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

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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 a coordinated system, the US health care safety net comprises a disparate array of providers and services. There is a long history of efforts to integrate service delivery across inpatient and outpatient settings, but few systems have achieved success.[4] Previous studies have identified barriers related to misalignments in policy, regulations, and financing.[5–7] Even with a rapidly changing policy environment that aims to support system integration, safety net leaders cite challenges such as inadequate reimbursement, differences in governance, and disparate payment mechanisms for hospitals versus community health centers.[6]

In this study, we describe how organizational culture may also impede integration of health care safety net services. Organizational culture is "the pattern of shared basic assumptions . . . as the correct way to perceive, think, and feel, in relation to [problems of external adaptation and internal integration]."[8] In this study, we focus on the assumptions and beliefs related to external adaptation, such as organizational mission, identity, direction, and consumer orientation.[9] Although safety net providers are collectively recognized for their commitment to disadvantaged communities, they often operate as independent entities with distinct missions and ideologies. Drawing from interviews with safety net leadership in 5 US cities, we highlight conflicts in the organizational cultures between hospitals and community health centers that create a barrier to service integration, as well as initiatives that have been successful in helping them to overcome this challenge.

METHODS

We conducted interviews with executives 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. As described previously,[6] sites were selected based on national recognition as leaders in health care integration among safety net providers.[4,7,10] All sites agreed to participate, with the exception of community health center leadership from Minneapolis. The interview guide consisted of open-ended questions on integration of primary and acute care services.

Interviews lasted an average of 60 minutes and were recorded and transcribed. We supplemented transcripts with interviewer notes. Two researchers coded interview documents independently to identify themes, which they then iteratively revised and recoded until consensus was achieved on main themes.

For this study we focused on barriers to integration of services related to organizational mission and culture. Because these sites had received recognition as providers on the forefront of integration, we sought to understand which strategies had been most constructive in overcoming those barriers.

RESULTS

Respondents made general comments about the coordination challenges between inpatient and 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

Theme	Illustrative Quote
Health center identity as an independent, community-based organization	"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
	"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
Safety net hospitals as providers of last resort, not the providers of choice	"Candidly speaking . . . you might want to go to the place that doesn't have a metal detector at the door, you know." —health center leader
	"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
	"Low-income people have fewer choices. . . . I mean . . . we took them for granted." —hospital leader
	"The demand will always outstrip resources . . . the better we do, the more resources we have, the more demand we'll have." —hospital leader
Distrust between hospitals and community health centers	"The ability to truly drive change because of a truly committed common goal is not there." —hospital leader
	"The competition is coming forward. [The safety net hospitals] need to recruit patients . . . for survival, just as we do." —health center leader

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

TABLE 2—Initiatives to Overcome Organizational Cultural Barriers to Integration in the Health Care Safety Net: Perceptions of Safety Net Leaders in 5 US Cities, 2013

Theme	Illustrative Quote
Demonstration projects for highly targeted populations	"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
	"We're changing the language . . . by saying that we actually need to work together, that we are not competition, so I think that's one way of reframing the partnership framework." —health center leader
Health information exchange	"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
Collaboration with health plans	"[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

Note. The 5 US cities were Boston, MA; Denver, CO; Los Angeles, CA; Minneapolis, MN; and San Francisco, CA.

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.[11] 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.[12] 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.[13]

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.[11] 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

of California, San Francisco, Committee on Human Research.

References

1. McGinnis T, Crawford M, Somers SA. A state policy framework for integrating health and social services. *The Commonwealth Fund.* 2014;1757–14.

2. Smith VK, Gifford K, Ellis E, Rudowitz R, Snyder L. *Medicaid in an Era of Health and Delivery System Reform: Results From a 50-state Medicaid Budget Survey for State Fiscal Years 2014 and 2015.* Menlo Park, CA: Kaiser Family Foundation; 2014.

3. Shaw S, Rosen R, Rumbold B. *What is Integrated Care?* London, UK: Nuffield Trust; 2011.

4. Gabow P, Eisert S, Wright R. Denver Health: a model for the integration of a public hospital and community health centers. *Ann Intern Med.* 2003;138(2): 143–149.

5. Shortell SM, McCurdy RK. Integrated health systems. *Stud Health Technol Inform.* 2010;153:369–382.

6. Murphy J, Ko M, Kizer KW, Bindman AB. Policy levers to integrate safety net hospitals and community health centers: are they being utilized? *J Health Polit Policy Law.* 2015;40(2):403–419.

7. Perez B, Cummings L, Schrag J, Mead H, Jewers M. *Facilitators and Barriers to Providing Patient-Centered Care to Patient Populations at Risk for Health Disparities in Safety Net Settings.* Washington, DC: Essential Hospitals Institute, America's Essential Hospitals; 2013.

8. Schein E. *Organizational Culture and Leadership.* San Francisco, CA: Jossey-Bass; 1985.

9. Scott T, Mannion R, Davies H, Marshall M. The quantitative measurement of organizational culture in health care: a review of the available instruments. *Health Serv Res.* 2003;38(3):923–945.

10. Mohan A, Grant J, Batalden M, McCormick D. The health of safety net hospitals following Massachusetts health care reform: changes in volume, revenue, costs, and operating margins from 2006 to 2009. *Int J Health Serv.* 2013;43(2): 321–335.

11. Medicaid Accountable Care Organizations. *State Update.* Hamilton, NJ: Center for Health Care Strategies; 2015.

12. Lewis VA, Colla CH, Shoenherr KE, Shortell SM, Fisher ES. Innovation in the safety net: integrating health centers through accountable care. *J Gen Intern Med.* 2014;29(11):1484–1490.

13. Medicaid Accountable Care Organizations. *Program Characteristics in Leading-Edge States.* Hamilton, NJ: Center for Health Care Strategies; 2014.