobile units. The number of school-based sites declined by 10 in 2005 when Clinica Adelante transitioned them to a mobile unit.

"It's one thing to shop around for health care, and it's another thing to actually find a place where you can afford to shop."

Safety Net Provider

All of the SBHCs serve primarily low-income children. Five years ago, about 90% of these children were uninsured, but that number has dropped to about 60-70% in Maricopa County alone as more children were able to qualify for AHCCCS and the KidsCare program. Funding for the uninsured comes primarily through Arizona's primary care funding from the Arizona Department of Health Services (formerly Tobacco Tax monies). As in past years, establishing referrals and links to specialty care, dentistry and behavioral health is difficult at best.

Community Health Services Clinic

The Community Health Services Clinic (CHSC) provides health care services for a predominantly low income, uninsured population in the south Scottsdale-North Tempe section of the Valley. Staffed and partially funded (28%) by the Arizona State University College of Nursing, the clinic employs a nursing model of health care and provides a clinical site for faculty practice and research in addition to primary care services.

CHSC reported 8,072 client visits in the 2004-2005 period, of which 92% were self-pay. This was a combination of on-site visits (4,723) and the delivery of business and community outreach services (3,349). Practically all of these clients work full- or part-time; those who are not eligible for AHCCCS may qualify for a Client Assistance Program that is funded through community donations.

As reported throughout the safety net system, CHSC clients exhibit more chronic conditions and complex health problems than in past years, when more of them were seen for "well visits" and simple health problems. Referrals to specialists remain an issue; officials also report that more clients are likely to inquire into the costs of the health care services and the immediate financial impact of their visit.

As one safety net provider noted, "It's one thing to shop around for health care, and it's another thing to actually find a place where you can afford to shop."

No Margin, No Mission: *The Maricopa Integrated Health System*

One of the significant changes since our first *Squeezing the Rock* report in early 2002 is the status of the Maricopa Integrated Health System (MIHS), which has been pronounced to be in a state of crisis for over a decade. In 2003, Maricopa County voters approved Proposition 414, forming a Maricopa County Special Health Care District (SHCD) that allowed for the creation of a dedicated revenue source in the form of up to $40 million annually in new property taxes on County residents. In November 2004, voters elected a governing board for the new District, transitioning responsibility for Maricopa Medical Center and its affiliated outpatient clinics, psychiatric treatment facilities, and burn center away from their historical control by the County Board of Supervisors.

As a result, Maricopa Medical Center can no longer be called "the County Hospital."[15]

MIHS is Maricopa County's largest safety net provider, and as such their ability to provide comprehensive services to the uninsured and other populations that find it difficult to access health services is of critical importance to the entire local health care system. In addition to operating a major teaching hospital with trauma services and a burn center, MIHS provides outpatient services through a Comprehensive Health Center, the McDowell Healthcare Clinic and 10 Family Health Centers.

Health Center Visits Decline

Both the Comprehensive Health Center and the Family Health Centers, which are similar to community health centers, offer a sliding fee scale for outpatient visits. Because of the precarious budget situation of the past years, the cost of a visit has been prohibitive for many uninsured clients, even on the sliding fee scale. The result: MIHS outpatient visits went from 406,000 in 2001 to 333,000 in 2004 – an 18% decline.

Even with a new dedicated funding stream, MIHS remains under severe financial pressure to attract patient revenue, invest in much needed capital renovation and technology upgrades, and provide primary and specialty services to a low income population that, on average, has significant health care needs compared to other groups with more resources.

The issue is the same as it was five years ago: *No margin, no mission*. Dedicated health care funding streams for the uninsured and low income populations, at least at current levels, are insufficient by themselves to keep a comprehensive public hospital system afloat in a competitive environment for a scarce professional workforce, investment capital and patients who can pay their bills. While MIHS – and all public hospitals for that matter – have limited ability to provide free or reduced-fee care, there is a distinct expectation in the broader health care market that this is their sole mission, and that they shouldn't be "competing" for patients who have the resources to go elsewhere for services.

Had Elizabeth Visited an MIHS Clinic

With her monthly income of $1,315 in 2004, she would have paid $150 for a primary care visit or $175 for a specialist visit. Either way, that's over 10% of her total take-home pay.

The Chaplains Prayed

Difficult times call for difficult measures. In 2004, MIHS's orthopedic residency training program was closed, a victim of the unstable financial condition of the system. In the same year, MIHS discontinued its contract to provide medical services for Arizona's long-term care patients (ALTCS). Presumably, this is one reason visits to MIHS's Family Health Centers that represent Medicare claims were down 32% in the first nine months of 2005 compared to a similar period in 2004.

While MIHS – and all public hospitals for that matter – have limited ability to provide free or reduced-fee care, there is a distinct expectation in the broader health care market that this is their sole mission, and that they shouldn't be "competing" for patients who have the resources to go elsewhere for services.

Yet at the end of September 2005, MIHS was on the road back to financial stability. Between January and September, Maricopa Medical Center turned a $12 million debt into $25 million in the bank.[16] The turnaround was particularly significant in light of the fact that the new tax authorized by Proposition 414 was not levied until July 2005, with initial revenues collected in October 2005.

