Squeezing the Rock II:

Maricopa County's Health Safety Net

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

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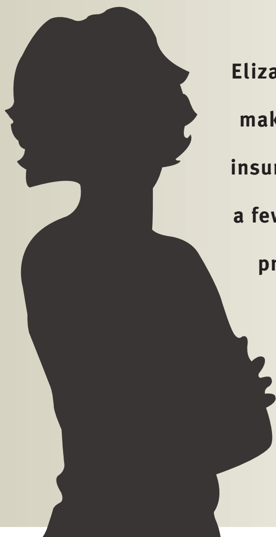
A Report from St. Luke's Health Initiatives

MAY 2006



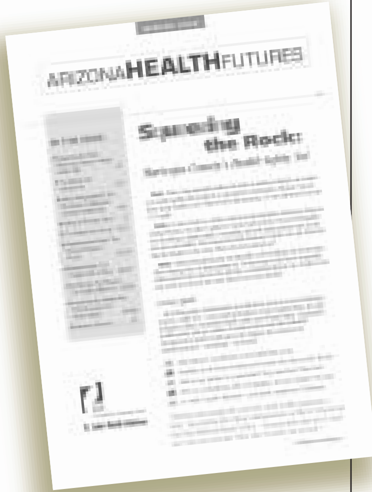
Meet Elizabeth

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.

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.

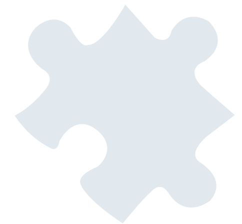
TABLE 1*: Health Insurance Coverage 2001-2004, People Under 65 Years Old

	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]

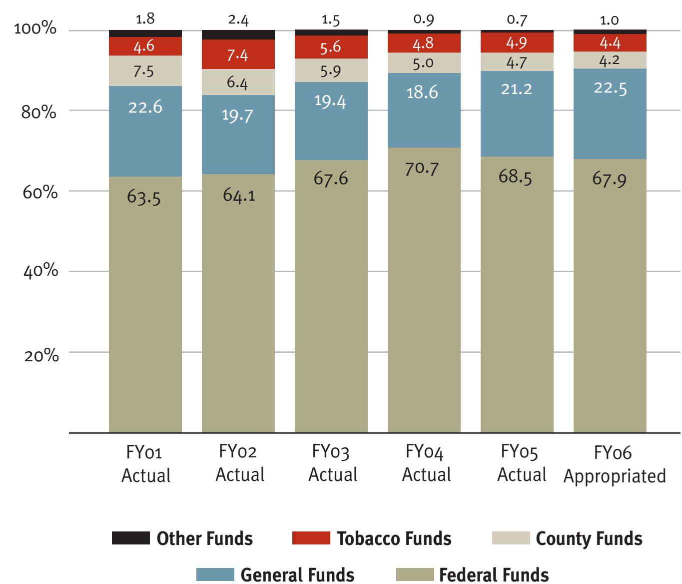
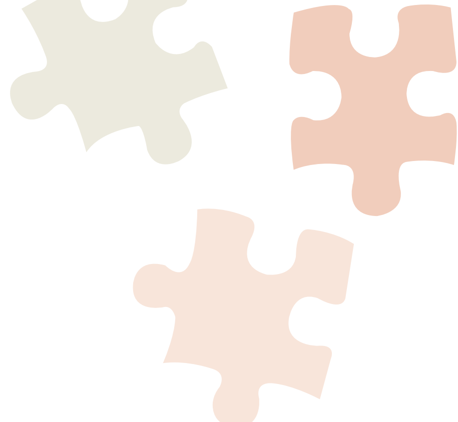


FIGURE 2: AHCCCS-Administered Programs and Enrollments, 2005[9]

