Title
Integrating health care for the most vulnerable: Bridging the differences in organizational cultures between US hospitals and community health centers

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Integrating Health Care for the Most Vulnerable: Bridging the Differences in Organizational Cultures Between US Hospitals and Community Health Centers

Policymakers have increasingly promoted health services integration to improve quality and efficiency. The US health care safety net, which comprises providers of health care to uninsured, Medicaid, and other vulnerable patients, remains a largely fragmented collection of providers. We interviewed leadership from safety net hospitals and community health centers in 5 US cities (Boston, MA; Denver, CO; Los Angeles, CA; Minneapolis, MN; and San Francisco, CA) throughout 2013 on their experiences with service integration. We identify conflicts in organizational mission, identity, and consumer orientation that have fostered reluctance to enter into collaborative arrangements. We describe how smaller scale initiatives, such as capitated model for targeted populations, health information exchange, and quality improvements led by health plans, can help bridge cultural differences to lay the groundwork for developing integrated care programs. (Am J Public Health. 2015;105:S676–S679. doi:10.2105/AJPH.2015.302931)

SAFETY NET PROVIDERS ARE providers that deliver a significant level of health care to uninsured, Medicaid, and other vulnerable patients. Policymakers have introduced a number of programs to promote integration in the health care safety net, including Accountable Care Organizations (ACOs) and Community Care Organizations (CCOs) within Medicaid, demonstrations to integrate care for dually eligible individuals, and state Medicaid programs to integrate health and social services.1,2 Care integration has been touted as a means to improve quality of care while reducing waste and inefficiency.3 These benefits may be particularly salient in the health care safety net, where resources are limited and patient populations are at risk for disparities in access and quality. Despite a name that suggests ambulatory care, but the dominant themes were specific to the health care safety net. Leaders described differences rooted in the historical evolution of safety net providers: health centers were described as independent and community-based, hospitals as...
TABLE 1—Organizational Cultural Barriers to Integration of Services in the Health Care Safety Net: Perceptions of Safety Net Leaders in 5 US Cities, 2013

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<th>Theme</th>
<th>Illustrative Quote</th>
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<td>Health center identity as an independent, community-based organization</td>
<td>“The [health centers] are very linked into their communities . . . their identity is tied up in their independence. . . . [Partnership] is like a big step for them . . . what are we giving up, are we retaining our community roots?” —hospital leader</td>
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<td>Safety net hospitals as providers of last resort, not the providers of choice</td>
<td>“It would have made more sense to do one charter among everybody . . . one of the last ways that [the clinics] are acting out their independence, is through selection of their [electronic health records].” —health center leader</td>
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<td>Distrust between hospitals and community health centers</td>
<td>“We had an example with [the hospital] where someone referred to specialty care died before she could get in for an appointment. . . . It’s kind of like Survivor: Specialty Care Edition.” —health center leader</td>
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<td>“Low-income people have fewer choices. . . . I mean . . . we took them for granted.” —hospital leader</td>
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Note. The 5 US cities were Boston, MA; Denver, CO; Los Angeles, CA; Minneapolis, MN; and San Francisco, CA.

regional providers of last resort. These conflicting identities fostered distrust and reluctance to enter into closer organizational arrangements. Table 1 provides illustrative quotes from interviews.

Cultural Barriers to Integration

Health center identity as an independent, community-based organization. Participants described health centers’ historical identity as independent and highly responsive to community needs. To avoid dependence on other institutions and maximize patient choices, health centers maintained relationships with multiple hospital systems. One consortium executive noted that the culture of independence hampered efforts to improve care coordination among its own members. Tightened networks with a safety net hospital would threaten health centers’ autonomy and their perceived ability to prioritize the needs of their respective communities.

Safety net hospitals as providers of last resort, not the providers of choice. Although health centers have a mission to serve all regardless of ability to pay, leaders from both organization types characterized safety net hospitals as the traditional provider for patients who have no other choices. Health center leadership reported referring uninsured patients to the local safety net hospital but referring insured patients elsewhere whenever possible. Hospital leaders reported that, pursuant to their mission, they have not prioritized strategies to become more attractive to patients, even if they provide high quality care. One leader expressed concerns that increased strain on hospitals already stretched to capacity is an unintended consequence of these efforts. Investing in integration may require a shift in hospitals’ traditional identity, which may appear counterproductive to hospitals’ mission as the provider of last resort.

Distrust between hospitals and community health centers. Respondents described how conflicting institutional identities contributed to distrust between safety net hospitals and community health centers. Health center leaders perceived that safety net hospitals devalued consumer choice and could not be trusted to provide consistently high-quality care. In turn, hospital leaders perceived health centers’ autonomy as overriding collaboration and expressed skepticism as to whether health centers could be trusted to keep patients within the hospital network. Thus, despite sharing care for disadvantaged patient populations, leaders reported the absence of a commitment to work together. Furthermore, a few interviewees reported increasing competition following expansions in insurance coverage, which could hamper future efforts toward integration.