A press release issued by MIHS at the time gave the following reasons for the turnaround:

> *People began taking days off without pay. Overtime was cut in non-clinical areas. Contracts were renegotiated. Consulting firms were phased out and permanent staff was hired — mostly from the private sector. Staffing practices were revamped. Billing and collections were strengthened. Software programs replaced manual processes. A $15 million line of credit, along with other financial assistance, was negotiated with Maricopa County. And the chaplains prayed.*

By January 2006, revenue from the property tax had generated $21 million. The special district's precarious financial position had been stabilized. New leadership with an ambitious vision is in place, and an intense strategic planning exercise is underway. The future, however, is anything but assured. Here are some issues:

To Build or Not to Build

Over the past decade MIHS has lacked adequate capital to maintain and improve the Maricopa Medical Center hospital building. As a result, it needs significant upgrading and repair. In February 2005, faced with the question of whether to rehabilitate the current deteriorating structure or to build anew, the District Board aired the possibility of a new hospital located near the new medical school in Phoenix, which would enhance their long-standing residency programs. Funding would come from bonds, for which the issuing authority was granted in the legislation that created the SHCD.

Tackling this politically fraught issue so soon after receiving responsibility for the health system immediately raised the ire of other hospitals in the area. While their support for MIHS core safety net mission was instrumental in getting the SHCD established in the first place, they viewed a new downtown hospital, even when characterized as a "replacement facility," as duplicative of existing hospital services within a three-mile radius and "unnecessarily competitive" to boot.

Not to put too fine a line on it, other hospital systems in the Central Phoenix corridor are perfectly willing to let MIHS absorb costly burn and trauma services and treat

most of the County's uninsured population, but they are unwilling to allow MIHS to compete for profitable revenue-generating services.

In the meantime, the issue of the Maricopa Medical Center's deteriorating physical plant remains. If the SHCD is to "fill service gaps" not provided by other "excellent hospitals in the area," as one news editorial put it, they will still need a refurbished physical plant to provide acceptable levels of quality and service, not to mention a structure that is attractive to physicians and can handle large numbers of residents training there.

Exactly how many *profitable* "service gaps" remain in the Central Phoenix corridor that haven't already been picked off by other hospitals in a competitive healthcare industry remains to be seen.

Reacquiring the Health Plans

When the SHCD was created, the Maricopa County Board of Supervisors initially retained control over what was presumed to be a profitable line of business – the Maricopa Health Plan and a long-term care plan. These products – both AHCCCS health plans – had been viewed over the years as the financial "shock absorbers" that allowed MIHS to remain afloat while its health care service operations faltered.

Ultimately, this proved to be untrue: Instead of making money, the plans were losing millions of dollars. In the spring of 2005, the County Board of Supervisors, citing significant financial losses associated with managing the health plans, publicly announced their desire to turn over management of the plans to the Special Health Care District.[17]

Several months and almost $35 million in cash incentives later, the SHCD Board agreed to the transfer. Using some of its new contracting flexibility, the Board entered into a contract with University Physicians Health Plans to manage Maricopa Health Plan, which serves about 50,000 AHCCCS members. While the health plans do bring insured patients to MIHS's outpatient and hospital services, it's an open question whether the revenue so generated will be offset by high health care costs of a low income population with a potentially greater burden of chronic disease and acute care services, as well as the need to cross-subsidize services for a continuing influx of uninsured persons.

If Medicaid reimbursement rates decline, as some observers project, owning Medicaid health plans could be a dicey proposition.

Financial Stability

Key to financial stabilization is the SHCD's ability to contract and purchase as a private entity rather than to be obliged to go through the county procurement process. In an important move, the District recently applied for and received Federally Qualified Health Center (FQHC) look-alike status for its outpatient services. This designation allows MIHS outpatient clinics to receive cost-based payment for Medicaid services. This is a positive development, for under conventional Medicaid reimbursement practices, payment for services may not cover the actual cost of service delivery. FQHC status helps to address the inability of safety net clinics to shift costs to cover this deficit.

Meanwhile, the taxing authority of the SHCD, which generated approximately $21 million in the first six months ending October 2005, is potentially subject to revision under Arizona House Bill 2112, which compromises the taxing authority of the SHCD with the promised allocation of additional federal disproportionate share (DSH) payments in FY 2006-2007. It remains to be seen where this bill and any subsequent revisions will fall out in state budget negotiations. Suffice it to say that DSH payments affect other hospital systems besides MIHS, and few people fully understand the labyrinth-like flow of DSH payments throughout the state. SLHI investigated DSH payments in an earlier health policy primer.[18]

Regardless of the economic and political vagaries of funding sources, MIHS, along with all safety net providers in Maricopa County, struggles with the uninsured and uninsurable. Based on an analysis of encounter data for the second half of 2005 and early 2006, MIHS officials estimate that 80% of persons in the "self-pay" category are undocumented immigrants. Safety net providers throughout the system are faced daily with the tension between caring for a fellow human in need and frustration with the lack of available financial resources. The pressures of undocumented immigrants on the safety net system generally, and on MIHS in particular, are not likely to decrease in the foreseeable future. This critical issue requires public debate and direction.

The Promise and Peril of Mission

MIHS and SHCD officials dance carefully around the question of the new District's mission. Until they complete the strategic planning process, no one is willing to commit to a specific future vision. However, a sense of responsibility to serve the public mission and an awareness of voter intent in continuing the core functions of MIHS are clearly evident. The hospital's designation as a teaching institution is a critical piece of its public mission.

Also clear is leadership's struggle with the question of balancing its public mission with the realities of resource allocation. A frequent comment, echoed by other safety net providers, is that MIHS cannot be all things to all people. The planning process will include decisions about which service lines to offer, and which simply are not feasible. If MIHS can't provide such services to safety net clients, who will?