- **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**

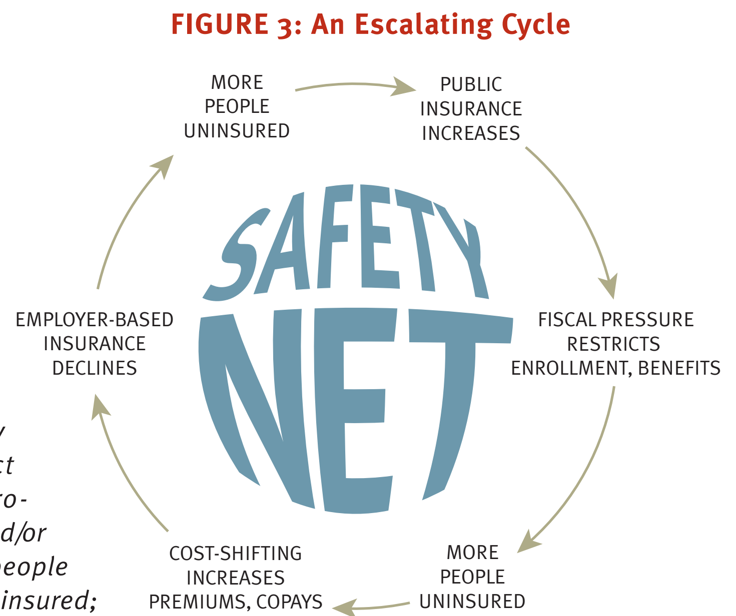
CHARGES

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**

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.

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.

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.

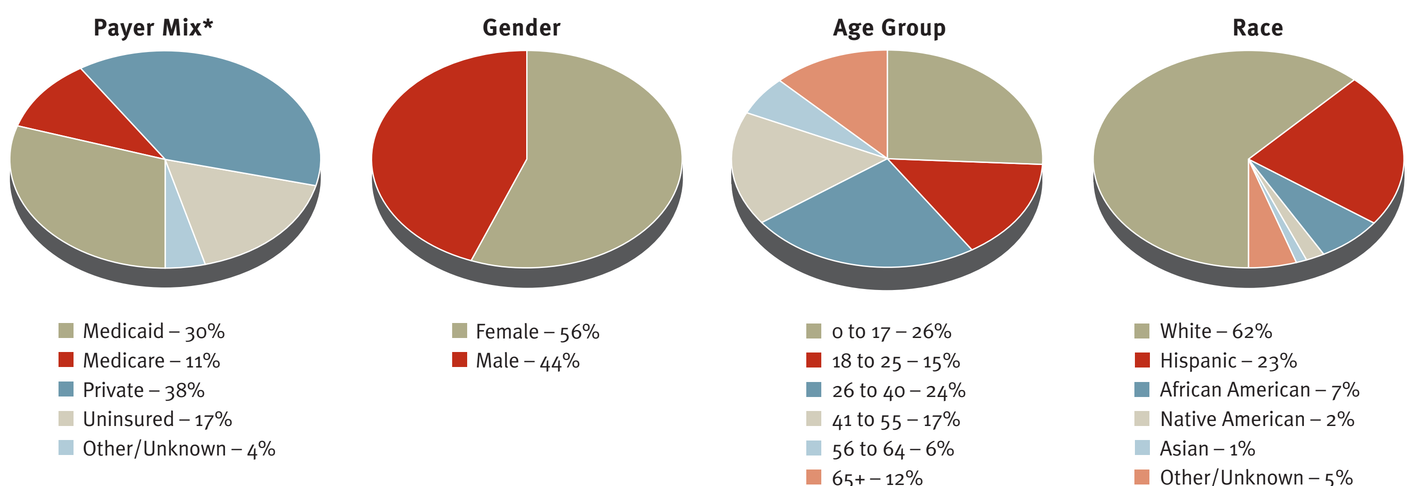
ED Use Increases

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

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."

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.

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.

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

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."

Action Steps: *Then and Now*

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

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.

Sources

1 Stemmler, P., Hughes, R., *Squeezing the Rock: Maricopa County's Health Safety Net*, St. Luke's Health Initiatives, Winter 2002, p. 1. www.slhi.org.

2 *Fact and Fiction: Emergency Department Use and the Health Safety Net in Maricopa County*, April 2004. St. Luke's Health Initiatives, www.slhi.org.