Bridging the Divide

Despite the challenges described, interviewees detailed how smaller-scale efforts engaged providers to navigate differences in institutional cultures and ease distrust. One site—Denver Health—has integrated services over a period of decades and did not exhibit the same conflicts seen in other sites. However, in the absence of exceptionally strong leadership and significant policy reforms, it is unrealistic to expect that most safety net providers will transform into Denver Health in the near future. Respondents from other sites described 3 types of initiatives that fostered integration of services: capitated payment models for highly targeted populations, health information exchange, and collaboration with local Medicaid health plans (Table 2).

Demonstration projects for highly targeted populations. Two sites engaged in pilot projects involving capitated payment and integrated care for a limited subset of patients: in one case, low-income, uninsured adults identified as high utilizers of services; in the other, a demonstration involving 1 health center, the health plan, and the safety net hospital. Leaders from both sites reported that the projects produced no spillover effects in integration of care for their broader patient populations. However, the initiatives fostered development of a shared mission and collaboration. Respondents...

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<td>Demonstration projects for highly targeted populations</td>
<td>“It’s the principle that got us going . . . we’re much further; we could never have had the discussions about an ACO a year ago.” —hospital leader</td>
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<td>Health information exchange</td>
<td>“The trust develops because your information is transparent . . . if all is in front of me, I’m not worried that health center X is sending a patient to [another hospital] because I know it.” —hospital leader</td>
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<td>Collaboration with health plans</td>
<td>“[The health plan] put a lot of effort in collecting really good data that’s actionable, and many of the integration changes that we’ve had have come out of pilot programs sponsored by the health plan.” —hospital leader</td>
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described these experiences as critical first steps to guide conversations around formation of an ACO.

Health information exchange. Respondents reported barriers to broad health information exchange across providers (lack of resources, threats to independence), but a few sites described benefits from a focused effort on electronic referrals to specialty care. Implementation required considerable engagement between the hospital system and health center sites and offered an opportunity for providers to gain experience in working on a shared initiative. Furthermore, respondents described information exchange as a means to increase trust.

Collaboration with health plans. Respondents also described positive experiences from quality improvement initiatives developed with Medicaid managed care plans. In one site, the health plan created a shared objective, engaged multiple providers, and provided information exchange. Managed care organizations that operate as cooperative partners may be more effective in driving integration through expertise in leadership, quality measurement, and data systems capacity. Respondents highlighted these experiences, rather than the influences of reimbursement mechanisms, as driving collaboration across providers.

DISCUSSION

Despite a common mission to care for our nation’s most vulnerable, community health centers and safety net hospitals experience conflicts over autonomy, institutional prejudices, and trust. Interviews reflected deep-seated cultural differences, even among a limited set of providers at the forefront of care integration. The findings imply that, among safety net providers, formation of networks through ACOs, CCOs, or similar arrangements will not happen overnight. As of August 2015, only 9 states had active Medicaid ACOs or CCOs, with an additional 9 states pursuing them. In addition to known regulatory and policy barriers, providers may face substantial cultural barriers. This study focused on a small set of safety net providers with a demonstrated interest in care integration. The findings may understate challenges faced by safety net providers who have no plans to integrate care or by the broader population of providers who are not deemed “safety net” providers but provide a large proportion of care to disadvantaged populations. A growing number of non-safety net ACOs are bringing in community health center partners, suggesting that traditional roles of safety net providers in these markets may be shifting. These factors may provide insights as to why, to date, only a limited number of states and organizations have pursued integrated safety net delivery systems.

Instead, study respondents cited the benefits of preliminary small-scale initiatives in overcoming fundamental obstacles to collaboration. Limited projects may not produce system transformation, but rather may lay the groundwork of creating dialogue and reorienting providers toward a shared mission. As of this writing, providers from one site (Denver) have joined a regional CCO, another site (Minneapolis) has implemented a Medicaid ACO, and yet another site (Boston) has received ACO designation. Our findings indicate that even as policymakers tackle the regulatory and finance barriers to broader system integration, we should continue to appreciate the contributions of pilot programs. These initiatives are not only a means for testing new ideas and models of care but also necessary first steps to bridge the cultural and institutional divides in a fragmented safety net.

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Contributors
J. Murphy and A. B. Bindman originated the design of the study and provided critical review of the article. J. Murphy conducted interviews. M. Ko and J. Murphy coded transcripts and analyzed major themes. M. Ko wrote the article and subsequent revisions. All authors approved the decision to publish.

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Human Participant Protection
The study design and procedures were reviewed and approved by the University...
References