The challenge of any public hospital with a mission to serve a low income and uninsured population is clearly evident: how to stay afloat and even prosper in the super-competitive healthcare industry – attracting paying customers, building centers of excellence, recruiting top-flight physicians, solidifying graduate medical education programs – and all the while stay true to the public mission without angering the major private sector players in town.

If it were easy, more public hospitals would still be in business today.[19]

Hungry for Mission

But in MIHS's distinctively public mission lies a singular opportunity: to create a mission-driven culture of excellence that, in a world of industrialized and fragmented health care, attracts people who are hungry for a mission- and purpose-filled life.

One common theme emerges from interviews with both safety net providers and mainline healthcare institutions alike: Physicians and other healthcare professionals want to help people who desperately need their time and skills, and aren't among the well-heeled and "worried well." They want to work in integrated settings, provide consistent, effective care for persons with chronic diseases, and feel good in their hearts about their work instead of looking at it as just one more way to earn a living.

Why couldn't MIHS create a mission-driven culture of excellence? Why couldn't its leaders tap into this community reservoir of idealism and talent to create a health care experience that is, in fact, integrated across primary, specialty, community and public health settings? Why couldn't this mission serve as the core of innovative and revitalized residency training programs?

It would be ironic – and refreshing – for a safety net institution like MIHS to lead the way toward better community health for all Arizonans, and not just our most impoverished citizens. That is the opportunity – and the challenge – facing its leaders today.

One common theme emerges from interviews with both safety net providers and mainline healthcare institutions alike:

Physicians and other healthcare professionals want to help people who desperately need their time and skills.

The Big Box:
Hospital Emergency Departments

Hospital emergency departments (EDs), of which there are 31 in Maricopa County, figure prominently in any definition of the health care safety net. They might be considered the "Big Box" of health care: the place where consumers perceive they can get everything under one roof, anytime they need it.

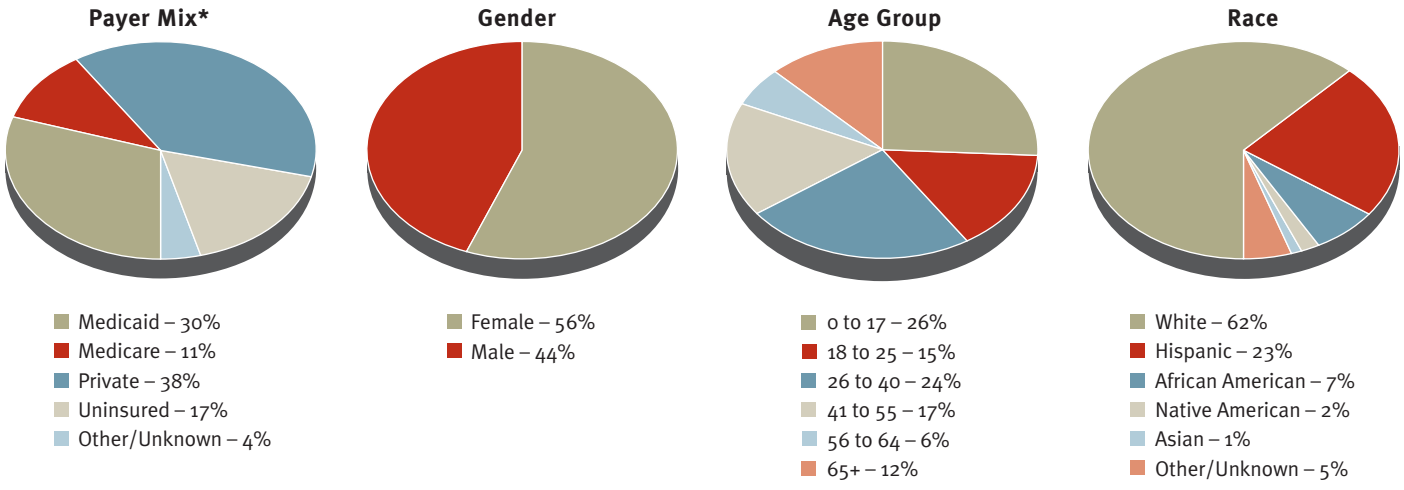
ED Use Increases

According to Arizona Hospital fiscal trends compiled by the American Hospital Association, total ED visits in Arizona went from 1,401,509 in 2001 to 1,701,614 in 2004 – a 25% increase.[20] Meanwhile, estimated hospital patient days during the same period increased 10%. Officials estimate that somewhere between 40-60% of hospital inpatient admissions come through the ED; some facilities in Maricopa County report figures as high as 75-80%.

An increase in ED admissions during the 2001-2004 period is due in large part to more people with health insurance using the ED for convenient, 24/7 care. But while ED use among all groups continues to rise, use by AHCCCS clients has become more stable. As more people get access to primary care and a "medical home," they conceivably have less occasion to use the ED for non-emergent conditions. This is especially true for AHCCCS enrollees in Maricopa County: only 1% used the ED as their *only* source of care in FY 2005.[21]

An analysis of Maricopa County ED data (most, but not all, EDs reporting) over a two-year period between July 1, 2003 and June 30, 2005 indicates that ED use might be stabilizing: 552,333 visits in FY 2004 and 555,242 visits in FY 2005. The following charts provide a general sketch of ED use in Maricopa County in FY 2005:

FIGURE 4: Maricopa County ED Profile FY 2005 (N = 555,242)



* Payer mix can vary widely across EDs. The Maricopa Medical Center ED, for example, reports 51% Medicaid and 30% uninsured (2004 data). Regardless, on average, 82% of persons using Maricopa EDs have some form of public or private insurance.