3 Nolan, Lea., et. al., *An Assessment of the Safety Net in Phoenix, Arizona*, Urgent Matters, Department of Health Policy, The George Washington University Medical Center, March 2004. www.urgentmatters.org.

4 Arizona HealthQuery is under the direction and management of William G. Johnson and his research team in the Center for Health Information and Research, W.P. Carey School of Business, Arizona State University. It is principally supported by SLHI and, increasingly, by others.

5 On the issue of behavioral health, see *Into the Light, The Humpty Dumpty Syndrome, and Mind, Mood and Message*. On oral health, see the *Open Wide* series of reports. www.slhi.org.

6 Kaiser Commission on Medicaid and the Uninsured, Nov. 4, 2005. http://www.kff.org/uninsured/kcmu110405nr.cfm.

7 See, for example, Johnson, William, et. al., *The Arizona Physician Workforce Study, Part 1*, 2005, Arizona State University, University of Arizona Health Sciences Center (www.wpcarey.asu.edu/pubs). See also *Boom or Bust: The Future of the Health Care Workforce in Arizona*, St. Luke's Health Initiatives, Spring 2002 (www.slhi.org), among others.

8 Rodgers, A., *AHCCCS: Why Other States are Looking to Arizona as a Model for Medicaid Reform*, Presentation to the Arizona Chamber of Commerce 2005 Health Care Summit, October 21, 2005.

9 Taken from *Health Bullets – Financing Mechanisms*, St. Luke's Health Initiatives, December 2005, www.slhi.org.

10 http://www.ahcccs.state.az.us. State population estimates are from the Department of Economic Security, and differ slightly from figures presented in Table 1, which are from the census population survey.

11 Public hospitals generally, and those in Arizona specifically, were discussed in Stemmler, P., Hughes, R., *Crisis of Mission: The Future of the Public Hospital in Arizona*, St. Luke's Health Initiatives, April 2003, www.slhi.org.

12 See *The Safety Net on the Edge*, National Association of Community Health Centers, August 2005, for one of several reports on this subject. www.nachc.com/research/Files/SNreport2005.pdf.

13 Cunningham, P., May, J., "A Growing Hole in the Safety Net: Physician Charity Care Declines Again," March 2006, Center for the Study of Health Systems Change, http://www.hschange.org/CONTENT/826/.

14 Asplin, R., et. al., "Access to Care for Serious Conditions Commonly Identified in the Emergency Department, *JAMA* 2005; 294: pp. 1248-1254.

15 For readers who wish more detailed information, we reviewed MIHS specifically in *Crisis of Mission: The Future of the Public Hospital in Arizona*, op. cit.

16 A 2004 audit showed an improving financial picture. Operating income rose, in part from increased patient revenues and in part from capturing revenues previously booked as bad debt. Even with improved operating income, however, cash flow remained a significant concern.

17 Anglen, R., "Maricopa County Expected to Lose $95 mil Over Health Plans," *The Arizona Republic*, April 27, 2005.

18 Cannon, L., *Deconstructing DSH*, St. Luke's Health Initiatives, April 2003. www.slhi.org.

19 According to a recent study, the number of public hospitals in major cities declined 16% between 1996-2002 and 27% in suburban areas during the same period. See http://www.rwjf.org/newsroom/newsreleasesdetail.jsp?id=10364.

20 Communication from the Arizona Hospital and Healthcare Association, November 2005.

21 Based on an analysis of ED use in Maricopa County taken from data in Arizona HealthQuery, an integrated health data warehouse that currently contains over 6 million records and allows de-identified patients to be tracked across time and across providers.

22 In our study of how Maricopa County residents utilize both formal and informal networks of behavioral health services, we noted striking differences in the use patterns of Hispanics and Whites, as well as differences between second generation Hispanic immigrants and undocumented immigrants. Essentially, undocumented and/or recently arrived immigrants tend to rely more on an informal system of care (family, church, personal networks) and less on the formal system of hospitals, clinics and physician offices. See Hughes, R., *Mind, Mood and Message: Pathways in Community Behavioral Health*, St. Luke's Health Initiatives, January 2005, www.slhi.org.

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.

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