Source: AzHQ

The Uninsured: A Data Profile

Arizona HealthQuery (AzHQ) is an integrated warehouse of health encounter administrative data that is growing rapidly. The privacy-compliant information it contains allows partner health systems to assess the way their clients use not only their own system, but related systems as well. For example, it is possible to determine whether clients at a community health center also use the emergency department for primary care, or whether clients only use the emergency department for care.

AzHQ is constantly being updated and expanded. It contains information from almost every emergency department and hospital in Maricopa County, the community health centers, and several large group practices. In addition, AzHQ contains all administrative encounter data from AHCCCS members throughout Arizona.

In Maricopa County alone, AzHQ contains encounter data for over 3.4 million individuals of all ages. This is a moving target – as of April 2005, AzHQ contained over four million records for individuals in Maricopa County, and six million statewide.

Big Slice, Small Slice

Although many AzHQ data partners are organizations that are most likely to see the uninsured, it is interesting to note that despite representing approximately 17% of the total state population – a big slice – *the uninsured represent only 2.9% of the 3.4 million clients in the AzHQ Maricopa portion of the database* – a small slice. Since AzHQ data are generated by health system contacts, the most likely explanation is that the uninsured use care much less frequently that insured clients.

This confirms the conclusions of practically every study of uninsured persons in the U.S. Not only do they use care much less frequently than persons with health insurance, but they tend to have higher incidences of chronic diseases and show up in the health care system with acute conditions that, with good access to primary care and prevention, might have been avoided. Our interviews with safety net providers confirm this in Maricopa County as well.

Table 5 illustrates the distribution of uninsured visits in Maricopa County in FY 2005.

TABLE 5: Maricopa County FY 2005 Health System Use by the Uninsured

Ages	Uninsured Visits	Total Maricopa Co. Visits	Uninsured as % Age Group
<1	2,067	128,747	1.6%
1-4	6,594	454,006	1.5%
5-9	4,503	428,709	1.1%
10-13	3,076	282,506	1.1%
14-19	7,491	372,009	2.0%
20-39	45,443	817,910	5.6%
40-49	13,267	287,891	4.6%
50-59	7,780	216,782	3.6%
60+	7,266	407,587	1.8%
Unknown	31	1,519	2.0%
CPS Estimate of Uninsured in Maricopa County			17%
TOTAL	**97,518**	**3,397,666**	**2.9%**

Source: AzHQ

DO HISPANICS USE HEALTH CARE DIFFERENTLY?

Interestingly, use of the ED for non-urgent care seems to vary by race/ethnicity. A greater proportion of uninsured Whites, Asian/Pacific Islanders, and Native Americans use the ED for non-urgent care than do uninsured Hispanics. Although it is impossible to draw any firm conclusions about the influence of immigration from this data, it would be helpful to understand if immigration status influenced this usage pattern, or whether Hispanics use the primary care system differently – and arguably more effectively – than other race/ethnicities.[22]

Based on FY 2005 AzHQ data, the uninsured in Maricopa County are:

- Most likely to be 20-49 years old
- White (46%) and female (55%). Hispanics are a close second (39%)
- Receive majority of care in the ED (54% of visits)
  - 30% of visits occur in ambulatory settings
  - 14% of visits are hospitalizations
- For those uninsured who use the ED for care, more visits are for non-urgent care, or care that could have been better handled in an outpatient setting. This is illustrated in Table 6.

TABLE 6: Urgent or Not? Uninsured ED Use by Race/Ethnicity

	Urgent		Non-urgent	
Unknown	409	24.4%	1,264	75.6%
Asian/Pacific Islander	169	19.7%	687	80.3%
Black	2,469	45.4%	2,967	54.6%
Native American	250	29.8%	588	70.2%
White	14,870	39.0%	23,269	61.0%
Other	489	11.4%	3,784	88.6%
Hispanic	13,078	62.2%	7,946	37.8%
TOTAL	**31,734**	**43.9%**	**40,505**	**56.1%**

Source: AzHQ

- In the non-urgent category, most uninsured persons (and insured, for that matter) are seen for a varied list of diagnoses, the most common of which are ear infections, colds, sore throats, urinary tract infections, and stomach pain.
- For adults, the largest category of the uninsured are those who are not offered (or who don't purchase) employment-based coverage, and who make too much money to qualify for AHCCCS. Public coverage for children was expanded in 1998 through KidsCare (Arizona's SCHIP program). Parents of these children have been able to also receive coverage through an expansion of KidsCare, but this program faces perpetual threats at the legislative level because of fiscal concerns.

Immigration Pressures Continue

As AHCCCS has expanded, the poorest of the uninsured are increasingly immigrants, both legal and undocumented, who are not qualified for Medicaid under federal law. Legal permanent residents of the US may not receive AHCCCS until they have been in the country for five or more years. Undocumented immigrants are eligible only for emergency coverage, and that is paid fully through federal, not state, funds. AHCCCS rolls show 75,000 Federal Emergency Services (FES) clients as of November 2005, but at any given time, only a handful of these clients actually may receive coverage for care. Many of these are maternity-related.

The safety net providers interviewed for this update all remarked on an increasing number of immigrants seeking services compared to five years ago. Many health care providers do not ask for immigration status so they won't discourage clients from seeking necessary care. As one clinic manager observed, "If we don't take a proactive stance at managing problems, they become a greater exposure to the system."

Nevertheless, like many Arizonans, these same providers are frustrated by the increasing demand for services in a period of tight budgets and access to specialists and integrated care. "Squeezing the Rock" continues regardless.

Immigrants receive care through emergency rooms, community health centers and other safety net providers mentioned previously. What is clear, however, is that immigrants receive less care, and enter care with a greater burden of disease, than their economically equivalent counterparts who can get health coverage through jobs or AHCCCS.

Squeezing the Rock: *Immigrants With Cancer*

A good example, cited by several interviewees, is immigrant patients with cancer.

Cancer is not an emergency under the Federal Emergency Services guidelines. Clients are often diagnosed with advanced stage disease after deferring care due to concern about the expense and possible exposure to immigration authorities. There are often delays in communicating test results due to false addresses and phone numbers. Chemotherapy is very expensive; radiation oncology is virtually inaccessible without health coverage. Often, treatment takes place only when serious complications create qualifying emergency conditions.

Hospitals in Arizona and other border states lobbied successfully for federal funds to pay for uncompensated care delivered to immigrants. These funds, authorized under Section 1011 of the Medicare Modernization Act of 2003, will channel up to $45 million annually for four years to help Arizona hospitals provide this medically necessary care. The money will not, however, offset costs to many outpatient safety net providers, who continue to "squeeze the rock."

Update: The Safety Net Financial Puzzle

In our 2002 *Squeezing the Rock* report, we outlined the various types of financial support mechanisms available to safety net providers: Medicaid/Medicare, HRSA payments, DSH, Tobacco Tax payments, hospital charity care and philanthropic contributions. Putting these pieces of the financial puzzle together to create a sustainable funding stream for low income and uninsured persons was described as more an art than a science four years ago, and that remains the case today.

Various types of financial support mechanisms are available to safety net providers:

- Medicaid/Medicare
- HRSA Payments
- DSH
- Tobacco Tax Payments
- Hospital Charity Care
- Philanthropic Contributions

Medicaid

The biggest difference in safety net financing between 2001 and 2004 is the expansion of AHCCCS through Prop 204. In 2001, AHCCCS represented about 11% of the state's total budget, or $588 million; in 2005, it more than doubled to around $1.3 billion. This doesn't include federal matching dollars, which provide roughly $2 for every $1 the state contributes.

The upside, of course, is that more people are eligible for Medicaid and receive health care in both regular community health care venues as well as the types of safety net facilities outlined here. These individuals are more likely to receive risk appropriate care – a good thing for them as well as for the system. Without this vital public support, the pressure on safety net providers would be untenable.

The downside is the continuing pressure on the state budget, which must deal with competing claims for limited resources. The national picture is considerably more gloomy, with dire predictions being made for both Medicaid and Medicare unless a way can be found to "reform" the entire U.S. health care system to make it more efficient, affordable and equitable.

Medicare

Compared to Medicaid, Medicare funding is a relatively minor component of the safety net financial puzzle. In addition to direct payments for care, teaching hospitals like MIHS and others receive indirect payments through the Medicare portion of DSH.

Tobacco Tax

A portion of sliding fee scale care is subsidized by state revenues. In FY 2001, the Arizona Department of Health Services Tobacco Tax (TT) Primary Care Program awarded $15 million transferred from the Tobacco Tax Medically Needy/Medically Indigent account at AHCCCS to 23 safety net contractors. Funding was cut to $11 million in 2002 and then to $10 million in 2003.

Due to budget shortfalls in 2004, the Tobacco Tax funds were rolled into the General Fund. ADHS received a direct appropriation of $10 million in FY 2004 and FY 2005. New awards were made in FY 2006. The $10 million appropriation is distributed to 20 safety net contractors, 11 of which are federally qualified health centers. ADHS has requested $13 million for FY 2007.

Even this important source of safety net funding, however, does not keep up with the increasing numbers of people without health insurance or the repeated visits of persons with myriad chronic and complicated health conditions. It is a necessary funding source, but hardly sufficient by itself, to meet a growing need for safety net services.

DSH

Medicaid's Disproportionate Share Hospital Program (DSH) provides supplemental payments to safety net hospitals that serve "a disproportionate number of low-income patients with special needs." In addition to MIHS and other Arizona hospitals, this includes the Arizona State Hospital (ASH), which provides inpatient psychiatric services to persons with severe mental illnesses in the public behavioral health system.

In FY 2005, Arizona private hospitals were allocated approximately $26 million in DSH payments, and ASH was allocated approximately $28 million. However, what is allocated as DSH funding from both federal and state sources is not necessarily what is actually received by DSH recipients. The state general fund gets "paid" as well: A net gain of $579 million has found its way into state coffers as a result of DSH payments between 1992-2006. More information on this admittedly arcane but important subject is available in our previously cited 2003 report.

HRSA

Federally Qualified Health Centers (FQHCs) in Maricopa County receive federal financial support through the Health Resources Service Administration (HRSA), specifically through its Bureau of Primary Health Care. In 2004, Mountain Park Health Center and Clinica Adelante received $4.49 million and $2.8 million respectively from HRSA.

In addition to regular HRSA support for indigent primary care itself, additional grant monies for the construction of new clinics have been utilized by FQHCs as the result of President Bush's $780 million community health initiative mentioned earlier. The increase in targeted funds for the expansion of community health services since our first report in 2002 has proven to be beneficial for the health of Maricopa County's safety net.

Uncompensated Care

Uncompensated care – the amount of care "written off" by tax-exempt hospitals and other providers – is generally interpreted as a proxy for how much care is provided to people who, for one reason or another, can't pay for it. It is broken down into two categories: *charity care* – services provided with no intention of being compensated – and *bad debt* – services provided for which payment is intended but not received.

Uncompensated care is itself nearly as complicated and arcane as DSH payments. For example, there is the difference between calculating uncompensated care based on *charges* for services, and calculating it based on *costs* of services (determined by cost/charge ratios that can vary widely across institutions). Then there is the issue of how costs are calculated in the first place, etc.

In our first *Squeezing the Rock* report, we listed the top five health systems in Maricopa County in terms of percentage of total uncompensated care and as a percentage of hospital system gross charges. Given the variance in how hospitals calculate and report these figures, we concluded that such a listing is a dubious exercise at best.

What we can say with certainty is that uncompensated care is rising rapidly in Arizona. According to member data reported to the Arizona Hospital and Healthcare Association (AzHHA), gross charges for uncompensated care increased from $412 million in 2001 to $585 million in 2004 – an increase of 42%. Actual figures are estimated to be higher, since not all members report this data.

Uncompensated care is broken down into two categories: ***charity care*** *– services provided with no intention of being compensated – and* ***bad debt*** *– services provided for which payment is intended but not received.*

In Maricopa County itself, MIHS officials report that the percentage of total gross charges that are classified as uncompensated care was 19% in 2004, about the same as in 2001. The county-wide average in 2004 was 3.2%. For the second half of 2005 and the first quarter of 2006, however, MIHS reports that uncompensated care as a percentage of gross charges has increased to 22%. This translates to actual uncompensated care costs of roughly $33 million annually – not far from the $40 million provided through the SHCD tax.

In terms of total gross charges alone for uncompensated care in Maricopa County in 2004, the leading hospital providers are St. Joseph, MIHS, Banner Good Samaritan and Banner Desert respectively.

Self-Pay/Sliding Fee

People who are uninsured and receive care are classified different ways by different safety net providers. Some are classified as "self-pay," others as "sliding fee scale," and still others as simply "uninsured." The lack of uniform health accounting and reporting requirements across the safety net system – and indeed, across the entire U.S. health care system – complicates the comparison of funding mechanisms across providers.

Practically all uninsured and low-income patients are expected to pay something for their care, even if it's only a token amount. The ability of a clinic to provide some type of sliding fee arrangement depends on the availability of funding sources such as grants, contributions and tobacco tax payments.

In Table 6, we compare funding sources for representative safety net providers in Maricopa County to illustrate the significant portion of uninsured/self-pay/sliding fee clients in these facilities, and why additional sources of funding are so critical to providing necessary care.

TABLE 6: Comparison of Funding Sources in Different Clinic Models (2004)

	Mountain Park	Clinica Adelante	St. Vincent de Paul	MIHS ED	MIHS Outpatient Clinic
Private Insurance	15%	8%		6%	8%
Medicaid (AHCCCS)	40%	35%		51%	44%
Medicare	2%	4%		5%	23%
Uninsured/ Self-Pay/ Sliding Fee	43%	53%	100%	30%	25%*
Other				8%	

* MIHS Family Health Centers report approximately 25% in the "Other" category, but this turns out to be a combination of no-pays, self-pays, sliding fee and special populations such as people incarcerated in Maricopa County jails. We arbitrarily lump these together in this category to illustrate that, no matter how you define it, safety net institutions provide a major portion of care to persons with limited ability to pay for it themselves. Hence the importance of public tax support, federal and state grants, and philanthropic contributions.

How do 2004 funding sources for safety net providers compare to 2001?

- Private insurance is down at the FQHCs, while Medicaid and the entire uninsured category are both up. Medicare is stable.
- St. Vincent de Paul and clinics such as the Neighborhood Christian Clinic continue to rely solely on private grants and contributions. The good news is that these sources have increased since 2001.
- EDs generally are seeing significantly more AHCCCS clients – and insured clients generally – compared to 2001. Medicare is stable at the MIHS ED, but private insurance is up. Uninsured/self-pay is down.
- MIHS Family Health Centers are seeing more private insurance, slightly less Medicaid, slightly more Medicare (in 2004 at least – Medicare numbers are down in 2005, as mentioned earlier), and slightly more uninsured.

How do 2004 funding sources for safety net providers compare to 2001?

Grants/Gifts

Grants and contributions are literally the lifeblood of safety net clinics like St. Vincent de Paul, Las Fuentes, the Neighborhood Christian Clinic and Mission of Mercy. They are less of a critical factor for FQHCs and hospital clinics, although when it comes to capital and infrastructure expenses (new clinic space, technology, equipment), targeted grants and philanthropic contributions play an important role.

A growing philanthropic sector is emerging in the Phoenix metro area as large foundations and individuals with significant financial resources begin to take a more proactive role in developing community resources. With regard to the health safety net specifically, foundations like the Virginia G. Piper Charitable Trust, the Nina Mason Pulliam Charitable Trust and the BHHS Legacy Foundation have all made major grants to improve the area health safety net. That's the good news.

The concern, however, remains the same as it was in 2001. As important as these grants and gifts are, they are a drop in the bucket of need. Very few of these grants are ongoing or for general operations, and, as we said in 2002, safety net organizations "can only go back so many times to the same charitable well until it runs dry."

Safety net clinics need a sustainable source of funding to respond to a growing need for medically necessary services. Philanthropy cannot play that role.

Volunteers

Although it's hard to put a financial number on it, it's clear that literally millions of dollars in services are contributed to the health care safety net by a corps of committed volunteer physicians, nurses, technicians, drivers, greeters, interpreters, administrators and the like. Mission of Mercy, for example, estimates that its volunteers contribute in excess of $400,000 annually through in-kind services to its mobile clinics. The health care safety net literally would not run without volunteers. Somehow, somewhere, safety net providers continue to recruit and find dedicated volunteers today, just as they have done ever since they first opened their doors.

Ongoing Concerns: *The Provider Perspective*

Interviews with safety net providers and officials underscored a number of cross-cutting concerns:

Pharmacy Costs

Pharmacy costs remain a large and growing concern for safety net providers. Although Community Health Centers have access to discount pricing for medications, the cost of the medications is consuming an ever-increasing portion of their budgets. Providers at the centers are concerned about getting medications, particularly for the uninsured with **chronic conditions** such as diabetes and asthma.

One provider summed up the frustration regarding pharmacy costs: "You know in advance that the treatment will fail because there is not access to the right medications."

One provider summed up the frustration: "You know in advance that the treatment will fail because there is not access to the right medications." Clinica Adelante spends well over $500,000 per year for drugs. Even that amount is insufficient to meet the need.

Limited Scope of Service

Many providers told us that "we can't be everything to everyone." A **growing number of uninsured** patients is forcing safety net providers to reevaluate the scope of services that they can realistically and economically provide. In the case of Mission of Mercy and other safety net clinics that treat uninsured patients exclusively, they have chosen to see fewer clients and provide them with better care than to see more patients and provide them with minimal care.

Cost Determines How Care is Managed.

Most safety net physicians who work with uninsured patients do so because of a **strong sense of mission**. Still, they are angry and discouraged by their inability to treat patients appropriately. One doctor stated,

> *"I have a patient with a thyroid nodule. She needs an ultrasound, but can't afford it. I can't get the right diagnostic tests. All I can do is wait for her to come back in with advanced disease that I'll finally be able to treat, but without good results."*

Lack of Communication, Monitoring and Tracking

While the lack of basic communication, monitoring and tracking between primary care physicians and specialists is an issue throughout the entire health care system, it is especially disruptive for safety net providers. Once a patient is referred out for additional care, the primary provider has difficulty finding out what treatment is subsequently provided. Safety net providers told us that the Community Health Centers and other large public clinics are seen by some private physicians as an occasional source for care, not as an ongoing site for primary care to be **treated with the same courtesy** as other referral sources.

Behavioral Health

Behavioral health issues continue to be a major concern. Although we do not address the system issues here, managing mental and behavioral issues can make or break medical care. One provider, frustrated at the lack of access to services, put it this way: "The best way to address behavioral health is to not ask the question."

Keeping Clients on AHCCCS

AHCCCS provides a critical revenue source for safety net providers. Clients, faced with administrative misunderstandings, confusion with paperwork or **sheer inertia**, often lose AHCCCS coverage. Providers must then dedicate staff to re-enrolling eligible clients in order to maintain this revenue stream. Ironically, this increases administrative overhead, reduces the time available to actually treat patients, and necessitates a greater need for sustainable payer sources such as AHCCCS.

Financial Tensions

Safety Net officials report tensions between clinical morbidities and financial need. Several administrators stated that they have to be financially responsible about how they spend the money that is set aside for these needs.

For example, is it better to pay for one operation at $7,000, or to get 50 people at risk for diabetes and heart disease into nutrition and exercise programs? Should one spend scarce resources to treat a 5-year-old child with cerebral palsy who has not had previous medical care if it means having to deny care to many others with low-cost problems that can be cured? **Ethical trade-offs** are found throughout the health care system, of course, but they are especially acute in the health safety net because of extreme financial pressures.

The Sheer Inefficiency of the System

All of these concerns are expressed in the sheer inefficiency of the safety net web of services and providers. As one administrator put it, "The system is broken. We only have pockets of service available."

"The system is broken. We only have pockets of service available."

Communications and time spent hunting for specialists are two types of inefficiencies; the manner in which services are provided – or not – is another. At one hospital, clinic administrators expressed frustration with the **piecemeal funding** for breast cancer treatment and diagnosis. They have the facilities and funding to evaluate patients, but treatment funds are lacking. They report funding going to many nonprofits in the community for **outreach and screening**, but not for **coordination and treatment**. One administrator pleaded, "We need coordination of resources from the beginning to the end."

An update on progress, or lack of, since our 2002 Squeezing the Rock report.

Action Steps: *Then and Now*

In 2002 we concluded our first *Squeezing the Rock* study of the safety net in Maricopa County with a list of six action steps. Here is one take on our progress:

1. Come Together

THEN: We recommended that Maricopa County policymakers and safety net providers come together to explore *cooperative* models with the potential to improve safety net services.

NOW: Little has changed. Safety net providers still work primarily in a *competitive* model. Some exceptions exist, such as the development of the HealthCare Connect discount care program, and we are also beginning to see cooperative discussions around new clinic locations. Still, the highly competitive nature of the entire health care industry reverberates throughout the safety net as well.

2. Aggressively Pursue Subsidies for Care

THEN: We recommended aggressive pursuit of federal community health center funding, market reforms to increase health insurance coverage rates, and the development of a public subsidy for funding care for the uninsured.

NOW: We've made progress. Maricopa County did in fact receive several federal grants to enhance services and increase the number of clinic sites. Proposition 414, establishing the special health care district for MIHS, was created through a collaborative effort of many health care providers and community leaders. MIHS also received FQHC status. As we prepare this update, several market solutions for insurance accessibility are under consideration by the 2006 Arizona Legislature.

3. Pay Attention to Specialty Care

THEN: We recommended financial and/or legal incentives to attract specialists to high need areas.

NOW: Access to specialty care remains a major need.

4. Streamline Administration and Regulation

THEN: We had high hopes for incorporation of electronic technologies to streamline medical records, application forms and other administrative paperwork.

NOW: Health system adoption of electronic records continues to move slowly, but the pace has picked up over the past year on both the national and local front. Governor Napolitano's Health-e-Connection Task Force recently completed its Roadmap assignment to develop initiatives to create a state-wide health information exchange within the next five years. Although only 13-15% of Arizona physicians use electronic health information systems currently, another 25% plan to implement them in the next two years. We expect this to gather steam over the next five years.

5. Develop an Independent Source of Quality Information and Analysis of Safety Net Issues

THEN: We encouraged the development of such information sources.

NOW: Over the past four years, SLHI has focused some of its resources on the development of Arizona HealthQuery (AzHQ), which we alluded to earlier, and which has been used to inform portions of this safety net update. AzHQ shows substantial promise to both describe how the safety net is used and to evaluate indicators of quality, access and cost throughout the entire Arizona health care system. As the integrated data warehouse is populated with more ambulatory care data, its power and use should continue to increase over time.

6. Continue Efforts to Ensure All Arizonans Have Basic Insurance Coverage

THEN: We recommended increasing the number of people with health insurance as the key to improving access to care and specialty coverage.

NOW: The implementation of Prop. 204 AHCCCS expansion made a significant reduction in the ranks of the uninsured in Arizona, but this has been offset in recent years by a continuing decline in employment-based health coverage. The proportion of uninsured has stabilized around 17% since 2004, but the total numbers have increased slightly because of population growth. States are becoming more aggressive in efforts to provide all of their citizens with basic health insurance coverage. We continue to recommend that Arizona do the same.

The Road Ahead

Even though Maricopa County has made progress in several dimensions of improving safety net services since 2002, services for uninsured, low income and medically indigent citizens and non-citizens alike remain stretched. Our description of the system as "run on a shoestring with compassion, grit and resolve" in 2002 still fits the system we have today.

The safety net has traditionally been viewed as organizations that provide medical care for patients regardless of their ability to pay. In a world where employment-based health coverage is becoming obsolete, and where government subsidies for uncompensated care are increasingly under the fiscal gun of huge budget deficits, it is becoming painfully obvious that the historical model of the safety net itself is incongruent with our population's needs.

Fundamentally, the safety net is held together by **mission-driven people** – people who believe that access to a basic level of health care services is a right, and should not depend on income or social status alone. These mission-driven people will go to extraordinary lengths to provide compassionate care. As we have documented in this updated report, they continue to develop creative solutions to a myriad of health care and health system issues.

But at what point is a dedication to mission no longer sufficient by itself to meet the challenges described in this report?

At what point is a dedication to mission no longer sufficient by itself to meet the challenges described in this report?

An Agenda for Today

The health safety net alone can't address the larger issues of access to affordable, high quality health care that, in the end, impact all of us. Here is one action agenda for today and well into tomorrow:

INSURE EVERYONE. We're agnostic about the method, but not about the end. Everyone should be required to have basic health insurance coverage, and everyone, to the degree they are able, should have some personal responsibility for contributing to that coverage.

INCENTIVIZE PREVENTION AND WELLNESS. Encourage healthy behaviors and lifestyles. The only sure way to reduce health care costs across the board and improve health outcomes is to keep people out of the acute care system in the first place by staying healthy. Our health care system feeds on sickness. We need to invest in health.

INTEGRATE CARE. Developing funding mechanisms that can be distributed across providers and systems of care is one way to encourage the integration of the services for persons with multiple chronic conditions. Training people to work across teams and networks of care is another. We have one system of care for the mind, and another for the body. This is absurd on the face of it, and bad health care to boot. We need to invent the neck.

INVEST IN A STATEWIDE HEALTH INFORMATION EXCHANGE. Arizona now has a roadmap for how to go about connecting all actors in the health care system in a transparent, confidential and efficient electronic network. Yes, it will take a major investment of time and resources, and yes, it's not going to happen overnight. But it's coming. Look for ways to get involved in implementing Arizona's roadmap today.

SOLVE THE IMMIGRATION DILEMMA. Immigration is a hot button issue everywhere, but it's particularly vexing for safety net providers who supply compassionate and effective care to everyone, regardless of their origin, legal status and ability to pay. The burden of providing that care should not be the safety net's alone, but should be spread fairly across the entire society. That's why we need to craft an intelligent immigration policy today.

The health safety net alone
can't address the larger issues of
access to affordable, high quality health care
that, in the end, impact all of us.

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Our Mission

To improve the health of people and their communities in Arizona, with an emphasis on helping people in need and building the capacity of communities to help themselves.

An *Arizona Health Futures* publication, *Squeezing the Rock II* is an update to the 2002 *Squeezing the Rock* report. Here we take a look at the health safety net in greater Phoenix metro area: its principal providers and clients, track what's changed and what hasn't, review progress in addressing the policy issues raised earlier and make suggestions for future policy consideration and action.

In short, we're working to help Elizabeth.

Comments and suggestions are always 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 those in need.

ARIZONA HEALTH FUTURES

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